

**Governing Body**

**Meeting to be held at 2pm on Thursday 26<sup>th</sup> November 2015 in the  
Board Room, Sanger House, Brockworth, Gloucester GL3 4FE**

<b>No.</b>	<b>Item</b>	<b>Lead</b>	<b>Recommendation</b>
1	Apologies for Absence	Chair	
2	Declarations of Interest	Chair	
3	Minutes of the Meeting held on 24 <sup>th</sup> September 2015	Chair	Approval
4	Matters Arising	Chair	
5	Patient's Story	Becky Parish	Information
6	Public Questions	Chair	
7	Chair's Update	Charles Buckley	Information
8	Accountable Officer's Update	Mark Walkingshaw	Information
9	Gloucestershire Living With and Beyond Cancer Programme	Ellen Rule	Information
10	Equality and Diversity Strategy	Marion Andrews-Evans	Approval
11	Devolution Gloucestershire	Ellen Rule	Information
12	Policies for approval <ul style="list-style-type: none"> <li>• Counter Fraud and Corruption Policy</li> <li>• Policy on Engagement of external and internal auditors for non-audit work</li> </ul>	Cath Leech	Approval
13	Planning 2016/17	Ellen Rule	Information
14	Performance Report	Cath Leech	Information

15	West of England Academic Health Science Network Board Report	Mark Walkingshaw	Information
16	Assurance Framework	Cath Leech	Information
17	Auditor Panel Approach	Cath Leech	Approval
18	Integrated Governance and Quality Committee Minutes	Julie Clatworthy	Information
19	Audit Committee Minutes	Colin Greaves	Information
20	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
21	Priorities Committee Minutes	Ellen Rule	Information
22	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 28 <sup>th</sup> January <b>2016</b> at 2pm in Board Room at Sanger House			

**Gloucestershire Clinical Commissioning Group  
 Governing Body**

**Minutes of the Meeting held at 2pm on  
 Thursday 24 September 2015 in the  
 Board Room, Sanger House, Gloucester GL3 4FE**

<b>Present:</b>		
Alan Elkin	AE	Vice Chair, Lay Member - Patient and Public Engagement
Mark Walkingshaw	MW	Deputy Accountable Officer
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Ellen Rule	ER	Director of Transformation and Service Redesign
Julie Clatworthy	JC	Registered Nurse
Colin Greaves	CG	Lay Member - Governance
Dr Malcolm Gerald	MGe	GP Liaison Lead
Helen Goodey	HG	Director of Locality Development and Primary Care
Dr Will Haynes	WH	GP Liaison Lead
Cath Leech	CL	Chief Finance Officer
Dr Tristan Lench	TL	GP Liaison Lead
Dr Hein Le Roux	HLR	GP Liaison Lead
Dr Andy Seymour	AS	Deputy Clinical Chair
Valerie Webb	VW	Lay Member - Business
Sola Aruna	SA	Public Health Consultant, GCC
<b>In attendance:</b>		
Zoe Barnes	ZB	Corporate Governance Support Officer
There was 1 member of the public present.		

**1 Apologies for Absence**

- 1.1 Apologies were received from Dr Helen Miller, Dr Caroline Bennett, Dr Jeremy Welch, Dr Sadaf Haque, Sarah Scott (OA in attendance), Mary Hutton, Dr Charles Buckley and Margaret Wilcox.

**2 Declarations of Interest**

- 2.1 WH, AS, and HLR declared an interest in discussions relating to the closure of St. Luke's Medical Practice as they are partners of surgeries that may be taking on patients following its closure.

2.2 WH declared an interest in item 10 as he is married to a Cancer Consultant at Gloucestershire Hospitals NHS Foundation Trust (GHT).

### **3 Minutes of the Meeting held on Thursday 30 July 2015**

3.1 The minutes were approved subject to one amendment as follows:

- Item 11.4 to read 'implementation was clear and coherent.'

### **4 Matters Arising**

4.1 **28.05.15 Agenda item 12.23 Cirencester Hospital Development Plan** – MW confirmed that the diagram to support the implementation plan had been forwarded to the Governing Body as requested. **Item closed.**

4.2 **28.05.15 Agenda item 18.5 Report from West of England Academic Health Science Network Board** - MW advised that the meeting regarding the Industry Advisory Group would be held w/c 28 September therefore an update would be given after this date. **Item to remain open.**

4.3 **30.07.15 Agenda item 9.7 Accountable Officer's Report** – MAE advised that the engagement activity plan was on the agenda for the next Integrated Governance and Quality Committee (IGQC) meeting. **Item to remain open.**

### **5 Public Questions**

5.1 There were no questions received from the public.

### **6 Chair's Update**

6.1 AS presented the Chair's report which provided a summary of the key issues arising during August and September 2015.

6.2 AS highlighted the key issues from the report which included:

- Respiratory team COPD Emergency Pathways Workshop (2.2);

- MSK team redesign programme during 2015 (2.3);
- Cancer service to be rebranded as Gloucestershire Macmillan Next Steps (2.4);
- Launch of G-care; AS also noted that a cancer video is now available on the site (2.5);
- Devolution bid for Gloucestershire now published outlining five sections, further work is to be completed over the next few months with further devolution deals to be announced in November (3);
- Winter planning underway (4);
- Meetings attended (5).

**6.3 RESOLUTION: The Governing Body noted the contents of the report which was provided for their information.**

## **7 Accountable Officer's (AO) Update**

7.1 MW presented the AO update in the absence of MH.

7.2 MW highlighted the key issues from the report which were:

- Strategy and Prevention which is an area of renewed focus for the CCG, work around obesity and diabetes were highlighted in particular (2);
- Mental health (3.1);
- Crisis concordat (3.2);
- The Dementia strategy in its final stages prior to approval and had been shared with the Governing Body members and would be forwarded for approval at the November GB meeting (3.3);
- Procurement of Commissioning Support Services – a number of issues had been highlighted and the GB were therefore requested to agree the recommendation at point 4.4. (4);
- GCCG had been accepted as the co-chair for the Severn Network alongside Proff. Johnathan Benger, for a one year term (5).

7.3 JC queried if the CSU would be able to continue to provide services beyond 31 March 2016. CL advised that the initial indication is that they would however discussions are currently taking place to confirm arrangements.

7.4 SA noted that the GCC public health team were actively involved in the work around Diabetes.

**7.5 RESOLUTION: The Governing Body:**

- **Agreed the extension to the CSU contract beyond 31 March 2016, subject to negotiation and terms and;**
- **noted the contents of the report which was provided for information.**

**8 Locality Development Plans 2015-17**

8.1 HG presented the report which provided the remaining four locality development plans for Gloucester City, Cheltenham, South Cotswolds and Stroud and Berkeley Vale. The plans for the Forest of Dean, Tewkesbury & Staunton, and North Cotswolds were presented in July 2015.

8.2 HG gave an overview of the key achievements for each locality as outlined within the report.

8.3 HG requested comments from the Governing Body (GB) on the locality development plans prior to sign off.

8.3.1 VW suggested that inter-locality working is demonstrated with regards to social prescribing within the plans. HG while advising that this was not a consistent model agreed with the suggestion.

8.3.2 AE queried what the next steps would be once the plans have been approved. HG confirmed that engagement is the next action, particularly with Patient Participation Groups (PPGs). HG also advised that information would be presented to the GB at regular intervals to report on the delivery of the plans.

8.3.3 HLR commended the Locality Development and Primary Care team for their work on the reports.

8.3.4 JC applauded the sense of ownership within the plans. JC also queried the length of the minor ailment pilot scheme within Gloucester Locality as this felt a long time. HG advised that she had contacted the medicines management team and was awaiting more information. WH advised that the reason for the

timescale may be due to Pharmacists training schedules.

8.3.5 WH suggested that copies of the plans are forwarded to every GP and practice staff for each locality. It was agreed that this would be actioned along with providing hard copies to be available within each practice.

8.4 HG confirmed that the key action for the CCG is about delivery and to get the plans out in the community amongst providers and partner organisations and to develop a cohesive engagement plan.

8.5 SA noted that the plans were clear and detailed. SA also recommended that there was room for joint working with the County Council in terms of Facts 4 Life (point 2.3.3).

8.6 **RESOLUTION: The CCG Governing Body:**

- **Noted the key achievements for 2013 – 2015 for the four locality plans presented; and**
- **provided sign off of the Locality Development plans for Gloucester City, Cheltenham, South Cotswolds and Stroud and Berkeley Vale localities.**

9 **An Approach to Planning 2015/16**

9.1 ER presented the report and document '*Approach to Planning 2015/16: Making it Happen*'. ER noted that the paper *An Approach to Planning* had been approved at the Governing Body meeting on 30 July 2015 and that this report was intended to:

- List the key dates in the 2015/16 planning round;
- Clarify the process for prioritising business cases;
- Clarify the governance arrangements.

9.2 ER highlighted the engagement calendar on page 8 and explored the key dates in Engagement, Planning and Contracting and Business Case Prioritisation and QIPP Definition.

9.3 ER described the business case approval process which aims to simplify the arrangements for prioritising.

9.4 ER discussed the draft prioritisation criteria on page 13 and

outlined the key changes, including the new criterion added. It was noted that all criteria had an equal weight of one as more testing was required to establish how criteria should be weighted and in addition, also testing around the costs per point would be conducted. ER also noted that the 'mandatory' box needs to be well thought through and the status about what is and is not mandatory needs to be clear.

- 9.5 WH advised that a common sense check is undertaken against other tests and queried what the likelihood of deliverability is in terms of sustainability. ER advised that sustainability is a requirement for the CCG to consider as part of its responsibilities and this may need to be moved from deliverability to another category. It was agreed that this should remain as part of deliverability and that workforce is also part of this aspiration.
- 9.6 In reference to the business case approval process on page 10, HLR queried if Core team will have a prioritisation matrix and how they will prioritise. It was confirmed that Core team will not be the group responsible for prioritising business cases but will check their readiness for onward approval to the Priorities Committee.
- 9.7 MGe suggested that items forwarded to the Priorities Committee (PC) need to be assessed in terms of cost issues and that a group should be identified to pick up issues. ER confirmed that a discussion would be held at the PC meeting on the 8 October regarding this.
- 9.8 JC requested that the commissioning cycle was linked to the planning cycle and included beforehand in terms of presentation within the document. ER agreed to adjust this.
- 9.9 CG congratulated ER on the production of the document and requested that Lay Members were invited to attend the Locality Executive Group meetings.
- 9.10 SA noted that it was good to see that health and equalities had been included and queried how the CCG envisages the health and equalities plan would help to deliver the *Approach to Planning* document. ER advised that the health and equalities plan was still undergoing development however she hoped that

the plan would be actively shared with the working groups e.g. Clinical Programme Groups and that these would input into how they would be working to deliver. VW supported this integration of work.

9.11 AE summarised that the report was welcomed by the GB and suggested that a recommendation was added to adopt the policy represented in principle by the paper.

**9.12 RESOLUTION: The CCG Governing Body:**

- **Noted the key planning dates;**
- **approved the business case approval process;**
- **approved the role of the groups in the planning process;**
- **approved the prioritisation matrix in principle, pending a review of weighting and its use in practice; and**
- **adopted the policy represented in principle by the paper.**

**10 Performance Report**

10.1 CL presented the Performance Report which provided an overview of the CCG's performance against the organisational objectives and national performance measures for the period to the end of August 2015.

10.2 The report was broken down into the five sections of the CCG Performance Framework as highlighted in Section 1. CL advised that a Lead Director had been assigned to respond to each area.

**10.3 Clinical Excellence**

10.3.1 MAE highlighted the key issues from clinical excellence as described within the report. The overall rating for this area was Amber for the year to date.

10.3.2 MAE advised that there was continued compliance with NICE guidance and that the Clinical Quality Review Group (CQRGs) meeting have increased to include additional meetings to take place where necessary on an adhoc basis.

10.3.3 MW highlighted the ambulance indicators on page 14 and noted

that performance continues to be achieved in terms of Red 1 and referral to treatment targets. Performance was not at a desired standard for Red 2 and Red 19 incidents. MW described the actions being taken around the ambulance service including:

- Introduction of Dispatch on Disposition
- Work to support management of demand

10.3.4 MW advised that 4 hour performance continues to be a daily area of focus for the CCG and a comprehensive recovery plan is in place which is focused on four key areas including acute bed capacity.

10.3.5 MW drew attention to emergency department four hour performance which a lot of work was focused around with the support of the System Resilience Group. MW advised that a winter modelling exercise would be taking place at Sanger House on the 25 September 2015 to begin to stress test winter plans.

10.3.6 ER discussed cancer waiting times and advised these continue to underachieve however the CCG is actively involved to seek improvement. ER advised that the 31 day target had been achieved. ER discussed work completed over the last few months including a visit from the intensive support team and a member of the PMO team from the CCG on site at GRH to provide practical support to improve administration issues. ER noted that Urology was the most challenged area noted as part of this review with diagnostic issues identified which could now be looked into and support provided. ER advised that further information would be brought to the GB regarding Urology once all work was in place.

10.3.7 ER discussed Diagnostics and noted Echocardiography as a particular issue in terms of capacity. It was advised that an active approach had been taken to train internal staff to take these roles and that a cardiology workshop had been held to look at the pathway. It was noted that the current urgent referral waiting time was around two months.

10.3.8 ER advised that there were also issues in Endoscopy and that the IBS service pathway would be available online again by December 2015.

- 10.3.9 ER added that the planned care team have been working hard at looking to locate additional capacity and advice for GPs around Diagnostics would be going onto G Care.
- 10.3.10 WH suggested that more resilience should be incorporated into the system and that horizon scanning should be undertaken. ER noted the absence of a three counties cancer network. ER advised that the Breast MDT was found to be the best during the administration review undertaken by a member of the PMO team at GHT.
- 10.3.11 WH recommended a temporary additional heading is included in the dashboard to flag up particular issues. AE queried how this would be organised in terms of who would flag it up. ER advised that highlighting issues was about looking into the services at a deeper level i.e. root cause analysis which can highlight a greater understanding.
- 10.3.12 JC queried if there is further information about the 12 hour A&E breach as outlined within page 15 of the report. MW advised that a full root cause analysis had been undertaken and that there had been problems with the administrative process. Clear lessons had been learned from the case about which the Trust were are open and appropriate changes have been made as a result.
- 10.3.13 JC also queried the Never Event referred to which was reported in July. MAE informed members that this occurred in Radiology and the patient did not suffer as a result. MAE advised that a surgical checklist was now in place.

## **10.4 Patient Experience**

- 10.4.1 MAE provided an update with regards to patient experience and highlighted the key issues including:
- The CCG will be a 'beacon CCG' for Sign up to safety
  - The CCG will continue to monitor the Friends and Family test and all providers would be participating in the National Patient Survey programme
- 10.4.2 MAE noted that Gloucestershire Care Services NHS Trust (GCSNHST) have received their final CQC report which gave

them an overall rating of 'Requires Improvement'. MAE advised that the feedback from patients regarding the quality of care was extremely positive and considered. MAE informed the GB that 2gether NHS Foundation Trust have their inspection scheduled to commence in October.

## **10.5 Partnerships and staffing**

10.5.1 MW discussed the partnerships section of the report and highlighted the key areas of positive work:

- Collaborative commissioning
- Gloucestershire Devolution bid
- Gloucestershire Strategic Forum
- Internal Joint Staff Consultative Committee

## **10.6 Finance and Efficiency**

10.6.1 CL gave an update with regards to Finance and advised that the CCG is currently on target to achieve the surplus.

10.6.2 CL drew attention to the financial risks as described at point 6.9 of the report. It was advised that there was a potential significant overspend in prescribing identified following the data received for April and June. The CCG was analysing the underlying detail to clarify the robustness of this early indication.

10.6.3 CL highlighted the pressures at GHT in elective care and noted there was a slight backlog that was impacting on the contract with the Trust. This was currently being worked through in order to meet the requirements of the Constitution.

10.6.4 CL discussed the under and over spends as outlined within the table at 6.3 of the report.

10.6.5 CL advised that there was some slippage in terms of the QIPP schemes and that delivery against the plan was currently forecast to under achieve. The CCG was constantly reviewing the QIPP position to mitigate any shortfall.

10.6.6 SA queried how assured the GB was with regards to collaborative commissioning. MW confirmed that the CCG was currently partially assured and that there was more work to do.

10.6.7 HLR noted that the GCSNHST CQC report made specific

reference to the positive leadership style of the Chief Executive at the Trust.

**10.7**      **RESOLUTION: The CCG Governing Body:**

- **Noted the performance against local and national targets and the actions taken to ensure that performance is at a high standard;**
- **Noted the financial position as at month 5;**
- **Noted the risks identified in the Finance & Efficiency report and;**
- **Noted the progress on the QIPP.**

**11**            **Assurance Framework**

11.1          CL presented the Assurance Framework (AF) and highlighted the red rated risks of which there were two:

- Q3 – Specialised commissioning transferring to NHS England leading to fragmentation of pathways;
- C6 – Non-delivery of Constitution standard for maximum wait of 4 hours within the Emergency Department.

11.2          CG advised the GB that the Audit Committee would be discussing the AF in terms of the way in which the format demonstrates assurance at the meeting scheduled on the 29 September 2015.

**11.3**        **RESOLUTION: The CCG Governing Body:**

- **Noted the paper and the attached Assurance Framework**

**12**            **Integrated Governance and Quality Committee (IGQC) Minutes**

12.1          JC presented the paper and attached minutes and highlighted the key areas of work for the IGQC including:

- Quality report
- Primary Care Clinical Audit Report
- Effective Clinical Commissioning Policies
- Risk Management
- Suicides and Attempted Suicides

**12.2**      **RESOLUTION:** The Governing Body noted the minutes which were provided for information.

**13**            **Primary Care Commissioning Committee (PCCC) Minutes**

13.1        In addition to the attached minutes, HG gave an overview of the key working areas for the PCCC as the minutes attached were from May 2015.

13.2        HG advised that the contract for St Luke's Medical Centre would cease on the 30 September and patients were being dispersed to other practices. HG noted that the CCG had set up an advice line which was still in place to assist the practices and patients with registration.

13.3        HG discussed the contract for Springbank Surgery and advised that procurement had completed and the new contract had been awarded to Church Street in Tewkesbury. HG noted that patients had been written to and PPGs were also involved in the process. The CCG was now working on transition in preparation or the new contract to commence on the 1 December 2015.

**13.4**        **RESOLUTION:** The Governing Body noted the minutes from the meeting held 7 May 2015.

**14**            **Any Other Business**

14.1        There were no items of any other business.

**15**            **The meeting closed at 3:45pm.**

**16**            **Date and Time of next meeting: Thursday 26 November at 2pm in the Board Room at Sanger House.**

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair): \_\_\_\_\_ Date: \_\_\_\_\_

## Matters arising from previous Governing Body Meetings – September 2015

Item	Description	Response	Action with
28.05.15 Agenda Item 18.5	Report from West of England Academic Health Science Network Board (WEAHSN)	<p>MH felt that further clarity was required regarding the Industry Advisory Group and what it meant for Gloucestershire. It was noted that a meeting was held in March 2015 and that the CCG were not advised of the meeting date.</p> <p><i>30.07.2015 MH advised that a meeting was being organised with the Local Enterprise Partnerships (LEPs) and WEAHSN in September 2015 regarding the Industry Advisory Group. MH agreed that she would update members following this meeting.</i></p> <p><i>24.09.2015 MW advised that the meeting regarding the Industry Advisory Group would be held w/c 28 September therefore an update would be given after this date.</i></p> <p><b>Post meeting note:</b> <i>This meeting will now take place in late November 2016.</i></p>	MH
30.07.2015 Agenda Item 9.7	Accountable Officer's Report	<p>MH drew attention to Section 6 of the report outlining engagement activities and advised that an engagement activity plan was being developed and should be available for a future Governing Body meeting.</p> <p><i>24.09.2015 MAE advised that the engagement activity plan was on the agenda for the next Integrated Governance and Quality Committee (IGQC) meeting.</i></p>	MAE



**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Gloucestershire Clinical Commissioning Group Chair's Report</b>
<b>Executive Summary</b>	This report provides a summary of key issues arising during October and November 2015
<b>Key Issues</b>	<p>The key issues arising include:</p> <ul style="list-style-type: none"> <li>• Clinical Programmes – Healthy Individuals</li> <li>• Service of Thanksgiving for the National Health Service</li> <li>• Primary Care Strategy Event</li> <li>• Clinical Programmes</li> <li>• Respiratory</li> <li>• Diabetes</li> <li>• Diabetes Footcare</li> <li>• Diabetes and Frailty</li> <li>• Musculoskeletal</li> <li>• Circulatory</li> <li>• Cancer</li> <li>• Strategic Planning and Healthy Individuals</li> <li>• Meetings attended</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	None.
<b>Financial Impact</b>	None.
<b>Legal Issues (including NHS Constitution)</b>	None.
<b>Impact on Health Inequalities</b>	None.
<b>Impact on Equality and Diversity</b>	None.
<b>Impact on Sustainable Development</b>	None.

<b>Patient and Public Involvement</b>	Not applicable.
<b>Recommendation</b>	The Governing Body is requested to note this report which is provided for information.
<b>Author</b>	Andy Seymour
<b>Designation</b>	Gloucestershire CCG Deputy Clinical Chair
<b>Sponsoring Director (if not author)</b>	

## **Gloucestershire Clinical Commissioning (GCCG) Clinical Chair's Report**

### **1. Introduction**

- 1.1 This report provides a summary of key issues arising during October and November 2015

### **2. Clinical Programmes – Healthy Individuals**

#### **2.1 Obesity**

An obesity needs assessment is currently being jointly undertaken between GCC Public Health and the CCG. The findings will be presented at a strategic, multi-agency workshop on 16th December 2015. The main aim of the workshop is to agree joint priorities to tackle obesity in the county and get sign up from partners to take individual work streams and actions forward as part of a countywide Healthy Weight partnership. This work will inform the Health & Wellbeing Board Obesity Action Card - one of five Action Cards reflecting the Health & Wellbeing Board priorities for the coming three financial years (2016/17 – 2018/19)

#### **2.2 NHS Diabetes Prevention Programme**

This national programme has been applied both by Gloucestershire individually and the South West collectively. Feedback has been received from the national programme lead as to the exceptional response received, with applications from single local authorities and CCG partnerships and from clusters of organisations operating across larger geographies. The Programme Team will now start the work on assessing all expressions of interest received and will release a further update on the 9th November.

#### **2.3 PHE Clinical Champions for Physical Activity**

PHE are funding a programme for 'GP Clinical Champions' to promote physical activity. The GP Clinical Champions programme provides peer-to-peer training by a GP with a specialist interest in physical activity through one-off education and development sessions. The aim of the clinical champions is to educate primary and secondary care doctors about the importance of physical activity and how to implement advice effectively. Dr Christine Haseler has recently been appointed as GP clinical champion for Gloucestershire.

### **3. Service of Thanksgiving for the National Health Service, Gloucester Cathedral**

- 3.1 A service of celebration for the NHS was held at Gloucester Cathedral on 21<sup>st</sup> October. This was a well-attended event, initially organised by the Gloucestershire Hospitals Trust, with contributions from individuals from the acute trust, the 2Gether Trust, South West Ambulance Trust, Gloucestershire Care Services Trust and the CCG. The theme was a reflection on the NHS of the past, present and future with the Deputy Clinical Chair speaking for a few minutes on the aspiration for the future journey. He outlined the need for courage, creativity and compassion amidst the ever increasing challenges facing the NHS.
- 3.2 This is now intended to be an annual event and the CCG will take the lead for organising next year's event.

### **4. Primary Care Strategy Event**

- 4.1 The GCCG Primary Care and Localities Team hosted an event on 5<sup>th</sup> November to start the conversation about the future of Primary Care in Gloucestershire. Primary Care, nationally and locally, is at a critical point in its history, with very real concerns about the viability and sustainability of many practices. With Dr Phil Yates, Chair of the National Association of Provider Organisations (NAPO), as guest speaker, the event generated huge interest, with over 100 primary care colleagues in attendance. The significant part of the afternoon was facilitated sessions within localities to discuss a shared vision for the future and how they could potentially coalesce to create resilience and deliver more joined up services for patients locally. As a CCG, we need to have a robust, sustainable and vibrant primary care for the future, and will be looking to support practices and localities to continue these conversations and help them develop in to new models of care.

### **5. Clinical Programmes**

- 5.1 The Service Redesign team are maintaining their keen focus on delivering pathway transformation together with health service, social care and third sector partners. Excellent progress has been made across all our clinical programmes; however on this occasion we

pleased to feature a little more detail on some key achievements in our Respiratory and Diabetes. We would like to take the opportunity to recognise the significant contribution of Duncan Thomas, who has been the managerial lead for this work. After many years of dedicated health service improvement for the people of Gloucestershire, Duncan will be leaving the CCG to pursue new career challenges in the third sector.

## **6. Respiratory**

- 6.1 Given anticipated demand pressures associated with the winter period, the focus of the Respiratory CPG has been around the development of urgent care chronic obstructive pulmonary disease (COPD) and Community Acquired Pneumonia pathways.
- 6.2 COPD – clinical representatives from acute, community and primary care providers have now completed the development of Primary Care Guidance for the Management of Acute Exacerbation. The aim was to develop intuitive and intelligible guidance (on a single page), that would support primary care healthcare professionals in making clear choices around their referral options, ensuring optimum utilisation of existing community specialist and support services and aiming where possible, to unburden both the patient and hospital of unnecessary admissions.
- 6.3 Community Acquired Pneumonia (CAP) – colleagues from ED, AEC, Rapid Response and Gloucestershire Respiratory Team have worked collaboratively in completing the development of a comprehensive suite of information to support alternative pathways and choices for those with CAP other than admission. This work includes the development of an integrated care pathway facilitating improved patient flows through ED and increased utilisation of AEC and Rapid Response as alternatives to admission; a pathway to improve more timely discharge, a patient information leaflet, ‘top tips’ for the primary care management and follow-up of CAP and the development of new antibiotic guidelines.
- 6.4 The guidance and supporting information for both COPD and CAP will be available on G-Care from early November and will be distributed widely via What’s New This Week and other locality fora. It is planned to follow up and consolidate the educational components of these

initiatives with a Respiratory Study Day in March 2016.

## **7. Diabetes**

7.1 The Diabetes Clinical Programme Group have overseen a number of projects to support primary care healthcare teams in the improvement and management of those with diabetes:

7.2 Diabetes Enhanced Service - the implementation of this service improvement and the encouraging uptake of 76 practices has resulted in:

- Practices now taking on responsibility for initiating insulin therapy following a comprehensive programme of education and mentoring
- A large number of patients with Type 2 diabetes who are stable/non-complex who previously had their ongoing care and follow-ups in hospital, being repatriated to care provided by their practice teams
- An increase in the number of patients receiving the recommended NICE 9 Care Processes

## **8. Diabetes Footcare**

8.1 The Diabetes CPG has established a Diabetes Footcare Group to oversee and implement service improvements in diabetes footcare following reported higher than national average rates of minor (lower limb) amputations; the work has also been informed by a South-West Clinical Network Peer Review of our diabetes footcare services and a Gloucestershire Healthwatch report and recommendations for Podiatry services.

8.2 The group will be responsible for developing an integrated care pathway including prevention and patient and healthcare professional education. To further support these developments, we have organised a stakeholder workshop on November 26th where patients/carers and healthcare professionals alike will have the opportunity to discuss and inform the most appropriate model of care.

8.3 The CCG has also commissioned a CQUIN to support GHNHSFT in improving their pathway of foot care for people who present with

complications arising in the main, as a result of their diabetes; it is anticipated that the funding and redesign of the pathway will result in the development of a multidisciplinary team approach which will bring significant improvements in the management and outcomes for this patient group.

## **9. Diabetes and Frailty**

- 9.1 The Diabetes CPG has been working collaboratively with Ian Donald to develop local guidance to support primary and community healthcare teams in the management of diabetes in frailty given the increasing evidence regarding the relative risks and benefits of treatment of diabetes in older people. Frail older people with diabetes are at a marked increase in risk of adverse effects of treatments including hospital admission, and are less likely to benefit from the long-term benefits of good glycaemic control. There is therefore a need for local guidance on achieving a balance in controlling both blood pressure and glycaemia in this context.
- 9.2 The guidance which will be uploaded on G-Care will be distributed via What's New This Week in November as well as being 'soft launched' at the forthcoming Diabetes Interest Group meeting scheduled for the 18th November.

## **10. Musculoskeletal**

- 10.1 The MSK team have directed an extensive redesign programme during 2015. Following a stakeholder event on 15th September a new MSK Service Model has gained the endorsement of key partners and decision makers. A suite of Service Specifications are now being prepared for the range of pathways including: Physiotherapy, Interface Services, Pain Services, Orthotics, Podiatry and Orthopaedics.
- 10.2 For Falls and Bone Health progress has been made with service improvement work, including gaining support for a business case to build community capacity for proactive prevention and the development of a pilot with the Gloucestershire Fire and Rescue Service addressing Winter Social Isolation. A successes workshop for Fractured Neck of Femur was held on 15th October and a recommendations report is being developed.

## **11. Circulatory**

11.1 The CPG led a service walkthrough and workshop to review service improvement for Cardiology. During October recommendations have been set out with a proposed work plan for programme of work to address the pathways for Heart Failure, Atrial Fibrillation, Chest Pain, Hypertension and Outpatient Clinics. Improving Acute Stroke Care a high priority and the team continue to give close attention and support to the ongoing action plan, including the appointment of 2 additional therapists and revising the emergency scanning pathway. Working in collaboration with the Academic Health Science Network we have progressed the Don't Wait to Anti-Coagulate Project, the first training sessions have been well attended and 50% of practices are signed up to participate.

## **12. Cancer**

12.1 The Macmillan Next Steps Project : our team have been working with Macmillan Cancer Support, Gloucestershire Care Services, Prostate Cancer UK and other key partners on the development of an innovative pilot for community based cancer survivorship support. Plans are now agreed for the launch and recruitment has now begun for a small specialist team of Allied Health Professionals.

12.2 On the 30th September 2015 the Cancer CPG hosted our first Gloucestershire Cancer Summit, with over 150 participants this recapped on Early Diagnosis Education Programme and introduced the Gloucestershire Living With and Beyond Cancer Programme. The CCG's work on Cancer Diagnosis Significant Event Audits (SEAs), incorporated in the primary care offer, has been recognised by the RCGP as part of a national quality improvement programme. Our first joint workshop with the RCGP was held on 19th October, with an excellent attendance this reinforced the systematic use of SEAs within primary care. Our Macmillan GP Masterclass series continues with a Haematology event on 11th November 2015, when we will be joined at Sanger House by a multidisciplinary team of GHNSFT specialist and about 70 Gloucestershire GPs.

12.3 The team continues to build on the successful launch of G-Care. This on-line resource provides all Gloucestershire GPs with vital information about our local health services and support for patients. A

Coordinator has now been appointed in the planned care team to maintain and develop the content as being up-to-date, comprehensive and useful for our primary care colleagues.

### **13. Strategic Planning and Healthy Individuals Update**

13.1 We are currently engaging with key partners, providers and stakeholders on the refresh of the CCG 5 year plan and response to the 5 Year Forward View. An engagement event with a wide range of stakeholders was held at Sanger House on 22nd October. Further engagement events include workshops on the 18th November with the VCS Alliance and on 1st December with the membership of HealthWatch.

13.2 The CCG, working with the Forest Locality Executive Group, has initiated a review of community health and care services in the Forest of Dean. The aim of the project is to develop a plan for delivering high quality and affordable community health and social care services to the people of the Forest of Dean which meet their needs now and in the future, and is developed with patients, the public and our key partners. The review will encompass all community services in the Forest of Dean including those within the community hospitals. We are currently engaging with community groups and health and care professionals in the Forest of Dean. We will be developing options for public consultation in spring/summer 2016.

13.3 The Healthy Individuals Programme Group are finalising their 3 year delivery plan. This has identified prevention, workforce expertise, information and advice and patient led approaches as key areas of work. A range of projects are currently underway:

- Our review of self-management education programmes is now complete and we have developed a new service model. A business case is currently being developed as part of the CCG planning round. This will include a proposal to increase the level of online support and offer an increased number of courses for the Expert Patient Programme. The new service model is being shared at Clinical Programme Group meetings for comment and discussion.
- The CCG has been working with the West of England Academic

Health Science Network on their Diabetes Digital Coach Programme. The 'digital diabetes coach project' is a grant based programme inviting providers to test out innovative solutions to support people who already have diabetes to better self-manage. Two Providers have been identified by the Diabetes CPG to pilot their products in the county

- We are continuing to roll out Florence phase two. Training days were held in September and a range of organisations across primary and community care attended. Florence is currently being trialled in community specialist teams (diabetes) and the independent living centre (telecare). Work is ongoing to increase take-up within primary care.
- During July and August the CCG invited Arts and Culture organisations to apply for funding via the cultural commissioning grant programme. The aim of the grant programme is to test out opportunities for arts and culture interventions to support health and wellbeing outcomes for participants. The CCG received a total of 24 applications and awarded grants to six of the nine projects open to the VCSE arts and culture sector. Clinical Programme Groups will now work alongside clinicians, lay members and the VCSE to co-develop appropriate and effective service models.
- Active Gloucestershire was recently informed that it has been successful in securing a development grant in order to develop a social investment model to increase levels of physical activity across areas in Gloucestershire. The CCG, GCC and Sport England have all been identified as potential commissioners.

#### **14. Meetings attended by the Deputy Clinical Chair**

- 8<sup>th</sup> October – Health and Well-being Board Extraordinary Meeting, Shire Hall
- 13<sup>th</sup> October – Service of Thanksgiving for the National Health Service, Gloucester Cathedral
- 22<sup>nd</sup> October – Joining Up Your Care – Five Year Forward View Engagement Event
- 27<sup>th</sup> October – Gloucestershire Healthy Weight Partnership, Shire Hall

- 4<sup>th</sup> November – Gloucestershire Hospitals Trust Council of Governors, Cheltenham
- 5<sup>th</sup> November – Primary Care Strategy Event, Hatherley Manor
- 11<sup>th</sup> November – NHSCC Annual Members Event and Dinner, Manchester
- 12<sup>th</sup> November – NHSE Commissioning System event, Manchester

## **15. Recommendation**

15.1 This report is provided for information and the Governing Body is requested to note the contents

**Agenda Item 8**

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Gloucestershire Clinical Commissioning Group Accountable Officer's Report</b>
<b>Executive Summary</b>	This report provides a summary of key issues arising during September, October and November 2015
<b>Key Issues</b>	The key issues arising include: <ul style="list-style-type: none"> <li>• Strategic Estates Plan</li> <li>• Development of the IM&amp;T Roadmap</li> <li>• ASAP Winter Campaign</li> <li>• Urgent Care</li> <li>• Update on Learning Disability Services</li> <li>• Transport Update</li> <li>• Meetings attended</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	None.
<b>Financial Impact</b>	None.
<b>Legal Issues (including NHS Constitution)</b>	None.
<b>Impact on Health Inequalities</b>	None.
<b>Impact on Equality and Diversity</b>	None.
<b>Impact on Sustainable Development</b>	None.
<b>Patient and Public Involvement</b>	Not applicable.
<b>Recommendation</b>	The Governing Body is requested to note this report which is provided for information.
<b>Author</b>	Mary Hutton
<b>Designation</b>	Gloucestershire CCG Accountable Officer
<b>Sponsoring Director (if not author)</b>	

## **Gloucestershire Clinical Commissioning (GCCG) Accountable Officer's Report**

### **1. Introduction**

1.1 This report provides a summary of key issues arising during September, October and November 2015

### **2. Strategy Estates Plan**

2.1 The Department of Health wrote to CCGs in the summer requiring them to produce a local estate strategy to ensure that the local NHS:

- fully rationalise its estate;
- maximise use of facilities;
- delivers value for money; and
- enhances patients' experiences.

2.2 The CCG is working with NHS Property Services and partners to develop a draft estates strategy including the primary and community estates within Gloucestershire by the end of December. The CCG work stream on primary care premises will feed into the overall estates strategy. The estates strategy will be developed further in as the CCG takes forward and refreshes its five year strategy, Joining Up Your Care, in each locality. Further updates will be brought to future Governing Body meetings.

### **3. Development of the IM&T Roadmap**

3.1 The National Information Board (NIB) is tasked with setting the strategy for data and technology in healthcare. The NIB has published "Personalised Health and Care 2020" which sets out a series of proposals to transform the way information is used with the following priority domains which are intended to become programmes that will help transform health and care services through data and technology:

- enable me to make the right health and care choices;
- give care professionals and carers access to all the data they need;
- make the quality of care transparent;
- build and sustain public trust;
- bring forward life-saving treatments and support innovation and

growth;

- support care professionals to make the best use of data and technology; and
- assure best value for taxpayers and open up existing infrastructure.

This is with a view that by 2018 all urgent and emergency care records will be paper free and by 2020 all health and care records will be paper free.

3.2 The process for each area is to be led by CCGs to ensure that roadmaps are aligned to wider service development in the health and care community. The stages are:

- confirm a footprint detailing the partners and the governance arrangements to drive the local plan;
- providers baseline and benchmark using a new digital maturity self-assessment tool;
- a local Digital Roadmap, a plan as to how a local health and care community will be paper free at the point of care by 2020, is developed; and
- the community take forward and review and refresh the local plan as required.

3.3 Gloucestershire CCG has proposed a local footprint covering Gloucestershire and including the providers and GP practices. It is envisaged that this may need to be reviewed in the future as services develop. There is a County-wide IM&T Steering Group and it is proposed that this Group, with a slightly revised membership, is used to drive the development of the roadmap. The Group includes members from Gloucestershire Hospitals NHSFT, Gloucestershire Care Services NHST, 2Gether NHSFT, Gloucestershire County Council, South West Ambulance NHSFT, County-wide IT Services and the CCG and is chaired by a CCG Governing Body GP. It is proposed that a lay representative is included in future.

The IM&T roadmap will form part of the CCG's operational planning process for 2016/17 and the draft will form part of the CCG's operational plan.

## 4. ASAP Winter Campaign

4.1 The NHS in Gloucestershire launched its Winter ASAP (Choose Well) public information earlier this month.

The campaign targets adults and parents of young children with advice on what to do if they are ill or injured and are unsure where to turn.

The promotional material encourages them to check out the **A**pp, **S**earch the website, **A**sk NHS 111 or pop in to their local **P**harmacy for advice.

The ASAP website and App allows users to 'Search by Service' or 'Search by Condition' – providing a step-by-step guide through symptoms, self-care and signposting to the appropriate NHS service/s if this is needed.

Users can also find opening hours and service location information, including distance from home.

Local people are encouraged to add the website [www.asapglos.nhs.uk](http://www.asapglos.nhs.uk) to their favourites list and download the App free from the App store (ASAP Glos NHS).

4.2 The campaign is part funded by GDOC and includes:

- features and adverts in local Media titles and web banners on media sites;
- radio advertising;
- targeted Facebook advertising – mix of linked ads to ASAP App download and the website and awareness ads e.g. Pharmacy, Community Minor Illness and Injury Units, GHAC;
- promotion for ASAP twitter 'follow' and Facebook 'like' sign up;
- collateral in public places including GP surgeries, pharmacies and hospitals;
- ASAP Mailer to all households in Gloucestershire;
- bus advertising (interior and exterior); and
- Information Bus tour to multiple locations across the county (also promoting the 'Stay Well this Winter campaign).

## **5. Urgent Care**

- 5.1 The Urgent Care Team have worked with provider and NHS England colleagues to finalise the Winter Resilience and Escalation Plan. This includes agreed commissioner and provider actions during periods of system pressure
- 5.2 As part of the plans, the Ambulatory Emergency Care service has now extended opening hours on the Gloucestershire Royal Hospital site to 10pm, with the aim of assessment, diagnosis, treatment and discharge the same day – avoiding the need for a hospital admission.
- 5.3 GHNHSFT have received confirmation from Monitor of the closure of the investigation into 4 hour performance. A comprehensive action plan is in place and will continue to be closely monitored.
- 5.4 The formation of the Severn Urgent and Emergency Care Network, with Gloucestershire as the co-chair has taken place during the Autumn, early work has focussed on undertaking a network wide stocktake of current urgent/emergency care provision, examination potential models of integrated clinical hubs and further developing the role of the Directory of Services.

## **6. Update on Learning Disability Services**

- 6.1 This month I wanted to provide a fuller update on the important work the CCG is undertaking in relation to Learning Disability Services which we commission in partnership with the local authority.
- 6.2 The key drivers for commissioning activities within the field of Learning Disabilities are as follows:
- the Commissioning Strategy of the CCG- Joining Up Your Care. In this strategy the broad nature of community based services for people with a learning disability is laid out; and
  - the need for services to be close to home, inclusive and to tackle health inequalities is paramount.
- 6.3 The national agenda - The national agenda is currently being driven by several parameters which will drive our ambitions over the next year. These are namely:

- Transforming Care - following Winterbourne there is a need to ensure care for those with the most complex and challenging needs is being delivered in the local community. Placing people out of county must be minimised and new opportunities developed to ensure that Assessment and Treatment beds are used for only the highest needs and for the shortest possible time;
- Tackling Health Inequalities - there is a national aspiration to ensure that the learning from the health indicators for people with a learning disability are appropriately tackled and the use of health care plans and health checks increased;
- The Confidential Inquiry into the Deaths of people with a Learning Disability made a number of nationally agreed recommendations. These need to be rigorously planned for and followed up on;
- Employment - the NHS has agreed to ensure it is a model of leadership in employing people with disabilities. Initiatives and opportunities must be sought to ensure people with a learning disability can find themselves as part of our workforce;
- Integration with social care - the national agenda demands and invites local commissioners to seek every opportunity to integrate work between the various aspects of health and social care. This asks local commissioners to ask themselves whether they are truly joined upon and whether there are further avenues for integration which need to be sought; and
- Devolution - the county has plans to capitalise up on the opportunities presented by central government in the devolution proposals being followed.

6.4 Each of the forces which drive the local and national agendas identified above have been considered in the formulation of the following commissioning activities undertaken within the Community Commissioning Team. These strategies converge into a number of key actions:

#### 6.4.1 Transforming Care

1. The redevelopment of Hollybrook and Westridge has provided us with the opportunity to meet a number of agendas. In this redevelopment the number of Assessment and Treatment beds will be minimised to what is entirely essential.
2. Board: Work with the Out Of County Board will continue in order

to facilitate the return of those people placed from out of county. Best practice commissioning practices will be followed to ensure this is done within agreed procurement standards and employs the established brokerage system including the Complex and Challenging Behaviour joint framework.

3. Under the auspices of the Out of County board a Priority Placement Committee is being established to keep track of all future potential out of county placements and to recommend alternative arrangements.
4. The newly integrated Learning Disability Intensive Support Service will require continuing support and guidance in order to ensure its successful embedding in current front line practice. An evaluation report by NDTI is just being completed. Within the next year CCG commissioners will review the report and will conjointly review the service specification with council and children's commissioners to see whether changes are necessary and to put those changes into place as necessary.
5. Challenging Behaviour Strategy: as a major contributor to the Challenging behaviour strategy the CCG commissioners will provide leadership and support to the Strategy, including co-chairing all meetings and actively participating and contributing to each Community of Practice session.

#### 6.4.2 Health Inequalities

1. A robust commissioning plan will be developed by the CCG to tackle the issue of health inequalities. This will be presented to the Governing Body and will be thorough in the analysis of all health inequalities and all resulting actions that will be necessary.
2. A reference group containing service users, family members and carers will act as a reference group for this work. This group could be the existing Health Action Group. They will review the work planned by the CCG and offer advice on whether they find it comprehensive and results oriented.
3. Health Checks and Health Action Plan indicators will be reported

at each Learning Disability Partnership Board and an update on progress provided.

#### 6.4.3 The Confidential Inquiry into the deaths of people with a Learning Disability

1. A CCG led review of the CIPOLD report will be made and actions to be performed by commissioners will be listed under each action and each recommendation. The CCG review report will be endorsed by the LD Partnership Board and following their endorsement will be taken to the Governing Body for approval.
2. A Commissioner led death review panel will be established in line with national guidelines. The responsible commissioner will report back on a quarterly basis to the CCG and the LD partnership board on the number of fatality reviews completed and the learning that has emanated from those reviews. The framework and context for this will be taken to the health and Well Being Committee for approval and sign off.

#### 6.4.4 A Review of the Community Learning Disability Teams (CLDTs) operated through 2gether

1. A report on the CLDTs has now been concluded.
2. The report is now in the hands of senior managers who are synthesising the results and discerning next steps.
3. A summary report will be issued.
4. The senior management group will liaise with commissioners on the need to re-write service specifications based on the learning from the experience and from a consideration of other issues.

#### 6.4.5 Furthering the Integration Journey

There is a need to respond to the continuous call for further work on the Integration Agenda with Social Care. In order to further this integration these additional steps will be taken:

- The efforts to ensure a joined up social care and health

provisions will be furthered by establishing a fully integrated joint commissioning team.

- An Integrated High Needs team has been approved by the Joint Commissioning Executive Committee. This fits with the Transforming Care Agenda and will ensure joined up planning with the highest needs people and direct linkages to LDISS.
- The new Joint Commissioned frameworks will be used to ensure all CCG contracts are set at the best value rate. A comparator study will be performed by CCG commissioners along with their council counterparts to ensure contract payments are fully aligned and represent best value.
- The Joint Funding Project will be completed with the full cooperation of the CCG and will deliver planned efficiencies.

#### 6.4.6 Employment for people with learning disabilities

Consistent with the NHS guidelines the CCG is spearheading a move to ensure there are people with a learning disability employed in NHS services. Commissioning Intentions include the following activities in the next year:

- A learning disabled intern working within the CCG.
- A continuation of using 'experts by experience' as Quality Checkers for health related services.
- The exploration of using the 'social value' option within existing contractual frameworks to encourage employment of people with a learning disability in current provision.
- Support to the newly created Forwards Employment team, noting that Gloucestershire is a leader in the employment of people with a learning disability and intends to maintain its excellence in this area.

## 7. **Transport Update**

7.1 The CCG is working closely with Gloucestershire County Council who have been awarded £350,000 (one of 37 successful bids nationally) from the Department for Transport to look at Total Transport solutions in Gloucestershire.

7.2 The project is designed to improve user experience and efficiency of

rural transport networks to improve economic growth and reduce rural isolation by integrating transport across health, home to school, social care, public bus services and voluntary and community car schemes, to enable greater efficiency and an improved network. The £350,000 is not intended to fund services, but to find ways to embed new ways of working so that solutions are cost effective and sustainable beyond the two year project.

7.3 Health transport is a theme in all 37 national bids but there are significant number of projects which currently do not have support from their local CCGs or (Patient Transport Service) PTS Providers. We see the potential for integration, reducing costs and improving services for patients and GCCG has been engaged from the start of the Gloucestershire project. Our Non-Emergency Patient Transport Provider, Arriva Transport Solutions Ltd is also involved. Our patient transport lead was invited to provide the CCG perspective at the Total Transport North Group conference in York last month where the Under Secretary of State for Transport outlined the importance attached by the Department of Transport and the DoH to the Total Transport initiatives. GCCG and Wiltshire CCG have jointly organised a national Patient Transport Study Day for CCGs to be held at Warwick University on 12th November where all things relating to patient transport, including Total Transport, will be discussed. Recommendations from this event will be shared with the DoH who will be sending a representative on the day.

## **8. Meetings attended**

8.1	29-Sep	GSF Forward Planning Workshop
	30-Sep	Commissioning in Healthcare Conference, London
	1-Oct	Quarterly Localities CCG Chairs
	6-Oct	Lay Members Interview
	8-Oct	Gloucester health & Well Being Extraordinary Meeting, Shire Hall, Gloucester
	21-Oct	Service of Thanksgiving for The National Health Service in Gloucester, The Cathedral
	22-Oct	Joining Up Your Care – Our Five Year Forward View Workshop
	26-Oct	2gether CQC Presentation, Hallmark Hotel, Gloucester
	29-Oct	Leadership Gloucestershire, Shire Hall, Gloucester
	2-Nov	Gloucestershire Care Services AGM

3-Nov Health & Care Overview Scrutiny Committee, Shire Hall  
5-Nov Gloucester Health & Well Being Board Provider  
Engagement Meeting, Shire Hall  
11 Nov NHSCC National Event, Manchester  
18-Nov CCG & Healthwatch Gloucestershire Quarterly Partners  
Meeting, Gloucester  
18-Nov VCS Engagement Event, Gloucester

## **9. Recommendation**

9.1 This report is provided for information and the Governing Body is requested to note the contents.

**Agenda item 9**

**Governing Body**

<b>Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Report Title</b>	<b>Gloucestershire Living With and Beyond Cancer Programme</b>
<b>Executive Summary</b>	<p>The Gloucestershire Living With and Beyond Cancer Programme is a transformational service redesign project addressing an increasing population health need.</p> <p>Our Strategy reflects national guidance and best practice, with a locally innovative approach for patient education and support in the community.</p> <p>Our goal is to improve patients' health and wellbeing outcomes whilst making sustainable use of hospital services.</p> <ul style="list-style-type: none"> <li>• System partners are supporting a new model of care that invests in supported self-management, which will reduce the need for routine outpatient appointments.</li> <li>• Together we are leading a shift towards promoting recovery, health improvement and addressing the after-effects of cancer treatment - both physical and psychological.</li> <li>• The transformation is being enabled by a development partnership with Macmillan Cancer Support.</li> </ul>
<b>Key Issues</b>	<p>Our flagship pilot project 'Macmillan Next Steps' is about to launch with Gloucestershire Care Services in January 2015.</p> <p>GHNHSFT are working towards introducing the Cancer Recovery Package and the design of risk-stratified follow up pathways for Breast, Colorectal and Prostate Cancers.</p>

	For primary care, the Macmillan GP Education Programme is incorporating key learning on supporting patients Living With and Beyond Cancer.
<b>Risk Issues:</b>  <b>Original Risk</b> <b>Residual Risk</b>	Key risks identified regarding workforce, the long-term financial model, service sustainability and the project interdependencies. See section 9 for full details.
<b>Financial Impact</b>	This is a primarily a quality improvement project.  Macmillan funding is enabling service redesign and testing, providing the opportunity to develop a sustainable model of care. In due course a full strategic business case will be presented to the Governing Body, followed by an evaluation of the pilot projects to inform long-term commissioning decisions.
<b>Legal Issues (including NHS Constitution)</b>	No significant legal issues - CCG Contracting colleagues engaged in project development work.
<b>Impact on Health Inequalities</b>	A more systematic model of care will improve the equity of recovery support in the county. Also, our community focus will help reduce health inequalities by ensuring improved access to interventions to enhance health and wellbeing improvement and long-term health outcomes.  An Equality Impact Assessment has been completed for Macmillan Next Steps and will also be progressed for other strands of the programme.
<b>Impact on Equality and Diversity</b>	Consideration has been given to the service design, location and communications in order to support a positive impact on equality and diversity issues. As above, assessments have been completed or are in progress.

<b>Impact on Sustainable Development</b>	Community based and self-managed care will reduce travel to some county level centres.
<b>Patient and Public Involvement</b>	<p>The programme has a Communication and Engagement Strategy and Action Plan.</p> <p>A range of stakeholder events and a public meeting have been held during the scoping phase. Also, the Cancer CPG Lay Champion has led the formation of the CCG's Cancer Patient Reference Group, which advises on key developments, engagement and communication. Patient representatives have attended design workshops. Going forward our work will include service co-design and specification of patient experience and quality measures. A range of cancer patient stories have been used to open GP education events.</p>
<b>Recommendation</b>	<p>This paper is primarily for information, and sets the context for future decision making papers.</p> <p>The Governing Body is invited to:-</p> <ul style="list-style-type: none"> <li>• endorse the high-level Model of Care;</li> <li>• recognise the launch of the 'Macmillan Next Steps';</li> <li>• encourage the project teams in their continued efforts; and</li> <li>• formally thank Macmillan Cancer Support for their generous support.</li> </ul>
<b>Author</b>	Kathryn Hall
<b>Designation</b>	Associate Director – Clinical Programmes
<b>Sponsoring Director (if not author)</b>	Ellen Rule Director of Transformation and Redesign

**Agenda Item 9**

**Governing Body**

**Thursday 26<sup>th</sup> November 2015**

**Gloucestershire Living With and Beyond Cancer Programme**

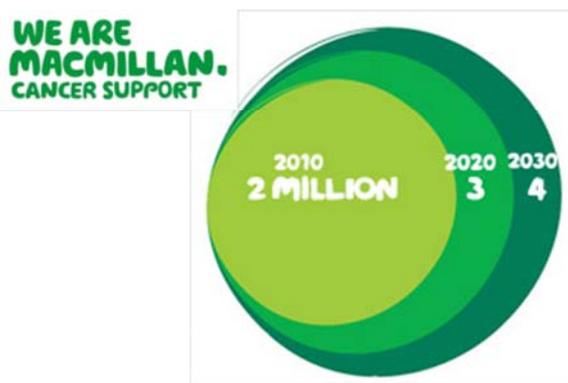
**1 Introduction**

- 1.1 Gloucestershire CCG's Cancer Clinical Programme Group is pleased to report on the progress against one key priority: improving the health and wellbeing outcomes and for people following cancer treatment in the county.
- 1.2 The Gloucestershire Living With and Beyond Cancer Programme formally launched in December 2014. It is a transformational service development as we shift our approach to enabling patients in recovery to be active partners, adopting supported self-management and health improvement.
- 1.3 This paper provides a brief summary of key drivers for change and how we are collaborating with partners across the health system to deliver the transformation. We especially acknowledge the pivotal strategic guidance and generous funding we have gained from Macmillan Cancer Support.
- 1.4 The paper also sets out our high-level model of care and provides an update on progress during this first year of the design and development phase.

**2 Health Trends – the changing face of cancer**

- 2.1 Cancer is a significant burden on the health of our population: it is the leading cause of death in county and cancer incidence is rising. With age being the most foremost factor in developing the disease there will be a significant impact on the rapidly aging population of our county.

- 2.2 It is estimated that 40% of cancers are related to preventable causes such as smoking, obesity, alcohol consumption and lack of physical exercise. Adopting a healthy lifestyle is important for the whole population, especially including those living beyond a cancer diagnosis.
- 2.3 However the good news is that due to improvements in cancer early diagnosis and treatment more people are surviving cancer. In April 2014 Cancer Research UK published the significant analysis that now 50% of people diagnosed with cancer in 2010-11 are predicted to survive for 10 years or more.
- 2.4 These large-scale trends have led Macmillan Cancer Support to predict that nationally the number of people surviving cancer will double from 2010 to 2030.



As of the end of 2010, around 18,700 people in Gloucestershire were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 36,400 by 2030.

- 2.5 However cancer and its treatment is a gruelling experience and as a result at least 1 in 4 people suffer significant long-term ill health, both physically and psychological. A Macmillan patient survey reported that approximately half of people in need of health or social support after treatment found a deficit in the support available.

### 3 Strategic Context

- 3.1 The **National Cancer Survivorship Initiative (NCSI)** was established in 2007 as a partnership between the Department of Health, Macmillan Cancer Support and NHS Improvement. The NCSI

promoted a strategic shift towards promoting recovery, care planning, supported self-management, managing the consequences of treatment and improving patient experience. Pilot sites were established across the country, building evidence of best practice. In March 2013 the NCSI published a landmark report **Living With and Beyond Cancer**. Key recommendations inform our Gloucestershire programme including the implementation of risk-stratified pathways for follow-up and the use of the Cancer Recovery Package, which comprises: Holistic Needs Assessments (HNA), Care Plans and Treatment Summaries.

3.2 In October 2014 NHS England's **Five Year Forward View** included a range of specific plans for the development of cancer services which included support for initiatives to bring cancer care closer to home and endorsing the wider use of the Cancer Recovery Package.

3.3 The new national cancer strategy **Achieving World Class Cancer Outcomes a Strategy for England 2015-2020** includes a number of key recommendations on improving the quality of life after treatment including:-

- Ensuring people are supported and have their needs met, including managing the late effects of disease or treatment.
- Commissioning of services to incorporate using the Cancer Recovery Package across all sites, and to implement risk-stratified follow-up now for breast cancer and for two other sites by 2020.
- Improving integration across primary, secondary and social care.
- Development of screening and services for cancer related depression.

3.4 Locally our work is guided by Gloucestershire's **Joining Up Your Care** strategy as we seek to deliver integrated planning and service delivery. We are also actively responding to Gloucestershire's **People and Place** model with our current service redesign across the community.

#### 4 **Service Transformation – applying the Clinical Programme Approach**

4.1 As a broad reaching transformation project we are applying the CCG's

Clinical Programme Approach to guide our programme development.

4.2 In working through the programme management cycle some of the key activities for the project have been as follows:-

<b>Programme Management Cycle</b>	
Review, Analysis, Planning	<ul style="list-style-type: none"> <li>• Population health trends and wider pathway analysis highlight cancer survivorship as priority, with review of best practice.</li> <li>• Programme initiation with a wide range of stakeholder events including patients, carers, community partners and clinicians.</li> <li>• Cancer CPG sub-group established, – Living With &amp; Beyond Cancer Steering Group, support planning, co-ordination and collaboration. Project Initiation Document agreed.</li> <li>• Formation of a Cancer Patient Reference Group.</li> </ul>
Programme and Project Design	<ul style="list-style-type: none"> <li>• Project teams for workstream.</li> <li>• Design workshops for new care pathways.</li> <li>• Broad engagement new community based services and person-centred models to shift to prevention and self-management.</li> <li>• Integrated business case to ensure a long term sustainable model of care. (in development)</li> </ul>
Deliver	<ul style="list-style-type: none"> <li>• Change management plans – focusing on communication, clinical education and test &amp; learn.</li> <li>• Innovative use of CQUINs and pilot project initiatives support delivery of development phase prior to full commissioning of new pathways.</li> </ul>
Evaluate	<ul style="list-style-type: none"> <li>• Formative and summative evaluation plans to measure benefits and direct future commissioning decisions (in development)</li> </ul>

## 5 High-level Model of Care

- 5.1 The Living With & Beyond Cancer Steering Group have agreed the follow project aim: *A cancer diagnosis is a life changing event and every person will have their individual needs for care and support and their own person experience. We aim to create a sustainable and joined up change to ensure the best outcomes for our population and to enable people to live well with and beyond cancer.*
- 5.2 The transformation of the whole patient pathway is delivered by partners across the system collaborating on a set of core projects.

These are shown in the high level model of care below:-



The components are all interdependent in contributing to the final realisation of improved outcomes. For example to introduce risk stratified follow up it is essential that the patient has been able to be involved in holistic needs assessment and an education programme in order for them to be supported into self-management.

- 5.3 The rationale of the Strategic Business Case for the programme is based on quality improvement, enhanced health outcomes and building a sustainable model of care. The evidence of the NCSI shows that the traditional model of annual follow-up appointments is not especially effective in picking up the recurrence of cancer. Significant system savings can be made by shifting to models of remote

monitoring. This enables investment in measures to support education, adoption of healthy lifestyles and support for people suffering from the consequences of cancer treatment.

## **6 Project Components – objectives and progress to date**

### **6.1 Holistic Needs Assessments and Care Plans**

Holistic Needs Assessments (HNA) – this begins with a wide ranging questionnaire during treatment, patients have the opportunity to discuss important issues, fears and problems – whether these be physical, emotional, spiritual or financial. Our first step is to ensure all patients have the opportunity to participate in at least one HNA during their active treatment, but in due course repeat assessment maybe helpful for some patients later in the pathway.

Care Plan – in partnership with a Cancer CNS patients develop a plan to manage their personal needs through treatment and recovery; this will include signposting to third sector organisations. Patients with a care plan will complete their treatment readier to self-manage and with more of their support and recovery needs identified.

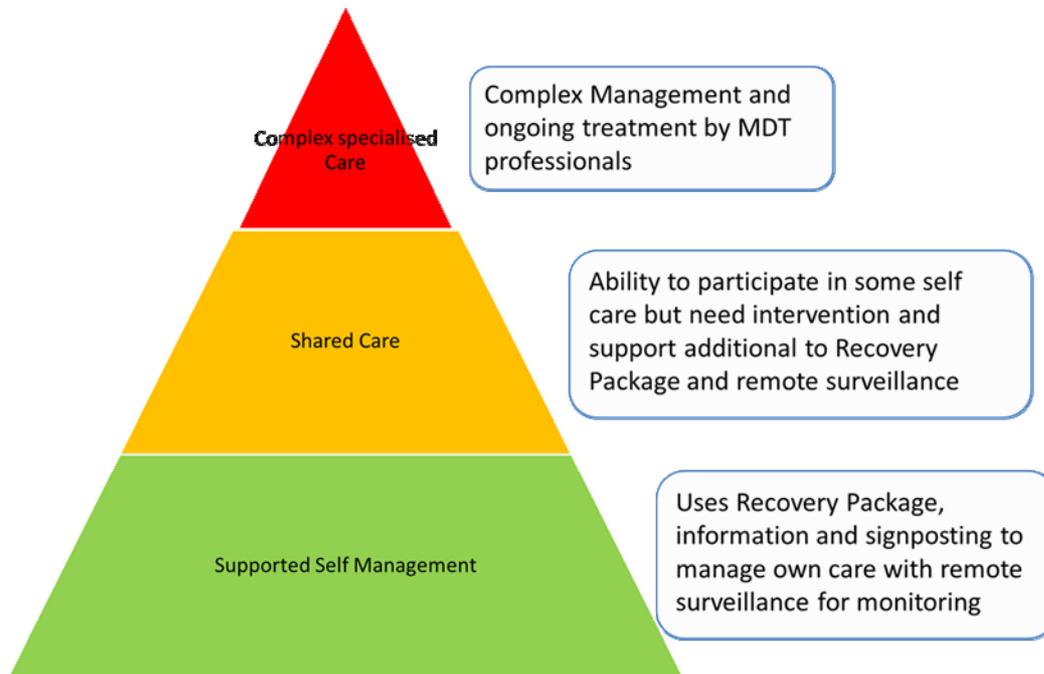
#### **Progress to date:**

- GHNSFT multi-disciplinary teams have agreed the use of the Holistic Needs Assessment (HNA)
- A clinical training programme has commenced
- Use of the HNA is being piloted by each team and the progress is being piloted.

### **6.2 Needs Based Follow Up Pathways (risk stratified pathways)**

This is the process of identifying the following up pathways that is most clinically appropriate for a patient following treatment. There are typically 3 classifications of risk stratified follow up:-

- Supported self-management
- Shared care
- Ongoing Hospital Care for complex cases.



The work of the NCSI pilot sites indicated that for some of the most common cancers that support self-management is appropriate for the majority of patients:-

Breast	77%
Colorectal	45%
Prostate	36%

Patient surveys indicate that people prefer being in control and enabled if they know the right support in place, i.e. the recovery package, education and access to support to overcome after-effects.

**Progress to date:**

- High-level design workshops for the Breast, Colorectal and Prostate pathways completed Summer 2015
- Detailed development of full pathway proposals informed by patient involvement is now a key priority for the forthcoming months.

**6.3 Treatment Summaries**

Treatment Summaries – national teams have been focussing on how communication could be improved between hospital clinicians and primary care. Many GPs report issues in both picking out key points

within extensive correspondence and concerns when relevant information is not communicated. The Treatment Summary will provide GPs and patients with succinct information in a simple standardised format.

**Progress to date:-**

- Format and content of documents developed in workshops with secondary care clinicians, GPs and patient representatives.
- Operational delivery plan in development.

## 6.4 Macmillan Next Steps

**Gloucestershire Macmillan Next Steps** aims to improve health and wellbeing outcomes after cancer treatment and to help people to make behavioural changes that prevent cancer recurrence or development of other health conditions.

We are taking an innovative community based approach. The team will include a range of allied health professionals, a nurse specialist and health trainers. Macmillan Next Steps provides:-

- 1:1 clinical services to address the consequences of cancer.
- Group support and education with a programme of interventions to encourage self-management, resilience and the adoption of healthy lifestyles and physical activities.
- Education for community based health professionals on cancer rehabilitation.

Macmillan Next Steps is being piloted in Gloucester City and North Cotswold, and will take referrals from hospital on discharge or directly from GPs.

**Progress to date:**

- Scoping and design phase completed.
- Service specification agreed with provider partner Gloucestershire Care Services.
- Recruitment commenced for clinical team and health trainers.
- Launch scheduled for January 2016.

## Key components of Macmillan Next Steps:-



## 6.5 Primary Care Development

The prime focus of this work is to raise the profile of best practice cancer recovery clinical practice with Gloucestershire GPs, enabling them to deliver high quality care and support for patients and their families. Key objectives are to:-

- Promote the introduction of Treatment Summaries to support joined up care.
- Enhance the use of the GP cancer reviews.
- Ensure best practice cancer recovery and knowledge around symptom control
- Promote well informed referral to supporting community services.

**Progress to date:-** The Macmillan GP Masterclass series is the

key mechanism for developing primary care knowledge and awareness, enhanced by the use of the G-Care on-line information platform. So far the cancer team have run 13 successful educational covering a range of cancer sites.

## **7 Development Partnership with Macmillan Cancer Support**

7.1 This is a wide-reaching programme that requires a significant investment in workforce resources to plan and lead improvement and also to build clinical and support team capacity in the system. As a health community we are fortunate in having developed a strategic partnership with Macmillan Cancer Support. We are benefitting from both their specialist expertise on national best practice and a range of generous grant agreements.

7.2 Some of the key programme developments that are now being supported following successful bids to Macmillan include:-

- **Macmillan Next Steps** – in 2014 the CCG secured a major grant for the development of an innovative community based pilot. Two exceptional allied health professionals with leading expertise in cancer survivorship were appointed to job share the role of Clinical Project Lead. In 2015 the funding level was increased to enable extended patient education programmes to a total value of £750K. The operational phase commences in January 2016 for a 20 month period. The project leads are being seconded to Gloucestershire Care Services as Consultant Allied Health Professionals to lead the build the new team.
- **Macmillan GP** (Dr Sadaf Haque) Gloucestershire's first Macmillan GP facilitator started in this strategic development and education role in 2013, initially for a 3 year period and further year's extension to this key role has been agreed.
- **Holistic Needs Assessment** - Health Psychologist GHNHSFT secured a 2 year post to support the project delivery and clinical education support for Holistic Needs Assessments.
- **Macmillan Project Manager** – 2 year role GHNHSFT post supporting the project planning and delivery of risk stratified follow up and the Cancer Recovery Package.

- **Adoption of CCG Project Manager** – the CCG funds this permanent post in the Service Redesign team; however “adoption” offers post holder specialised professional development and access to educational funds to support ongoing GP Education Programme.

## 8 Commissioning Approach

- 8.1 **Secondary Care** - A CQUIN for 2015/16 has been agreed with GHNHSFT which supports service development and early implementation. A second year CQUIN is proposed to support the second year of delivery. To embed the new pathways the CCG is exploring appropriate longer term contractual models and will be considering the recommendations of the South West Strategic Clinical Network for Cancer.
- 8.2 **Community Services** – our model of care for patient education, 1:1 recovery support, self-management and onward signposting is highly integrated with our developing model for Integrated Community Teams. Macmillan Next Steps is commissioned to Gloucestershire Care Services as a development project within a contract variation. The project evaluation will inform a longer term commissioning decision.
- 8.3 **Primary Care** – The new model of care will increase the level community based support for patients once they have returned to primary care. Primary care already holds a significant responsibility for management of patients following cancer treatment. Careful analysis will be undertaken on any detailed options for pathway change, so that potential service changes are appropriately reviewed and agreed.

## 9 Headline Programme Risks

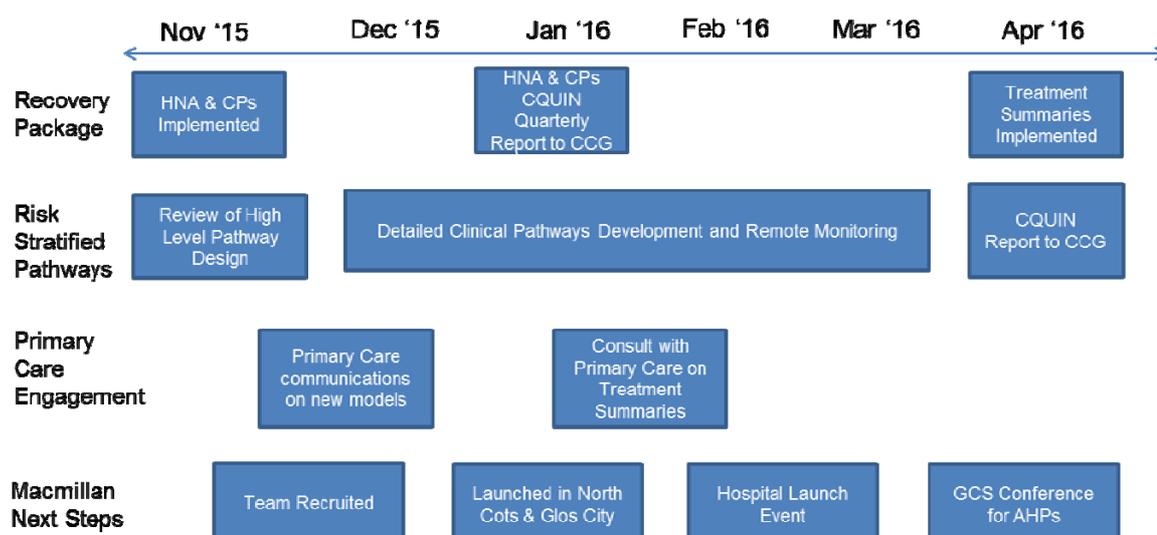
The programme holds a detailed risk register, key headlines are as follows:-

Risk	Mitigating Action
<b>Workforce</b> - capacity of project management and clinical leads to effect change at pace.	Partnership with Macmillan is providing key resource and CQUIN seeks to enable

	contributing clinical leads.
<b>Financial Model</b> – risk that we may be able to deliver sufficient transformation to fund a long term sustainable model.	Development work on the strategic business case, close reference to national best practice, focus on robust evaluation.
<b>Sustainable Services</b> – risk that if we fail to deliver redesign current model is unsustainable given rising demand.	Ensure current and future requirement addresses in strategic business case.
<b>Project Interdependencies-</b> the model is dependent on the delivery of a range of projects with partners across the system.	Project Steering Group formed to support aligned delivery and cooperation across the project.

## 10 Next Steps – programme timeline

The component projects all have detailed project plans, co-ordinated by an overarching Project Initiation Document for the programme. Below is a high level diagram of the next steps for the project over the forthcoming months:-



## 11 Recommendations

The Governing Body is invited to:-

- endorse the high-level Model of Care;
- recognise the launch of the 'Macmillan Next Steps';
- encourage the project teams in their continued efforts; and
- formally thank Macmillan Cancer Support for their generous support.

### Appendices

- Information leaflet on Macmillan Next Steps

## Why did Macmillan Next Steps come about?

- Improved support after cancer treatment can deliver significant patient benefits in terms of improved quality of life. It can also encourage behaviours that prevent recurrence of cancer or acute presentations back to the NHS<sup>1</sup>
- The growth in demand for cancer services has had a significant impact on capacity and has created pressures within the health system. Continuing as we are is not sustainable and we are not meeting patients' holistic needs. A lack of attention of these issues may result in poorer quality of life for patients, increased pressure on family and inefficient use of scarce health resources<sup>1, 2</sup>

## How does it work?

A multidisciplinary team of cancer specialists including Allied Health Professionals and a Nurse Specialist will support people affected by breast, prostate and colorectal cancer by delivering:

- 1:1 community based clinical service to address the consequences of cancer and its treatment
- Group support and a programme of interventions to encourage self-management, resilience and the adoption of healthy lifestyles and physical activity
- Health professionals education programme around the rehabilitation and support needs of people living with and beyond cancer

## What are the Next Steps?

- The Macmillan Next Steps Team will be recruited and in post early 2016.
- The group support programme and health professionals education will start in early 2016
- The team will visit all General Practices in the project localities of North Cotswolds and Gloucester City over the winter months to provide detail about the service and referral procedures

## What is the Aim?

Holistically support and empower people living with and after breast, prostate and colorectal cancer to take an active role in their health and care to:

- Prepare for their transition into supported self-management
- Promote recovery and reduce recurrence by keeping as healthy as possible
- Create sustainable and coordinated change to ensure the best outcomes



**MACMILLAN**  
**NEXT**  
**STEPS**

## Approaches to Care

To address these support and sustainability needs in Gloucestershire, Macmillan Next Steps is based on:

- Person-centered care: Using shared decision making, our aim is to deliver a coordinated service that is tailored and responsive to individual's needs and values
- Value-based: To achieve the best value for money, we aim to evaluate, understand and respond to what people affected by cancer need and want. We aim to deliver the support that they need (and no less)<sup>3</sup>

### References

1. Independent Cancer Taskforce. Achieving world class cancer outcomes 2015-2020. 2015
2. Macmillan cancer Support. Throwing Light on the Consequences of Cancer and its treatment. 2013
3. The Kings Fund, People in Control of Their Health and Care. 2014

NHS Gloucestershire Clinical Commissioning Group, Macmillan Cancer Support, Gloucestershire Care Services NHS Trust and Gloucestershire Hospitals NHS Foundation Trust and others are working together to improve:

- The way in which people with cancer are supported after they have finished their treatment, both in hospital and when they have returned home.
- The way in which people with cancer are supported in their communities after they have finished their treatment.

Macmillan Cancer Support has provided more than one million pounds to support a complete transformational change in Gloucestershire cancer services over the next three years.

Please contact Macmillan Next Steps Co-Leads/Consultant Cancer Allied Health Professionals for more information:

Nikola Hawkins – [nikki.hawkins@nhs.net](mailto:nikki.hawkins@nhs.net)

Sara Mathewson – [sara.mathewson@nhs.net](mailto:sara.mathewson@nhs.net)

**WE ARE  
MACMILLAN.  
CANCER SUPPORT**

If you have any questions about cancer, need support, or just want to chat – even if there's something on your mind not mentioned on this leaflet – please don't hesitate to get in touch.

 Call the Macmillan Support Line free on 0800 808 00 00 (Monday to Friday, 9am-8pm) or visit [macmillan.org.uk](http://macmillan.org.uk)

 You can also join our online community at [community.macmillan.org.uk](http://community.macmillan.org.uk) to chat online with people who are going through similar experiences.

**WE ARE  
MACMILLAN.  
CANCER SUPPORT**



**A new, innovative project supporting people living with and beyond cancer in the North Cotswolds and Gloucester City Communities from January 2016.**

Gloucestershire Care Services NHS Trust,  
NHS Gloucestershire Clinical Commissioning Group  
and Gloucestershire Hospitals NHS Foundation Trust

**Agenda item 10**

**Governing Body**

<b>Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Report Title</b>	<b>Strategy for Promoting Equality and Valuing Diversity, 2015 – 2018</b>
<b>Executive Summary</b>	This three year strategy is for all CCG staff. It sets out how we will ensure that equality is embedded in all aspects of our commissioning. It also establishes our commitment as an employer to ensure that staff have equal access to career opportunities and receive fair treatment in the workplace.
<b>Key Issues</b>	<p>An Action Plan is attached to the strategy, which focuses on how we intend to deliver the CCG equality objectives (previously agreed as part of the CCG authorisation process):</p> <ul style="list-style-type: none"> <li>• to develop a fresh strategy and action plan for promoting equality, diversity, human rights, inclusion and reduction in health inequalities including the implementation of the revised Equality Delivery System (EDS2);</li> <li>• to increase awareness of the importance of promoting equality/ reducing health inequalities agenda within the CCG and across member practices;</li> <li>• to improve quality of, and accessibility to, the demographic profile of Gloucestershire by protected characteristics and identify variations in health needs to enable staff to undertake meaningful equality impact analysis on the work as it develops; and</li> <li>• support staff to put equality/reduction in health inequalities at the heart of the commissioning cycle.</li> </ul> <p>The Action Plan will be reviewed on an annual basis.</p>

<b>Risk Issues: Original Risk Residual Risk</b>	n/a
<b>Financial Impact</b>	n/a
<b>Legal Issues (including NHS Constitution)</b>	The Strategy recognises our commitment to, and legal obligations under: <ul style="list-style-type: none"> <li>• the Equality Act 2010 and Public Sector Equality Duty;</li> <li>• Health and Social Care Act 2012;</li> <li>• Human Rights Act 1998 and the FREDA principles;</li> <li>• Convention on the Rights of the Child;</li> <li>• NHS Constitution; and</li> <li>• NHS Workforce Equality Standard</li> </ul>
<b>Impact on Health Inequalities</b>	Equality Impact Assessment completed
<b>Impact on Equality and Diversity</b>	Yes – Equality Impact Assessment completed
<b>Impact on Sustainable Development</b>	No
<b>Patient and Public Involvement</b>	GCCG staff, provider organisations and community partners have been invited to comment on the draft Strategy. A table of feedback and the action taken in response to this is included in Appendix 4 of the Strategy.
<b>Recommendation</b>	The Integrated Governance and Quality Committee recommend that the GCCG Governing Body approve the Strategy for Promoting Equality and Valuing Diversity and its respective Action Plan.
<b>Author</b>	Caroline Smith
<b>Designation</b>	Senior Manager, Engagement & Inclusion
<b>Sponsoring Director (if not author)</b>	Marion Andrews-Evans

**Gloucestershire Clinical Commissioning Group  
Strategy for Promoting Equality and Valuing Diversity  
2015 - 2018**



*A strategy for promoting equality*

# Strategy for Promoting Equality and Valuing Diversity 2015 – 2018

## Contents

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## Appendices

Appendix 1: Equality Action Plan

Appendix 2: Our legal obligations in relation to Equality, Diversity and Human Rights

Appendix 3: The NHS Equality Delivery System 2 (EDS2)

Appendix 4: Feedback summary

## 1. Introduction

- 1.1 NHS Gloucestershire Clinical Commissioning Group (GCCG) is responsible for planning and buying (commissioning) health services to meet the needs of local people. We are a membership organisation of all local GP practices from across seven localities of Gloucestershire. We bring our clinical knowledge of patient care to look at how services are planned and how the patient's journey through care can be improved.
- 1.2 Our mission is to “commission excellent and modern health services on behalf of the NHS for all people in Gloucestershire through effective clinical leadership, with particular focus on patient safety and continuous improvements in the patient experience”.
- 1.3 Our Constitution includes a commitment to “focus on clinical benefit and health outcomes” and sets out how we will fulfil our statutory duties under the Public Sector Equality Duty.
- 1.4 This strategy is for all staff of the GCCG. It is our expectation that all staff will take responsibility for promoting equality; commissioning accessible services that respond to the diverse needs of communities in Gloucestershire. The strategy also establishes our commitment as an employer; to ensure staff have equal access to career opportunities and receive fair treatment in the workplace.
- 1.5 In the context of this strategy, the following definitions apply:
- Equality is ensuring individuals, or groups of individuals, are treated fairly and provided with equity of access and opportunity.
  - Diversity aims to recognise, respect and value people's differences, creating an environment or culture where everyone can participate and thrive.
  - Health inequalities are differences between people or groups due to social, geographical, biological or other factors, resulting in them experiencing poorer health and/or shorter lives.

- 1.6 The Integrated Governance and Quality Committee is responsible for overseeing equality and diversity compliance within GCCG and throughout its work. To provide the committee with the assurances it needs to discharge these responsibilities, an Equality and Health Inequalities Working Group<sup>1</sup> has been established.
- 1.7 GCCG is committed to upholding the NHS Constitution and, specifically in relation to equality, diversity and human rights, the principle which requires us to provide “a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marital or civil partnership status”.
- 1.8 We recognise that Gloucestershire has a diverse population and that individuals may have multiple identities which can cut across more than one protected characteristic; e.g. we all have an age and a racial identity. Some of our characteristics may change over the course of our lives, e.g. we may acquire a disability, some of us may change our religion.
- 1.9 In light of this, GCCG is committed to understanding the needs of our diverse community and our aim is to treat everyone as an individual, with dignity and respect, in accordance with their human rights.

## **2. Equality Objectives**

- 2.1 This strategy sets out how we will ensure that promoting equality and valuing diversity is embedded in the planning, commissioning and delivery of local health services. It also recognises our commitment to, and legal obligations under, the Equality Act 2010 and Public Sector Equality Duty; Health and Social Care Act 2012; Human Rights Act 1998 and the FREDA<sup>2</sup> principles; Convention on the Rights of the Child; NHS Constitution and NHS Workforce Equality Standard (a synopsis and references for further reading on each of these is included in Appendix 2).

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<sup>1</sup> Further information on the role of this group is included in Section 9: Monitoring and Evaluation. The Terms of Reference are available at <http://www.gloucestershireccg.nhs.uk/about-us/equality-diversity/>

<sup>2</sup> FREDA - There are five principles of human rights which are: fairness, respect, equality, dignity and autonomy, called the FREDA principles, which also form part of the NHS Constitution.

2.2 We are keen to build upon the work that has already been undertaken since GCCG was established in 2013. GCCG has adopted the following Equality Objectives:

- To develop a fresh strategy and action plan for promoting equality, diversity, human rights, inclusion and reduction in health inequalities including the implementation of the revised Equality Delivery System (EDS2).
- To increase awareness of the importance of promoting equality/ reducing health inequalities agenda within the CCG and across member practices.
- To improve quality of, and accessibility to, the demographic profile of Gloucestershire by protected characteristics and identify variations in health needs to enable staff to undertake meaningful equality impact analysis on the work as it develops.
- Support staff to put equality/reduction in health inequalities at the heart of the commissioning cycle.

2.3 An action plan, included as Appendix 1, sets out how GCCG will ensure that these objectives are met.

### **3. Equality in engagement - 'Our open culture'**

3.1 Our aim is to ensure that 'quiet voices' are heard and that we are recognised as 'commissioners on the ground'. 'Our Open Culture' – a strategy for engagement and experience, promotes 'Equality' and working in 'Partnership' and the desire to enable 'Anyone and Everyone' to have a voice. It sets out how, as a CCG, we ensure engagement activity is embedded in the culture of our organisation.

3.2 The work of GCCG is underpinned by listening to the voices of patients, carers, the public and staff, to ensure that we develop inclusive services that meet the needs of our local population. This includes working with partner organisations across health and social care to establish a better understanding of the diversity across the county.

3.3 Good patient and public engagement is vital in providing insight into the needs of our local communities<sup>3</sup>, fostering good relationships and reducing discrimination and health inequalities. The intelligence we gather through inclusive engagement activity informs our commissioning, locality work and procurement.

#### **4. Equality in commissioning**

4.1 We have adopted an integrated and holistic approach to understanding the health care needs of Gloucestershire's population, commissioning services to meet these needs. We have developed a strong clinical and multi-professional focus with significant member engagement and meaningful involvement of patients, carers, staff and the public in all our work. Health outcomes and patient experience are therefore key considerations in all our commissioning decisions.

4.2 Reducing health inequalities is viewed as a key factor in all our decision-making, with particular regard to the nine protected characteristics as outlined in the Equality Act 2010: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation. Our aim is to include equalities considerations as an integral part of commissioning business and not as an after-thought.

4.3 Partnership working with colleagues in Public Health, Gloucestershire County Council, the Health and Wellbeing Board, and other statutory/non-statutory bodies will increase our understanding of the needs and diversity of our local communities. Our commissioning is informed by the Joint Strategic Needs Assessment<sup>4</sup> (JSNA) for Gloucestershire and other relevant research and policy. The Health and Wellbeing

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<sup>3</sup> Our local communities include groups of people who share a common interest, geographical location, one or more protected characteristic, or who have traditionally been referred to as "seldom heard". A fuller explanation is included in *Our open culture* <http://www.gloucestershireccg.nhs.uk/feedback/gccg-engagement-and-experience-strategy/>

<sup>4</sup> The Joint Strategic Needs Assessment (JSNA) is a strategic planning tool which brings together the latest information on the health and wellbeing of people who live in Gloucestershire and people who use Gloucestershire public services. Further information is available at <http://jsna.gloucestershire.gov.uk/Pages/home.aspx>

Strategy<sup>5</sup> and Health Inequalities Plan (currently being developed by Public Health) will underpin our service development and design.

4.4 GCCG has adopted a Clinical Programme approach to developing and improving health and care services across Gloucestershire. This approach brings together:

- clinical input from across primary, community and secondary care;
- information and statistics from local needs assessments;
- insight from patient experience and engagement;
- and service specific /financial data

to provide a clear picture of the current situation and projections of future need, ensuring that we develop, deliver and maintain robust health care services.

4.5 An Equality Impact Assessment (EIA) is undertaken to assess the impact of service review, design and delivery and ensure our services are non-discriminatory. The EIA also identifies particular communities who may be disadvantaged by any proposals for change and allows us to target our engagement activity, support and information to help mitigate against this risk. Our governance arrangements ensure that an EIA is integral to our service review and project management procedures.

4.6 We work with provider organisations to ensure that access to health services is equitable across Gloucestershire. Contracting arrangements enable us to ensure that, as a health community, we are working together to reduce health inequalities in the county.

4.7 We work with voluntary and community sector (VCS) organisations, in particular network organisations such as the VCS Alliance and Healthwatch Gloucestershire, to ensure that the assets and diversity of our communities informs local developments in services.

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<sup>5</sup> An overview of the Gloucestershire Health & Wellbeing Strategy 2012 - 2032: Fit for the future is available at <http://www.gloucestershire.gov.uk/CHttpHandler.ashx?id=56736&p=0>. The Health Inequalities Plan is currently being developed by Public Health, Gloucestershire County Council.

## **5. Equality in Locality Development**

- 5.1 The county of Gloucestershire covers a diverse range of populations, from the very deprived to the very affluent, from people living in very rural areas to people living in one of two large urban areas where there are a significant number of immigrant populations. This leads to a countywide population with very different health and social care needs, spread over a large geographic area.
- 5.2 In recognition of the need to understand and represent these differences, GCCG has formed seven localities. The Locality Executive Group in each of these areas work to:
- Provide vital intelligence for GCCG on local health needs and the reality of services on the ground;
  - Lead local service developments, ensuring strong links with the local community; and
  - Support two way engagement – communicating with GP practices and ensuring practices input into the work of GCCG;
- 5.3 Each locality has an annual Development Plan which describes the specific health needs of their population and sets out how the Locality Executive Group will lead work to meet these needs and reduce variation in health outcomes compared with other localities in the county.

## **6. Equality in Procurement**

- 6.1 Our Procurement Strategy<sup>6</sup> sets out our commitment to the principles of public procurement, ensuring our procurement activities are transparent, equitable, and non-discriminatory.
- 6.2 Equality assessments form a key part of our evaluation and decision making processes throughout the procurement of services. Our specification and tender

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<sup>6</sup> Our Procurement Strategy for the Purchase of Health Care Services and other relevant documentation, can be found on the GCCG website at <http://www.gloucestershireccg.nhs.uk/about-us/procurement/policy-and-document-library/>

documentation incorporate specific requirements relating to equality duties. The evaluation of all bids assesses the strategies and working practice that bidders have in place relating to these duties.

- 6.3 The NHS Standard Contract, which is applicable to all providers of NHS services, includes the requirement for providers to ensure their services are non-discriminatory. Under this Contract the Provider must comply with the obligations contained in the Equality Act 2010 the Human Rights Act 1998.
- 6.4 From April 2015, the Contract also requires providers to implement the Equality Delivery System 2 (EDS2) and Workforce Race Equality Standard (WRES).
- 6.5 Our quality and contracting teams ensure continuing compliance with specific equality duties throughout the lifetime of any contract awarded.

## **7. Equality in Primary Care**

- 7.1 NHS England has delegated authority to GCCG for the commissioning of GP primary care. Our role includes ensuring that GP primary care services for Gloucestershire improve health outcomes and take account of the diversity of our local communities. We will undertake a health needs assessment to help determine the GP primary care needs of the local population and inform our commissioning of future services.
- 7.2 Through our Primary Care Commissioning Committee, governance arrangements are in place to ensure that our community has access to high quality, effective and safe primary care services.
- 7.3 We will ensure that GP primary care services are fully accessible to all. Location, availability of services and quality of GP estates are central to fulfilling this requirement. GCCG will provide access to, and contract management of, a Translation and Interpretation Service for all of our local GP practices and support to ensure compliance with the requirements of the Accessible Information Standard, published in July 2015.

## **8. Equality in our workforce**

8.1 We respect and value the diversity of our workforce and are committed to:

- making best use of the range of talent and experience available within our workforce and potential workforce;
- supporting our workforce through learning and development, recruitment and succession planning;
- ensuring that our legal obligations are fulfilled.

8.2 As an employer, we will support our staff to undertake training and development to ensure that there is a high level of awareness of equality issues. Our mandatory training for all staff includes specific modules on equality and diversity. Our induction process underpins our zero tolerance of bullying and harassment.

8.3 We will adhere to equality principles across all the protected characteristics within the recruitment, retention, development and management of our workforce and take measures to ensure that any opportunity for discrimination is minimised. GCCG's employment policies contain an equality dimension throughout and core policy user guides provide specific advice for managers in relation to implementing the policies in a positive manner and line with discrimination law. GCCG is supported in monitoring and reporting compliance; ensuring policy and practice is up-to-date and applied without prejudice by our Commissioning Support HR and Equality/ Diversity Service.

8.4 Transparent and fair recruitment practice is key to GCCG's approach to managing employment opportunities and our Recruitment Policy and Temporary Promotion Policy provides guidance for managers with regards to overall process. GCCG is a Two Tick Disability Symbol User which means applicants with a disability are guaranteed an interview if they meet the minimum criteria for the post and are supported to attend interview and remain in work with the use of reasonable adjustments. All employment opportunities are advertised on the NHS Jobs website which facilitates an anonymised shortlisting process whilst actively and confidentially monitoring the diversity of our staff. Objective selection criteria are used to select staff and the decision-making process is recorded to demonstrate that appointments

are made on merit. GCCG adheres to the NHS Employment Check Standards, which ensures that appropriate checks are made prior to appointment and the information gathered is managed sensitively and in accordance with the Data Protection Act and Equality Act 2010.

8.5 We will comply with the legal requirements of the Workforce Race Equality Standard, initially seeking to improve the collection and understanding of the data in relation to our workforce. Systems are in place to monitor and report on compliance against the standard.

8.6 We will use the results of our annual staff survey to monitor equality issues, identify areas for action and evaluate the initiatives such as Time to Change and other support mechanisms available to our staff.

## **9. Monitoring and Evaluation**

9.1 The Integrated Governance and Quality Committee is responsible for overseeing equality and diversity compliance within GCCG and throughout its work. To provide the committee with the assurances it needs to discharge these responsibilities, an Equality and Health Inequalities Working Group has been established.

9.2 The purpose of the Equality and Health Inequalities Working Group is to ensure that GCCG is meeting its strategic objectives regarding avoidable health inequalities, diversity, human rights, and the establishment of a single equalities scheme. It will do so by actively promoting equality and supporting partnership working to reduce health inequalities across Gloucestershire.

9.3 GCCG will ensure that the equality performance of all providers is monitored alongside overall contract management. This will include implementation of contractual and legislative requirements such as EDS2, WRES and the Accessible Information Standard.

- 9.4 Our monitoring and evaluation work of both GCCG's equality performance, and that of our providers, will be informed by engagement with our local communities. Implementation of EDS2 will play an integral part in this work.
- 9.5 Every January, GCCG publishes an Annual Report which demonstrates how we fulfill our obligations under the Public Sector Equality Duty (PSED). This includes examples of good practice from across Gloucestershire.

Appendix 1: GCCG Equality Action Plan

Appendix 2: Our legal obligations in relation to Equality, Diversity and Human Rights

Appendix 3: NHS Equality Delivery System 2

Appendix 4: Feedback summary

Date approved: 22 October 2015, Integrated Governance and Quality Committee,  
Gloucestershire Clinical Commissioning Group  
(tentative) 26 November 2015, Governing Body, Gloucestershire  
Clinical Commissioning Group

Review Date: September 2017

Gloucestershire CCG Equality Objectives and Action Plan April 2015 – March 2018 (subject to annual review)

Action	Details	Outcome	GCCG Lead	Target completion date
<b>Objective 1 - To develop a fresh strategy and action plan for promoting equality, diversity, Human Rights, inclusion and reduction in health inequalities including the implementation of the revised Equality Delivery System.</b>				
i. Produce an equality strategy and action plan	To inform staff and local stakeholders of how the CCG will promote equality and value diversity.	<p>An agreed strategy and action plan will be published on the CCG website.</p> <p>The action plan will be subject to ongoing monitoring by the Integrated Governance and Quality Committee. A full review will be undertaken on an annual basis to ensure that the CCG is responsive to changes in:</p> <ul style="list-style-type: none"> <li>• relevant legislation; and</li> <li>• the changing needs of our local communities.</li> </ul>	Equality and Health Inequalities Working Group	November 2015

Action	Details	Outcome	GCCG Lead	Target completion date
ii. Formally adopt and implement EDS2 as a tool to monitor and audit our performance against equality objectives.	<p>Using the stepped approach outlined in the NHS England guidance (refer to Appendix 4), the CCG will undertake a full assessment and grading of its performance against the eighteen goals and outcomes of EDS2.</p> <p>Helps to meet our duties under the Public Sector Equality Duty and the NHS Constitution.</p> <p>Develop best practice by integrating equalities/health inequalities considerations in day to day business.</p>	<p>An initial assessment and grading of our performance against the goals and outcomes of EDS2 is completed.</p> <p>Key priorities for development in 2016/17 are identified.</p>	Senior Manager, Engagement & Inclusion	March 2016

Action	Details	Outcome	GCCG Lead	Target completion date
<b>Objective 2 – to increase awareness of the importance of promoting equality/reducing health inequalities within the CCG and across member practices</b>				
i. Ensure that consideration of equality and diversity is taken into account in our decision-making processes.	<p>Raise awareness with staff and member practices by delivering regular briefings/training and development sessions as required. Equality and diversity forms part of the mandatory training package.</p> <p>Supports integration of equalities and diversity into day to day business. Helps to meet legal and regulatory requirements.</p>	<p>Staff within GCCG and member practices become more aware of why equality in provision and health outcomes is important.</p> <p>Revision of GCCG Equality Impact Assessment process will include a number of staff briefing sessions.</p>	Senior Manager, Engagement & Inclusion	<p>Subject to annual review and informed by EDS2.</p> <p>March 2016</p>
ii. Ensure that staff use the GCCG Equality Impact Assessment (EIA) process as a planning tool and consider equalities and health inequalities issues at all stages of the commissioning cycle.	<p>A review of the EIA framework.</p> <p>Demonstrate legal compliance with the Public Sector Equality Duty and other regulatory requirements.</p> <p>Open and transparent decision-making meeting legal and regulatory requirements developing best practice and improving performance.</p>	GCCG carries out robust EIA and uses the information to support its decision-making.	Senior Manager, Engagement & Inclusion	Subject to annual review as part of Public Sector Equality Duty (PSED) reporting process.



Action	Details	Outcome	GCCG Lead	Target completion date
v. Compliance with Workforce Race Equality Standard (WRES)	<p>The WRES, introduced in April 2015, requires NHS organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.</p> <p>Milestones for WRES reporting include:</p> <ul style="list-style-type: none"> <li>• 1<sup>st</sup> July 2015 – Publication of data (as at 1<sup>st</sup> April 2015) including identification of essential shortcomings.</li> <li>• April 2016 – Baseline data for comparison with April 2015 should be completed including steps underway to address shortcomings in data, or significant gaps between treatment and experience of white and BME staff.</li> </ul>	<p>Submission and publication of data using WRES template.</p> <p>Submission of comparison data as at April 2016</p>	Equality and Health Inequalities Working Group	<p>July 2015</p> <p>April 2016</p>

Action	Details	Outcome	GCCG Lead	Target completion date
vi. Increase targeted engagement with local communities of interest.	<p>Explore new mechanisms to ensure good engagement with specific communities of interest, eg. localities, health conditions, or protected characteristics/vulnerable groups.</p> <p>This could include the active promotion of equality and health inequalities issues.</p> <p>It is envisaged that these concepts would be tested with stakeholders as part of the engagement and assessment process for implementation of EDS2.</p>	<p>Local engagement recognises and responds to the diversity of our communities of interest.</p> <p>Representatives from across our diverse communities contribute to the assessment process and development of an action plan for EDS2.</p>	Equality and Health Inequalities Working Group	July 2016

Action	Details	Outcome	GCCG Lead	Target completion date
<b>Objective 3 - To improve quality of and accessibility to demographic profile of Gloucestershire by protected characteristics and identify variations in health needs to enable staff to undertake meaningful equality impact analysis on the work as it develops.</b>				
i. Work in partnership to develop accessible information and resources on health outcomes for specific communities in Gloucestershire	<p>Better understanding of the health needs of different protected groups and subsequent development of services to meet these needs</p> <p>Information is available via the JSNA and Health Inequalities Plan, overseen by Public Health.</p> <p>Raise staff awareness of this information to ensure it supports commissioning decisions.</p>	<p>GCCG demonstrates a good understanding of the health needs of its population by different protected characteristics and vulnerable groups. We commission appropriate services, informed by local engagement.</p> <p>Clinical Programme Groups utilise needs assessments and local sources of information (e.g. JSNA) to inform service design. EIA demonstrate consideration of equality issues.</p>	Equality and Health Inequalities Working Group	Subject to annual review as part of PSED reporting process.
ii. Develop resources on specific health conditions and their incidence for different protected and vulnerable groups.	GCCG is working in partnership with others e.g. Public Health, to develop easy to access information and resources on health variations among specific communities in Gloucestershire	<p>Easy to access resources are readily available to inform day to day commissioning.</p> <p>Public Health is actively involved in all Clinical Programme Groups and provide condition specific needs assessments.</p>	Clinical Programme Leads	Examples of good practice will be included as part of PSED reporting process.

Action	Details	Outcome	GCCG Lead	Target completion date
<b>Objective 4 - Support staff to put equality/reduction in health inequalities at the heart of commissioning cycle.</b>				
i. Develop reporting processes to ensure provider organisations are compliant with equality duties.	<p>With effect from 2015/16 the NHS Standard Contract requires providers to</p> <ul style="list-style-type: none"> <li>• implement EDS2; and</li> <li>• implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing that standard.</li> </ul>	Processes in place to monitor compliance with equality duties for all providers	Senior Manager, Engagement & Inclusion	December 2015
ii. Raise staff awareness of how they can engage with disadvantaged and vulnerable groups to ensure their feedback informs decision-making.	<p>Supporting and developing staff skills and competencies to ensure that service developments and redesign are informed by a wide range of patient experiences.</p> <p>Continue to build a stakeholder map to ensure that GCCG is engaging across a broad range of communities.</p>	Staff and stakeholders have a clear understanding of how to engage with people from different protected/vulnerable/seldom heard groups and the CCG can demonstrate good engagement.	Associate Director, Patient Engagement & Experience	Examples of good practice will be included as part of PSED reporting process.

Action	Details	Outcome	GCCG Lead	Target completion date
iii. GCCG leadership promotes an open culture, demonstrating appropriate skills relating to equality and reduction in health inequalities.	Senior leaders routinely demonstrate their commitment to promoting equality and reducing health inequalities within and beyond GCCG.	Papers that come before the Governing Body and other Committees identify equality-related risks and steps taken to mitigate against these.  Review of the Equality Impact Assessment process.	Equality and Health Inequalities Working Group	Examples of good practice will be included as part of PSED reporting process.

## **Appendix 2: Our legal obligations in relation to Equality, Diversity and Human Rights**

### **Equality Act 2010 and Public Sector Equality Duty**

The Equality Act 2010 brought together previous and separate pieces of anti-discrimination legislation into one Act of Parliament. The Act covers the following “protected characteristics”:

age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

It consists of a general duty and specific duties for public sector organisations. The Public Sector Equality Duty came into force in April 2011. It requires GCCG, in the exercise of its functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

As a public body GCCG must publish information to demonstrate how we fulfil these requirements.

Further information is available at: <https://www.gov.uk/government/publications/public-sector-equality-duty>

### **Equality Act 2010 and Our Staff**

The Equality and Human Rights Commission sets out guidance for employers on all areas of human resource management practice. ,

Further information is available at:

<http://www.equalityhumanrights.com/private-and-public-sector-guidance/employing-people/guidance-employers>

## **CCG Safer Staff Recruitment**

The CCG's Recruitment and Selection Policy and Temporary Promotion Policy are available at:

[http://10.162.216.140/ConsultHR/Pages/A-Z\\_Core\\_Policies\\_and\\_User\\_Guides.aspx](http://10.162.216.140/ConsultHR/Pages/A-Z_Core_Policies_and_User_Guides.aspx)

More information on the Two Ticks Disability Symbol is available at:

<https://www.gov.uk/recruitment-disabled-people/encouraging-applications>

Information relating to the NHS Employment Check Standards can be found at:

<http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards>

## **GCCG as a MINDFUL EMPLOYER®**

GCCG has signed-up to the Charter for Employers who are Positive About Mental Health. This is a voluntary agreement seeking to support employers in working within the spirit of its positive approach. The Charter is one element of the MINDFUL EMPLOYER® initiative which is aimed at increasing awareness of mental health in the workplace and supporting businesses in recruiting and retaining staff.

Further information about the scheme is available at: <http://www.mindfulemployer.net/>

## **Reducing health inequalities – The Health and Social Care Act 2012**

The Health and Social Care Act 2012 enshrines in legislation for the first time, explicit duties on the Secretary of State for Health, NHS England and CCGs to have regards to the need to reduce health inequalities in the benefits which can be obtained from health services. The duty on the Secretary of State extends to functions in relation to both the NHS and public health. The duties on NHS England and CCGs incorporate both access to, and benefits from, healthcare services.

Clinically-led commissioning - the Act puts clinicians in charge of shaping services. A number of CCGs' key responsibilities are directly designed to help reduce health inequalities these include:

- **Promoting integration** - NHS England and CCGs are responsible for promoting better integration of health services with health, social care and other health-related services, where this would improve service quality or reduce inequalities.

- **Quality reward** - NHS England is able to reward CCGs for providing high quality services, for improving outcomes and reducing inequalities
- **No decision about me, without me** - NHS England and CCGs are required to involve the public in the planning of commissioning arrangements and proposals to change those arrangements and decisions affecting them. (adapted from DH factsheet C2 provides details regarding health inequalities and the Health and Social Care Act 2012)<sup>7</sup>
- **New innovative services** – the act enables providers, including the independent 3<sup>rd</sup> sector, to develop innovative services to tackle complex problems such as health inequalities

Further information is available in a series of fact sheets at:

<https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets>

### Human Rights Act

Public sector organisations also need to have due regard to the Human Right Act 1998 [HRA]. There are five principles of human rights which are: fairness, respect, equality, dignity and autonomy, called the FRED A principles which also form part of the NHS Constitution.

In commissioning and delivering services which are compatible with the HRA, the CCG commits to undertaking human rights based approach in line with PANEL principles: Participation, Accountability, Non-discrimination, Empowerment and Legality.

Further information is available at: <http://www.equalityhumanrights.com/your-rights/human-rights/what-are-human-rights/human-rights-act>

### The United Nations Convention on the Rights of the Child

The [United Nations Convention on the Rights of the Child](#) (commonly abbreviated as the CRC, CROC, or UNCRC) is a human rights treaty setting out the civil, political, economic, social, health and cultural rights of children. The Convention defines a child as any human being under the age of eighteen, unless the age of majority is reached earlier under a state's own domestic legislation.

Article 12 of the convention states that ‘parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child’.

Further information is available at: <http://www.unicef.org/crc/>

## **The NHS Constitution**

The NHS constitution revised in March 2012 contains seven principles that guide the NHS as well as a number of pledges for patients and the public. A number of these demonstrate the commitment of the NHS to the requirements of the Equality Act and the Human Rights Act.

The first of the seven principles requires that the NHS “provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marital or civil partnership status”.

There are also a number of rights contained in the constitution which underpin the NHS’s commitment to equality and human rights and which include:

- the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.
- the right to be treated with dignity and respect, in accordance with your human rights.
- the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this
- the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent
- the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

Further information is available at:

<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>

### **The NHS Constitution and Our Staff**

NHS staff have extensive legal rights, embodied in general employment and discrimination law. These are summarised in the Handbook to the NHS Constitution available at:

<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/handbook-to-the-nhs-constitution.pdf>

In addition to these legal rights, there are a number of pledges within the NHS constitution, which the NHS is committed to achieve. The pledges can be found at:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/448466/NHS\\_Constitution\\_WEB.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/448466/NHS_Constitution_WEB.pdf)

### **The NHS Equality Delivery System**

The Equality Delivery System is designed by NHS for the NHS. The main purpose of the Equality Delivery System v2(EDS2) is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. EDS2 provides a systematic way for the CCGs to show how it is doing against the four goals and outcomes (see Appendix 3).

The EDS2 eighteen outcomes are grouped under four goals:

Better health outcomes
Improved patient access and experience
A representative and supported workforce
Inclusive leadership

Essentially, there is just one factor for NHS organisations to focus on with the grading process. For most outcomes the key question is: how well do people from protected groups fare compared to people overall? There are four grades:

- **Undeveloped** if evidence shows that the majority of people in only two or less protected groups fare well.
- **Developing** if evidence shows that the majority of people in three to five protected groups fare well.
- **Achieving** if evidence show that the majority of people in six to eight protected groups fare well.
- **Excelling** if evidence shows that the majority of people in all nine protected groups fare well.

Further information is available at: <http://www.england.nhs.uk/ourwork/gov/equality-hub/eds/>

### **Workforce Race Equality Standard**

Recent research has demonstrated that the treatment and experience of BME staff within the NHS is very significantly worse, on average, than that of NHS white staff. The publication of "*The Snowy White Peaks of the NHS*" (2014) demonstrated that BME staff were absent from the leadership of many organisations even where the workforce had substantial numbers of BME staff and where the organisation provided services to communities with large number of BME patients.

The report also summarised research over recent years showing that BME staff were treated less favourably by every measure, including promotion, grading, discipline, bullying, and access to non-mandatory training. It demonstrated that such evidence as exists showed little or no progress in recent years despite the growing number of BME staff employed as doctors, nurses and other staff.

During 2014, the Equality and Diversity Council (EDC) carefully considered the combined impact of available research and concluded that it was in the best interests of patients (as well as staff) that early and decisive steps be taken to remedy this inequity.

The challenge to ensure black and minority ethnic (BME) staff are treated fairly and their talents valued and developed is one that all NHS organisations need to meet because:

- Research shows that unfair treatment of BME staff adversely affects the care and treatment of all patients;

- Talent is being wasted through unfairness in the appointment, treatment and development of a large section of the NHS workforce;
- Precious resources are wasted through the impact of such treatment on the morale, discretionary effort, and other consequences of such treatment;
- Research shows that diverse teams and leaderships are more likely to show the innovation, and increase the organisational effectiveness, the NHS needs;
- Organisations whose leadership composition bears little relationship to that of the communities served will be less likely to deliver the patient focussed care that is needed.

In response to this challenge, the 2015/16 NHS Standard Contract includes a new Workforce Race Equality Standard (“the Standard”) which will require almost all NHS providers of NHS services (other than primary care) to start to address this issue. It states at Service Condition 13:

‘The Provider must implement EDS2; and implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing the Standard’.

The Care Quality Commission will also consider the Workforce Race Equality Standard in their assessments of how “well-led” NHS providers are from April 2016.

Further information is available at: <http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/>

### **Accessible Information Standard**

On 24 June 2015, the new ‘accessible information standard’ was approved by the Standardisation Committee for Care Information (SCCI). The standard is known officially as SCCI1605 Accessible Information.

An Information Standard is a formal guidance document which health and social care organisations must follow by law.

Organisations must follow the standard in full by 31.07.16.

The aim of the accessible information standard is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

The accessible information standard tells organisations how they should make sure that patients and service users, and their carers and parents, can access and understand the information they are given. This includes making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email.

The accessible information standard also tells organisations how they should make sure that people get any support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or an advocate.

Further information is available at:

<http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/>



## Equality Delivery System goals and outcomes (taken from NHS England – A refreshed Equality Delivery System for the NHS)

The goals and outcomes of EDS2		
Goal	Number	Description of outcome
Better Health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local population
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
	2.3	People report positive experiences of the NHS

## The goals and outcomes of EDS2

	2.4	People's complaints about services are handled respectfully and efficiently
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	3.3	Training and development opportunities are taken up and positively evaluated by all staff
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	3.6	Staff report positive experiences of their membership of the workforce
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

## Feedback summary

GCCG staff and key stakeholders were provided with an opportunity to comment on the original draft of this Strategy and its Action Plan. This final version of the Strategy has benefitted in terms of content and structure as a result of the feedback received.

In total GCCG received 12 items of feedback. Responses have been received from: Healthwatch Gloucestershire, Gloucestershire County Council, Gloucestershire Care Services NHS Trust, 2gether NHS Foundation Trust and individual GCCG staff and community partners. Feedback was received in a range of formats. A template was sent out with the Strategy to facilitate feedback, although its use was optional. Some responses were received on the template, but some felt that it was too restrictive. Extracts from written feedback have not been used, as permission to do so has not been sought. Instead themes have been identified under two headings 'general' and 'specific'.

GCCG is grateful to all who took the time to read the draft Strategy and Action Plan and to visit the online resources. We appreciate your constructive comments which we believe have improved and enhanced this final draft.

<b>General themes, with GCCG response</b>	
<b>Themes from comments/questions received</b>	<b>GCCG response (where possible)</b>
<b>Overall</b>	
We think it is a very clear document that sets out aims and expectations very well. It will certainly help us when focussing on equality issues and objectives and inform our own action plans	
Document is welcomed as a formal commitment to promoting equality and valuing diversity.	
The strategy is clearly set out and the structure and sections make sense.	
Needs to be consistency – either GCCG or CCG.	We have updated the Strategy to use GCCG throughout.
Reads well. Could we have some examples to illustrate how GCCG is working with others to make a tangible difference?	We intend the Strategy to form part of a web-based resource. Examples of good practice will form part of this resource. Having these separately will ensure they are up-to-date and more easily accessible for future reference. We will also include examples as part of our annual reporting process, which is completed as part of the requirements of the Public Sector Equality Duty.
I am sure it meets all the requirements, but does it need a few real ambitions in terms of measurement and evidence	Over the coming months, GCCG will be using the Equality Delivery System 2 toolkit to assess our performance against the specified goals and outcomes. We

	envisage an action plan will be developed with our local partners/communities that will provide key focus for 2016/17.
Clarity around GCCG's intentions and actions to tackle health inequalities.	Gloucestershire County Council Public Health Department are currently leading the development of a Joint Health & Wellbeing Strategy Delivery Plan. We anticipate that this will set out countywide objectives for tackling health inequalities.
Should the reader assume that this document partly fulfils the CCG's formal E&D requirements?	Formal requirements under the Public Sector Equality Duty do not specify the need to have an Equality Strategy. However, we believe this Strategy is essential in providing guidance for our staff on this important agenda.
Much of the strategy, for understandable reasons, describes processes and mechanisms that promote equality etc, but they are essentially, inputs rather than results. It would be good if the strategy could identify core objectives for the first year.	The accompanying Action Plan sets out our specific goals for the coming months. The Action Plan will be reviewed and updated on an annual basis. The Annual Report, published in January each year, provides us with the opportunity to evaluate our work in respect to equality.
Can further thought be given to how the CCG will communicate progress on this outside the organisation?	This will be considered as part of the assessment and action plan for EDS2. In addition, the Action Plan includes a specific review of our web-based materials relating to equality.
Insufficient on what equitable services could look like – user engagement, design differentiation, resource implication etc – and on what place they would have in a wider strategy to help reduce health inequality.	We anticipate developing this work in response to the Joint Health & Wellbeing Strategy Delivery Plan. This will also inform our assessment and action plan for EDS2.
The Strategy sets the general direction of travel and promises the tools for GCCG staff to better understand and consider health inequalities. I think it could go further by saying how this will change or influence commissioning decisions.	It is difficult to include this level of detail in a three-year Strategy, without it becoming quickly out-of-date. We envisage that this information will feature in specific project/programme plans and be reported through the latest Annual Report.

<b>Specific comments, with GCCG response</b>	
<b>Comments received relating to specific sections of the Strategy</b>	<b>GCCG response (where possible)</b>
<b>Section 1</b>	
Suggest protected characteristics should be named somewhere in the document or in the appendices.	The protected characteristics were listed under the Equality Act 2010 information in Appendix 2. In addition, we have now incorporated them into section 4.2 of the main document.

Equality, diversity, health inequalities are terms that are capable of many meanings. A working definition of each in the context of this document would be helpful.	A definition of these terms, in the context of this Strategy, is now included in section 1.5 of the document.
Needs to be more explicit: does this include responsibility of GCCG staff to work with providers to ensure that equality and diversity is reflected and respected in care delivery.	Our Clinical Programme Group approach to commissioning and contract monitoring arrangements are some of the ways that GCCG staff work with providers to ensure services are equitable and reflect the diverse needs of our local communities.
Include some information here about responsibility for overseeing equality compliance.	GCCG governance arrangements for equality compliance are now included in section 1.6 of the document.
<b>Section 2</b>	
Can the lay reader assume that this document meets the legal obligations?	The audience for this document is GCCG staff and member practices. This document sets out our intentions and commitment to ensuring equality and recognising diversity. Our legal obligations are defined in the Public Sector Equality Duty and other legislation noted in Appendix 2.
Can you expand FREDA	An explanation has been included in Appendix 2
Equality objectives - complex verb structures dilute the impact of this document.	The Equality Objectives were set out as part of the authorisation process for GCCG in 2012. We recognise that they may not be accessible for the general public and will work to address this as part of our EDS2 and annual reporting process.
Reference to HRA could be strengthened by similar reference to CRC, embedding specific rights of the child into English law.	We have included reference to the United Nations Convention on the Rights of the Child – further information is also available in Appendix 2.
Insufficiently robust on the right of children and young people to be engaged and involved in all aspects of services that affect them	More detailed information is included in the GCCG Engagement and Experience Strategy. We have included information about the legal rights as noted above.
<b>Section 3</b>	
HWG ought to be mentioned as a partner in this section in the light of its specific statutory responsibilities	We have included reference to the role of Healthwatch Gloucestershire in the GCCG Engagement and Experience Strategy. We have also added them as a named partner under section 4.7.

“Good engagement” – what does this mean?	This refers to Patient and Public Engagement and is further explained in the GCCG Engagement and Experience Strategy.
<b>Section 4</b>	
Could this be more specific about where responsibilities lie for ensuring GCCG takes account of needs assessment, development of EIAs, etc	This is detailed in the terms of reference for specific Clinical Programme Groups. Our governance arrangements for GCCG projects and a work programme require evidence that the EIA has been completed.
At the moment there is a sense that the reader is assumed to know what equality in commissioning is and that they will agree that all the structures and processes that the CCG adopts will lead to equality. Is that a safe assumption?	Our Clinical Programme Group approach, project management toolkit and governance arrangements have clear procedures to ensure that equality has been given due consideration.
4.2 Could you include other non-statutory bodies here?	Updated to include in partnership working.
Some repetition became apparent in this section eg 4.2 echoes some of 2.2. Could there be a way at 2.2 of using the material in a way that means it doesn't then have to be repeated in the more detailed sections?	As detailed above section 2.2 has previously been agreed as part of the GCCG authorisation process. We feel that the current Equality Objectives need to be clearly set out in this document, but recognise that this may lead to some duplication of themes in the more specific sections of the Strategy.
4.3 “Partnership working...ensures we understand the needs and diversity of our local communities” – this is a bold statement. So we don't need an equalities strategy then?	This section has been changed to recognise our ambition to increase our understanding of the changing needs and diversity of our population.
4.4 - a case where there is an opportunity it slim down the paragraphs and take out extraneous material. Final sentence could perhaps end at "need".	We felt it was important to set out some context around the Clinical Programme approach. The wording of the final sentence has been amended.
4.5 A good point on mitigating the risk, this is what we have to keep doing and will never eliminate this, in my view.	
4.6 Need to specify this is about access to services	Section updated to reflect this point.
<b>Section 5</b>	
Local plans need to address health inequalities, not just meet its equality duties.	The Locality Executive Group in each area has reflected on health needs assessments provided by Public Health and where possible included work to address specific inequalities in their local plan.

What are the aspirations of each of the seven locality's development plans?	The Locality Development Plans have recently been approved and will be publicised on our website in the near future. They will also be shared with community partners in the respective localities.
<b>Section 6</b>	<b>No comments</b>
<b>Section 7</b>	
Need to be explicit that the CCG only has responsibility for commissioning GP primary care services.	This has been amended in the final version of the Strategy.
May be worth making it explicit that 'ensuring services are accessible' is about more than just information needs. It includes opening hours, premises, taking services to people and groups, and awareness raising (amongst other things!).	This has been amended in the final version of the Strategy.
<b>Section 8</b>	
The heading for this section isn't quite right – section doesn't flow well from the earlier sections.	Heading has been amended.
GCCG, as a public sector employer, will have made pledges, or be governed by certain legislation, relating to equality of opportunity – these are not detailed in this Strategy	Additional information has been included in the strategy, with links to supporting documentation
Inclusion of a separate WRES is good, but what about standards, plans and targets for Positive about Disability or LGBT, or young workers, or protecting older workers from age discrimination?	Further information has been included in this strategy. The WRES is specifically mentioned as it forms part of the NHS contractual requirements from April 2015.
Include more on recruitment here. Something about positive actions?	Additional information regarding GCCG recruitment has been included.
8.5 Not just monitor, but put a realistic action plan in place	Section updated to include this point.
<b>Section 9</b>	
We can only know if we are making a difference if we have trusted monitoring and audit processes in place.	EDS2 provides us with a nationally mandated self-assessment tool. We envisage a specific action plan will be developed following the completion of the self-assessment, which will be monitored by the Equalities and Health Inequalities Working Group.

9.4 Felt very vague. What would it mean?	The wording of 9.4 has been amended to reflect the important role of the implementation of EDS2. This work will be undertaken in partnership with our local communities, being mindful of the nine protected characteristics and locally identified health inequalities.
9.4 How will it be informed by engagement with our local communities?	
<b>Action Plan</b>	
Expand/explain acronyms	We have ensured that each acronym is given in full the first time it appears.
“Ongoing” as a target completion date isn’t good – needs to be more specific	We have reviewed the Action Plan and allocated specific target completion dates where practical to do so.
Objective 2: Will this action increase the number of contracts/services which have explicit requirements to address specific inequalities in identified groups/communities?	The Joint Health and Wellbeing Strategy Delivery Plan 2016 – 2019 (currently being developed) will inform commissioning organisations and enable us to consider specific requirements and gaps in service provision.
Objective 3: Perhaps need to be more explicit about how the information will inform commissioning. Reads as though commissioners will consider the information, but may not necessarily act on it	Difficult to capture this level of detail in an over-arching action plan. The EIA process ensures that equality issues are considered and where possible mitigated against. Specific project documentation will identify these issues and set out plans to address them.

## CCG Equality Impact Analysis

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### What's it about?

Refer to equality duties

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### What is the proposal? What outcomes/benefits are you hoping to achieve?

This Strategy sets out how GCCG will ensure that promoting equality and valuing diversity is embedded in the planning, commissioning and delivery of local health services. It also recognises our commitment to, and obligations under, equality principles and legislation.

As an employer, GCCG strives to ensure that staff have equal access to career opportunities and receive fair treatment in the workplace.

---

### Who's it for?

The Strategy is written for staff of the GCCG. It is our expectation that all staff will take responsibility for promoting equality; commissioning accessible services that respond to the diverse needs of communities in Gloucestershire. The strategy also establishes our commitment as an employer; to ensure staff have equal access to career opportunities and receive fair treatment in the workplace.

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### How will this proposal meet the equality duties?

The Strategy recognises our commitment to, and legal obligations under:

- the Equality Act 2010 and Public Sector Equality Duty;
- Health and Social Care Act 2012;
- Human Rights Act 1998 and the FREDA principles;
- Convention on the Rights of the Child;
- NHS Constitution and
- NHS Workforce Equality Standard

The principles set out in this legislation are intrinsic to this Strategy. The Strategy aims to embed equality into the work of GCCG, ensuring that we provide equity of access to services irrespective of gender, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

---

### What are the barriers to meeting this potential?

Ensuring that GCCG staff access the Strategy and use the resources and information available to inform their commissioning work. The Action Plan for this Strategy sets out overarching plans to raise staff awareness of equality considerations and health inequalities in the county.

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## 2 Who is using it?

Refer to equality groups

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What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?

Information from the 2011 census tells us that in Gloucestershire:

- 19.48% (vs. 16.4% England average) of our population are aged 65 years plus. There are
-

district variations with the Forest of Dean and Tewkesbury having the highest proportion of older people.

- 16.7% of Gloucestershire residents reported having a long term limiting health problem. Forest of Dean had the highest proportion of residents reporting a long term limiting health problem at 19.6% of the total population.
- The overall gender split in Gloucestershire is slightly skewed towards females, with males making up 49.0% of the population and females accounting for 51.0%.
- There are no official estimates of gender reassignment at either national or local level. However, recent studies estimate that between 0.6% and 1% of the UK's adult population experience some degree of gender variance. This equates to between 2,900 and 4,700 adults in Gloucestershire.
- There were 6,880 live births in Gloucestershire in 2012.
- There is no definitive data on sexual orientation among the local population. A recent estimate from the ONS Integrated Household Survey suggests that 1.9% of the adult population is gay, lesbian or bisexual. This would equate to around 9,200 adults in the County.
- Gloucestershire has a lower proportion of people who are single or separated when compared to the national average. In contrast the proportion of people who are married, divorced or widowed exceeds the national average.
- According to the 2011 Census 95.4% of Gloucestershire's population is white. Black or Ethnic Minorities make up the remaining 4.6% of the population. Asian and Asian British account for the largest proportion of Black or Ethnic Minorities in Gloucestershire.
- 63.5% of residents in Gloucestershire are Christian, making it the most common religion. This is followed by "no religion" which accounts for 26.7% of the total population. Cotswold has the highest proportion of people who are Christian. Cheltenham has the highest proportion of Buddhists, Hindus and people who have no religion. Gloucester has the highest proportion of Muslims.

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How can you involve your customers in developing the proposal?

Through the implementation of the Equality Delivery System 2 (EDS2), GCCG will undertake a self-assessment process, the outcomes of which will be tested with local communities.

With regard to our responsibilities as an employer, views of staff will be obtained via the staff survey and newly established Joint Staff Consultative Committee (JSCC)

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Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)

N/a

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### 3 Impact

Refer to dimensions of equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation

and if appropriate: financial economic status, homelessness, political view, gypsies & travellers, sex workers, people who misuse drugs & alcohol

Using the information in parts 1 & 2 does the proposal:

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**a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified?**

The Strategy aims to ensure equity of access and opportunity. There should be no adverse impact.

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**What can be done to change this impact?**

N/a

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**b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for other groups?**

n/a

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**Does further consultation need to be done? How will assumptions made in this Analysis be tested?**

The Action Plan for this Strategy will be regularly reviewed. The Annual Report (as required under the Public Sector Equality Duty), and our implementation of EDS2 will ensure that GCCG fulfils its commitments.

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**4 So what?**

[Link to business planning process](#)

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**What changes have you made in the course of this EIA?**

None

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**What will you do now and what will be included in future planning?**

The Action Plan will be regularly reviewed and developed. The Strategy will be updated to include changes in relevant legislation and reflect good practice and guidance.

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**When will this be reviewed?**

As above

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**How will success be measured?**

The Action Plan will be subject to review on at least an annual basis. Implementation of EDS2 will allow us to assess our success to date and develop plans for future improvement.

The impact of the Strategy will be formally monitored and evaluated by the Equality and Health Inequalities Working Group and reported to the Integrated Governance and Quality Committee.

For the record	
Name of person leading this EIA Caroline Smith	Date completed 08/10/15
Names of people involved in consideration of impact Equality & Health Inequalities Working Group	
Name of director signing EIA Marion Andrews-Evans	Date signed 08/10/15

Agenda item 11

Governing Body

<b>Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Report Title</b>	<b>We are Gloucestershire – Devolution Proposal: Health and Social Care</b>
<b>Executive Summary</b>	<p>This paper sets out our devolution ‘asks’ of government and ‘offers’ from Gloucestershire, so we can drive economic growth and public sector reform.</p> <p>Devolution will offer the opportunity for the CCG to make a step change in delivering improvements for health and social care through key programmes such as Prevention and Self Care, Enabling Active Communities and Social prescribing.</p> <p>An indicative working set of criteria has been developed for the Board to consider, however, the final principles, decision criteria, and process will be further refined as the Devolution Bill develops.</p> <p>The Governing Body is asked to support the key recommendations within the paper.</p>
<b>Key Issues</b>	<p>In summary, this Deal is proposing the following for Health and Social Care in Gloucestershire:</p> <ul style="list-style-type: none"> <li>• A devolved place-based health and social care budget for Gloucestershire with a minimum five year settlement.</li> <li>• To work with regulators to develop a co-ordinated approach</li> <li>• To work with Government to develop true outcomes based commissioning for</li> </ul>

	<p>health and social care</p> <ul style="list-style-type: none"> <li>• Government to delegate authority for commissioning and funding of other primary care services</li> <li>• Devolve immunisation and screening services which are currently commissioned by NHSE.</li> <li>• Develop simplified funding, governance and regulatory framework to support person centred commissioning.</li> <li>• This is subject to an evaluation process from NHS England.</li> </ul>
<p><b>Risk Issues: Original Risk Residual Risk</b></p>	<p>Risks and Issues are detailed in section 5.0 along with a suggested approach to mitigations; engagement with membership, key stakeholders, patients and the public, governance arrangements and capacity to deliver.</p>
<p><b>Financial Impact</b></p>	<p>There are no financial implications arising from this paper at this stage.</p>
<p><b>Legal Issues (including NHS Constitution)</b></p>	<p>Governance arrangements for the combined authority are under development and following passage of the Bill, the CCG will obtain legal advice to gain assurance on the full implications of any potential changes.</p>
<p><b>Impact on Health Inequalities</b></p>	<p>A key focus of the health and social care proposal is to improve quality, reducing health inequality and improving patient outcomes and experience.</p>
<p><b>Impact on Equality and Diversity</b></p>	<p><b>No</b> The recommendations in the paper do not have a specific impact on equality and diversity as they describe proposals.</p>
<p><b>Impact on Sustainable Development</b></p>	<p>Gloucestershire is in a good shape to move forward, but there remain significant challenges to deliver a sustainable future for health and care services. We believe devolution will help us to address these and transform our system</p>

	for the benefit of all of the people of Gloucestershire.
<b>Patient and Public Involvement</b>	We are Gloucestershire is endorsed by the county council, the six district councils, the NHS Clinical Commissioning Group, the Local Enterprise Partnership (LEP), the Gloucestershire Constabulary and the Office of Police and Crime Commissioner. Public involvement is embedded as part of all ongoing commissioning and service reviews.
<b>Recommendation</b>	The Governing Body is asked to: <ul style="list-style-type: none"> <li>• Note the current status of the devolution proposal for Gloucestershire</li> </ul>
<b>Author</b>	Ellen Rule
<b>Designation</b>	Director of Transformation and Service Redesign
<b>Sponsoring Director (if not author)</b>	Mary Hutton Accountable Officer

**Thursday 26<sup>th</sup> November 2015  
Governing Body**

**We are Gloucestershire – Devolution Proposal: Health and Social  
Care**

**Executive Summary**

The Five Year Forward View committed us to empowering patients and local communities. Devolution builds on this and will transform the quality of care and support for people in Gloucestershire and could support us to deliver a proactive whole system avoiding the wasted costs of episodic care.

Manchester and Cornwall proposals have already been agreed, and other parts of the country are in the process of developing their own bespoke devolution deals.

The Gloucestershire devolution proposal has so far received positive feedback from Government and partners. The CCG leadership team is working to ensure that the proposal will deliver significant improvements for health and wellbeing for people in Gloucestershire by impacting on the wider determinants of health, whilst also maintaining the organisational integrity of the CCG as a clinically led, membership organisation with clear autonomy and accountability for health resources in Gloucestershire.

**Recommendations**

The Governing Body is asked to:

- Note the current status of the devolution proposal for Gloucestershire

**Appendices**

- Annex 1 – References

# We Are Gloucestershire

## Devolution Proposal: Health and Social Care

### Development process

Group	Review Date	Notes
Development session comment on draft	12/11/2105	Draft shared through development session for high level feedback and comment
Public Board Paper development	16/11/2015	Updated paper for public board following development session feedback

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## PART A: Rationale for Change

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The core proposition behind devolution is that by enabling place based devolution of public sector spend, and ensuring integration between different arms of the state public services, devolution will be able to deliver a step change in terms of support offered to local people to really transform lives. We believe this presents a unique opportunity to do better for health and social care in Gloucestershire by ensuring that all key decisions are taken locally for and on behalf of Gloucestershire with a greater level of mutuality than currently exists between public sector organisations. We believe that although we have a good track record of public services working together in Gloucestershire, under the current structural and regulatory arrangements delivery incentives may still be disjointed or at worst conflicting.

Gloucestershire has a huge advantage in taking forward devolution in that the boundaries for our key strategic partners already align. Our devolution proposal has been developing in partnership with

- Gloucestershire Local Enterprise Partnership
- Gloucestershire Constabulary
- Gloucestershire's Police and Crime Commissioner
- Gloucestershire's 7 local authorities

Almost all indicators for health, wellbeing, crime, economy, employment and income in Gloucestershire are above the national average, but we do still have challenges at address:

- At the most local level we have a dozen neighbourhoods amongst the most deprived in England.
- We have challenges of accessibility in the rural parts of the county.
- Our population is 611,000 and growing and ageing. The number of people aged over 65 is projected to grow by over 35 % by 2025.
- We have a higher prevalence for those long terms health conditions associated with ageing – e.g the number of people with dementia is predicted to rise by two thirds in the next 15 years.
- Life expectancy varies by 6.3 years for women and 7.8 years for men between the most and least deprived areas.

- While levels of employment are high, there are hard to fill vacancies in skilled trades and the number of young people taking up apprenticeships is below the national average.
- Whilst crime rates have consistently fallen for the past 12 years, local variations exist and incidents of domestic abuse and sexual violence are increasing.
- Demand on services for safeguarding children and adults are increasing

These are some of the reasons why we believe devolution is an option worth pursuing to deliver real change and improvements for people's lives in Gloucestershire. We believe that devolution will offer the opportunity for the CCG to make a step change in delivering improvements for health and wellbeing through key programmes such as Prevention and Self Care, Enabling Active Communities and Social prescribing.

## **1. Devolution Context and Legislation**

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Two areas of the country (Cornwall and Manchester) have already had formal agreement to proceed with the development of fully devolved arrangements. Gloucestershire submitted an outline proposal in September and has been in negotiation with Government around the detailed asks and offers set out in the proposal through October and November.

Devolution has been enabled by the Cities and Local Government Devolution Bill, which is intended to be an enabling Bill to transfer functions to, or allow functions to be exercised concurrently with, or (following a Government amendment) allow functions to be exercised jointly with a Combined Authority or local authority upon the Secretary of State making a relevant order. The Bill does not in itself transfer or devolve any powers or functions so any future decisions about the transfer of functions would need to be set out in an Order, with affirmative agreement in both Houses of Parliament.

The Devolution Bill completed its third reading in the House of Lords in July 2015. Several Government amendments were tabled in the Lords and accepted. These included proposed amendments to further support the effective and appropriate devolution of health functions. An amendment was also successfully tabled by Lord Warner with the intention of providing greater

clarity about the continuation of NHS accountabilities towards the NHS Constitution and regulatory responsibilities under devolved arrangements.

The bill was considered in a committee of the whole house (of commons) on Wednesday 21<sup>st</sup> October 2015. The date planned for the second reading is Tuesday 17<sup>th</sup> November 2015. It is expected that this reading will occur over two days. The full progress and transcripts for the bill can be found on the following link.

<http://services.parliament.uk/bills/2015-16/citiesandlocalgovernmentdevolution.html>

The decision making process for NHS England will involve the commissioning committee of the NHS England board making proposals for areas that should be approved in line with a set of decision principles and criteria (set out later in this paper). Final approval will then be given by the NHS England board. It should be noted that the final principles, decision criteria, and decision process will be further refined as the Devolution Bill develops. The potential implications for NHS England statutory duties are still under consideration.

## 2. Devolution Principles

NHS England have set out a number of principles that should be considered when determining any decisions about future devolution proposals. These have been informed by the agreements set out within the Greater Manchester MOU. These include:

NHS England Principles	Gloucestershire high level assessment
i. An overarching principle that all areas will remain part of the NHS, upholding national standards and continuing to meet statutory requirements and duties, including the NHS Constitution and Mandate.	CCG retains all statutory functions in our proposal
ii. Ensuring that commissioners, providers, patients, carers and wider partners, including the voluntary and community sector, are able to work together to shape the future of the local area, supported by regular communication and engagement from development to implementation.	Key element of our proposal is embodied in EAC work to strengthen role of communities and voluntary sector. Gloucestershire proposal has been in the public domain throughout with extensive communication and engagement with a wide range of stakeholders.
iii. The principle of subsidiarity, ensuring that decisions are made at the most appropriate level.	A devolution governance framework is under development to ensure this principle is met
iv. Having clear and appropriate accountability arrangements for services and public expenditure to be devolved.	A devolution governance framework is under development to ensure this principle is met
v. Putting in place a clear plan to support long term clinical and financial sustainability.	CCG leads on statutory responsibilities for health and makes allocation decisions for health expenditure
vi. A governance model which is simple to operate and minimises bureaucracy and overheads in the system.	A devolution governance framework is under development to ensure this principle is met

### 3. Devolution Decision Criteria

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The draft decision criteria that will be used by the Department of Health and NHS England when considering requests for devolution, are set out below. The CCG will complete a full self-assessment against these criteria to be shared with the governing body prior to submitting any business case to NHS England. The decision criteria will inform the further development of an outline business case for devolution.

NHS England Decision Criteria
i. <i>Clarity of vision</i> about the benefits devolution will bring to the health and social care of local people, and the plan for delivery of these and wider benefits including a clear articulation of what specific additional functions and responsibilities are being requested;
ii. A <i>'health geography'</i> that supports devolved decision-making, being largely a self-sufficient community with a matching corporate infrastructure rather than relying on other areas of the country for delivery of devolved functions;
iii. <i>Quality and continuity of care</i> , particularly linked to the safe transfer of responsibilities and emergency planning, preparedness and resilience arrangements;
iv. <i>Impact on other populations</i> , including appropriate safeguards for users of local services from outside the relevant geography;
v. <i>Financial risk management</i> , including mitigation actions by, and residual risk to, NHS England;
vi. <i>Support of local health organisations</i> , and local government (including political leadership) so that there is a solid basis of co-operation on which to build shared decision-making and robust, devolved arrangements;
vii. <i>Demonstrable leadership capability and track record of collaboration between NHS bodies and local government</i> , implementing transformation and securing consistent delivery, making full use of pre-existing powers;
viii. <i>Demonstrable track record of collaboration and engagement with patients and local communities</i> , including evidence of sufficient consultation on, and broad support for, the devolution proposals;
ix. <i>Clear mitigation plan and exit route in the case of failure.</i>

#### 4. Governance Model for Health and Social Care

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A set of proposed governance arrangements for the combined authority are under development, but cannot be completed until the legislation has been passed (passage of bill described in section 1). The CCG will obtain legal advice to gain assurance on the full implications of a potential transition from existing to any proposed governance arrangements.

#### 5. Risks and Issues

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There are a number of key challenges that exist for the health and social care system in developing Devolution arrangements. A number of these risks and Issues are set out below alongside a suggested approach to mitigations.

<b>Risk / Issue</b>	<b>Approach to Mitigations</b>
Engagement with Membership, Key stakeholders, Patients and the Public	Devolution has progressed at pace and to date the CCG has not specifically undertaken engagement work around devolution for health and social care. There has been local authority led public engagement programme. Specific consideration will need to be given to engagement with the membership particularly if any constitutional change is required (which if is required is not envisaged to be required before 2017 at the earliest)
Governance Arrangements	There is considerable complexity to be considered in the potential governance arrangements that the CCG may wish to develop with regards to any future devolution arrangements for health and social care. Legislation is still evolving and so the frameworks are unclear. The CCG will procure independent legal advice to provide assurance, and this will be offered to the CCG Audit committee for detailed review and consideration prior to any recommendations made to the Governing Body.
Capacity to Deliver	The CCG has a challenging work programme and this is only one of a number of key strategic priorities under consideration. The CCG needs to be confident that there is sufficient management capacity to support this work alongside other priorities. This will support mitigation of other risks and issues listed in this table.

## 6. Conclusion and Next Steps

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The Gloucestershire devolution proposal has so far received positive feedback from Government and partners. The CCG leadership team is working to ensure that the proposal will deliver significant improvements for health and wellbeing for people in Gloucestershire by impacting on the wider determinants of health, whilst also maintaining the organisational integrity of the CCG as a clinically led, membership organisation with clear autonomy and accountability for health resources in Gloucestershire.

## PART B: DRAFT DECISION TIMELINE

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The NHS England Devolution board paper states that the preferred option is for a timeline of about 18 months from any expression of interest in devolution by a particular geography to implementation of devolution arrangements. This reflects the trajectory set out by Greater Manchester. Any approval will be subject to submission of a clear outline business case that responds to the outline principles and decision criteria outlined in this paper. Any change in statutory accountabilities would need to be prefigured in a formal arrangement such as the joint signing of a Memorandum of Understanding (MOU) and shadow running of the devolved functions in the new body. In particularly large or complex geographies, piloting in a selected sector of the area concerned may be required. Given the coterminous nature of Gloucestershire this approach is unlikely to be desirable or required.

A draft high level timetable for how Devolution could develop in Gloucestershire is set out below (Dates in italics are provisional):

<b>Delivery Date</b>	<b>Activity</b>
September 2015	Outline proposal submitted and shared on public website, further iteration developed by end of September
October 2015 – December 2015	More detailed development of asks and offers in negotiation with government leads
<i>January 2015 – March 2016</i>	<i>Development of outline business case for devolution, engagement continues alongside ongoing negotiation with government</i>
<i>April 2016</i>	<i>Shadow Combined Authority starts to meet to develop new working arrangements</i>
<i>April 2017</i>	<i>Devolution arrangements formally commence</i>

## Annex 1: References

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### Key reading list / references for this Document:

<b>NHS England Board paper on Devolution approach and principles</b>	<a href="https://www.england.nhs.uk/wp-content/.../item4-board-29-09-15.pdf">https://www.england.nhs.uk/wp-content/.../item4-board-29-09-15.pdf</a>
<b>Kings fund paper on Devolution</b>	<a href="http://www.kingsfund.org.uk/publications/devolution">http://www.kingsfund.org.uk/publications/devolution</a>
<b>Greater Manchester Health and Social Care Devolution Proposals</b>	<a href="http://gmhealthandsocialcaredevo.org.uk/">http://gmhealthandsocialcaredevo.org.uk/</a>
<b>Full Gloucestershire Devolution Bid</b>	<a href="http://weareglos.com/devolution-bid-for-gloucestershire/our-bid/">http://weareglos.com/devolution-bid-for-gloucestershire/our-bid/</a>

**Agenda Item 12**

**Governing Body**

<b>Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Policies for Approval</b>
<b>Key Issues</b>	The attached policies are intended to outline the CCG's approach in the following areas: <ul style="list-style-type: none"> <li>• Counter Fraud and Corruption; and</li> <li>• Engagement of Internal and External Auditors for Non-Audit work.</li> </ul>
<b>Risk Issues:</b>	The absence of comprehensive and up to date policies could result in inappropriate actions being taken by CCG officers.
<b>Original Risk (LxC)</b>	8 (2x4)
<b>Residual Risk (LxC)</b>	4 (1x4)
<b>Financial Impact</b>	Not applicable
<b>Legal Issues</b>	Legal issues are addressed in the individual policies.
<b>Impact on Health Inequalities</b>	There are no impacts on Health Inequalities.
<b>Impact on Equality and Diversity</b>	Impact assessments must be undertaken for all CCG policies to assess their impact on equality and diversity prior to implementation. The assessments have been attached to the policies.
<b>Impact on Sustainable Development</b>	Not applicable
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Committee is requested to approve the attached policies for implementation within the CCG.
<b>Author</b>	Cath Leech
<b>Designation</b>	Chief Finance Officer
<b>Sponsoring Director (if not author)</b>	

## POLICY AUTHORISATION FORM

1

<b>NAME OF POLICY:</b>	Counter Fraud and Corruption Policy
<b>JOB TITLE OF AUTHOR:</b>	Local Counter Fraud Specialist
<b>SPONSOR:</b>	Chief Finance Officer
<b>NAME OF GROUP:</b> (if applicable)	

2

<b>EQUALITY AND DIVERSITY – Mandatory Requirement</b>	
An Equality & Diversity assessment has been completed <i>(Please contact the Equality &amp; Diversity Lead)</i>	<b>Date Completed:</b> 14/07/15
<b>CONSULTATION</b>	
<b>NAME OF GROUP (S)</b> (complete where relevant)	<b>DATE CONSIDERED</b>
Name of Local Committee or Specialist Group?	*
Name of Countywide Committee or Specialist Group? County Wide Policy YES / NO	*
Other relevant Forum/Individual?	*

3

<b>APPROVED BY GOVERNING BODY / IGQC</b>	
<b>NAME</b> Audit Committee	<b>DATE APPROVED</b> 29 <sup>th</sup> September 2015
<b>TO BE REVIEWED BY: (Author)</b>	<b>DATE TO BE REVIEWED:</b>
*	*

4

<b>TO BE COMPLETED BY CO-ORDINATOR</b>	
<b>DATE PUT ONTO POLICY REGISTER:</b>	
<b>POLICY NUMBER:</b>	
<b>DATE PLACED ON INTRANET:</b>	

<b>POLICY UPDATES/CHANGES</b> <i>(AFTER GOVERNING BODY/IGQC APPROVAL)</i>				
Date	Summary of Changes	Author/Editor	Approved by	Version
July 15	Cosmetic			

The Policy Authorisation Form is part of the overall policy template and forms the front of the document and must be completed in all cases

**Equality and Diversity** - Part 2 of the form (Appendix 1)

The policy should be checked to see if it has any adverse effect on any personal group covered by Discrimination Legislation. In order to do this an 'Impact Assessment' must be completed. Further advice can be obtained from the Equality and Diversity Lead.

**Approval & Review** - Part 3 of the form

Once the Policy has been approved the name of the group / individual and date of approval should be included. The policy document should be sent to the Policy Co-ordinator to log on the Policy Register.

Review and amendments are the responsibility of the Author and Director of the Policy and a date for review must be set and included on the form. However, the Policy Co-ordinator will give a reminder to an author when a policy is overdue a review. The review date must be at least annually.

If, after a review, changes are made the document must be resubmitted, by the Author, for approval and therefore the 'Policy for Policies' must be followed again. Any changes should be included in the necessary 'Policy updates/changes' section at the beginning of the document.

**CCG Policy Spreadsheet ' Information Register'**- Part 5 of the form

The Policy Co-ordinator will input the approved policy onto the Policy Register and allocate a Policy Number which will be inserted onto the authorisation form and also communicated to the Author via email. The Policy Co-ordinator will also ensure that after a review a new version number is allocated and noted on the register.

# Counter Fraud and Corruption Policy

<b>Version</b>	V2
<b>Policy ID No</b>	9
<b>Author</b>	Local Counter Fraud Specialist
<b>Sponsor</b>	Chief Finance Officer
<b>Approved By</b>	Governing Body
<b>Approval Date</b>	26 <sup>th</sup> November 2015
<b>Review Date</b>	31 <sup>st</sup> November 2018

*This document may be made available to the public and persons outside of the CCG as part of the CCG's compliance with the Freedom of Information Act 2000.*

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## **1 Introduction**

- 1.1 One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of, and means of, enforcing the rules against fraud and other illegal acts involving dishonesty (for example: offences contrary to the Fraud Act 2006 and / or the Bribery Act 2010, fraud related matters contained in the Theft Acts 1968 and 1978 and the Proceeds of Crime Act 2002). For simplicity, all such offences are referred to as “fraud” or “corruption”, except where the context indicates otherwise. “Fraud” covers any activity involving dishonesty and deception that can drain value and resources from Gloucestershire CCG, directly or indirectly, whether or not there is personal benefit to the fraudster.
- 1.2 The Governing Body has existing procedures in place that reduce the likelihood of fraud occurring. These include Standing Orders, Prime Financial Policies, documented procedures and systems of internal control and risk assessment. Additionally the Governing Body endeavours to ensure that a culture of zero tolerance to fraud exists in the CCG.
- 1.3 The Governing Body is absolutely committed to maintaining an honest, open and well- intentioned atmosphere within Gloucestershire CCG. It is therefore also committed to the elimination of any fraud against or within Gloucestershire CCG and to the rigorous investigation of any cases brought to its attention.

## **2 Purpose**

- 2.1 This document sets out Gloucestershire CCG’s policy and procedures for managing cases of suspected or detected fraud and corruption.
- 2.2 The Policy intends to provide direction and assistance to employees dealing with suspected cases of fraud or corruption.
- 2.3 The Governing Body encourages anyone having reasonable suspicions of fraud to report them. It is also the Governing Body’s policy that no employee will suffer, in any way, because of reporting reasonably held suspicions. For these purposes “reasonably held suspicions” shall mean any suspicions other than those, which are raised maliciously and found to be groundless.
- 2.4 The Code of Conduct for NHS Boards sets out the following public service values. It states that high standards of corporate and personal conduct, based on the recognition that patients come first, have been a requirement throughout the NHS since its inception.
  - 2.4.1 **Accountability**  
Everything done by those who work in the organisation must be able to stand the tests of parliamentary scrutiny, public judgments on propriety and professional codes of conduct
  - 2.4.2 **Probity**  
Absolute honesty and integrity should be exercised in dealing with NHS

patients, assets, staff, suppliers and customers.

#### **2.4.3 Openness**

The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff and the public.

2.5 All those who work in the organisation should be aware of, and act in accordance with, these values.

### **3 ROLES AND RESPONSIBILITIES**

3.1 Responsibility for updating and amending this policy lies with the Local Counter Fraud Specialist (LCFS). The LCFS will review the policy 3-yearly unless required more frequently due to changing legislation.

3.2 The effectiveness of this policy will be reviewed by the Audit Committee who, at each meeting, will receive reports from the LCFS on counter fraud activity within the CCG.

### **4 DEFINITION**

4.1 This policy is issued in response to the updated Secretary of State's Directions of November 2004 (NHS Act 1977– Directions to NHS Trusts regarding counter fraud) and incorporates the requirements of Prime Financial Policies and the NHS Counter Fraud and Corruption Manual.

### **5 POLICY DETAILS**

#### **ROLES AND RESPONSIBILITIES**

#### **5.1 Employees & Contractors**

5.1.1 All employees and staff of other organisations performing work for the CCG, such as Commissioning Support Units (CSU) and contractors have a duty to protect the assets of Gloucestershire CCG. Assets include information and goodwill as well as property.

5.1.2 Guidance to employees and contractor staff is attached at Appendices 1 & 2.

5.1.3 All employees and contractor staff have a right and a duty to report any suspicions of fraud or corruption. This should be done through Gloucestershire CCG's Local Counter Fraud Specialist (LCFS), the Chief Finance Officer or the NHS Fraud and Corruption Reporting Line. See Appendix 1 & 2 for telephone numbers and web addresses). These arrangements do not replace CCG procedures for handling complaints, grievances or incident reporting.

5.1.4 If managers receive any allegations of fraud and corruption, they must take them seriously, but must not conduct any investigation into the allegation themselves. They should report any matters to the CCG's Local Counter Fraud Specialist.

5.1.5 The Human Resources service shall provide, to those conducting an investigation, advice and guidance on any requirements relating to matters of employment law and in other procedural matters, such as disciplinary and complaints procedures.

## **5.2 Accountable Officer/Chief Finance Officer**

5.2.1 The Accountable Officer and Chief Finance Officer are responsible for ensuring compliance with the Secretary of State's Directions on Counter Fraud.

5.2.2 Gloucestershire CCG is responsible for maintaining a named and accredited person, nominated to act as its Local Counter Fraud Specialist (LCFS).

5.2.3 Gloucestershire CCG will facilitate and co-operate with NHS Protect and its LCFS, giving them prompt access to CCG staff, workplaces and relevant documentation, particularly in relation to:

- investigating alleged cases of fraud and corruption;
- quality inspections;
- fraud measurement exercises;
- national or local proactive exercises;
- fraud prevention reviews;
- reporting arrangements;
- publicity.

## **5.3 Chief Finance Officer**

5.3.1 The Chief Finance Officer is responsible for monitoring compliance with the Secretary of State's Directions and with any other instructions issued by NHS Protect.

5.3.2 The Chief Finance Officer is responsible for ensuring that an adequate CounterFraud provision is in place including agreement with the LCFS on an annual Counter Fraud work plan, which will be subject to scrutiny and approval by the Audit Committee. This will cover all aspects of Counter Fraud activity and meet the needs of Gloucestershire CCG:

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

5.3.3 The Chief Finance Officer will liaise and reach agreement with the LCFS and NHS Protect where the appropriate sanction is considered prosecution, before either party takes any further action. Such liaison will also take place before any referral of a case to the Police or any other body prior to any investigative action, unless where a scene of crime needs to be preserved and the Police called as quickly as possible.

5.3.4 The Chief Finance Officer shall inform and consult the Accountable Officer in cases where the incident may lead to adverse publicity.

#### **5.4 Commissioning Support Units (CSU)**

5.4.1 Where an employee of the CSU discovers or has a suspicion of fraud relating to Gloucestershire CCG then they shall follow the same protocol as if they were an employee of Gloucestershire CCG.

5.4.2 If the CSU discovers or has a suspicion of fraud concerning one of their employees which relates to Gloucestershire CCG then the CSU shall report this to the CCG nominated contact as per the procedure and the CCG and the CSU shall agree which counter fraud department will lead any investigation.

#### **5.5 Local Counter Fraud Specialist (LCFS)**

5.5.1 The LCFS represents the CCG when dealing with fraud matters.

5.5.2 The LCFS will report all cases where fraud or corruption is thought to be present to the Chief Finance Officer, so that agreement on the most appropriate course(s) of action can be reached. The Chief Finance Officer and LCFS will consider further action in accordance with the NHS Counter Fraud and Corruption Manual.

5.5.3 The LCFS will report to the Chief Finance Officer and Audit Committee, details of systems weaknesses identified following investigations or other proactive work. Any recommendations for changes to systems/processes will also be recorded and monitored for progress by the LCFS, Chief Finance Officer and Audit Committee.

5.5.4 The LCFS will be entitled to attend any Audit Committee meeting and have a right of access to all Audit Committee members and to the Chair and Accountable Officer of the CCG.

#### **5.6 Auditors**

5.6.1 External Audit and the Gloucestershire CCG's Internal Auditors will report any systems weaknesses detected in the course of their work that may allow fraud to take place, to the LCFS. A protocol between internal audit and the LCFS will define the process for the sharing of this information.

#### **5.7 Investigations With Clinical Implications**

5.7.1 When investigating suspicions of fraud, it is important to consider whether there may be any clinical or health and safety implications which could have an adverse impact on the organisation. In such cases, the overriding consideration must be one of patient care.

5.7.2 It must be appreciated that every case is different and it is therefore not possible to provide definitive guidance.

5.7.3 In such an instance, the LCFS is responsible for ensuring that the Chief Finance Officer is informed of the potential risk at the earliest opportunity. The Chief Finance Officer, or designated deputy, will decide which of his/her senior colleagues

should be informed and consulted before reaching a decision. Any appropriate professional body may also be notified. It is essential this happens to ensure that the Chief Finance Officer's decision can take account of the full consideration of the clinical and non-clinical risks facing the organisation. To ensure that the investigation is not compromised however, it is vital that the number of people aware of the investigation is kept to an absolute minimum. If in any doubt, advice should be sought from the Area Anti-Fraud Lead or NHS Protect.

5.7.4 It may be essential for immediate action to be taken. All previously agreed parties should be involved in this process and should be kept informed of any action taken and the outcomes. Any decision to contact or suspend / exclude the individual(s) under suspicion must involve the Chief Finance Officer, Head of Human Resources and the LCFS.

5.7.5 Fraud investigations will not compromise clinical issues and / or patient care.

## **6 CONSULTATION**

6.1 The policy requires approval by the Audit Committee.

## **7 TARGET AUDIENCE**

7.1 This policy applies to all employees of the CCG, regardless of position held, as well as consultants, vendors, contractors, and/or any other parties who have a business relationship with the CCG. It will be brought to the attention of all employees and form part of the induction process for new staff.

7.2 Staff will need to be aware that a breach of this policy renders them liable to prosecution and may also lead to loss of their employment and pension rights in the NHS.

## **8 COMMUNICATION**

8.1 This document is a freely available public document without any restrictions of confidentiality. It may be made available to the public and persons outside of the CCG as part of the CCG's compliance with the Freedom of Information Act 2000.

8.2 This policy is located on the CCG's internet and intranet sites.

## **9 TRAINING**

9.1 Training related to the Counter Fraud Policy will form part of the CCG's induction training.

9.2 The Local Counter Fraud Specialists will conduct an on-going series of fraud awareness presentations to staff groups.

## 10 REFERENCES

10.1 This policy should be read in conjunction with the following policies. Adherence to these policies is mandatory and is integral to ensuring that an anti-fraud and corruption culture is maintained.

- Response Plan for dealing with detected or suspected fraud
- Standing Orders
- Standing Financial Instructions
- Financial Procedures
- Standards of Business Conduct
- CCG Policies relating to:
  - Corporate Governance
  - Gifts
  - Hospitality
  - Conflicts of Interest
  - Purchasing
  - Disciplinary Action
  - Whistleblowing / PIDA
  - Use of electronic communications
  - Use of mobile telephones and other mobile communications equipment

### FRAUD REPORTING GUIDANCE

This document is designed to outline the action to be taken where fraud or other illegal acts are discovered or suspected. Managers are encouraged to copy this to staff and to display it on staff notice boards in their department.

### REPORTING FRAUD OR CORRUPTION

Staff concerned about how to raise their suspicion can receive independent and confidential advice from their Local Counter Fraud Specialist, the NHS Fraud and Corruption Reporting Line, the online fraud reporting tool (FCROL) -

<https://www.reportnhsfraud.nhs.uk/>;

from the charity "Public Concern at Work" or from the Trust's own whistleblower contact, Alan Elkin.

### DEFINITIONS

#### FRAUD

A dishonest act by a person in order to make a gain (or attempted gain) for themselves or another, cause loss to another or expose another to the risk of loss. The law is enshrined in the Fraud Act 2006.

- Section 2: Fraud by false misrepresentation (eg. false timesheets)
- Section 3: Fraud by failing to disclose information (eg. Not declaring criminal convictions)
- Section 4: Fraud by abuse of position (eg. Inappropriate authorisation)
- Section 6: Possession of articles for use in fraud (eg. fake qualifications)
- Section 7: Making or supplying articles for use in fraud (eg. Selling false qualification certificates)
- Section 11: Obtaining services dishonestly (eg. Obtaining free NHS treatment)

#### BRIBERY

Bribery is defined by the Serious Fraud Office as giving or receiving something of value to influence a transaction. The Bribery Act 2010 extended the framework of offences to cover bribery both in the UK and abroad.

The three offences most relevant to the NHS are:

- Section 1: Offering, promising or giving a bribe to another person to perform a relevant 'function or activity' improperly or to reward a person for the improper performance of such a function or activity.
- Section 2: Requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly.
- Section 7: Failure of a commercial organisation to prevent bribery (the corporate offence).

## **CORRUPTION**

Corruption is defined as the abuse of entrusted power for private gain, for example someone making a decision that benefits themselves rather than the Trust or its service users.

**Other offences under which charges may be brought following a fraud investigation are (this list is not exhaustive):**

- **THEFT**

A person is guilty of theft if he/she dishonestly appropriates property belonging to another with the intention of permanently depriving the other of it (S1(1) Theft Act 1968)

Property includes money and all other property, real or personal, including things in action and other intangible property (S4(1) Theft Act 1968).

- **FORGERY**

A person is guilty of forgery if he/she makes a false instrument with the intention that he/she or another shall use it to induce someone to accept it as genuine. Also links to section 7 Fraud Act 2006 (S1 Forgery and Counterfeiting Act 1987).

- **IDENTITY CARDS**

It is an offence for a person to be in possession or control of an identity document to which he is not entitled, or of apparatus, articles or materials for making false identity documents...(Identity Cards Act 2006 section 25-30)

- **COMPUTER MISUSE**

- Section 1 Unauthorised access to computer material
- Section 2 Unauthorised access with intent to commit or facilitate commission of further offences
- Section 3 Unauthorised modification of computer material (Computer Misuse Act 1990 [c.18]). These may also constitute a breach of the CCG's IT Policy.

**Listed below are just a few examples of fraud that have been discovered in the NHS:**

- Submitting false or forged timesheets.
- Falsifying travel and / or expense claims.
- People working elsewhere whilst off sick within the NHS.
- Patient falsification of prescription forms.
- Outside agencies duplicating invoices for payment by the NHS.
- Contractors claiming payment for merchandise or services they have not delivered.
- The unauthorised selling of CCG property or assets.

## APPENDIX 2 – FURTHER GUIDANCE

### WHO TO CONTACT

Anyone (staff, patients, visitors or the public) having reasonable suspicions of fraud or corruption should raise them through the following reporting arrangements:

- **Directly via the CCG's LCFS – 01452 318826 or e-mail [fraud.account@glos.nhs.uk](mailto:fraud.account@glos.nhs.uk);**
- **Contact the NHS Fraud and Corruption Reporting Line – 0800 028 4060 - or the online fraud reporting tool (FCROL) - <https://www.reportnhsfraud.nhs.uk/>;**
- **Contact the Chief Finance Officer – Cath Leech - 0300 421 1934;**
- **Via the Whistleblowing contact – Alan Elkin; 07739804542**
- **Where staff have raised suspicions with a line manager or Director the latter must immediately inform the LCFS or Chief Finance Officer.**

All reports, whether verbal or written, will be treated in confidence by trained staff and any information professionally assessed and evaluated.

### WHEN TO CONTACT

It is essential that all employees act at the time of their concerns, as time is likely to be of the utmost importance to prevent further loss to the CCG.

However, staff must not confront any individual that they suspect. Nor should staff contact the police directly. They must contact the LCFS or Chief Finance Officer.

Staff should keep or copy any document that arouses their suspicions but should not go looking for more.

### WARNING SIGNS

**The following examples or circumstances may provide an indication of fraud, and should therefore alert both managers and staff.**

**The examples are not in themselves 'conclusive' proof of fraud.**

- Altered documents (correcting fluid, different pen or handwriting).
- Duplicate claim forms.
- Claim form details not readily checkable.
- Changes in normal patterns, of e.g. cash takings or travel claim details.
- Text erratic or difficult to read or with details missing.
- Delay in completion or submission of claim forms.
- Lack of vouchers or receipts in support of expense claims, etc.
- Staff seemingly living beyond their means.
- Staff under constant financial or other stress.
- Staff choosing not to take annual leave (and so preventing others becoming involved in their work), especially if solely responsible for a 'risk' area.
- Complaints from public or staff.
- Always working late.
- Refusal of promotion.

- Insistence on dealing with a particular individual.

## **ACTING ON YOUR SUSPICIONS - SOME DOs AND DON'Ts**

If you suspect fraud or corruption within the workplace, there are a few simple guidelines that should be followed:

<p><b>DO</b></p>	<ul style="list-style-type: none"> <li>• Make an immediate note of your concerns.</li> <li>• Where possible note all relevant details, such as what was said in telephone or other conversations, the date, time and the names of any parties involved.</li> <li>• Convey your suspicions to the Local Counter Fraud Specialist (LCFS), Chief Finance Officer or the NHS Fraud and Corruption Reporting Line.</li> <li>• Deal with the matter promptly. Any delay may cause the Trust to suffer further financial loss.</li> </ul>
<p><b>DON'T</b></p>	<ul style="list-style-type: none"> <li>• Do nothing.</li> <li>• Be afraid of raising your concerns. You will not suffer any recrimination from the Trust as a result of voicing a reasonably held suspicion and any matter you raise will be dealt with sensitively and confidentially.</li> <li>• Approach or accuse any individuals directly.</li> <li>• Try to investigate the matter yourself. There are special rules surrounding the gathering of evidence for use in criminal cases. Any attempt to gather evidence by people who are unfamiliar with these rules may damage the case. The LCFS is trained in handling investigations in accordance with the <b>NHS</b> Counter Fraud and Corruption Manual.</li> <li>• Convey your suspicions to anyone other than those with the proper authority.</li> <li>• Speak or write to representatives of the press, TV, radio, or to another third party without the express authority of the Accountable Officer. (Care needs to be taken to ensure that nothing is done that could give rise to an action for slander or libel. Remember individuals are innocent unless proved otherwise. It is possible that there may be other explanations for what is occurring)</li> </ul>

**ACTION TO BE TAKEN IF YOU DISCOVER OR SUSPECT FRAUD OR CORRUPTION**

<p><b>FRAUD</b></p>	<p><b>False representation failing to disclose information abuse of position.</b></p>	<p>These needs to be reported IMMEDIATELY. You therefore must discuss your suspicions or what you have discovered with one of the following;</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>LCFS on 01452 318826</b> or e-mail <a href="mailto:fraud.account@glos.nhs.uk">fraud.account@glos.nhs.uk</a></li> <li><input type="checkbox"/> <b>The Chief Finance Officer on 0300 421 1934</b></li> <li><input type="checkbox"/> <b>The Fraud &amp; Corruption Reporting Line on 0800 028 40 60</b></li> <li><input type="checkbox"/> <b>The online fraud reporting tool (FCROL) - <a href="https://www.reportnhsfraud.nhs.uk/">https://www.reportnhsfraud.nhs.uk/</a></b></li> <li><input type="checkbox"/> <b>Whistleblowing Contact Alan Elkin</b></li> </ul>
<p><b>CORRUPTION</b></p>	<p>Where someone is influenced by bribery, payment or benefit in kind to unreasonably use their position to give some advantage to another.</p>	
<p><b>THEFT</b></p>	<p>Includes any <b>dishonest appropriation of property.</b></p>	<p>These need to be reported <b>IMMEDIATELY</b> to the Local Security Management Specialist (LSMS) or out of hours to the Senior on-call manager.</p>

**DO'S & DON'TS FOR FRAUD**

If you are suspicious or have concerns

- DO** tell someone – confidentiality will be respected.
- DO** keep or copy any document that arouses your suspicions
- DO NOT** confront the individual with your suspicions.
- DO NOT** try to investigate your suspicions yourself.

Further information can be found on the CCG's Website and Intranet or by contacting the Local Counter Fraud Specialist.

## POLICY AUTHORISATION FORM

1	<b>NAME OF POLICY:</b>	Policy for the engagement of Internal and External Auditors for Non Audit Work		
	<b>JOB TITLE OF AUTHOR:</b>	Cath Leech Chief Finance Officer		
	<b>SPONSOR:</b>	* as above		
	<b>NAME OF GROUP:</b> (if applicable)	Audit Committee		
2	<b>EQUALITY AND DIVERSITY – Mandatory Requirement</b>			
	An Equality & Diversity assessment has been completed (Please contact the Equality & Diversity Lead)		<b>Date Completed:</b> *	
	<b>CONSULTATION</b>			
	<b>NAME OF GROUP (S)</b> (complete where relevant)		<b>DATE CONSIDERED</b>	
	Name of Local Committee or Specialist Group?		*	
Name of Countywide Committee or Specialist Group? County Wide Policy YES / NO		*		
Other relevant Forum/Individual?		*		
3	<b>APPROVED BY GOVERNING BODY / IGQC</b>			
	<b>NAME</b> <i>Audit Committee</i>		<b>DATE APPROVED</b> *	
	<b>TO BE REVIEWED BY: (Author)</b>		<b>DATE TO BE REVIEWED:</b>	
	Cath Leech Chief Finance Officer		*	
4	<b>TO BE COMPLETED BY CO-ORDINATOR</b>			
	<b>DATE PUT ONTO POLICY REGISTER:</b>			
	<b>POLICY NUMBER:</b>			
	<b>DATE PLACED ON INTRANET:</b>			
<b>POLICY UPDATES/CHANGES</b> (AFTER GOVERNING BODY/IGQC APPROVAL)				
Date	Summary of Changes	Author/Editor	Approved by	Version



**Policy for the engagement of Internal and  
External Auditors for Non Audit Work**

VERSION	v0.1
POLICY NO	TBC
AUTHOR	Cath Leech, Chief Financial Officer
SPONSOR	
APPROVED BY	Audit Committee
APPROVAL DATE	29 <sup>th</sup> September 2015
REVIEW DATE	September 2018

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## **1. INTRODUCTION**

- 1.1 It is not uncommon for non-audit work to be undertaken by the internal or external auditors engaged by an organisation. In many cases it makes business sense to enlist the internal or external auditors to undertake non-audit work, firstly because auditors are trained to understand the dynamics of an organisation such as the CCG, and can readily review areas without significant additional preparation, and the associated costs and discontinuity associated with enlisting a completely new provider.
- 1.2 However, it is important that clear procedures are in place to clarify the types of work, potential conflicts of interest, and approval procedures where internal or external auditors carry out non-core audit work.

## **2. PURPOSE**

- 2.1 The purpose of this Policy is to identify the types of core audit and non-audit work which may be undertaken by the internal and external auditors, and the reporting and disclosure routes for both service-providers, as separate suppliers of the CCG, each of which may be approached, or nominate themselves, to undertake work identified which is additional to the core agreed annual programme.
- 2.2 In the event that the CCG's internal or external auditors are engaged on non-core audit work, the CCG is required to take steps to ensure that auditor independence is safeguarded. To ensure that an institution adequately addresses this issue, it is recommended that audit committees develop a policy on the provision and pre-approval of all non-audit services provided by the external auditors. However, this Policy has been extended to cover the work of internal auditors, who may also be asked to undertake non-audit work on behalf of the CCG.
- 2.3 The Policy supports the broader principles that internal and external auditors adhere to the professional and ethical standards. This includes taking care to avoid personal and professional conflicts of interest, being clear about their reliance on each other's work and acting with due care.

## **3. DEFINITIONS AND SCOPE**

- 3.1 Prior to defining non-audit work it is appropriate to define the key components of the core audit programme for internal and external auditors.
- 3.2 Core External Audit Work:  
The primary role of external auditors is to report on the Financial Statements of the CCG and carry out whatever examination of the Statements, and the underlying records, data and control systems, necessary to reach their opinion on the Statements.
- 3.2 Core Internal Audit Work:

Core internal audit work is normally much wider in scope than that of the

external auditors and arguably makes the distinction between core audit and non-audit work less clear-cut. In the broadest terms, the core internal audit programme relates to any audits which are intended to provide assurance on the adequacy and effectiveness of risk management, control and governance arrangements provided to the Accountable Officer, Audit Committee and Governing Body.

### 3.3 Non-audit work:

Non-audit work may be defined as activities which fall outside the core audit programme. This is not intended to cover the commissioning by the CCG of additional days which straightforwardly build on, or can be seen as a natural extension of, the audit areas of focus included in the core programme. If the work undertaken is sufficiently distinct from the core audit programme and represents a distinct and discrete series of days which have not been previously approved by the Committee, then this is likely to constitute non-audit work.

The external auditor should not provide any services which would directly compromise their independence and would call in to question the adequacy of the CCG's governance arrangements and reputation

### 3.4 Common to both the internal and external auditors, the Institute of Chartered Accountants identified a number of threats to auditor independence which could arise from undertaking non-audit work:

1. The auditors or a member of the engagement team have a financial or other interest that might cause them to be reluctant to take action that would be adverse to the interests of the firm or a member of the engagement team (self-interest threat).
2. The results of the non-audit service performed by the auditors may be included in the Financial Statements, and thus not subject to proper audit review (self-review threat).
3. The auditor undertakes work that involves making judgments and taking decisions which are the responsibility of management (management threat).
4. The audit firm undertakes work that involves acting as advocate for the institution and supporting a position taken by management in an adversarial context (advocacy threat).
5. The auditor is predisposed, for example because of a close personal or family relationship, to accept or not sufficiently question the institution's point of view (familiarity threat).
6. The auditor's conduct may be influenced by fear or threats from management (intimidation threat).

### 3.5 Examples of the type of non-audit work which should not be approved to be undertaken by either the internal or external auditors include, but not limited to:

1. Selection, design or implementation of major financial systems
2. Maintaining or preparing financial accounts, or bookkeeping or other services related to the accounting records or financial statements of the CCG

3. Management or human resource functions, including provision of out-sourced financial systems or operational management functions
4. recruitment or secondment of senior management
5. Remuneration advice in respect of senior management
6. Valuation services
7. Broker or dealer, investment adviser, or investment banking services
8. Litigation support
9. Any other services specifically prohibited by UK or other relevant legislation or regulation

#### **4. POLICY DETAILS**

##### **4.1 Commissioning non-audit services**

4.1.1 In addition to the specific type of work undertaken and whether it should be prohibited, the following points need to be considered:

1. whether it is in the best interests of the CCG from a continuity and challenge perspective to commission the internal and external auditors to undertake the work;
2. Does the work compromise, or give the perception of compromising, the auditor's independence?
3. Do the auditors have the appropriate knowledge/experience of the business area to undertake the work?
4. transparency of procurement and openness and fairness in line with the Financial Regulations, tendering and competition law
5. the number of days' work and costs associated with it, relative to the core internal or external audit programme.

4.1.2 Advice must also be sought from the Head of Procurement and the Associate Director of Corporate Governance, before discussing the issue with the Chief Finance Officer.

##### **4.2 Approval of non-audit work**

4.2.1 The Audit Committee is responsible for overseeing the relationship with, and between, the internal and external auditors and for keeping the nature and extent of non-audit services under review. Accordingly, the Audit Committee should satisfy itself that the objectivity of the internal or external audit service has not been affected by the extent and nature of other work carried out.

4.2.2 The Audit Committee has final approving authority for the appointment of the internal and external auditors for non-audit work, on the recommendation of the Chief Finance Officer, who is jointly responsible for liaising with the auditors on any work undertaken. Further information may be sought from the auditors and/or from the Chief Finance Officer to inform the Audit Committee's opinion in this area.

4.2.3 The Associate Directors of Corporate Governance, as Secretary to the Audit Committee, is responsible for seeking the approval of the Audit Committee by placing the proposal on the agenda for a scheduled meeting.

## **5. REPORTING REQUIREMENTS**

5.1 The reporting of core audit and non-audit remuneration is disclosed in a number of documents:

1. the Audit Committee's Annual Report to the Governing Body;
2. the Financial Statements;
3. the annual reports and memoranda of the internal and external auditors.

## **6. CONSULTATION**

6.1 All members of the Audit Committee, Accountable Officer, Chief Finance Officer and the Associate Director of Corporate Governance are to be consulted on this policy.

## **7. TARGET AUDIENCE**

7.1 The target audience for the policy is the CCG Governing Body, members of staff and any other person working on behalf of the CCG or are members of the CCG committees.

## **8. COMMUNICATION**

8.1 The policy will be sent to members of the Governing Body and the wider CCG membership via email and placed on the CCG intranet site.

**Agenda item 13**

**Governing Body**

<b>Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Report Title</b>	<b>Planning 2016/17</b>
<b>Executive Summary</b>	This paper provides an update on the progress towards delivery of the 2015/16 Operational Plan, a high level overview of the approach to develop the strategic Commissioning Intentions for 2016/17 and the final proposed version of the Prioritisation Matrix (for approval) post testing at the QIPP Monitoring and Assurance Group. It is the third in an ongoing series of planning papers presented to the Governing Body to ensure visibility through the 2015/16 planning round.
<b>Key Issues</b>	Delivery of the 2015/16 Operational Plan is a CCG commitment and any under or over delivery will impact on the 2016/17 Commissioning Intentions. Approval of the Prioritisation Matrix is required prior to the Priorities Committee meeting in January 2016.
<b>Risk Issues: Original Risk Residual Risk</b>	There is the potential for reputational risk to the CCG if not delivering against key commitments, and financial risk if the prioritisation matrix does not effectively support decision making during the prioritisation process.
<b>Financial Impact</b>	A structured prioritisation process using an agreed matrix will ensure that cost effective business cases will be approved for 2016/17.
<b>Legal Issues (including NHS Constitution)</b>	The Commissioning Intentions include a commitment to ensure compliance with NHS Constitution Standards.

<b>Impact on Health Inequalities</b>	The prioritisation matrix includes the assessment of issues relating to health inequalities. In addition, the Commissioning Intentions include a commitment to reduce health inequalities and, therefore, there will be a net positive impact on health inequalities as a result of implementing this paper.
<b>Impact on Equality and Diversity</b>	The prioritisation matrix includes the assessment of issues relating to equality and diversity. In addition, the Commissioning Intentions include a commitment to ensure equality and value diversity and, therefore, there will be a net positive impact on equality and diversity as a result of implementing this paper.
<b>Impact on Sustainable Development</b>	The CCGs Commissioning Intentions support sustainable development.
<b>Patient and Public Involvement</b>	Commissioning Intentions describe the CCGs future intentions for improving patient and public involvement.
<b>Recommendation</b>	The Governing Body is requested to: <ul style="list-style-type: none"> <li>• note the progress update on the 2015/16 Operational Plan <b>(for information)</b></li> <li>• agree the approach for developing the GCCG Commissioning Intentions for 2016/17 <b>(for approval)</b></li> <li>• agree the final Prioritisation Matrix <b>(for approval)</b></li> </ul>
<b>Author</b>	Ellen Rule (Director of Transformation) Ian Goodall (Associate Director of Operational Planning), Jenny Bowker (Associate Director of Strategic Planning)
<b>Designation</b>	See above
<b>Sponsoring Director (if not author)</b>	Ellen Rule Director of Transformation and Service Re-design

**Thursday 26<sup>th</sup> November 2015**

**Planning for 2016/17**

**Executive Summary**

This paper is the third planning paper presented to the Governing Body. The previous papers in July and September set out the approach for the planning round, an engagement timeline and sought agreement to the approach for prioritisation and planning in 2015/16. This paper provides an update on progress made to date in delivering the planning round for 2015/16 including an approach to developing the commissioning intentions, the updated prioritisation matrix for approval and an assessment of the delivery against the objectives set out in the operational plan so far in 2015/16.

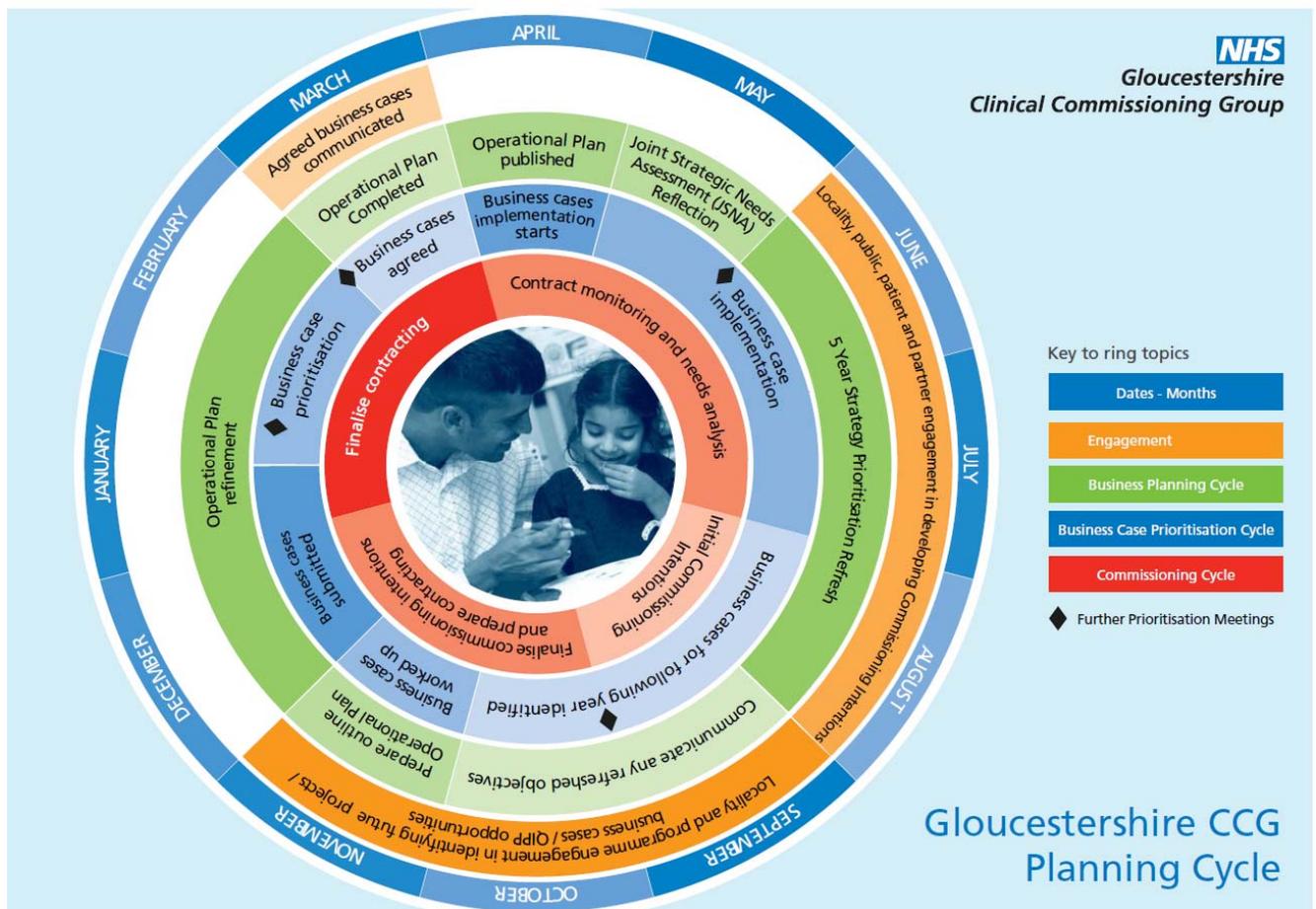
The detailed operational plan review is included at Annex 1 and evidences significant progress against key objectives that the CCG can be proud of, although it should be noted that challenges remain in delivery of constitutional standards.

In addition to the work programme described in our operational plan the CCG has worked on a number of areas that have emerged as priorities in year, such as development of a Devolution proposal for health and social care and taking on the chairmanship of the newly established regional urgent care network for the South West.

# 1. Introduction

The CCG follows a relatively standard cycle of planning activities, this is described in the cycle set out in the diagram shown at *Figure 1*, to allow for ease of communication with a wide range of stakeholders. The Planning Cycle describes the required planning activities during each month of the year. Each circle represents a different type of planning activity, namely:

- The commissioning cycle
- The business case prioritisation cycle (including the principle of prioritisation of most business cases in late January/early February and two additional prioritisation opportunities throughout the year)
- The business planning cycle including writing and refreshing our strategic plan JUYC, and the Operational Plan
- The engagement cycle:



## **2. Planning Round: Progress to Date**

This years' planning round is focussed on ensuring that there is a more comprehensive approach to engagement throughout the planning process. A detailed and updated calendar of events is set out in Annex 1 showing engagement undertaken to date and future planned activities.

To support the development of the plan for 2016/17 the CCG is engaged in the following activities:

- A detailed review of delivery against the CCG Operational Plan for 2015/16. This is set out in Annex 2 to this paper
- A review of the existing prioritised business cases and schemes to evaluate delivery. The Governing Body will review and re-prioritise existing schemes where there are questions about deliverability / viability as part of the prioritisation process in January
- Development of an outline financial plan based on current assumptions, to inform commissioning and contract intentions. It should be noted that this work is very much in outline until formal allocations and national planning guidance is received
- Development of proposals for new business cases for 2016/17 (led by programme and project group)

## **3. Commissioning Intentions**

The CCG has issued high level contracting intentions to providers, and is developing strategic intentions for 2016/17 as an output of the ongoing engagement work and the activities set out in section 2 above. The strategic direction for 2016/17 will be built from the following assumptions:

- That the CCG will continue to work towards the vision set out in our five year strategic plan – Joining Up Your Care
- That the strategic objectives will strongly focus on delivery within our means and take account of the financial challenges facing our

system, including development of system wide financial incentives to ensure the principles of One System, One Budget are met

- That our strategic intent will take account of the development work undertaken during 2015/16 through the GSF workshops, and the new emerging thinking on devolution and 'five year forward view' new models of care
- That in support of the above, the key objectives set out in our Operational Plan for 2016/17 will broadly roll forward to ensure continuity and maintained focus on delivery in key projects and programmes

#### **4. Prioritisation Matrix:**

The final prioritisation matrix for use in the planning round towards the 2016/17 operational plan is set out below. This has been tested through the QIPP assurance and monitoring group and is now presented to the Governing Body for final approval.

The matrix will support the work of the Priorities Committee in January as the investment priorities for 2016/17 are considered.

Factor		Scale			Score	Weight	Mark
<b>Mandatory (Core to confirm status)</b>	<b>DO NOT SCORE FURTHER</b>						
	Detail	Low (0-3)	Mid (4-7)	High (8-10)			
Strategic Fit	Supports delivery of Gloucestershire priorities, Joining Up Your Care, national policy, managing access (care closer to home/reduced waiting times and LOS) and reducing variation, reputational or other imperative (e.g. procurement)	Does not address the objectives of Joining Up Your Care or meet national/local priorities. Does not improve access or reduce variation. No risk to reputation or other imperative.	Partially addresses one or more of the objectives set out in Joining Up Your Care or national/local priorities. Makes some contribution to improving access or reducing variation. Some risk if not delivered.	Fully supports one or more of the objectives set out in Joining Up Your Care or national/local priorities. Significant improvement to access or significant reduction in variation. High risk if not delivered.			1
Addressing Health Inequalities	Reduces identified health inequalities, proportionate universalism	Little contribution towards reducing health inequalities or needs identified in JSNA / Health Inequalities delivery plan	Some contribution towards reducing health inequalities or needs identified in JSNA / Health Inequalities delivery plan	Significant contribution towards reducing health inequalities or needs identified in JSNA / Health Inequalities delivery plan			1
Quality and Outcomes	Clinical evidence base, patient experience, measurable impact on health and wellbeing outcomes and/or life expectancy, negative impact on care if not delivered	Limited benefit to patients is demonstrated	Some Benefits demonstrated	Significant and measurable benefits to patients			1
Deliverability	Do-ability, Workforce, Sustainability, Environmental Impact	Significant questions of deliverability, resourcing or sustainability, adverse environmental impact	Some questions of deliverability, resourcing or sustainability, neutral or evidence of some positive impact on environment	Clear evidence of deliverability, resourcing or sustainability. Significant positive impact on the environment			1
Cost Effectiveness	Return on Investment expected (supporting schedule - can be quantified or qualitative assessment), investment vs benefits delivered, use of resources and Value for Money	Limited evidence of return on investment, investment vs benefits and significant questions about value for money	Some evidence of return on investment, investment vs benefits, some questions about value for money	Clear evidence of return on investment, investment vs benefits and clear value for money			1
					<b>TOTAL</b>		
					<b>Maximum</b>		<b>50</b>
Cost (£)							£0.00
Cost (£) per point							£0.00

## 5. Recommendations

The Governing Body is asked to:

- note the progress update on the 2015/16 Operational Plan **(for information)**
- agree the approach for developing the GCCG Commissioning Intentions for 2016/17 **(for approval)**
- agree the final Prioritisation Matrix **(for approval)**

## 6. Appendices

Annex 1:	Key Dates in the Planning Round (Updated)
Annex 2:	Progress in Delivery of the Operational plan for 2015/16

## Annex 1 - KEY DATES IN THE PLANNING ROUND

MONTH	EVENT CATEGORY	DATE	EVENT
<b>Sept 2015</b>	Engagement	3 <sup>rd</sup>	AGM
	Planning and Contracting	30 <sup>th</sup>	Contract intentions
<b>Oct 2015</b>	Finance	1 <sup>st</sup>	Draft summary 5 year financial plan shared with NHSE
	Scheme Development	7 <sup>th</sup>	Priorities Committee
	Engagement	22 <sup>nd</sup>	Engagement Event with key stakeholders – Joining Up Your Care Five Year Forward View
	Scheme Development	29 <sup>th</sup>	QIPP Development and Monitoring Group
	Scheme Development	30 <sup>th</sup>	High level benchmarking for programme Groups
	Planning and Contracting	30 <sup>th</sup>	Outline Commissioning intentions
	Finance	30 <sup>th</sup>	Budget meetings with Directors to assess baseline spend
<b>Nov 2015</b>	Engagement	2 <sup>nd</sup>	Cheltenham Locality Executive Group
	Engagement	3 <sup>rd</sup>	Tewkesbury, Newent & Staunton Locality Executive Group
	Engagement	10 <sup>th</sup>	Gloucester Locality Executive Group
	Engagement	11 <sup>th</sup>	Stroud & Berkeley Vale Locality Executive Group
	Scheme Development	12 <sup>th</sup>	Board Development : Overview of 15/16 Operational Plan progress
	Scheme Development	13 <sup>th</sup>	Directorates, clinical programmes and localities submit outline business cases
	Engagement	18 <sup>th</sup>	Forest of Dean Locality Executive Group
	Engagement	18 <sup>th</sup>	VCS Alliance Provider Forum
	Engagement	23 <sup>rd</sup>	North Cotswolds Locality Executive Group
	Engagement	24 <sup>th</sup>	South Cotswolds Locality Executive Group
	Scheme Development	26 <sup>th</sup>	QIPP Development and Monitoring Group
	Planning and Contracting	26 <sup>th</sup>	Governing Body Operational Plan Update
	Scheme Development	26 <sup>th</sup>	Governing Body : Overview of 15/16 Operational Plan progress
	Finance	30 <sup>th</sup>	Second cut 5 year financial plan shares in CCG Development session

<b>Dec 2015</b>	Engagement	1 <sup>st</sup>	HealthWatch Forum
	Planning and Contracting	21 <sup>st</sup>	NHSE Publishes Planning Guidance (assumed)
	Planning and Contracting	31 <sup>st</sup>	NHSE Publishes NHS Standard Contract Terms and Conditions (assumed)
	Finance	31 <sup>st</sup>	Third cut 5 year Financial Plan
	Finance	31 <sup>st</sup>	Allocations due (3-5 year)
<b>Jan 2016</b>	Scheme Development	21 <sup>st</sup>	QIPP Development and Monitoring Group
	Scheme Development	21 <sup>st</sup>	Priorities Committee
	Scheme Development	28 <sup>th</sup>	Directorates, clinical programmes, localities sign off draft QIPP schedules
	Planning and Contracting	26 <sup>th</sup>	
	Finance	29 <sup>th</sup>	5 year Financial Plan(post allocations) presented to Development session as prelude to Priorities Committee
	Finance	29 <sup>th</sup>	First cut summary financial plan to NHS
<b>Feb 2016</b>	Planning and Contracting	1 <sup>st</sup>	Updated contract intentions sent to providers
	Planning and Contracting	20 <sup>th</sup>	Contract signature
	Planning and Contracting	21 <sup>st</sup>	Completion of mediation (if required)
	Scheme Development	25 <sup>th</sup>	QIPP Development and Monitoring Group
	Finance	29 <sup>th</sup>	5 year financial plan including impact of Priorities Committee decisions
	Finance	29 <sup>th</sup>	Draft detailed financial plan to NHSE
<b>Mar 2016</b>	Scheme Development	3 <sup>rd</sup>	Priorities Committee
	Scheme Development	24 <sup>th</sup>	QIPP Development and Monitoring Group
	Planning and Contracting	30 <sup>th</sup>	All contracts signed
	Finance	31 <sup>st</sup>	Budget setting paper presented to Governing Body
<b>Apr 2016</b>	Scheme Development	21 <sup>st</sup>	QIPP Development and Monitoring Group
	Finance	4 <sup>th</sup>	Final detailed financial plan to NHSE
<b>May 2016</b>	Scheme Development	19 <sup>th</sup>	Priorities Committee
	Scheme Development	26 <sup>th</sup>	QIPP Development and Monitoring Group

## Annex 2: Review of 2015/16 Operational Plan Delivery

### PROGRESS UPDATE ON THE 2015-16 OPERATIONAL PLAN

#### 1. Background

1.1 All CCGs are required to produce an Operational Plan by NHS England which describes the following :

- Our vision and values
- System challenges
- Plans for improving health, wellbeing, experience and outcomes
- Plans to develop system wide integration
- Developments in operational delivery including planned, urgent and community care

1.2 The Operational Plan was first drafted in April 2014 as a two year plan which was significantly updated in April 2015. This progress update principally considers the objectives set out in the updated period of the Plan and describes the achievements to date set against the commitments made.

#### 2. High Level Messages in Key Delivery Areas

##### i) Our Vision and Values

The high level objectives and aims described in this section are below.

##### ii) System Challenges

#### CCG Commitments:

- We will ensure commitment to a risk share approach aligned to our priorities (including a risk sharing approach to the delivery of QIPP). This should be underpinned by an open, transparent

approach to the development of opportunities for change;

- We will commit to the principles of 'One System One Budget' to improve services and outcomes for our population, whilst working to ensure financial viability for both commissioners and providers;
- We will develop our clinical programme groups to the point where they are working with full visibility of programme budgets in 2015/16 to prioritise resources across programmes;
- We will work to the principle of moving care 'upstream', and will be aiming to prioritise resources within our care pathways towards primary care and prevention where possible;
- We will work to the principle of commissioning through a care pathways approach, and within commissioned pathways we will look for cost effectiveness, minimising the number of steps and driving greater efficiency;
- We will work to the principle of paying the right price for services delivered by our providers, working within tariff but also conducting a full review of non PbR services, undertaking informative rigorous benchmarking;
- We will consider whether the pilot(s) of innovative organisational forms are in line with the five year forward view new models for delivery of care which will require us to develop any new and innovative approaches to contracting;
- We will not commission services that are deemed by evidence cost or clinically ineffective.

***Key achievements to date:***

- Risk share arrangements are included in provider contracts including the delivery of QIPP.

- The principles of 'One System One Budget' are being supported through the Better Care Fund, plans for Devolution and the work of the Gloucestershire Strategic Forum, Health and Wellbeing Board and JUYC Board.
- The CCG is working towards the principle of moving care 'upstream' through the development of primary care as well as investment in prevention and self-management.
- Clinical and cost effective care pathways are being developed through the care pathways approach.
- Decommissioning services that are not clinically or cost effective occurs through the Priorities Committee and the development of new care pathways and service models.
- The Programme Budgeting Tool has been utilised in order to provide CPGs with benchmarking information for expenditure against defined programme areas, although further development is needed to provide clinical programme groups with all of the information they need to fully define their programme budgets.

### ***iii) Evidence Base***

The CCG continues to refine its' benchmarking methodology and to use established benchmark data such as Commissioning for Value from NHS Right Care in order to identify where the CCG is an outlier in terms of service delivery or health needs.

### ***iv) Building on Delivery***

No additional commitments made in this section.

### ***v) Core Delivery Principles***

The high level objectives and aims described in this section are covered in section vi to viii below.

## **vi) Health and Wellbeing**

### **CCG Commitments:**

- Actively seek to commit additional resources to the prevention agenda in line with the activities and projects set out in the Healthy Individuals Programme, including commissioning some pilot interventions through the Gloucestershire Voluntary and Community Services Alliance (VCS) in 2015/16 to support the objectives set out in our Cultural Commissioning programme;
- Further develop innovative ways to commission charitable and voluntary sector providers to support this agenda through our Arts Council funded Cultural Commissioning Programme;(This will take account of work by NHS England to develop a standard short model grant agreement)
- Work with the Health and Wellbeing board for Gloucestershire to increasingly ensure a strategic focus on the health and well-being agenda for Gloucestershire;
- Review of existing self-management services to commission appropriate services which best meet the need of our local population;
- Working with partners to ensure high quality health information is embedded across our care pathways;
- Across the community ensure effective utilisation of the well-being services available at a locality level through a co-ordinated approach (social prescribing);
- Further develop the role of assistive clinical technology within the community to support the defined models of care co-ordination, and commission an Integrated assistive clinical technology provider across primary and community care to be in place from April 2015;

- Develop a consistent personal care plan template into the health and social care system;
- Work with Public Health to review services and interventions commissioned to address individual and family lifestyle issues;
- Increase utilisation of the smoking cessation service for patients prior to an elective operation.
- Review NICE guidance published on health promotion and prevention, including guidance on promoting healthy workplaces and behavioural interventions relating to smoking, obesity and alcohol with a view to local adoption where best practice is not already in place.
- Work with providers to ensure that they develop and maintain a food and drink strategy in line with the requirements set out in the new NHS Standard Contract.
- Ensure that we respond to the national agenda on Diabetes, in line with the intention to implement at scale a national evidence based diabetes prevention model.

***Key achievements to date:***

- Additional resources have been committed to the prevention agenda (e.g. 150k for the Cultural Commissioning Programme; £190k investment in falls prevention for 2016/17).
- Innovative mechanisms have been developed to commission VCS providers via the Cultural Commissioning Programme.
- Continued to actively participate in the Health and Wellbeing Board.
- Review of self-management services complete and model for self-management in development.
- Countywide rollout of social prescribing.

- Ongoing investment in assistive clinical technology (Florence).
- Work ongoing with public health to jointly commission a health information portal and develop a 'health improvement offer'.
- The CCG and GCC are part of a regional submission to become a pilot site for the National Diabetes Prevention Programme. The CCG has been identified as the lead partner.

***vii) Locality Commissioning and Asset Based Community Development***

**CCG Commitments:**

- Develop indicative budgets at a locality level through the principles of 'one system, one budget';
- Focus on developing partnerships at the locality level with district councils;
- Develop profiles of locality services, bringing together a range of resources such as the taxonomy work for primary care;
- Develop an innovative approach to commissioning from 'non-standard' providers. In 2015/16 we intend to further develop innovative ways to commission charitable and voluntary sector providers to support the health and wellbeing agenda through our Arts Council funded Cultural Commissioning Programme. (This will take account of work by NHS England to develop a standard short model grant agreement). This work will be done through the VCS Alliance.
- Develop local arrangements to enhance the impact of local volunteers and lay people in line with national action in this area which is expected to include measures to improve support and training, better matching of people to opportunities and steps to raise the status of volunteering.

- Develop plans to better identify and support carers in our community, to provide better support to all carers but with a particular focus on vulnerable carers such as young carers and carers who are themselves over 85.

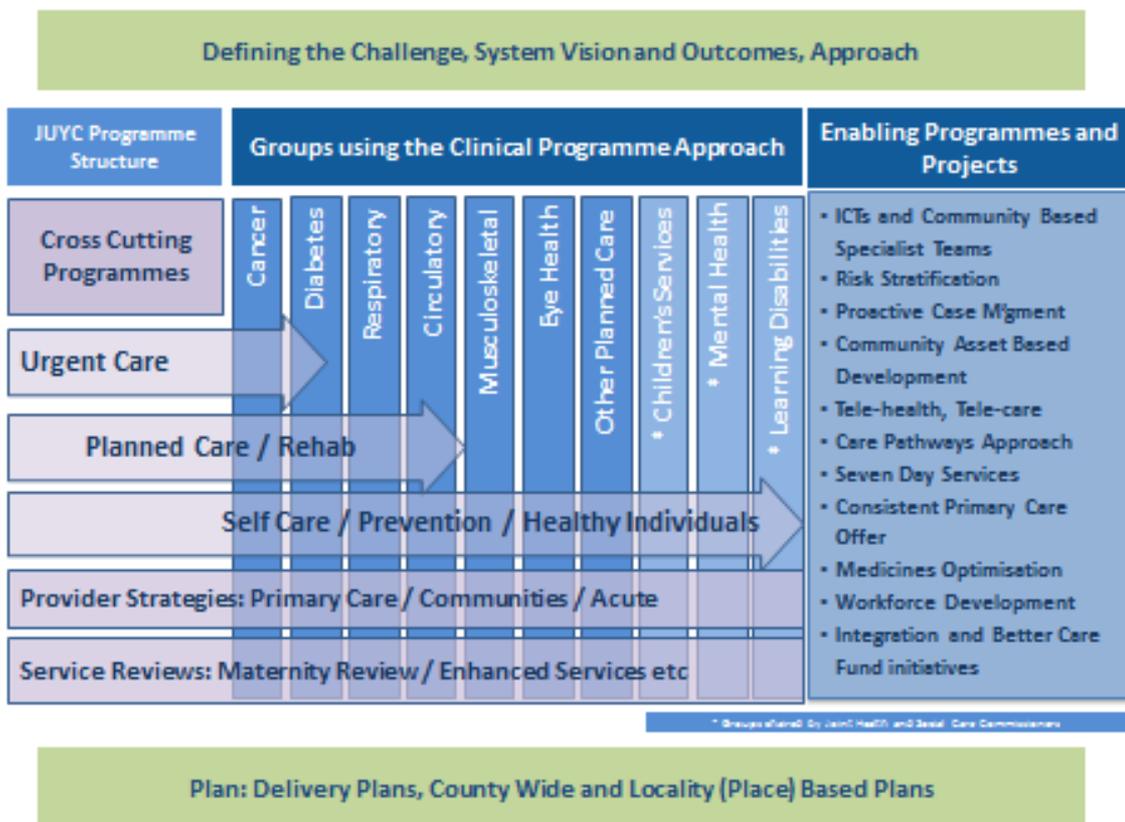
***Key achievements to date:***

- Indicative locality budgets are in development and being refined. Expected to be in place by April 2016.
- Strong partnerships being developed with County and District council partners through our devolution Gloucestershire Proposal and with district councils at locality level (e.g. Tewkesbury Borough Locality Partnership Group).
- Locality profiles, including links to taxonomy groups, developed and used to update Locality Executive Groups, for example in the development of Locality Development Plans.
- *See further achievements under 'Health and Wellbeing'.*
- CCG continues to work closely with GCC commissioners on monitoring the performance of the commissioned carers services remodelled through the Joint Carers Strategy so that this aligns to support the local Better Care Fund metric - Improving Quality Outcomes for Carers.
- NHSE have a South Central CCGs Carers Lead, who is currently mapping CCG carers support and activity; they are keen to develop a Commissioning Quality Assurance Framework for carers services which is being developed by the University of Sheffield; Glos CCG are engaged in that consultation process which is not dissimilar to the local joint health and social care response and has given an opportunity to ensure that Gloucestershire's priorities such as self-management, strengths based care and positive risk taking are included.

**viii) Experience and Outcomes**

**CCG Commitments:**

- The CCG set out an ambitious programme of Transformation and Service Redesign delivered through the Clinical Programme Approach, through the programme delivery structure set out on the following page.
- The detailed objectives for each of the transformation programmes is set out in the individual detailed programme briefs for each programme, and these are not recreated in detail in the operational plan



Given the ongoing delivery pressures on the Urgent Care System, some of the key aspects of the urgent care work programme are set out below in more detail:

- Reduced demand for urgent care admissions through commissioning alternative services, working with partners to reduce acute and community length of stay, and ensure sustained delivery of the 4 hour wait target
- All providers continue to develop and implement plans for 7 day services (focussing on the national clinical standards);
- Focus maintained on delivery of current schemes we are all jointly signed up to, namely Ambulatory Emergency Care, Older Persons Advice & Liaison, use of Single Point Clinical Access, Care Home Enhanced Service and Integrated Community Teams;
- Maintain focus on the areas of our strategy which will include: self-care (including use of NHS 111 in self-care advice) and signposting (within which SPCA, DOS and NHS 111 are all essential)
- Urgent care resilience schemes will be tested out post winter 2014 with a clear decision made regarding ongoing commissioning arrangements;
- Development of the psychiatric liaison services and the role of case manager in support of the urgent care agenda;
- Develop further the use of our community hospital provision to ensure a valuable contribution to communities across Gloucestershire.
- Take an active role in ensuring ongoing system resilience for planned and urgent care;
- Focus on delivering the CCG outcomes framework.

***Key achievements to date:***

- Continued delivery of major urgent care schemes including AECs, OPAL, ICTs and SPCA to support the provision of safe and effective care in appropriate settings

- Implementation of the Primary Care in ED scheme in order to provide GP and nurse practitioner support in A & E and thereby ensure patients receive the appropriate levels of care.
- Provider contracts stipulating the need to continue to move towards the implementation of 7 day service
- Whilst demand for urgent care services has continued to grow, overall length of stay at GHT has not risen since 2014/15.
- SWAST was appointed as the Out of Hours provider for Gloucestershire.
- Ongoing development of a model for self-management which should reduce demand on urgent care.
- Continued oversight of demand pressures and use of resilience funding by the System Resilience Group (SRG).
- During 2015/16 delivery against the CCG's Planned Care objectives have been made through both commissioning development projects and the progress of our Clinical Programme Approach.
- The CCG has prioritised the active operation of the following clinical programmes in 2015/16: MSK, Eye Health, Cancer, Respiratory, Circulatory, Diabetes, Children's & Maternity, Mental Health and Learning Disabilities.
- All projects and programmes support the agreed principles of a whole care pathway approach, supporting a shift to prevention and self-management and the objectives of delivering joined-up, evidence based and affordable care.
- During 2015/16 a range of clinical programme service improvements have been implemented e.g. Eye Health, Diabetes Care and Cancer early diagnosis.
- Major service transformation projects are in progress, and during 2015/16 a new service specifications for community base cancer recovery has been written and implemented and a suite of new MSK service specifications are being produced.

- Significant planned care projects in development include a Urology Review and joint working on Cardiology service.
- GCCG has successfully launched G-Care, an on-line platform providing GPs with comprehensive resources on local care pathways, guidance, referral routes and patient information.
- GCCG is effectively managing its IFR policy, with a clear understanding of thresholds and procedures with providers.
- CCG is currently undertaking the re-commissioning review for activity provided by Care UK, working in collaboration with 6 other CCGs;

***ix) Parity for Mental Health/Learning Disabilities***

***CCG Commitments:***

- Implementing integrated clinical care pathways (in line with the principles of our planned care programme) across mental and physical health care, ensuring increased access to psychological therapies.
- Improving access to psychiatric liaison services, to ensure comprehensive assessment of both the mental and physical health of patients.
- Increasing access to recovery focussed care pathways for people with serious mental health conditions, using an innovative approach
- Ensuring a focus on the needs of vulnerable children, including looked after children, those with mental health needs (including self-harm), and children with long term conditions;
- Expansion of the 2gether NHS Foundation Trust children's and young peoples service to meet the increase in demand, working

with mental health providers to support the delivery of: a wide range of therapeutic consultations, developing Improving Access to Psychological Therapies (IAPT) training, and undertaking of evidenced-based interventions such as Dialectical Behavioural Therapy, Interpersonal Psychotherapy and Family Therapy.

***Key achievements to date:***

- Continued delivery of national targets for Increased Access to Psychological Therapies (IAPT) including a pilot study in Stroud and Berkley Vale to enhance IAPT/GP psychological interventions.
- Introduced new waiting time targets for mental health services.
- Ongoing implementation of payments by results tariffs for mental health services.
- Implemented integrated mental health care pathways across primary care and acute care as part of the Mental Health clinical programme group approach.
- Implementation of the recommendations from the independent review of crisis and emergency responses for urgent mental health assessments including interface and responses with ambulance and police, including arrangements for children and young people.
- Completed a review of Adult Eating Disorders Pathway.
- Increased the dementia diagnosis to 65% (against a national target of 67%) and levels of post-diagnostic support for those with a dementia diagnosis.

***x) Integration, Culture Change and Governance***

***CCG Commitments:***

- Lead the ongoing development and delivery of the work set out on the GSF work programme;

- Deliver the plans set out in the Better Care Fund Strategy in partnership with Social Care;
- Continue the roll out of ICTs phase 1 to ensure Rapid Response and High Intensity Service is available in all localities;
- Develop and implement an agreed approach to case management across our community;
- Evaluate the test and learn ICTs phase 2 in Stroud and Berkeley Vale to inform further development across our county;
- Ensure the principles of living well are embedded into our approach for integrated care across the community.

***Key achievements to date:***

- The Gloucestershire Strategic Forum held three key workshops to review long term strategic options for improving integration and delivery across the whole health and care economy of Gloucestershire. The outputs of these workshops, including a focus on a 'people and place' focus to commissioning will be implemented in the coming months
- The CCG has continued to deliver an integrated operating model of care involving a range of health and social care professionals through the Integrated Community Teams (ICTs). The Rapid Response element of ICT has seen increasing referrals over the course of 2015/16
- The CCG has continued to work collaboratively with GCC in the implementation of the Better Care Fund Implementation Plan (2014-16) in order to embed a 'whole person' and 'strengths based holistic model of integration' within the ICTs.
- Simplification of the Reablement pathway, in conjunction with GCC and GCS, in order to support people to live at home safely, independently and meaningfully. This work involves

joint working with acute and community trusts in order to facilitate safe discharges home.

- Joint working with the Gloucestershire Fire and Rescue Service as part of the Community Offer in order to better identify risk factors, particularly for the elderly, linked to multiple morbidity, cognitive impairment, smoking, drugs, alcohol, physical inactivity, obesity, loneliness and cold homes.

### ***xi) Commissioning of Primary Care Services***

#### ***CCG Commitments:***

- Develop a Gloucestershire Primary Care Strategy;
- Pilot seven day services with a view to responding more flexibly to demand across the whole system where appropriate;
- Develop and test new ways of working in primary care to help manage some of the increasing primary care pressures and improve sustainability;
- Ensure good access to high quality primary care;
- Simplify access to urgent primary care to avoid unnecessary emergency hospital care;
- Ensure greater utilisation of technology to support new ways of working within primary care;
- Support GP practices to make more use of voluntary services for their patients;
- Increase collaborative working between GP practices to provide the full range of services across a large geographical area;
- Develop ways of working to ensure the interface between in and out-of-hours primary care services works more effectively;
- Ensure GPs continue to develop a key role in ensuring co-ordination of integrated care; through the consideration of how

primary care can better supports the integration of care for patients with long term conditions (developed through the clinical programme approach);

- Support primary care to undertake pro-active case management and co-ordination of care of patients in context of Gloucestershire out of hospital care. At the same time supporting the CCG ambition to reduce increasing pressure on the hospital based urgent care *system*;
- Support primary care to maintain a focus on medicines optimisation to ensure that the right medicine is prescribed to the right person at the right time in the right formulation, whilst ensuring that prescribing is as safe, clinically effective and cost effective as possible.
- Extend the range of services offered in primary care recognising diverse demography and health needs of the population across Gloucestershire;
- Reduce health inequalities through targeted commissioning across Gloucestershire.

***Key achievements to date:***

- Work is ongoing to develop a Primary Care Strategy for Gloucestershire including increasing collaboration across GP practices.
- Choice+ was introduced in order to improve patient access throughout the whole week.
- Ongoing investment in assistive clinical technology (Florence) to support new ways of working in primary care.
- Continued investment in improving integration through GP support for the ICTs.
- GPs supported to prescribe cost-effective medicines through the work of the Gloucestershire Joint Formulary Development,

Prescribing Improvement Plan 15/16 implementation and the development of prescribing decision support aids (e.g Scriptswitch)

- Social Prescribing introduced in order to broaden services to patients and access voluntary services
- Care Homes Enhanced Service provides urgent primary care and reduces unnecessary hospital admissions.
- Pharmacy First scheme signposts patients to pharmacies in order to reduce demand on primary care and other health services.

## ***xii) Patient Engagement and Involvement***

### ***CCG Commitments:***

- Ensure that patient/carer experience informs the work plans of the active Clinical Programme Group areas, supported by the role of Lay Champions and HealthWatch Gloucestershire within the CPGs
- Ensure a focus on equality and diversity; including positive promotion of 'protected' groups
- Continue to develop our approach to engagement in line with the NHS Citizen approach

### ***Key achievements to date:***

- Lay Champion and Healthwatch Gloucestershire representative attending Clinical Programme Groups (CPGs) and actively involved in pathway walkthroughs, focus groups and workshops.
- GCCG Strategy for Promoting Equality and Valuing Diversity 2015-2018 was approved in October 2015 which ensures a focus on equality and diversity and the promotion of 'protected' groups including the implementation of the Equality Delivery System (EDS2).

- The NHS Citizen approach adopted by NHS England to support engagement with people as 'NHS owners' and citizens. The CCG will review implementation when a clear approach is advocated by NHS England.

### ***xiii) Continuous Focus on Delivery***

#### ***CCG Commitments:***

- Meet NHS Constitution Standards
- All providers and commissioners to take part in local patient safety collaborative and encouraged to join the 'sign up to Safety' campaign
- All providers and commissioners to jointly develop plans to improve antibiotic prescribing, and all providers to validate their antibiotic prescribing in line with the Public Health England PHE validation protocol.
- All providers to agree Service Development and Improvement plans with commissioners setting out how they will make further progress to implement at least 5 of the 10 clinical standards for seven day services within available resources.
- All providers and commissioners to work together to embed the practice of clear clinical accountability, with a named doctor responsible for a patients care within and across different care settings.
- Using NICE standards and guidelines where appropriate, the CCG aims to commission services that ensure equity of access and continuity of care which is provided in the right place, at the right time by the most appropriate clinician and fully supporting agreed care pathways delivering clinical effectiveness;
- The CCG will expect providers to continue with the implementation of their action plans in line with the recommendations from the Francis Report, Keogh Reviews and Berwick Report. This will be monitored by the CCG through the quality review process. The service providers will be required to

present their plans and on-going progress to key stakeholders, including the public and patient groups, to confirm compliance and provide assurance to the CCG;

- The CCG will continue to include a number of local quality indicators in addition to the national standard contract relating to patient safety, clinical effectiveness and patient experience. Providers will be required to strengthen methods for gathering feedback from patients, service users and staff to triangulate information, including patient involvement in decisions relating to their ongoing agreed care plan;
- Gloucestershire CCG will take every opportunity to monitor and strengthen our commissioner assurance with regard to safeguarding for children and adults, including implementation of the CQC recommendations. The CCG will continue to focus on this aspect of contract reviews with our providers, and will ensure that safeguarding has a high profile within the assessment and review procedures carried out with individual service users;
- The CCG will work collaboratively with our service providers to support the implementation of the Chief Nursing Officer's Vision including the 6Cs. The CCG will drive initiatives across the healthcare community to ensure there is compassion in the care our patients receive;
- With regards to learning disability services, particularly following on from the Winterbourne View report, the CCG will strengthen our links with CQC, and will continue to monitor all safeguarding activity in relation to adults with Learning Disabilities. The CCG will ensure that adult safeguarding has a higher profile in Gloucestershire with a focus on the protection of vulnerable adults;
- The Control of Health Care Acquired Infections (HCAIs) remains a high priority for the CCG and it will continue to work with local NHS Trusts and Primary Care to reduce the incidence of infections both in hospital and in the community;
- In addition the CCG will be requesting an improved standard of patient record-keeping by clinical staff, as well as better records management systems both paper and electronic, which supports

the sharing of patient information to ensure continuity and safety of care.

- Ensure a structured approach to commissioning is fully embedded within the CCG, including robust contracting and performance management to hold providers to account;
- Ensure we deliver services within our means.
- From April 2015 all patients will have online access to their GP records;
- Providers will be expected to use the NHS number as the primary identifier in all settings when sharing information;
- Patients should have access to an easy to use online prescription service. 60% of practices should be electronically transmitting prescriptions to pharmacies by March 2016;
- Structured electronic discharge summaries should be available to health professionals everywhere as required, this is a legally binding requirement from October 2015;
- 80% of all referrals should be made electronically by March 2016 and providers will be required to publish all relevant services and appointment slots as part of standard contact obligation;
- Local commissioners will develop a roadmap by April 2016 for the introduction of fully interoperable digital records, including for primary and specialised care.

***Key achievements to date:***

- CCG signed up to 'Sign up to Safety' Campaign
- Ongoing review of NICE guidance through Clinical Effectiveness Group
- Ongoing programme of national and local CQUIN initiatives
- Ongoing review of compliance with national and local HCAI standards

- Robust contracting and performance management processes in place and improved during 2015-16, delivery of constitution standards remains at risk
- Financial plan remains to 'deliver services within our means'
- Promoting use of generic medicines and locally recommended formulary drug choices via Gloucestershire Joint Formulary Development and Prescribing Improvement Plan 15/16 implementation and development of prescribing decision support aids eg. Scriptswitch
- Medicines optimisation via direct participation in all CPG and clinical pathway development work involving medicines. Also, direct links from G-care to formulary and local prescribing guidelines.
- Working with health, social care and public health communities via the Gloucestershire Medicines Implementation Group to promote cost-effective use of medicines.
- Regularly run Eclipse Live medicines safety audits and informing practices of results for their patients in order to promote safe and effective medicines use in primary care.
- Reduce medicine wastage by supporting the increasing local use of electronic prescribing and repeat dispensing. Promoting proactive polypharmacy reviews in targeted patient groups.
- Clinical Programme Approach is developing an outcome rather episodic approach to developing and delivering new care pathways.
- High level of usage of the NHS number across the main providers.
- Electronic discharge summaries are made to health professionals as required.

- Patients have had access to their Summary Care since April 2015 and will be able to view a record of their Read codes from April 2016.
- 88% of practices (against a target of 60%) are signed up to allowing their patients to have access to the online prescription service.
- Expected that over 80% of all referrals will be made electronically by March 2016.
- Expected that local commissioners will develop a roadmap by April 2016 for the introduction of fully interoperable digital records, including for primary and specialised care.

### **3. Conclusions**

3.1 It is evident that there is a good deal of alignment between the commitments made in our Operational Plan and transformational activities being undertaken across the CCG. With 5 months to run before a new Operational Plan becomes effective the majority of commitments are being addressed to a good degree.

3.2 Our Operational Plan was designed to be challenging and as a consequence some slippage in delivery is inevitable, often due to changing priorities and approaches in-year. Large programmes of change are underway which will ensure future sustainability and the delivery of safe, effective services in the coming years. However, the benefits of some of these programmes of work have yet to be seen, partly because they are at an early stage, and this is reflected in some of the challenges faced so far this year in achieving some NHS Constitution Standards.

3.3 A full year review of delivery of the Operational Plan will be undertaken during 2016-17 to review overall progress and delivery.

**Governing Body**

**Agenda Item 14**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Performance Report</b>
<b>Executive Summary</b>	<p>This performance framework report provides an overview of Gloucestershire CCG performance against organisational objectives and national performance measures for the period to the end of October 2015.</p> <p>The performance report format is currently being reviewed. Some of the agreed changes from the review have been included within this report, others are still under development.</p>
<b>Key Issues</b>	These are set out in the executive summary within the report.
<b>Risk Issues: Original Risk Residual Risk</b>	All risks are identified within the relevant sections of this report.
<b>Financial Impact</b>	This report gives detail on the financial position to the end of October
<b>Legal Issues (including NHS Constitution)</b>	These are set out in the main body of the report.
<b>Impact on Health Inequalities</b>	Not applicable.
<b>Impact on Equality and Diversity</b>	There are no direct health and equality implications contained within this report.
<b>Impact on Sustainable Development</b>	There are no direct sustainability implications contained within this report.
<b>Patient and Public Involvement</b>	These are set out in the main body of the report.

<b>Recommendation</b>	<p>The Governing Body is asked to:</p> <ul style="list-style-type: none"> <li>• Note the performance against local and national targets and the actions taken to ensure that performance is at a high standard.</li> <li>• Note the financial position as at month six.</li> <li>• Note the risks identified in the Finance and Efficiency report.</li> <li>• Note the progress on the QIPP.</li> </ul>
<b>Author &amp; Designation</b>	<p>Sarah Hammond, Head of Information and Performance          Andrew Beard, Deputy CFO          Ian Goodall, Associate Director of Strategic Planning</p>
<b>Sponsoring Director (if not author)</b>	<p>Cath Leech, Chief Finance Officer</p>

**Gloucestershire CCG**

**Performance Report**

**1.0 Executive summary**

**1.1 Introduction**

The performance report is broken down into the five sections of the GCCG performance framework:

- Clinical Excellence
- Finance and Efficiency
- Patient Experience
- Partnerships
- Staff

A full summary of performance against all national and local standards is included within the relevant scorecard for that section of the report. An overarching GCCG performance dashboard is included as a supporting appendix; providing an overview of all key national and local targets. A further supporting appendix is provided in relation to the update on 2015/16 budgets.

Whilst inevitably this report focuses on areas of concern it should be noted that Gloucestershire is currently achieving the majority of the local and national performance standards.

**1.2 Balanced scorecard 2015/16 – up to 31<sup>st</sup> October 2015**

Ref.	CCG Internal Perspective	Overall rating Green
P1	Clinical excellence	Amber
P2	Finance & efficiency	Amber
P3	Patient Experience	Green
P4	Partnerships	Green
P5	Staff	Green

1.2.1 **Clinical Excellence – Amber,**

**Clinical excellence - Perspective highlights:**

- Strong progress is being reported across all active clinical programme groups with good clinical engagement across the system
- The CCG has had 100% sign up from Gloucestershire practices to its primary care offer which includes a strong focus on improving quality in primary care
- The primary care clinical quality group has been set up and is developing a set of indicators of primary care quality at practice level

**Good performance:**

- SWAST wide Red 1 ambulance target achievement
- Reduction in handover delays compared to 2014/15 levels
- Improved Incomplete RTT performance, with the 92% incomplete standard
- Continued achievement of Cancer 31 day targets
- Improvements to patient transport service targets

**Challenging performance:**

- Red 2 Ambulance response times following the introduction of the Dispatch on Disposition pilot. SWAST trajectory to reach 70% for Red 2 by Q3 is in place. It is recognised that the ambulance service are operating the Dispatch on Disposition pilot which has had an impact on this performance
- A&E 4 hour target. The YTD performance at the end of September was 91.4%.
- 62 day cancer waiting times
- 6 week diagnostic waiting times
- Planned endoscopy waiting times
- Cancelled operations

**Patient experience – Green.**

**Patient Experience - Perspective highlights:**

- The case review programme has now been finalised and the programme of case reviews started, the immediate priority is urgent care.
- GCCG will be a 'Beacon CCG' becoming one of the first CCG's to commit to the 'Sign up to Safety' campaign
- CCG Patient Engagement and Experience Teams continue to support a wide range of GCCG projects. Key activities in the last period include:
  - Eye Care and Muskulo-skeletal workshops
  - supporting the development of the Gloucestershire Shared Care Records Project communications and engagement campaign for summer 2015
  - development of Personal Health Budgets (PHB) Stakeholder Engagement
  - production of a patient survey to capture patient experience (including patient transport) of Renal Dialysis; and improving experience of End of Life care in community hospitals

**Good performance**

- Comprehensive experience and engagement activity supporting CCG work programme

**Challenging performance:**

- FFT - Results remain amber

**Partnerships – Green** rating with all indicators on target for achievement.

**Partnerships - Perspective highlights:**

- By the end of quarter two, 20 (24.6%) practices have regular weekly or fortnightly sessions provided in their practice by a social prescribing hub coordinator, with the scheme available to another 50 practices.
- A system resilience plan has been agreed for the winter period including a series of investments to improve system performance this winter.
- Engagement with the voluntary sector has been developed and a kitemark has been developed, social prescribing roll-out has continued. The CCG and partners have continued to develop the cultural commissioning programme.
- A cross system enabling active community groups has been established.

**Staff – Green** rating with all indicators on target for achievement.

**Staff - Perspective highlights:**

- Staff sickness levels remain below the upper threshold of 3%
- A working group is progressing the organisational development plan in 2015/16 and will complete a refresh for 2016/17.

## Finance and efficiency – Green

### Finance and Efficiency - Perspective highlights:

- The overall assessment for the finance and efficiency perspective against the NHS England criteria is amber. The CCG has seen a number of significant financial pressures emerge

### Good performance

- The CCG is forecasting to deliver a surplus of £7.3m.
- The better payment practice code performance for the year to date (for non-NHS invoices by volume) is 97.3% which is in line with the targeted figure.

### Challenging performance:

- Prescribing expenditure is significantly above budgeted level, primarily NOACs
- Emergency activity at GHFT is significantly above planned levels
- There is slippage against the QIPP programme

### 1.3 GCCG Performance Framework Overview

The sections below provide an overview of each domain. Each of the sections is broken down into success criteria which when combined provide an overall rating for the domain. The development of the partnerships section is ongoing as this is an area of development for the CCG.

All indicators are RAG rated, based on the 2015/16 NHS England planning thresholds. Key national and local indicators are given an overall rating by weighting their importance to the organisation. Indicators which feature in the NHS constitution, Quality Premium and CCG assurance framework receive the highest weighting with local targets being given a lesser value. The overall rating is then derived from the combined score of those targets rated Amber and Red.

Areas of performance assessed as being at risk of failure at year end, or other issues that engender concerns throughout the year, for which the Governing Body need to be made aware of, are reported upon within this report. Where standards are reported on a quarterly basis, the Governing Body will be informed of updates as and when data is available or new information comes to light.

#### Performance framework

The GCCG performance framework measures the in-year success of the organisation by linking the key organisational objectives to perspectives. Each of the five perspectives is given a Red, Amber or Green rating based on the progress made against a number of locally defined critical success criteria.

Key local and national commissioned performance targets are also reported under each domain; however, the overall rating of each perspective is derived from GCCG performance against those targets which link to the organisations objectives:

Internal Perspective	Organisational Objective
Clinical Excellence	(1) Develop strong, high quality, clinically effective and innovative services. We will deliver this through a multi professional focus, with a particular emphasis on clinical programme approach and developing our member localities.
Finance and Efficiency	(3) Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the

	reduction of harm, waste and variation.  (4) Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.
Patient Experience	(2) Work with patients, carers and the public; to inform decision making.
Partnerships	(5) Work together with our partners to develop and deliver ill health prevention and care strategies designed to improve the lives of patients, their families and carers.
Staff	(6) Develop strong leadership as commissioners at all levels of the organisation, including localities.

## 2.1 Clinical Excellence

### 2.1.1 Clinical Excellence – Period up to 31<sup>st</sup> October 2015

The overall rating for clinical excellence is Amber for year to date progress against the specified success criteria.

PERSPECTIVE 1	Clinical Excellence	Green
<b>Success criteria: 1.</b> Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.		G
Key performance indicators		
A robust process to timely monitor compliance with NICE, which provides assurance that all NICE publications are considered and Technology Appraisals are implemented within 90 days (or to have a valid reason if not which has gone through appropriate governance process).		G
Clinical Quality Review Groups meet quarterly and provide assurance to the Governing Body through the production of a bi-monthly provider quality report. Ad-hoc meetings take place with providers on specific concerns.		G
<b>Success criteria: 2.</b> Commissioning high-quality primary care services through the utilisation of exercising Delegated Commissioning responsibilities within a robust governance structure		Green
Key performance indicators		
Commission all Gloucestershire practices through a 'Primary Care Offer' enhanced service for 2015/16 that focuses on clinical quality improvement, reduces variation, tackles health inequalities and promotes innovation		G
Set-up and implement a Primary Care Clinical Quality Review Group (CQRG) and develop a set of indicators to measure primary care quality		G
<b>Success criteria: 3.</b> Progress in developing and implementing locality plans		Green
Key performance indicators		
Reporting to be bi-monthly with focus on one of the 7 localities and progress in implementation of plans.		G
<b>Success criteria 4.</b> Progress to develop outcomes for CPGs CPG success criteria & KPIs Outcomes – CPG programme/timelines in outline in appendix, KPIs re staying to timetable, output etc, narrative to focus, in brief, on one CPG area per month		In development

<b>Success criteria: 5. Key local and National standards relating to Patient Experience</b>	A
Key performance indicators	
Achievement of key local and National standards relating to Clinical Excellence – see section 2.2 to 2.8	A

**2.1.2 Success criteria 1: Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.**

The Quality Team has established quarterly Clinical Quality Review Groups (CQRG) chaired by the Executive Nurse and Quality Lead. These are held for Gloucestershire’s main providers, namely Gloucestershire Hospitals NHSFT, 2gether NHSFT, Gloucestershire Care Services Trust and a further CQRG for Care Homes. These meetings report directly to the relevant NHS Gloucestershire CCG/Provider contract boards, and provide a focused opportunity for quality to be discussed between provider and commissioner.

Bespoke datasets are reviewed at the quarterly Clinical Quality Review Group meetings for each of the provider organisations, as well as further CQRG’s for Care Homes and Primary Care

CQRG’s have the ability to escalate any issues to the full contract board, and where necessary to the regular wider Quality Surveillance meetings. Updates and minutes from CQRG’s are routinely reported to IGQC for assurance purposes.

The Quality Team, in conjunction with the Information Team have produced a draft Quality Assurance Framework which spans in-county NHS providers allowing for benchmarking of indicators across providers. Development of this assurance tool will continue.

In addition to the CQRG meetings the Quality Team has recently established a programme of bi-annual Quality Summits for the three main Providers. These Summits bring together Commissioners across the range of services to highlight issues or concerns and identify areas of good practice. The intention is that issues raised will be used to inform the commissioning intentions for the year 2015/16.

**2.1.3 Success criteria: 2: Commissioning high-quality primary care services through the utilisation of exercising Delegated Commissioning responsibilities within a robust governance structure.**

GCCG transitioned the commissioning of primary care services from NHS England in April 2015, using a robust project management approach. We have established a governance infrastructure, including a Primary Care Commissioning Committee, Primary Care Operational Group and commenced the establishment of work streams relating to workforce, estates, quality and innovation.

Since April 2015, in addition to commencement of the development of strategic objectives, we have also managed a number of operational contractual issues, including two GP providers serving notice on their GMS contracts resulting in one GCCG managed dispersal and one procurement, with extensive patient engagement for both. In addition, list closure and branch closure requests have also been received and managed within this period too, all within a good governance process that minimised real or perceived conflicts of interest.

The Primary Care Offer for 2015/16 builds on the success of the 2014/15 scheme, with four ‘building blocks’ across the enhanced service for practices to choose from. The new additions this year include quality indicators relating to antibiotic prescribing, improving Atrial Fibrillation (AF) diagnosis and use of anticoagulants, and identifying patients at risk of Acute Kidney Infection (AKI). The four blocks and the elements they include is summarised in the table below:

Primary Care Offer 2015/16			
<p><b>Improving Quality</b></p> <ul style="list-style-type: none"> <li>• Quality indicators, incl. AF and AKI</li> <li>• Cancer education                             <ul style="list-style-type: none"> <li>• EOL planning</li> </ul> </li> <li>• Practice variation</li> <li>• Clinical audit                             <ul style="list-style-type: none"> <li>• NICE</li> </ul> </li> </ul>	<p><b>Enhanced Primary Care</b></p> <ul style="list-style-type: none"> <li>• Care for Carers                             <ul style="list-style-type: none"> <li>• Amber Drugs</li> </ul> </li> <li>• Post Op Wound Care</li> <li>• Prostate Cancer Reviews</li> </ul>	<p><b>Supporting Urgent Care</b></p> <ul style="list-style-type: none"> <li>• Patient education</li> <li>• Emergency admissions peer review</li> <li>• Escalation reporting</li> </ul>	<p><b>Influencing clinical commissioning</b></p> <ul style="list-style-type: none"> <li>• Annual visits</li> <li>• Membership and locality engagement</li> <li>• Innovation</li> </ul>

For the second year running, we have achieved 100% sign-up to the Primary Care Offer, with all practices agreeing to undertake all four building blocks.

The Primary Care Offer ‘Improving Quality’ will form the basis of reporting through the year, particular with regards to the following elements:

- **Cancer education**
  - GP practices to give significant event consideration to all cancer diagnoses in the practice during 2015/16. To select one case per 2,000 head of population for conducting an in-depth Significant Event Audit
  - GP practices to participate in an education programme, consisting of Macmillan GP “Lunch/Supper & Learn” Master Classes and/or a full-day Cancer PLT.
  
- **Practice variation**
  - CCG to provide a practice variation report. The report will provide activity and performance detail across urgent care, planned care and referrals
  - Each practice to pick two areas where they are an outlier (e.g. T&O referrals) to review.
  - Practices to aim to reduce any unexplained variation
  - Each practice will be provided with a refreshed practice variation report at quarter three 2015.
  - Practices to discuss internally and develop an action plan in order to reduce unexplained variation in their two identified domains
  
- **Local Quality Improvement Indicators**
  - The CCG has developed four quality indicators as set out below, GP practices to review the benchmarking data and agree a practice action plan to improve the benchmarked position. This will involve peer discussion at locality level.
    - Smoking – recording status and advice given
    - Antibiotics Prescribing - (Antimicrobial Stewardship)
    - Improving Atrial Fibrillation (AF) diagnosis rates and use of Anti-coagulants
    - Identifying patients at risk of Acute Kidney Injury (AKI) (Package of measures and further clarity to follow).

2.1.4 A Primary Care Clinical Quality Review Group (CQRG) has now been established, reporting to the Integrated Governance Quality Committee (IGQC). The Group are now working to develop the indicators and processes that will be used to measure primary care quality, drawing on the Primary Care Offer, the Primary Care Web Tool, the Patient Survey, patient complaints and other relevant data sources to determine a Primary Care Quality Framework.

### 2.1.5 **Success criteria 3. 1**

All seven CCG localities have now developed two year Locality Development Plans for 2015 – 2017. Each plan was developed after working with their member practices, CCG colleagues and local stakeholders including Public Health colleagues and representatives from the district and borough councils to understand the influencing factors on health and wellbeing within each locality. These are being shared with a wide range of stakeholders across the county, including practice Patient Participation Groups (PPGs).

It is planned for locality projects to be reported through the HealthPerform system. In order to provide a focus on one particular locality as they start to commence implementation.

### 2.1.6 **Success criteria 4. CPG success criteria & KPIs Outcomes – CPG programme/timelines in outline in appendix, KPs re staying to timetable, output etc. narrative to focus, in brief, on one CPG area per month (timetable re which CPG each month) - Ellen Rule**

Please see section 3.1.6 (page 31)

## 2.2 **Reporting of key local and national standards – Clinical Excellence**

The following section provides an overview of key local and national standard relating to clinical excellence. Assessment against performance is as per defined local/ national guidance.

Issues identified in the following areas:

- Red 2 Ambulance response times
- 12 hour trolley waits in A&E
- A&E 4 hour target
- Stroke performance targets
- RTT 52 week waits
- Cancer waiting times
- 6 week diagnostic waiting times
- Planned endoscopy waiting times
- Cancelled operations

Areas of good performance include:

- Red 1 ambulance achievement
- Reduction in handover delays
- Incomplete RTT performance
- Cancer 31 day targets
- Improvements to patient transport service targets

### 2.3 **Unscheduled care:**

The dashboard below provides a more complete position statement for Unscheduled care. Each of the Amber and Red rated indicators are reported on by exception in section 2.3.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Local and National standards relating to Clinical Excellence							
Unscheduled care	Threshold	Month	Latest Performance	YTD performance	6 month trend		
SWAST Ambulance indicators							
Cat A RED 1 Ambulance incidents	75%	Sept	75.0%	●	76.0%	●	
Cat A RED 2 Ambulance incidents	75%	Sept	68.1%	◆	67.4%	◆	
Cat A 19 min response Ambulance incidents	95%	Sept	91.5%	■	91.6%	■	
Over 30 minute ambulance handover delays (GHNHSFT)	<2014/15	Sept	70	●	381	●	
Over 1 hour ambulance handover delays (GHNHSFT)	<2014/15	Sept	11	●	46	●	
A&E							
4-hour A&E target GHNHSFT	95%	Oct	84.9%	◆	90.5%	■	
4-hour A&E target GCS MIU	95%	Sept	99.7%	●	99.8%	●	
12 hour trolley waits	0	Sept	0	●	1	◆	
Enhancing quality of life for people with long-term conditions							
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	80%	Sept	88.0%	●	81.0%	●	
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	60%	Sept	28.0%	◆	41.8%	◆	

**2.3.1 SWAST Ambulance indicators**

Ambulance targets are monitored at a South Western Ambulance Trust wide aggregate level.

The introduction of the Dispatch on Disposition (DoD) has resulted in the prioritisation of responses to Red 1 incidents. As part of the changes to the dispatch process call handlers are provided with extra assessment time for all other classification of 999 calls (including Red 2 incidents).

Patient safety is of paramount importance and this is being monitored closely by NHS England. There have been no patient safety concerns raised or reported since the introduction of DoD.

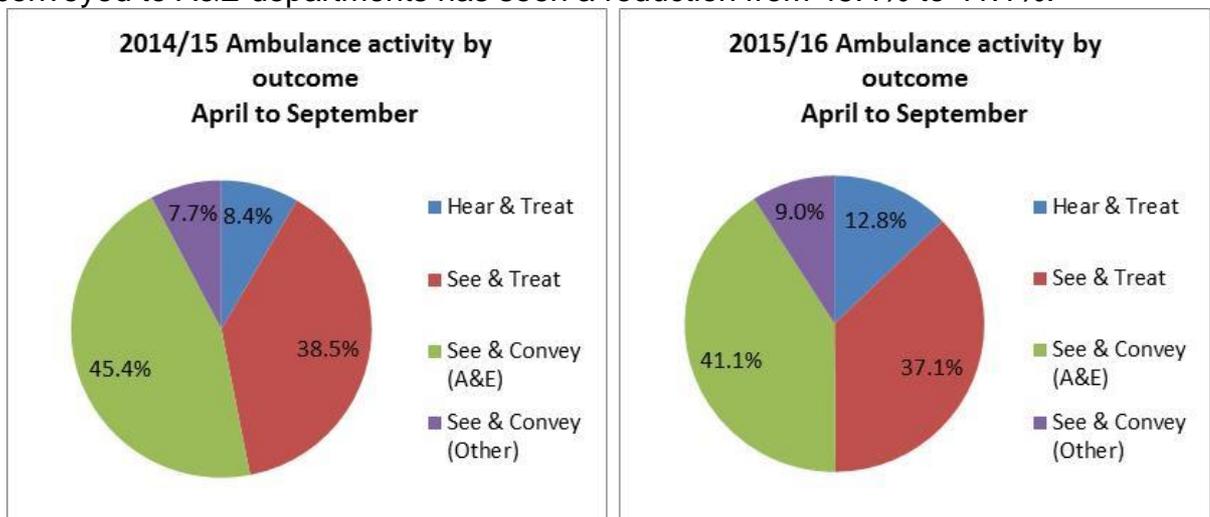
Current year to date performance is Green rated (76.0%) for Red 1; however, performance against the Red 2 and Red 19 minute targets is currently red rated.

It is estimated that impact there has been a 5% reduction in Red 2 performance due to the introduction of the discharge on disposition pilot. On this basis commissioners have received a trajectory from SWAST to reach 70% for Red 2 by the end of December 2015.

During the first 6 months of 2015/16, incidents with response in Gloucestershire have been 4.2% above contracted levels, which equates to 1,854 incidents, approx. 300 per month.

When analysed by case type/ outcome, the profile of quarter 1 Ambulance activity has changed.

The percentage of Hear and Treats has increased from 8.4% to 12.8% for the period April to September 2014/15 to 2015/16, with the number of patients conveyed to A&E departments has seen a reduction from 45.4% to 41.1%.

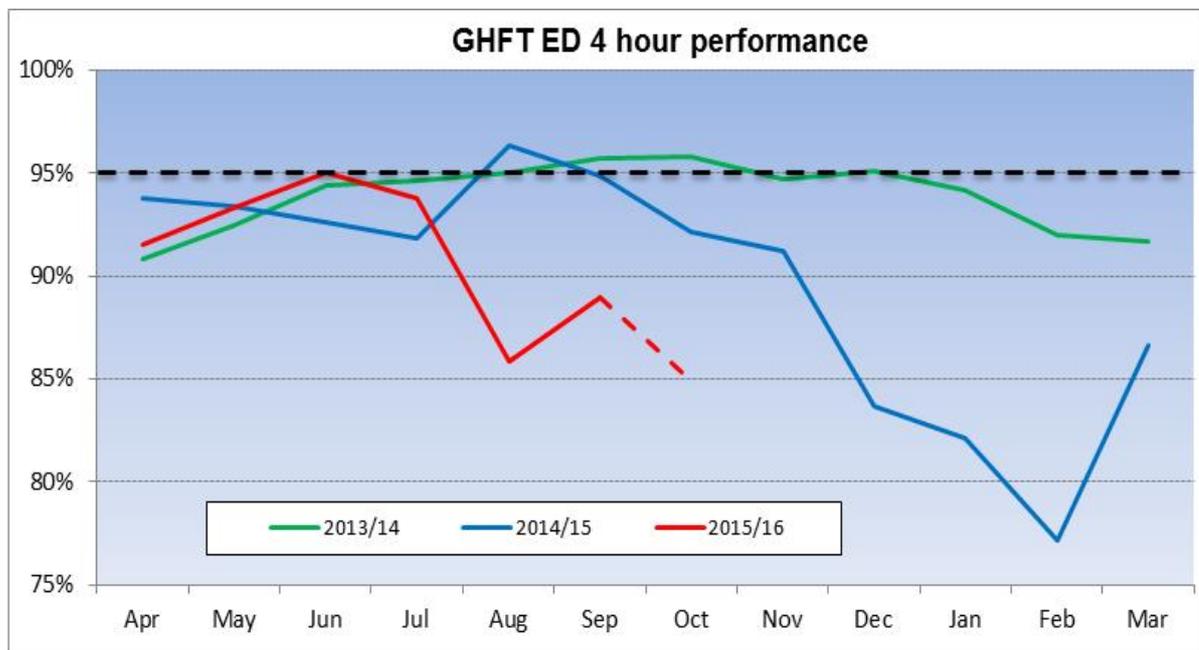


**4-hour A&E target - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge.**

Threshold – at least 95% of patients should be transferred, admitted or discharged within 4 hours.

Performance in September was 89.0%. Performance at Cheltenham General was 94.9% and Gloucestershire Royal was 85.5%. Provisional performance at GHFT during October was 84.9%.

The year to date performance for 4 hours has decreased to 90.5% at Gloucestershire Hospitals NHSFT (GHNHSFT); the quarter 1 and 2 all type performance (combined GHNHSFT, Gloucestershire Care Services MIU and Primary care in A&E) is 94.7%.



The CCG continues to implement a programme to increase urgent and emergency care system resilience to ensure that the system can cope with peaks in demand. These actions are set out in our system resilience plans and focus upon self-care, signposting, admission avoidance, in-hospital care, hospital discharge and community services.

**12 hour trolley wait – Gloucestershire Royal Hospital**

A 12 hour trolley wait occurred at Gloucestershire Royal Hospital on the 13<sup>th</sup> May. As a result of the investigation into the 12 hour trolley wait many additional actions have taken place in response which impact both on the Emergency Department

(ED) front door as well as facilitating patient flow. This includes additional ED Consultants working until midnight, introduction of a capacity and flow coordinator and the undertaking of extensive work to review patient flow across the Trust.

### **Stroke targets**

The proportion of patients spending the required amount of time on a specialist stroke unit increased to 81.0% (target is 80%) due to green rated performance in September.

Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (target 60%).

Performance indicator relates to high-risk transient ischaemic attacks (TIA) patients need to be assessed by experts and, wherever possible, scanned using magnetic resonance imaging (MRI) within 24 hours of experiencing symptoms. Compliance against this target continues to be of concern with performance year-to-date performance of 41.8%

Plans to increase stroke capacity are underway, plus review of admission pathway and discharge delays.

## **2.4 Planned care:**

The dashboard below provides a more complete position statement for Planned care. Each of the Amber and Red rated indicators are reported on by exception in section 2.4.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Planned care	Threshold	Sep-15	Month	Latest Performance	YTD performance	6 month trend
<b>Referral to treatment (RTT)</b>						
% of admitted pathways treated within 18 Weeks	90%	88.7%	Sept	88.7%	■	89.9% ■
% of non - admitted pathways treated within 18 Weeks	95%	94.2%	Sept	94.2%	■	95.5% ●
% of incomplete Pathways that have waited less than 18 Weeks	92%	92.3%	Sept	92.3%	●	92.2% ●
Zero RTT pathways greater than 52 weeks	0	25	Sept	25	◆	127 ◆
<b>Cancer waiting times</b>						
% of patients seen within 2 weeks of GP referral for suspected cancer	93%	94.1%	Sept	94.1%	●	91.3% ■
% of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected	93%	92.9%	Sept	92.9%	■	93.5% ●
Cancer - first definitive treatment within 31 days of a cancer diagnosis	96%	99.6%	Sept	99.6%	●	99.3% ●
Cancer - subsequent treatment for cancer within 31 days - surgery	94%	98.0%	Sept	98.0%	●	97.0% ●
Cancer - subsequent treatment for cancer within 31 days - Drug Regime	98%	100.0%	Sept	100.0%	●	100.0% ●
Cancer - subsequent treatment for cancer within 31 days - Radiotherapy	94%	100.0%	Sept	100.0%	●	99.8% ●
Cancer - first definitive treatment within 62 days GP referral	85%	72.1%	Sept	72.1%	◆	73.8% ◆
Cancer - first definitive treatment within 62 days screening service	90%	93.1%	Sept	93.1%	●	96.4% ●
Cancer - first definitive treatment within 62 days upgrade	90%	100.0%	Sept	100.0%	●	86.4% ◆
<b>Diagnostic waiting times</b>						
% of patients waiting more than 6 weeks diagnostic test	1%	4.6%	Sept	6.7%	◆	5.3% ◆
% of patients waiting more than 6 weeks for a Planned/ Surveillance diagnostic test from their to be seen date – Endoscopy procedures	1%	38.1%	Sept	38%	◆	38.1% ◆
<b>Local community waiting times</b>						
% referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	95%	87%	Sept	87%	◆	92.0% ■
% referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	95%	100%	Sept	100%	●	100.0% ●
% referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	95%	98%	Sept	98%	●	99.7% ●
% referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	95%	98%	Sept	98%	●	96.0% ●
% referred to the Podiatry Service who are treated within 8 Weeks	95%	98%	Sept	98%	●	98.0% ●
% referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	95%	83%	Sept	83%	◆	87.0% ◆
% referred to the Adult Physiotherapy Service who are treated within 8 Weeks	95%	92%	Sept	92%	■	91.0% ■
% referred to the Parkinson Nursing Service who are treated within 8 Weeks	95%	100%	Sept	100%	●	100.0% ●
% referred to the Diabetic Nursing Service who are treated within 8 Weeks	95%	96%	Sept	96%	●	98.7% ●

**2.4.1 Referral To Treat (RTT) incomplete pathways and Referral to treatment (RTT) pathways greater than 52 weeks**

GHNHSFT changed their RTT processing in December 2013, to ensure that it was in line with recommendations made by the National intensive support team. This has resulted in a greater number of RTT pathways being reported.

25 incomplete pathways of 52+ weeks were reported in September 2015. Of these, 21 were at North Bristol Trust (14 in Trauma and Orthopaedics, 4 in Neurosurgery, 3 Neurology) , 3 at GHNHSFT (all Urology) and 1 at Royal Orthopaedic Hospital (T&O)

During the first 6 months of the year there have been 127 incomplete pathways of 52+ weeks reported to the CCG.

The majority of the breaches have occurred within the Trauma and Orthopaedic specialty; the CCG is aware of capacity issues particularly for complex spinal services across a number of providers.

GCCG are having discussions with commissioners who manage the out of county acute contracts on behalf of GCCG to identify and understand the operational issues that contributed to these waiting times and agreed plans for the identification and active management of any other likely breaches for Gloucestershire patients.

**Cancer waiting times – first definitive treatment within 62 days GP referral\***

Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Performance in the first half of the year has been Red rated with the exception of August:

85% Target	62 day target - GP Referral		
	Total	Breaches	%
Apr-15	121	32	73.6%
May-15	102	29	71.6%
Jun-15	138	39	71.7%
Jul-15	150	47	68.7%
Aug-15	128	18	85.9%
Sep-15	136	38	72.1%
2015/16 Total	775	203	73.8%

Of the 203 breaches, 197 have occurred at Gloucestershire Hospitals NHS FT (GHNHSFT).

The majority of breaches have occurred in the following specialties:

- Urology – 88 breaches
- Lower Gastrointestinal – 23 breaches
- Lung – 17 breaches
- Upper Gastrointestinal – 17 breaches

GCCG are coordinating actions with the main providers to ensure that performance improves, with sustainable delivery during 2015/16; however, concerns remain with capacity issues in key specialties. The CCG is also looking at sourcing capacity from additional providers.

The CCG is co-ordinating a working group which is working with local providers to understand the impact of the NICE referral guidance for suspect cancer. GHNHSFT and GCCG are also actively engaged in working with the IMAS Intensive Support Team to aid improvements in performance.

### **Percentage of patients waiting more than 6 weeks for a diagnostic procedure**

The proportion of patients waiting over 6 weeks for a diagnostic procedure has increased in 2015/16. Performance in September (4.6%) was adversely affected by delays for Peripheral Neurophysio and Echocardiogram tests at GHFT.

The most significant number of breaches during 2015/16 has been due to pressure for Echocardiogram tests at GHFT.

Recovery plans have been implemented with Endoscopy breaches eliminated in September; Improved performance within Cardiology is anticipated by the end of October 2015.

## **2.5 Elective cancellations:**

The dashboard below provides a more complete position statement for Elective cancellations. Each of the Amber and Red rated indicators are reported on by exception in section 2.5.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Elective cancellations	Threshold	Month	Performance	YTD	6 month trend
Cancelled operations - 28 day breaches	0	Sept	7 <span style="color: red;">◆</span>	34 <span style="color: red;">◆</span>	
Urgent operations cancelled for a second time	0	Sept	1 <span style="color: green;">●</span>	3 <span style="color: red;">◆</span>	

**2.5.1 Cancelled operations - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days.**

The current year-to-date position shows that so far in 2015/16, 34 patients have been cancelled on the day of admission for non-medical reasons and patients have not been provided with another date within 28 days; the threshold is zero.

There were 206 last minute elective operations cancelled for non-clinical reasons during quarter 1. The number of cancellations was 2.8% lower than in the same period in 2014/15.

**2.6 Mental Health:**

The dashboard below provides a position statement for Mental health indicators. Each of the Amber and Red rated indicators are reported on by exception in section 2.6.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Mental health indicators	Threshold	Month	Performance	YTD	6 month trend
Dementia diagnosis rate	56%	Mar-15	64.6% <span style="color: yellow;">■</span>	64.6% <span style="color: yellow;">■</span>	
Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	95%	Q2 15/16	96.5% <span style="color: green;">●</span>	97.3% <span style="color: green;">●</span>	
The proportion of people who have depression and or anxiety disorders who receive psychological therapies	3.5%	Q2 15/16	8.3% <span style="color: green;">●</span>	8.3% <span style="color: green;">●</span>	
The proportion of people who complete therapy who are moving towards recovery	50%	Q1 15/16	44.0% <span style="color: red;">◆</span>	44.0% <span style="color: red;">◆</span>	
IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	75%	Sept	87.0% <span style="color: green;">●</span>	88.8% <span style="color: green;">●</span>	
IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	95%	Sept	99.0% <span style="color: green;">●</span>	99.3% <span style="color: green;">●</span>	

**2.6.1 Dementia diagnosis rate**

Dementia diagnosis increased by 10.2% during 2014/15. The final year end position was 64.6%, the publication of national data for 2015/16 on dementia diagnosis has been delayed and is now expected during November.

**The proportion of people who complete therapy who are moving towards recovery**

There are known discrepancies between nationally reported recovery figures and local reported figures from 2gether NHS FT (2G).

2G have an on-going programme of work that will help ensure better understand of

the variances in reporting of data. 2G Staff are being briefed and trained on the issues to ensure that true clinical performance of the service can be reflected within the national dataset.

Throughout the improvement programme 2G are using a reliable improvement rate (local indicator), showing those people who have made an improvement. This indicator is showing a reliable improvement rate of 59%.

A member of the National IAPT Team is supporting 2G and they have sought the advice from HSCIC. An improvement plan is in place to improve data quality by the end of December.

## 2.7 Patient transport:

The dashboard below provides a position statement for Patient transport. Each of the Amber and Red rated indicators are reported on by exception in section 2.7.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Patient transfer services	Threshold	Month	Performance	YTD performance	6 month trend
Arrival within 45 minutes before, to 15 minutes after, booked arrival time	95%	Sept	80.6%	84.2%	
Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey	85%	Sept	79.5%	81.6%	
Where booked on the day of travel, patients not to wait more than 4 hours for their (outbound) journey (within two hours for end of life patients)	85%	Sept	84.6%	83.3%	

### 2.7.1 PTS 04 - Arrival within 45 minutes before, to 15 minutes after, booked arrival time – Target 95%

Inbound on-time is an area where performance has been challenging. Improvements have been seen; however, further work is required in order for the target to be achieved on a sustainable basis. September's reports show 80.6% of patients arriving with KPI timescales.

### PTS 05 - Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey – Target 85%

The response timeframe for these is one hour from the time the patient is 'made ready'. Analysis for September shows that 79.5% were achieved within the one hour compared to the target of 85%. Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys.

### PTS 06 - Where booked on the day of travel, patients not to wait more than 4

**hours for their (outbound) journey (within two hours for end of life patients) –  
Target 85%**

This is generally being achieved or just below target. The response timeframe for these journeys is four hours from the time the patient is 'made ready'. Analysis shows for September that 84.6% of on-day booked journeys are achieved within 4 hours.

The longer period for on-the-day bookings recognises that PTS is a finite resource, across various vehicle types, to support different patient mobilities (from walking to wheelchair to stretcher), travelling between multiple collection and destination points. As a result, on-the-day bookings have to be integrated into the existing pre-planned programme as effectively as possible. Clearly, it follows that the higher the proportion of total activity that is booked on the day, the more challenging it becomes to ensure effective and efficient use of the resources, the greater the likelihood of all resource being fully utilised (but not necessarily optimally), and the harder it becomes to achieve the Key Performance Indicator standards. The service is seeing high numbers of on- day bookings from the hospitals, particularly during the recent urgent care pressures, which has a detrimental impact on performance.

Overall PTS performance has improved since service implementation. Further improvement is required in order to achieve all performance targets on a sustainable basis.

**2.8 Clinical quality:**

The dashboard below provides a more complete position statement for Clinical quality. Each of the Amber and Red rated indicators are reported on by exception in section 2.8.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Clinical quality	Threshold	Month	Performance	YTD performance	6 month trend
<b>Infection control</b>					
Number of MRSA infections (Health Community)	0	Sept	0 ●	5 ◆	
Number of MRSA infections (GHNHSFT)	0	Sept	0 ●	4 ◆	
Number of C.diff infections (Health Community)	157	Sept	15 ◆	81 ■	
Number of C.diff infections (GHNHSFT)	37	Sept	2 ●	18 ●	
<b>Mixed sex accommodation</b>					
Mixed-sexed accommodation breaches	0	Sept	0 ●	0 ●	
<b>Other quality indicators</b>					
Number of Never Events	0	Sept	0 ●	1 ◆	
Cardiology correspondence backlog	n/a	Q1	0 ●	0 ●	
Radiology reporting delays	n/a	Q1	0	0	
Outpatient follow-up pending lists	n/a	Sept	18,034	18,034	

### 2.8.1 Number of MRSA infections (Health Community)

Year to date performance is Red rated with 5 reported cases against a threshold of zero.

GCCG are investigating the cases reported in Q1; for CCG actions please see GCCG Quality report to the Integrated Governance Quality committee (IGQC).

### Number of total C. diff infections (Health Community)

The threshold for 2015/16 has decreased from 201 to 157 cases in line with NHS England guidance.

YTD performance is amber rated with 81 cases against a YTD threshold of 79.

### Never events

There was a never event reported at GHNHSFT in July, a full investigation is underway.

### Other Key Performance Issue:

### Cardiology correspondence delays

There has been some positive progress with the backlog of cardiology outpatient letters, with actions taken to increase secretarial support. Quarterly reports are provided on the position of all outpatient letters to ensure that performance across

all specialities is closely monitored. There is concern regarding capacity for ECHOs and the time to test results being reviewed by the consultants. At a joint meeting in June several further actions were agreed to mitigate these issues, however, as concern remains about the service this will remain on the risk register with the information updated to reflect the current position.

### **Outpatient follow-up pending list**

In line with new information sharing request set out in the contract agreement with Gloucestershire Hospitals NHS Foundation Trust (GHFT), detailed information regarding outpatient follow up pending lists was received in October and will now be reported monthly in the CCG performance reporting framework. Initial data received has highlighted a need for further data validation to correctly assess the position with regards to patients who may be overdue a follow up appointment, as the pending list currently may report all patients who are waiting for their follow up including those for whom the expected follow up date has not yet been reached. In some specialties, the follow up pending list may at this stage also include patients who are not actually waiting for a follow up appointment, but who have an arrangement to self-refer in to see a consultant should an issue with their on-going care arise. An example of this is for respiratory patients who are on long term treatment with Continuous Positive Airway Pressure (CPAP), Bi-level Positive Airway Pressure (BPAP) or Nebulisers. We have agreed with GHFT that we will work together to complete the assessment of the position, and will now receive weekly update reports at a specialty level as we do this. Where a problem is identified, we will work together to agree a specialty level action plan to improve the position that will focus on service redesign of pathways where this is required.

### **District Nursing**

Gloucestershire CCG and Gloucestershire Care Services (GCS) continue to work together to understand and address the specific concerns raised in relation to the District Nursing function within Integrated Care Teams across Gloucestershire.

GCS continues to focus on recruitment to community nursing vacancies. In relation to Band 5 posts GCS currently has a vacancy rate of 6.15 WTE substantive posts against a funded establishment of 151.55 WTE across the county. It is noted that the equivalent of 8 WTE applicants have been offered posts and are now going through the recruitment process. Successful completion of these recruitments will mean that GCS is over-established for Band 5 posts. This over-recruitment was planned to enable the release of Band 5 staff to complete Specialist Practitioner Qualifications (SPQ) with a view to upskilling members of this staff group to Band 6 roles.

The funded establishment for Band 6 District Nurses in the county is 57.59 WTE. Currently GCS has 15.99 WTE substantive vacancies for this staff group. 3 WTE Band 6 posts have been offered to applicants and these are going through the

recruitment process.

The CCG continues work closely with GCS with regards to District Nursing recruitment, meeting with the GCS HR team on a fortnightly basis to monitor progress.

Work continues to monitor and evaluate the effectiveness of the service through Datix incident reporting. Both GCS and CCG are working together to address concerns raised by Primary Care and identify themes and trends.

### 3.1 Patient Experience

#### 3.1.1 Patient Experience – Period to 31<sup>st</sup> October 2015

<b>PERSPECTIVE 3</b>	<b>Patient Experience</b>	<b>Green</b>
<b>Success criteria 1: Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.</b>		<b>Green</b>
Key performance indicators		
Outcomes measures for patient safety have been developed based on the CCG Outcome framework and sign up for safety initiative.		<b>G</b>
Quality Impact Assessments are undertaken for all new proposed initiatives and service developments. This is considered by the QIPP assurance board before decisions are made to support new initiatives. Mitigation is planned where necessary to ensure patient safety.		<b>G</b>
<b>Success criteria 2: Reporting: Improve reporting of patient experience including FFT (Marion Andrews-Evans)</b>		<b>Green</b>
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in patient and staff FFT		<b>G</b>
All providers of NHS funded services commissioned by GCCG achieving at or above national average in patient and staff FFT score		<b>A</b>
All providers of NHS funded services commissioned by GCCG participating in National Patient Survey Programme (2015/16)		<b>G</b>
All providers of NHS funded services commissioned by GCCG achieving at or above national average results in National Patient Survey Programme (2015/16)		<b>G</b>
<b>Success criteria 3: The CCG has a programme of case reviews in place across urgent care reporting into system resilience to influence service redesign including CPGs.</b>		<b>Green</b>
Key performance indicators		
CCG has a programme of case reviews across urgent care, which feed into System resilience / clinical programme groups as appropriate.		<b>G</b>
Focus on emergency admissions and discharge.		<b>G</b>
<b>Success criteria 4: National targets-PROMs</b>		<b>Green</b>
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in PROMs (2015/16)		<b>G</b>
All providers of NHS funded services commissioned by GCCG achieving at or above national average PROMs results (2015/16)		<b>G</b>
<b>Success criteria 5: All active Clinical Programme Groups are working with patients to ensure experience is incorporated into the programme and outcomes</b>		<b>Green</b>

Key performance indicators	
All CPGs have regular 'lay' input	G
All CPGs receive and review patient experience data	G
Work to ensure PE is incorporated within QIPP schemes	TBC
<b>Success criteria 6: Develop patient experience work within primary care through working with PPGs to help inform and influence commissioning across the whole spectrum</b>	<b>Green</b>
Key performance indicators	
PPGs are informing countywide priorities and Locality developments	G
All GP practices in Gloucestershire have a PPG by 31 March 2015	G

**3.1.2 Success criteria 1: Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.**

The CCG has a strong focus on patient safety and this forms a standing item on the agenda of the Clinical Quality Review Groups. In addition the CCG is fully involved as an active member of the South West Patient Safety Collaborative.

GCCG will be a 'Beacon CCG' becoming one of the first CCG's to commit to the 'Sign up to Safety' campaign. GCCG's support of this campaign is indicative of the high level of commitment the organisation places on improving harm free care and supporting staff in speaking up when things do go wrong.

A formal launch to GCCG Staff along with a briefing to the Governing Body was made on 30th July 2015.

**The five Sign up to Safety pledges are**

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are
3. **Being honest.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. **Collaborating.** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local

services that patients use

5. **Being supportive.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress
  - We commit to turn our actions into a safety improvement plan (including a driver diagram) which will show how the CCG intends to save lives and reduce harm for patients over the next 3 years
  - Committing to turn these actions into a Safety Improvement Plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
  - Identify the patient safety improvement areas we will focus on within the safety plans.
  - Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community
  - Make public our plan and update regularly on our progress against it.

An early benefit of this collaborative work is the networking that has evolved, sight of other provider initiatives and joining up of work streams. For example the South West ambulance service is developing a CQUIN to support roll out of NEWS across the South West.

### 3.1.3 **Success Criteria 2: Improve reporting of patient experience including FFT**

The Friends and Family test no longer has a CQUIN attached and has become part of the national contract for all providers.

The table below sets out the latest available results for August 2015, by service type at Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), response rates and performance. Results have been RAG rated against national performance.

GHNHSFT response rates remain below the national average for both indicators. % recommend are close to the national average for inpatients, but below the national average for Emergency Departments (ED). However, the response rates for both inpatients and ED are very small, so the data is unreliable.

FFT remains an item for discussion at the GHNHSFT CQRG, with a CQRG focussing on patient experience scheduled for January 2016.

		July		August	
		Provider	Nat Ave	Provider	Nat Ave
Inpatients	Response Rate	36.30%	27.60%	17%	25.50%
	% Recommend	95.00%	95.90%	95%	96%
	% Not	1.00%	1.40%	1%	1%
A&E	Response Rate	2.60%	15.20%	1%	14%
	% Recommend	76.00%	88.20%	65%	88%
	% Not	13%	6%	20%	6%

### 3.1.4 Success criteria 3: Programme of case reviews

A programme of clinical case reviews has been developed to support the delivery of urgent/emergency care programme.

These include reviewing and evaluating emergency admissions to hospital, with particular focus upon admissions which may have been preventable with appropriate support or through accessing alternative pathways to admission.

This is in addition to a programme of work to review the management of discharge from hospital. This includes a focus on the quality of discharge information.

These case studies are being undertaken with input from Governing Body GPs and localities and are being carried out in partnership with provider organisations.

### 3.1.5 Success Criteria 4: National targets-PROMs

Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to patient questionnaires before and after surgery.

A national-level overview of patient improvement is published monthly for each of the two financial years. More detailed publications are released each quarter, usually in February, May, August and November and are labelled as full data releases; these contain data at Provider and Clinical Commissioning Group (CCG) levels.

Publications are provisional until the data set is declared finalised. An annual publication is produced for each final data year, including a full report with extended analyses, followed by periodic special topics using the latest final data.

### **Provisional Monthly Patient Reported Outcome Measures (PROMs) in England – April 2015 to May 2015**

#### **Unadjusted Scores (national)**

Comparing pre- and post-operative 'EQ-5D Index' scores (a combination of five key criteria concerning patients' self-reported general health), an increase in general health was recorded for:

- 50.4 per cent of groin hernia respondents (49.4 per cent for 2012-13)
- 88.5 per cent of hip replacement respondents (87.9 per cent for 2012-13)
- 80.6 per cent of knee replacement respondents (79.7 per cent for 2012-13)
- 52.5 per cent of varicose vein respondents (52.7 per cent for 2012-13)

GHNHSFT and Care UK (Cirencester Hospital) both reported as 'not outliers'.

<http://www.hscic.gov.uk/catalogue/PUB18595>

### **3.1.6 Success criteria 5: All active CPGs are using working with patients to understand their experience, to inform the programme**

1. **November 15 : Eye health**
2. January 16 : MSK
3. March 16 : Diabetes
4. May 16 : Circulatory
5. July 16 : Cancer
6. September 16 : Healthy individuals
7. November 16 : Respiratory
8. January 17 : Children
9. March 17 : Mental health & LD

#### **Eye Health**

All Clinical Programme Groups (CPG) include a Lay Champion and a Healthwatch Gloucestershire representative. Experience and Engagement feedback is shared with CPGs, this includes Healthwatch Master Comments information.

The Eye Health Programme started a new project in March 2013 designed to redesign services. The project has had two distinct project phases. The first was service design and the second was commissioning implementation and then there will be handover to provider implementation and business as usual performance management within the CCG.

The service redesign project set out the following objectives at the start:-

- To map accurately and document the as-is state for the following complete patient pathways:
  - Community Eye Care and Screening pathway
  - Glaucoma Care Pathway
  - Cataract Care Pathway
  - Medical Retina Care Pathways
- To understand the opportunities for change associated with the aforementioned pathways
- To scrutinise and assess existing pathways and to make recommendations on how they could be improved and made more efficient and/or improve outcomes
- To reduce duplication, improve efficiency, thereby reducing costs as and when appropriate
- To understand patient experience and agree if any changes need to be made
- To ensure equity of access across the county
- To ensure that stakeholders feel their views have been listened to and considered in terms of how the project has been developed and delivered
- The approach taken to the service redesign project was to create a set of background document including:-
  - Eye Health Needs Assessment
  - 'As is' Pathway for each condition
  - Evidence Report for each condition
  - 'As is' Data and Finance Report for each condition
  - Patient Experience Report for each condition

This information has fed into workshop discussions and a set of recommendation reports were produced from this. These recommendations have been fed into the development of two workstreams: Quick Wins and Development of a new service model, which have informed the Project Initiation Document (PID) for the next phase of work commissioning implementation.

**Recent 'Eye Health' engagement activity: September 2015**

- Inequalities in Eye Health Workshop. Preparation for this workshop included targeted engagement with young homeless people from Stroud locality and collation of feedback on health needs from

representatives of other “vulnerable” groups.

- Following up opportunities to expand the use of the GCCG Information Bus in promoting messages relating to maintaining good eye health.

### **3.1.7 Success criteria 6: Overarching Patient experience, developing working relationships with Patient Participation Groups (PPG) in GP Practice (HG & BP)**

The CCG is developing its approach to engaging with PPGs. At the annual CCG Commissioning Event in September 2015, PPGs attended a workshop to discuss Delegated Commissioning of Primary Care and the Primary care Estate. It was agreed that a schedule of quarterly PPG Network meetings should be established. The first GCCG PPG Network meeting is now scheduled for 22 January 2016.

The CCG is supporting Gloucestershire GP Practices, which currently do not have a PPG, with advice about recruiting members, developing constitutions and considering work plans. Opportunities for mentoring of new PPGs by well-established PPGs are being explored, as well as mechanisms for sharing good practice.

A proposal for patient participation in the development of Primary Care Strategy is being presented to the November 2015 Primary Care Commissioning Committee. This proposal embeds lay involvement across all levels of the Governance Structure.

## 4.1 Partnerships

### 4.1.1 Partnerships – Period to 31<sup>st</sup> October 2015:

PERSPECTIVE 4	Partnerships	PERSPECTIVE 4
<b>Success criteria 1:</b> Building effective partnership working by putting in place a joint planning and governance framework to improve outcomes for the Gloucestershire population		<b>RAG</b>
<i>Key performance indicators</i>		
Developing a plan for Gloucestershire, via GSF, to identify the most appropriate service roadmap for Gloucestershire to take forward the five year forward view		Amber
GSF work plan – develop further and deliver with partners including GCC. GSF work plan to be attached as an appendix in January, update on one area of the programme each month.		Amber
Further develop and maintain system wide BCF forum encompassing all providers across health and social care, independent sector and voluntary sector and housing.		Green
<b>Success criteria 2:</b> Work with the voluntary sector alliance to take forward the work with the voluntary and community sector in Gloucestershire.		<b>Green</b>
<i>Key performance indicators</i>		
Roll out social prescribing and build on the existing evaluation to take forward learning		G
Develop the “kitemark” for voluntary sector organisation		G
Develop a cultural commissioning programme in conjunction with the New Economics Foundation, National Voluntary of Community Council’s and Arts Council England		G
Build capacity in the voluntary sector (re work with VCS)		G
<b>Success criteria 3:</b> Effective urgent care pathway to enable more patients to stay in their own home		<b>Amber</b>
<i>Key performance indicators</i>		
Effective relationships across adult social and health care to enable: <ul style="list-style-type: none"> <li>i) Reduce non-elective admissions which can be influenced by effective collaboration across the health and care system.</li> </ul>		G
ii) Reducing inappropriate admissions of older people (65+) in to residential care		G

iii) Rehabilitation / reablement, increase in effectiveness of these services whilst ensuring that those offered service does not decrease	G
iv) Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.	A
v) To develop a system which measures patient experience of integration over time, allowing any improvements to be demonstrated.	Year-end assessment
vi) Enhancing quality of life for people with care and support needs.	Year-end assessment

**4.1.2 Success criteria 1: Building effective partnership working by putting in place a joint planning and governance framework to improve outcome for the Gloucestershire population (Amber)**

A series of facilitated workshops for GSF (Gloucestershire Strategic Forum) members have been held, with more planned over the coming months to review the current service models and review against the objectives within the Five Year Forward View.

**4.1.3 Success criteria 2: Work with VCS to take forward the work of the voluntary & community sector organisations in Gloucestershire.**

**Roll out social prescribing and build on the existing evaluation to take forward learning**

As a part of the CCG's prevention and self-care agenda, we have worked with G.Doc and a range of voluntary and statutory partners to develop an innovative social prescribing model. Social prescribing is a structured way of linking patients with non-medical needs to sources of support within a community. These opportunities may include: arts; creativity; physical activity; learning new skills; volunteering; mutual aid; befriending; and self-help, as well as support for a wide range of problems including: employment; benefits; housing; debt; legal advice; and parenting problems.

By the end of quarter two, 20 (24.6%) practices have regular weekly or fortnightly sessions provided in their practice by a social prescribing hub coordinator, with the scheme available to another 50 practices. The aim is to run sessions from all practices by the end of December 2015. In addition staff from 5 of 21 Integrated Community Teams refer to the scheme. By the end of March 2016 referrals will be accepted from staff in all ICTs and all of the county's community hospitals. Voluntary and statutory sector partners act as employers for the hub coordinators in different localities. By the end of quarter 2, 15 whole time equivalent (WTE) staff were in post.

The CCG will this month commission an appropriate partner to conduct an independent evaluation to inform future development of the service.

### **Develop the “kitemark” for voluntary sector organisations engaged in social prescribing**

The VCS Alliance has been instrumental in the development of a kitemark for social prescribing. To date 50 organisations have completed the questionnaire which seeks assurance in areas such as staff training and support, policies and procedures and insurance.

### **Develop a cultural commissioning programme**

To build on our work on social prescribing, Gloucestershire has also been working alongside the New Economics Foundation, National Voluntary of Community Council's and Arts Council England to understand how arts and culture can be used to improve the health and wellbeing of our local population.

During September and October the Clinical Commissioning Group invited local VCSE arts and culture organisations to apply for funding to test out a series of feasibility pilots. The aim of the grant programme is to understand how the arts and culture can support the priorities of our clinical programmes (i.e. Cancer, Respiratory, MSK, CVD, Diabetes and improve health and wellbeing for our local communities, with a specific focus on prevention (raising awareness) and developing strategies for self-management of long term conditions. The learning will inform potential new ways of working with the VCSE sector, and new community based models of service delivery.

The grant programme has been support by a number of partners including the VCS Alliance, Forest of Dean District Council, Gloucester City Council and Tewkesbury Borough Council. Create Gloucestershire (the county umbrella organisation for art and culture) have also supported the grant programme by developing capacity within the VCSE sector. This included supporting organisations with their applications and acting as a bridge between the sectors

### **Build capacity in the voluntary sector (re work with VCS)**

The CCG approved a draft framework and action plan which suggested ways in which we might work with, support and learn from the VCSE in future. We are on target in terms of the delivery of the action plan and will be leading a conversation with partners on the areas covered by the framework in the Autumn. The VCS Alliance will support the CCG in this piece of work.

The CCG issued a two year grant to the VCS Alliance to cover the period 2015/16 and 2016/17. The predominant aims, in addition to the above, were for the VCS Alliance to act as the main conduit for all links into NHS commissioners in Gloucestershire and for the Alliance to actively promote two way engagement with smaller VCSE organisations and community groups in the county and feed the outcome to the CCG.

In future utilising an Enabling Active Communities (EAC) Commissioning Group

(involving CCG, GCC, Police and Crime Commissioner and districts) we will aim to co-produce specifications to commission VCSE sector services which support health and wellbeing.

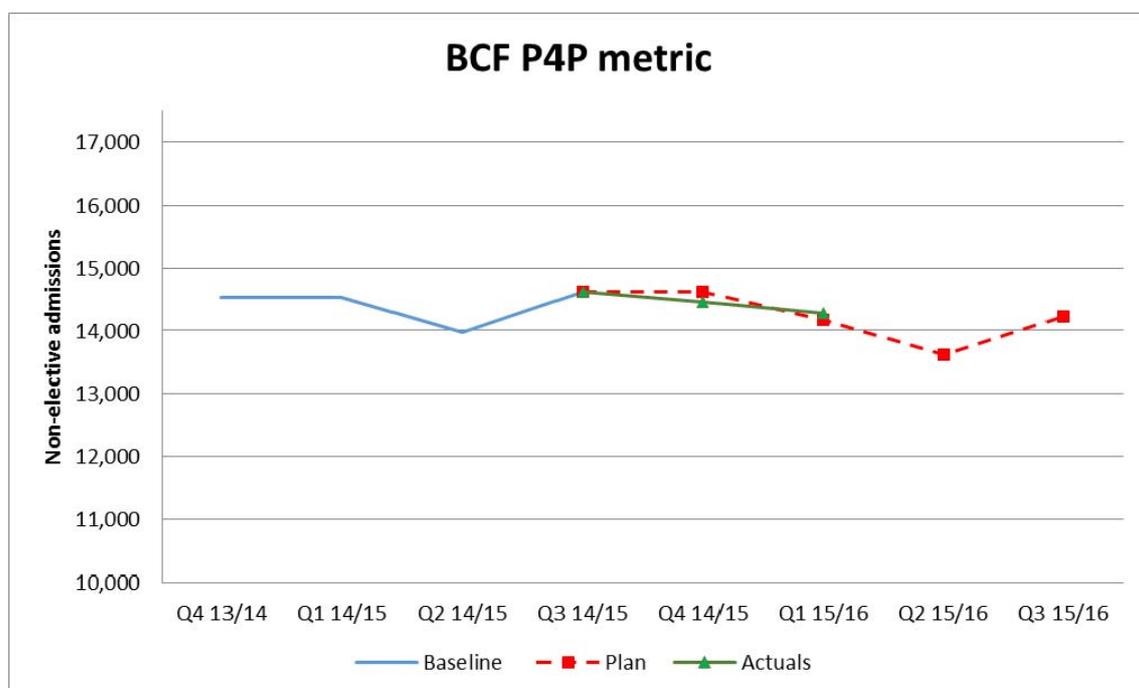
**4.1.4 Success criteria 3: Partnership working group established to review dashboard and set targets.**

As part of the Better Care Fund submission, Gloucestershire health and well-being board (H&WB) have committed to delivering a number of key indicators/ outcomes for the residents of Gloucestershire:

**Total non-elective admissions (general and acute)**

Avoidance of hospital admissions helps to ensure the most effective management of social care requirements. Minimising delayed transfers of care and avoidable admissions transforms the quality of care of individuals, enabling service users to receive the most appropriate care in the most appropriate location.

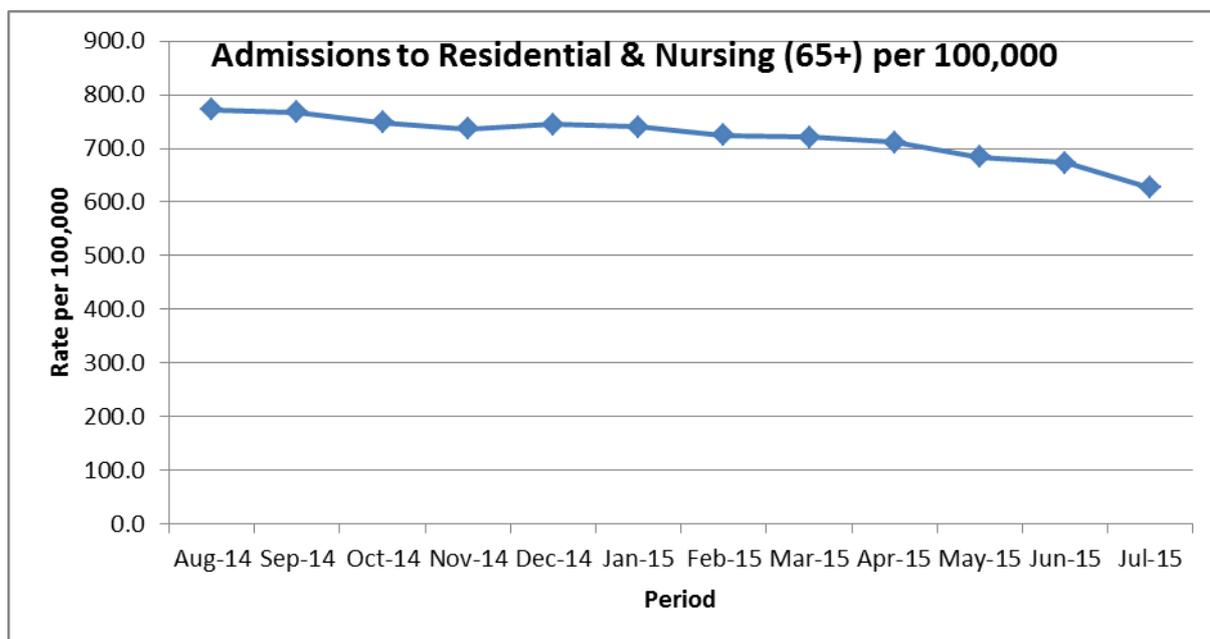
Admissions during quarter 1 were 1.8% lower than in the baseline period (Q1 of 2014/15) which is 0.8% (108 admissions) above planned reduction. Overall non-elective performance shows a 0.2% (43 admissions) reduction against the Health and well-being board plan. The following graph provides a summary of progress to date:



**Reducing inappropriate admissions of older people (65+) into residential care**

Indicator is part of the Adult Social Care outcomes framework (ASCOF). The number of permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.

Local data received from Gloucestershire county council supports this showing a decreasing trend in admissions continuing through 2015, indicating we are on track to hit our BCF target of 779.2 for 2015/16.



**Rehabilitation / re-ablement, increase in effectiveness of these services whilst ensuring that those offered service does not decrease**

Indicator is part of the ASCOF. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services.

The H&WB ambition factored through increased provision of the re-ablement/ rehabilitation services resulting in an annual increase of 3.3% in year 1 and a further 3.7% in year 2.

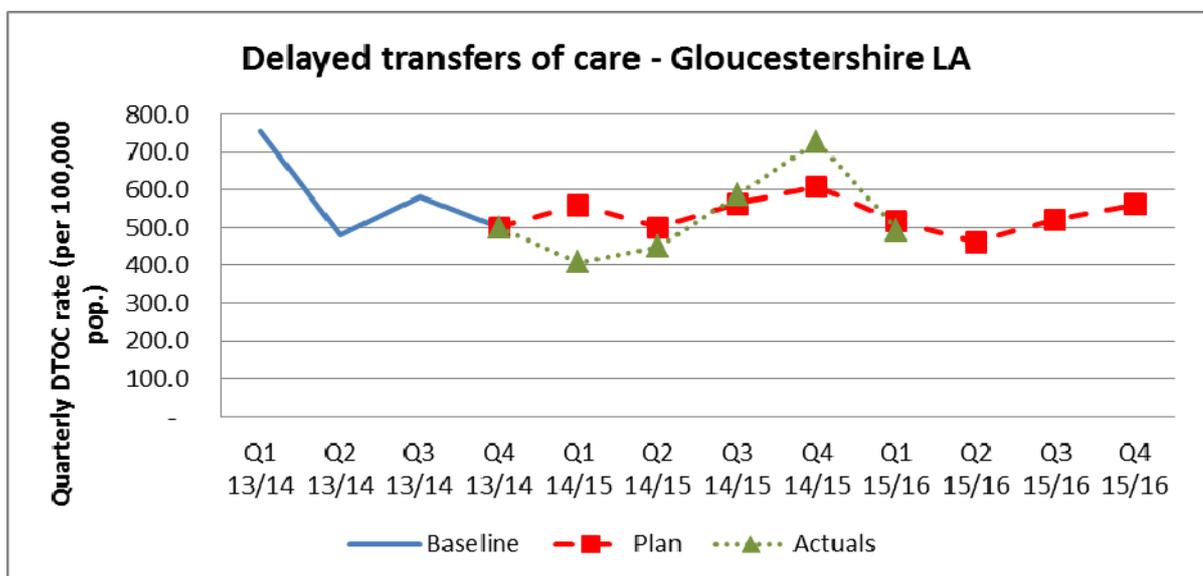
2014/15 provisional performance shows a 4.3% increase on 2013/14.

**Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate discharge from all hospitals for all adults.**

This indicator is based on the ASCOF Delayed transfers of care from hospital per 100,000 population metric.

During 2013/14 delayed transfers of care reduced significantly from those reported in 2012/13 (37% decrease).

The ambition was to further reduce delayed transfers by 2.8% in 2014/15 and 7.0% in 2015/16 from the 2013/14 baseline.



DTOCs during quarter 1 reduced by 4.4% when compared to the Health and well-being plan.

**To develop a system which measures patient experience of integration over time, allowing any improvements to be demonstrated.**

This is a locally set metric based on the Gloucestershire Care Services Integrated Community Teams Rapid Response Experience Comment Card.

The expectation is that this metric will assess the services ability to look at individual patient needs and improved health and social care outcomes.

**Enhancing quality of life for people with care and support needs.**

Locally selected measure which is part of the ASCOF. The indicator is based on

responses to 6 questions within the Adult Social Care Survey.

Ambitions against the above indicators have been set by Gloucestershire Health and well-being board. Health community QIPP schemes have been mapped to each of the relevant indicators to assess the impact and progress made against these ambitions.

Assessment against the Gloucestershire ambitions is being developed and will report by exception in this section of the performance framework report.

## 5.1 Staff

### 5.1.1 Staff – Period to 31<sup>st</sup> October 2015:

<b>PERSPECTIVE 5</b>	<b>Staff</b>	<b>Green</b>
<b>Success criteria 1: Attracting and retaining high quality staff aligned to the CCGs vision and values</b>		<b>G</b>
<i>Key performance indicators</i>		
Turnover - % of employees leaving the organisation		<b>0.86%</b>
Number of current Vacancies in structure		<b>9</b>
<b>Success criteria 2: Personal development processes that are linked to the strategic plan</b>		<b>RAG</b>
<i>Key performance indicators</i>		
All staff should have a PDP by the end of November (90% target) and should have had an appraisal in the last 12 months		<b>RAG</b>
95% of staff who have completed their mandatory training by the end of March 2016 – update from		<b>RAG</b>
<b>Success criteria 3: Staff are Happy and Motivated</b>		<b>G</b>
<i>Key performance indicators</i>		
Staff sickness levels		<b>2.23%</b>
Staff Survey		<b>To take place before end of March 2016</b>
Completion of OD plan by 31st March 2016		<b>Due 31<sup>st</sup> March 2016</b>

### 5.1.2 Attracting and retaining high quality staff aligned to the CCGs vision and values

Monthly turnover in August was 0.86%. The number of leavers since the 1<sup>st</sup> April is 12, giving a monthly average of 2.4 leavers per month.

There is 1 job live on NHS Jobs and 8 are in the recruitment process.

#### 5.1.3 **Personal development processes (PDP) that are linked to the strategic plan**

The CCG has commenced the collection of staff PDPs. Once collated a review against strategic objectives will take place.

The CCG organisational development plan is currently being updated and is on track to be finalised by March 2016.

#### 5.1.4 **Staff are Happy and Motivated**

Staff survey results to be reviewed annually when survey takes place.

Staff sickness levels up to the 31<sup>st</sup> August have equated to 2.23% which is below the GCCG target of less than 3%. Sickness levels show a decrease on the figure reported at the end of 2014/15.

2.23% equates to 752.12 full time equivalent (FTE) working days or 3.2 working days per employee since the 1<sup>st</sup> April 2015. The sickness absence rate is calculated by the total number of FTE days lost divided by the total number of working days.

## 6.1 Perspective 2. Finance and Efficiency

### 6.1.1 Finance and efficiency – Period to 31<sup>st</sup> October 2015

Summary:

Perspective 2	Finance & Efficiency	Amber	
<b>Success criteria: To ensure a financially viable commissioning organisation with an underlying recurrent surplus</b>			A
	Threshold	Lower threshold	RAG
Underlying recurrent surplus (%age)	2%	1%	A
Surplus - year to date variance to planned performance (%age)	0.10%	0.50%	G
Surplus - full year variance to planned performance (%age)	0.10%	0.50%	G
Running costs year to date (variance to running costs allocation)	Within RCA		G
Running costs forecast outturn (variance to running costs allocation)	Within RCA		G
BPPC performance on non-NHS invoices by value (year to date)	95%	80%	G
Cash drawdown in line with planned profiles (%age variance)	2%	5%	G
<b>Success criteria: QIPP Full year Forecast</b>			A
	Threshold	Lower threshold	RAG
QIPP - full year forecast delivery to planned performance (%)	95%	75%	A

- The CCG is forecasting to deliver a surplus of £7.3m; this is dependent on access to a non-recurrent surplus drawdown of £1.2m.
- Known risks and pressures have been fully assessed and included within the CCG's forecast position, with mitigating actions where appropriate
- There is significant overperformance in emergency activity against contracted levels.
- There is currently slippage on QIPP schemes for the financial year.
- Financial risks are monitored through a continuous review of budgets and proposed investments and the use of the CCG's contingency and activity reserves.
- The better payment practice code performance for the year to date (for non-NHS invoices by volume) is 97.36% which is in line with the targeted figure.
- Key risks:
  - Provider contracts over perform in excess of those levels provided within the year end forecast
  - Increased expenditure on prescribing (particularly NOACs)
  - Increased slippage on QIPP schemes (noting that the current RAG ratings are embedded within current financial forecasts)

The overall assessment for the finance and efficiency perspective is amber for which more detail is provided in the following sections. However, this assessment should be read in conjunction with those risks outlined within paragraph 3.9.

### 6.2 Resources

The CCG's current anticipated resource limit (see Appendix 2) is £810m. This includes all primary care co-commissioning delegated budgets which total £76.8m. There was a recurrent addition this month relating to transfer of specialist commissioning funding for wheelchairs and neurology outpatient services totalling £505k for which we are in discussions with the specialist commissioning team on the potential risks associated with this transfer. Other resource additions include £140k liaison psychiatry and £30k for Better Care Fund support.

### 6.3 Expenditure

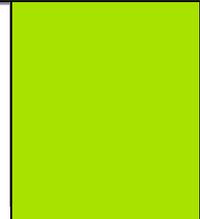
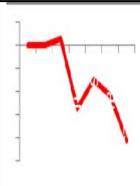
The financial summary as at 31<sup>st</sup> October 2015 shows a year to date surplus of £4.26m and a forecast surplus of £7.3m, which are both in line with plan. Further detail is shown at Appendix 3. Key budget areas with either a financial risk or forecast outturn variance are highlighted below:

<u>Key</u>	Trend	Forecast Over/ (Under) Spend £'000
<p>↑ Indicates a favourable movement in the month</p> <p>↓ Indicates an adverse movement in the month</p>		
<b>Gloucestershire Hospitals NHS FT</b>		
<p>The contract continues to overperform in all areas. PbR performance is above plan in elective activity by 1,441 spells and emergency spells are significantly over by 1,897, predominantly within Gastro and Medical specialities; equating to an over performance of £3.7m. Outpatients are also now above plan by 2,140 attendances, mainly relating to procedures within Breast, ENT, Ophthalmology and Dermatology, whilst ED activity is over-performing by 8%. Variable non PbR contract lines continue to overspend on excluded drugs and an explanation of this has been requested from GHFT. Throughout the year, a number of contract queries and potential penalties have been lodged with the Trust and the CCG is currently waiting for a full response on these issues prior to finalising the Quarters 1 and 2 financial positions.</p>		<p>£0</p>
<b>Winfield Hospital</b>		
<p>Both elective and outpatient activity continues to decline and is below plan by 359 and 521 spells respectively, specifically within T&amp;O, spinal and pain management. The waiting list position is above 4 weeks within General Surgery, Urology and Pain Management. Additional spinal clinics are now being held by the hospital.</p>		<p>(£681k)</p>

<b>Oxford University Hospitals NHST</b>		
<p>The position has not changed from the previous month's forecast, whereby over activity is seen across all areas of the contract. There has been a contract query logged regarding charges for elective hepatobiliary &amp; pancreatic surgery which is considered to be specialist commissioning. Previous queries regarding drugs and devices have been addressed.</p>	<p>↔</p>	<p>£450k</p>
<b>North Bristol NHS Trust</b>		
<p>This contract is continuing to underspend within the area of elective inpatients in hip &amp; knee procedures, non-elective and outpatients in T&amp;O. Non PbR is now under performing due to a query which resulted in removal of miscoded costs. Pressures are ongoing in the delivery of RTT performance targets with eighteen 52 week incomplete waiters. This position is being monitored closely. Penalties are being applied to this contract.</p>	<p>↑</p>	<p>(£400k)</p>
<b>Great Western Hospitals NHSFT</b>		
<p>The position remains slightly overspent. However, a long stay patient has now been transferred to another provider and the forecast for NCAs has been adjusted to reflect this. The underperformance in elective and non-elective activity continues which offsets the cost above. A contract query has been raised relating to the position in T&amp;O and general surgery specialties; as yet no response has been received.</p>	<p>↔</p>	<p>£46k</p>
<b>Royal United Hospital Bath NHSFT</b>		
<p>Activity in non-elective inpatients persists due to emergency cases in general surgery, T&amp;O and respiratory medicine. Elective inpatient activity is, also, over performing in T&amp;O for reconstructive procedures and major foot procedures for trauma. Non PbR high cost drugs has been queried with the trust and, as such, a breakeven position is now anticipated. A query has been lodged regarding Electives (hip and knee procedures and general medicine costs during June) and non-electives (General Surgery, Respiratory Medicine and T&amp;O during June), this has been followed-up but no</p>	<p>↔</p>	<p>£145k</p>

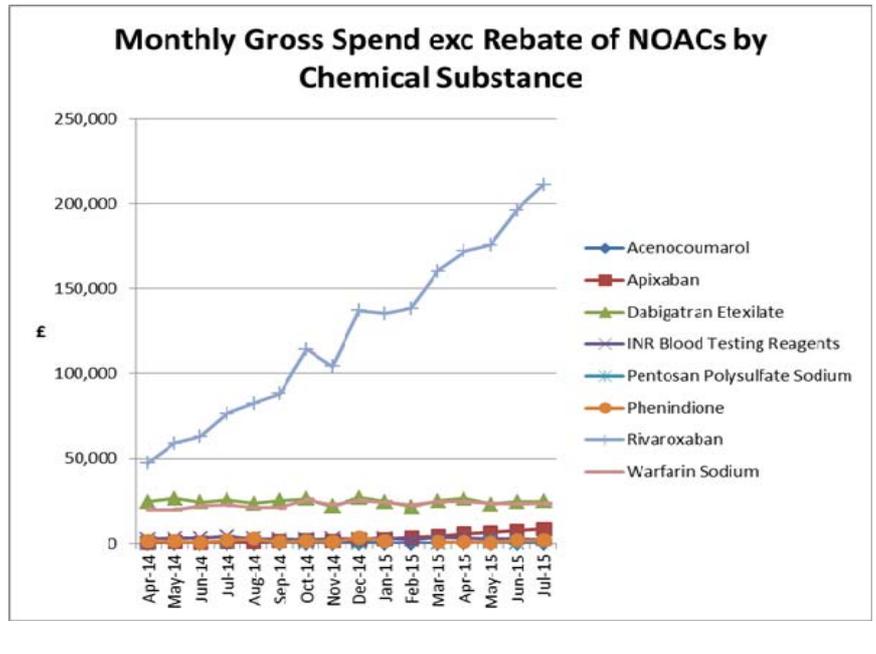
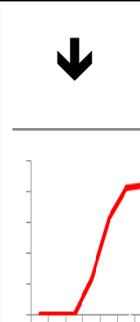
response has been received as yet.		
<b>Worcestershire Acute Hospital NHST</b>		
There are Day Case underspends in procedures involving the Digestive System and Urology and non-elective underspends within General Medicine; this being slightly offset by a Non PbR overspend in drug costs.		(£59k)
<b>Clinical Assessment &amp; Treatment Centre</b>		
Current performance at the ISTC still indicates a reduction in activity over last year. The current contract came to an end at the end of October 2015. The CCG has re-procured this activity under an Any Qualified Provider (AQP) contract with other activity being repatriated within existing contracts.		(£277k)
<b>Planned Care</b>		
Nutricia -The enteral feed contract has continued to overperform above the anticipated 6% growth and discussions are underway with both GHFT and Nutricia to establish and manage the cause of the increase in patient numbers.		£206k
Oxford Fertility –The budget was set on the basis of new access criteria for the new IVF policy which was expected to cost more in the first year. The IVF policy has only recently been finalised and the effects are not likely to be incurred this financial year hence there is a forecast underspend.		(£228k)
<b>Learning Difficulties</b>		
The improvement in position this month is due to one high cost patient having their care package end. Directly commissioned care packages remain consistent with last month.		(£93k)
<b>Continuing Healthcare</b>		
Extensive work has been undertaken in this area to understand the variation in costs. Although this remains a work in progress, forecasts for Domiciliary care are now based on patient data which produces a more robust estimate. Similar exercises are ongoing for funded nursing		(£2,048k)

care for which the results will be available shortly. Current forecasts for this area and council based placements are based on figures supplied by Gloucestershire County Council. Process mapping is still being finalised between CCG and local authority teams.



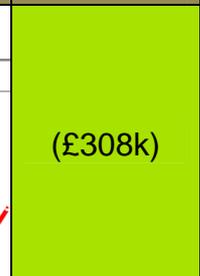
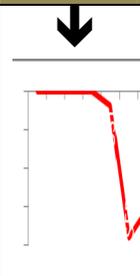
### Prescribing

Prescribing expenditure has shown a slight increase from the previous month due to a reduced anticipation of the drug rebate that will be received. Monthly analysis is being carried out to understand trends and a comparison is underway with a CCG that has already experienced this increase to ascertain when this growth may plateau. The graph below highlights the growth in Rivaroxaban since April 2014.



### Running costs

Corporate budgets continue to underspend, the main driver being non-recurrent slippage in pay costs due to appointment to vacancies. The adverse movement from last month is due to changes in the assumed timescales regarding the appointment to posts within the current establishment.



6.4

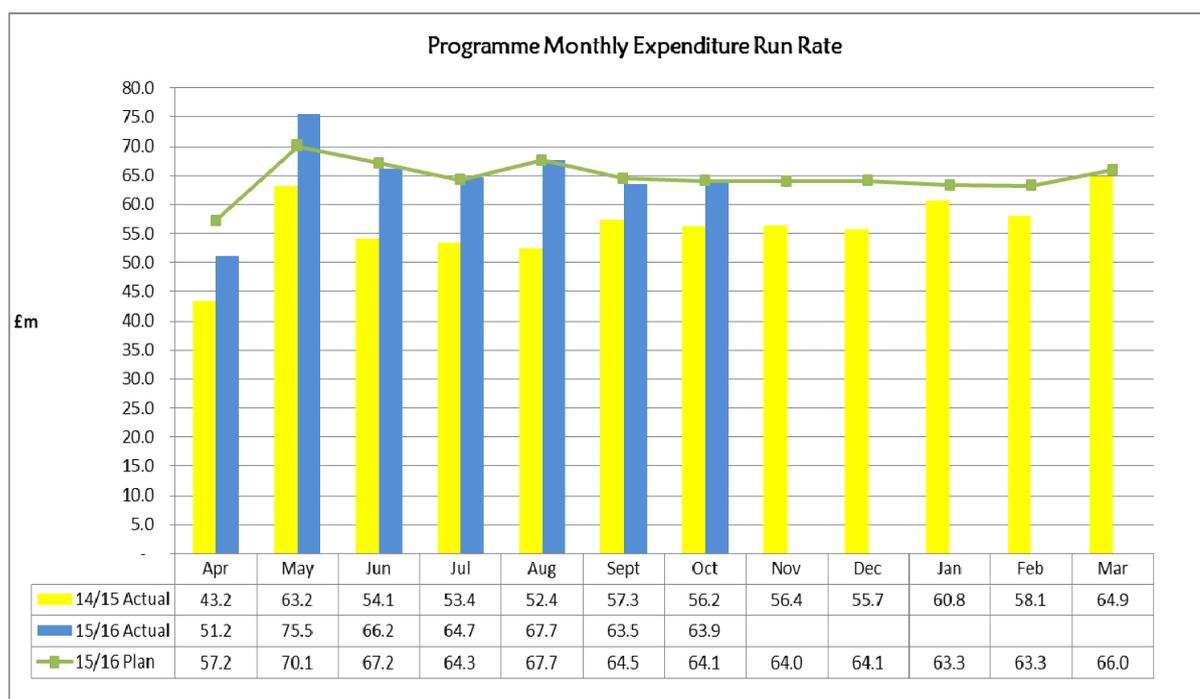
### QIPP

The CCG has a £17m QIPP target that has fully identified plans to achieve this. Delivery against the plan is currently forecast to under achieve by an estimated

£2.3m. Additional programmes are being reviewed to mitigate any shortfall and are being and will continue to be brought into the plan once identified.

Recognising that all forecasts have been based only on information available at the end of October, Appendix 4 reports the extent of QIPP performance against programme areas whilst Appendix 5 highlights scheme reports by exception.

### 6.5 Run Rate



The graph above highlights the expenditure relating to Programme budgets for this and last financial year, compared to the resource available for Programme excluding any reserves and the surplus. October is showing that programme is again just below anticipated spend by £0.2m.

### 6.6 Cash (Appendix 6)

By the end of October, the CCG has drawn down 58.9% of the total cash limit which is in line with the straight line profile. The cash balance at the end of October was £211k.

Government banking arrangements are shortly to change on a national basis and accounts will switch to RBS (under the NatWest brand) with existing Citibank accounts being discontinued. All banking mandates and signatory panels are currently being updated prior to the transition date of 7 December 2015.

### 6.7 Better Payment Practice Code (Appendix 7)

It is a national target that requires the CCG to pay 95% of non-NHS trade creditors within 30 days of receipt of goods or a valid invoice. The current year to date performance stands at 98.27% invoices paid by value and 97.36% by volume; both

being in line with the target.

#### **6.8 Statement of Financial Position (Appendix 8)**

The position shown includes the audited opening balances from the 2014/15 Annual Accounts as a reference point.

Provisions held at a national level for CHC costs (i.e. not within the CCG's own accounts) relating to previously unassessed periods of care (PUPoC) are being closely monitored by NHS England in both number and cost terms. Initially, 704 potential cases were lodged with the CCG by the claim deadline, of which 417 were deemed to merit further investigation and progressed to the checklisting stage. Currently, 222 await completion of the checklisting process which, potentially, could lead to a full assessment exercise of each case to reach an eligibility decision. To date, 24 claims have been found to be fully or partially eligible for reimbursement.

This has been a time consuming issue for both the CCG and potential claimants and, therefore, agreement in principle has recently been reached to devote additional resource to this exercise in order to accelerate the process.

#### **6.9 Financial Risk**

The following risks may be material to the current financial position:

- Contract Performance  
A large number of the CCG's contracts are variable and there is a risk of over performance against the contracted value, which in turn may create risk in further years.
- Prescribing  
The CCG has received prescribing data for April to July that highlights a potential significant overspend in this area. Although the CCG has now received the first nationally developed forecast (which is in line with initial local assumptions), the CCG is currently using historical data to further analyse local trends and underlying detail to clarify the robustness of these early indicators.
- Better Care Fund performance  
Performance under the conditions of the Better Care Fund is being reviewed on an ongoing basis in order to gauge whether conditions for release of the Performance Fund have been met (this necessitated a 2% reduction in non-elective admissions when compared with the previous financial year).
- QIPP slippage  
Due to the nature and scale of system changes within the QIPP programme along with the number of live schemes for the organisation there is a high risk of ongoing slippage to the programme.
- Specialised Commissioning  
The CCG is working through the allocation transfers from specialist

commissioning for wheelchair services and outpatient neurology services to ensure that they are accurate, initial indications show that this transfer should not leave the CCG with a financial pressure. A further review of specialist services is currently underway with further transfers potentially being undertaken in 2016/17.

- Properties  
Under the charging regime for NHS Property Services the CCG will be charged for any void space in properties owned or managed by NHS Property Service. The CCG should be invoiced on a quarterly basis and will continue to challenge any erroneous charges. Invoices for Qtrs 1 – 3 have just been received but as yet have not been validated.
  
- National position  
The overall NHS position in the current financial year has highlighted significant financial pressures within the overall service. As a result, all budgets and forecasts are being reviewed by NHS England, Monitor and the TDA. Potentially, the CCG may be requested to increase its surplus and this is likely to go hand-in-hand with a detailed review of delegated primary care co-commissioning budgets.

**Appendices:**

Ref	Description
1	GCCG Dashboard 2015/16
2	Resource Limit Position
3	Summary Financial Position
4	QIPP Programme
5	QIPP scheme reports by exception
6	Cash
7	Better payment practice code
8	Statement of financial position

# Gloucestershire CCG 2015/16 Integrated Performance Scorecard

Target	Principal Delivery Targets	2014-15 Outturn	Apr-15	May-15	Jun-15 / Q1	Jul-15	Aug-15	Sep-15 / Q2	Oct-15	Nov-15	Dec-15 / Q3	Jan-16	Feb-16	Mar-16 / Q4	Year / Quarter to date	Year End Forecast	Perf. Measured	Director	Responsible Manager	
<b>Unscheduled Care</b>																				
<b>Accident &amp; Emergency</b>																				
E.B.5	4-hour A&E target - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		C	Mark Walkinshaw	Maria Metherall
		GRH	88.1%	89.4%	92.2%	93.7%	92.3%	82.2%	85.5%							89.2%	89.2%			
		CGH	93.3%	95.2%	95.8%	97.2%	96.2%	92.1%	94.9%							95.2%	95.2%			
		<b>GHNHSFT total</b>	<b>90.0%</b>	<b>91.5%</b>	<b>93.5%</b>	<b>95.0%</b>	<b>93.7%</b>	<b>85.8%</b>	<b>89.0%</b>							<b>91.4%</b>	<b>91.4%</b>			
E.B.S.5	12 hour trolley waits (no A&E attender should wait more than 12 hours from the decision to admit to admission)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Mark Walkinshaw	Maria Metherall
		GRH	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0			
		CGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		<b>GHNHSFT total</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>			
E.B.15.i	Cat A 8 min response - The percentage of Category A RED 1 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	C	Mark Walkinshaw	Maria Metherall
		SWASFT	75.2%	79.0%	75.1%	75.3%	75.3%	76.2%	75.0%							76.0%	76.0%			
		Glos only	66.4%	72.7%	69.8%	64.9%	62.4%	60.0%	64.0%							65.7%	65.7%			
		<b>GHNHSFT total</b>	<b>71.4%</b>	<b>68.3%</b>	<b>66.3%</b>	<b>65.9%</b>	<b>66.7%</b>	<b>69.0%</b>	<b>68.1%</b>							<b>67.4%</b>	<b>67.4%</b>			
E.B.15.ii	Cat A 8 min response - The percentage of Category A RED 2 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	C	Mark Walkinshaw	Maria Metherall
		SWASFT	71.4%	68.3%	66.3%	65.9%	66.7%	69.0%	68.1%							67.4%	67.4%			
		Glos only	66.4%	64.8%	62.3%	65.2%	62.2%	63.8%	63.4%							63.5%	63.5%			
		<b>GHNHSFT total</b>	<b>93.6%</b>	<b>92.7%</b>	<b>91.8%</b>	<b>91.1%</b>	<b>90.7%</b>	<b>91.7%</b>	<b>91.5%</b>							<b>91.6%</b>	<b>91.6%</b>			
E.B.16	Cat A 19 min response - The percentage of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C	Mark Walkinshaw	Maria Metherall
		SWASFT	93.6%	92.7%	91.8%	91.1%	90.7%	91.7%	91.5%							91.6%	91.6%			
		Glos only	91.5%	90.2%	89.8%	89.7%	89.1%	90.3%	90.4%							89.9%	89.9%			
		<b>GHNHSFT total</b>	<b>91.5%</b>	<b>90.2%</b>	<b>89.8%</b>	<b>89.7%</b>	<b>89.1%</b>	<b>90.3%</b>	<b>90.4%</b>							<b>89.9%</b>	<b>89.9%</b>			
E.B.S.7	Ambulance handover delays - 30 to 60 mins (GHNHSFT)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Mark Walkinshaw	Maria Metherall
		Actual	1,038	51	85	50	37	88	70							381	381			
E.B.S.7	Ambulance handover delays - over 60 mins (GHNHSFT)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Mark Walkinshaw	Maria Metherall
		Actual	141	4	10	4	3	14	11							46	46			
E.B.S.8	Clear up delays of over 30 minutes	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Mark Walkinshaw	Maria Metherall
		Actual	1,201	142	159	179	188	181	188							1037	1037			
E.B.S.8	Clear up delays of over 1 hour	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Mark Walkinshaw	Maria Metherall
		Actual	105	13	20	12	16	14	26							101	101			
<b>Delayed Transfers of Care (DTOC)</b>																				
Local	Average number of Delayed Transfers of Care for acute patients in the month	GHNHSFT target		14	14	14	14	14	14	14	14	14	14	14	14	14	14	C	Mark Walkinshaw	Maria Metherall
		GHNHSFT actual	10.9	13.2	9.5	11.3	19.6	14.5	16.0	10.0						13.4	13.4			
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	GHNHSFT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	M	Mark Walkinshaw	Maria Metherall
Local	Average number of Delayed Transfers of Care for non-acute patients in the month	GCS target		10	10	10	10	10	10	10	10	10	10	10	10	10				
		GCS actual	2.3	5.2	3.0	2.0	1.8	1.8	2.5						2.7	2.7				
<b>Harmoni 111</b>																				
Local	Calls answered within 60 seconds	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	M	Mark Walkinshaw	Maria Metherall
		Actual	90.0	97.6%	96.5%	95.9%	94.8%	96.7%	88.6%	91.6%										
Local	Calls abandoned after 30 seconds	Target		5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	M	Mark Walkinshaw	Maria Metherall
		Actual	2.6%	0.4%	0.6%	0.7%	1.0%	0.7%	2.1%	1.0%										
Local	Calls triaged	Target		60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	M	Mark Walkinshaw	Maria Metherall
		Actual	79%	81.0%	82.2%	81.9%	82.1%	80.7%	82.0%	85.3%										
Local	% calls referred to ED	Target		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	M	Mark Walkinshaw	Maria Metherall
		Actual	5.8%	5.1%	4.9%	6.0%	6.2%	5.9%	6.1%	6.8%						5.9%	5.9%			
Local	Calls warm transferred	Target		98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	M	Mark Walkinshaw	Maria Metherall
		Actual	55.8%	41.3%	34.7%	38.3%	31.4%	38.7%	35.5%	41.5%										
Local	Longest wait for an answer	Target		00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	M	Mark Walkinshaw	Maria Metherall
		Actual	-	00:05:45	00:10:11	00:07:11	00:09:34	06:49:00	08:42:00	06:27:00										
Local	Longest wait for a call back	Target		00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	M	Mark Walkinshaw	Maria Metherall
		Actual	-	00:16:24	00:30:09	00:06:45	01:03:06	08:14:00	08:42:00	07:21:00										
<b>Planned Care</b>																				
<b>Acute Care Referral to Treatment</b>																				
E.B.1	Percentage of admitted pathways treated within 18 Weeks	Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	C	Mark Walkinshaw	Maria Metherall
		Actual	90.4%	88.6%	90.8%	90.1%	90.5%	89.2%	88.6%							89.9%	89.9%			
E.B.S.4	Number of completed admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Mark Walkinshaw	Maria Metherall
		Actual	-	6	2	6	8	3	3							0	0			
Local	Number of specialties where admitted standard was not delivered	Actual	-	8	7	7	8	8	7									C	Mark Walkinshaw	Maria Metherall
E.B.2	Percentage of non - admitted pathways treated within 18 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%				
		Actual	95.4%	95.8%	95.6%	95.2%	95.8%	95.0%	94.2%						95.5%	95.5%				
E.B.S.4	Number of completed non-admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Ellen Rule	Annemarie Vicary
		Actual	-	0	3	3	2	0	1							0	0			
Local	Number of specialties where non-admitted standard was not delivered	Actual	-	6	4	4	6	7	8											

# Gloucestershire CCG 2015/16 Integrated Performance Scorecard

Target	Principal Delivery Targets	2014-15 Outturn	Apr-15	May-15	Jun-15 / Q1	Jul-15	Aug-15	Sep-15 / Q2	Oct-15	Nov-15	Dec-15 / Q3	Jan-16	Feb-16	Mar-16 / Q4	Year / Quarter to date	Year End Forecast	Perf. Measured	Director	Responsible Manager	
E.B.3	Percentage of incomplete Pathways that have waited less than 18 Weeks	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	C			
		Actual	92.0%	92.1%	92.2%	92.2%	92.1%	92.3%	92.3%							92.2%				92.2%
E.B.S.4	Number of incomplete pathways greater than 52 weeks	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	C			
		Actual	-	20	23	21	17	21	25							127				127
Local	Number of specialties where incomplete standard was not delivered	Actual	-	8	8	9	8	8	6											
<b>Cancelled Operations</b>																				
E.B.S.2	<b>Cancelled operations</b> - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Ellen Rule	Annemarie Vicary	
		Actual	-	6	6	5	2	8	7											
E.B.S.6	<b>Urgent operations cancelled for a second time</b> - number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Ellen Rule	Annemarie Vicary	
		Actual	-	0	1	0	1	0	1											
<b>Diagnostics</b>																				
E.B.4	Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests	Target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	464	568	365	512	621	425							2955	2955				
		Actual Perf	5.0%	6.3%	3.9%	5.2%	6.6%	4.5%								5.3%				5.3%
<b>Cancer Waits</b>																				
E.B.6	Percentage of patients seen within 2 weeks of an urgent GP or GDP referral for suspected cancer	Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	1,290	137	81	131	180	150	87							766				766
		Actual Perf	92.0%	90.3%	94.1%	90.8%	89.0%	89.7%	94.1%							91.3%				91.3%
E.B.7	Percentage of patients seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	287	14	4	10	25	17	17							87				87
		Actual Perf	87.8%	93.9%	97.8%	95.3%	90.5%	92.3%	92.9%							93.5%				93.5%
E.B.8	Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis	Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	25	2	3	4	0	1	1							11				11
		Actual Perf	99.2%	99.2%	98.6%	98.5%	100.0%	99.6%	99.6%							99.3%				99.3%
E.B.9	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	21	3	2	3	0	0	1							9				9
		Actual Perf	96.2%	94.5%	96.0%	93.5%	100.0%	100.0%	98.0%							97.0%				97.0%
E.B.10	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regime	Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	0	0	0	0	0	0	0							0				0
		Actual Perf	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%				100.0%
E.B.11	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	4	0	0	1	0	0	0							1				1
		Actual Perf	99.6%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%							99.8%				99.8%
E.B.12	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	266	32	29	39	47	18	38							203				203
		Actual Perf	82.7%	73.6%	71.6%	71.7%	68.7%	85.9%	72.1%							73.8%				73.8%
E.B.13	Percentage of patients receiving first definitive treatment for cancer within 62 days from an NHS Cancer screening service	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	18	0	1	0	1	1	2							5				5
		Actual Perf	93.2%	100.0%	93.8%	100.0%	96.7%	92.3%	93.1%							96.4%				96.4%
E.B.14	Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	C	Ellen Rule	Annemarie Vicary	
		Actual breaches	3	1	--	1	0	1	0							3				3
		Actual Perf	93.5%	50.0%		50.0%	100.0%	83.3%	100.0%							86.4%				86.4%
<b>Long Term conditions</b>																				
Local	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit (GHT Only)	Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	C	Ellen Rule	Annemarie Vicary	
		Glos	70.6%	82.6%	86.0%	70.5%	81.7%	88.0%												
Local	Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (GHT Only)	Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	C	Ellen Rule	Annemarie Vicary	
		Glos	52.3%	38.1%	58.7%	38.1%	35.4%	28.1%												
E.A.S.1	Dementia diagnosis rate (Annual)	Target													66.7%	66.7%	C		Helen Vaughan	
		Glos																		
<b>Community Care Referral to Treatment (GLOUCESTERSHIRE only)</b>																				
<b>Paediatric</b>																				
Local	Percentage of patients referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C			
		Actual	97.9%	96.0%	99.0%	90.0%	85.0%	94.0%	87.0%							92.0%				92.0%
Local	Percentage of patients referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		Helen Ford	
		Actual	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%				100.0%
Local	Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C			
		Actual	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%							99.7%				99.7%
<b>Adult</b>																				
Local	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C			
		Actual	91.5%	93.0%	91.0%	99.0%	96.0%	98.0%	98.0%							96.0%				96.0%
Local	Percentage of patients referred to the Podiatry Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C			
		Actual	90.3%	98.0%	99.0%	99.0%	98.0%	98.0%	98.0%							98.0%				98.0%

# Gloucestershire CCG 2015/16 Integrated Performance Scorecard

Target	Principal Delivery Targets	2014-15 Outturn	Apr-15	May-15	Jun-15 / Q1	Jul-15	Aug-15	Sep-15 / Q2	Oct-15	Nov-15	Dec-15 / Q3	Jan-16	Feb-16	Mar-16 / Q4	Year / Quarter to date	Year End Forecast	Perf. Measured	Director	Responsible Manager	
Local	Percentage of patients referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		Debbie Clark	
		Actual	99.8%	99.0%	86.1%	84.9%	85.0%	83.0%							87.0%	87.0%				
Local	Percentage of patients referred to the Adult Physiotherapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C			
		Actual	96.9%	93.0%	90.0%	90.0%	90.0%	93.0%	92.0%						93.0%	93.0%				
<b>Specialist Nurses</b>																				
Local	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		Debbie Clark	
		Actual	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%				
Local	Percentage of patients referred to the Diabetic Nursing Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C			
		Actual	98.0%	100.0%	100.0%	100.0%	96.0%	100.0%	96.0%						98.7%	98.7%				
<b>Mental Health and Learning Disabilities</b>																				
<b>Adults of Working Age</b>																				
E.B.S.3	Proportion of those patients on a Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	Target	95%		95.0%			95.0%			95.0%			95.0%	95.0%	95.0%	C	Mark Walkinshaw	Eddie O'Neill	
		Glos	97.7%		98.0%			96.5%							97.3%	97.3%				
<b>Improving Access to Psychological Therapies (IAPT)</b>																				
E.A.3	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Glos target			3.75%			7.5%			11.25%			15.0%	15.0%	15.0%	C	Mark Walkinshaw	Eddie O'Neill	
		Glos actual	16.9%		4.1%			8.3%								0.0%				
E.A.S.2	The proportion of people who complete therapy who are moving towards recovery	Glos target			50.0%			50.0%			50.0%			50.0%	50.0%	50.0%	C			
		Glos actual	48.1%		43.0%			31.0%								0.0%				
E.H.1_B1	The proportion of people that wait 6 weeks or less from referral to their 1st IAPT treatment appointment against the no. of people who enter treatment in the reporting period.	Glos target			50.0%			52.7%			57.0%			75.1%	75.1%	75.1%				
		Glos actual	-		89.0%			90.0%								0.0%				
E.H.1_B2	The proportion of people that wait 18 weeks or less from referral to their 1st IAPT treatment appointment against the no. of people who enter treatment in the reporting period.	Glos target			60.0%			63.0%			72.0%			95.1%	95.1%	95.1%				
		Glos actual	-		99.0%			99.0%								0.0%				
<b>Quality</b>																				
<b>Quality Indicators</b>																				
E.B.S.1	Eliminate mixed-sexed accommodation breaches at all providers sites	GHT	0	0	0	0	0	0									C	Marion Andrews-Evans	Kay Haughton	
		Care Services	0	0	0	0	0	0												
		2gether	0	0	0	0	0	0												
		GHT	3	0	0	1	0	0												
		Care Services	0	0	0	0	0	0												
		2gether	0	0	0	0	0	0												
		SWAST	0	-	-	-	-	-	-	-	-	-	-	-	-	-				
		Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%				
		GHNHSFT		94.3%	93.9%	95.5%	94.6%	94.3%	93.1%											
		GCS		97.0%	97.8%	90.9%	96.1%	96.4%	98.8%											
<b>Cleanliness and HCAIs</b>																				
<b>Methicillin Resistant Staphylococcus Aureus (MRSA)</b>																				
E.A.S.4	Number of MRSA infections (Health Community)	Glos HC target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Marion Andrews-Evans	Teresa Middleton	
		Glos HC actual	11	2	1	1	0	1	0						5	5				
		GHNHSFT target	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
		GHNHSFT actual	10	2	1	0	0	1	0						4	4				
<b>Clostridium Difficile (C.Diff)</b>																				
E.A.S.5	Number of total C Diff infections (Health Community)	Glos HC target	162	15	12	12	16	16	8	12	10	9	16	16	15	79	157	C	Marion Andrews-Evans	Teresa Middleton
		Glos HC actual	153	15	14	16	10	11	15						81	81				
		GHNHSFT target	52	3	3	3	4	4	2	3	2	2	4	3	4	19	37	C		
		GHNHSFT actual	37	4	4	0	4	4	2						18	18				

## Appendix 2

## NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position as at 31st October (Month 07)

	2015/16			<u>Cash</u>
	<u>R</u>	<u>NR</u>	<u>TOTAL</u>	<u>Limit</u>
AS AT Month 07 2015/16	£000	£000	£000	£000
<b>2015/16 baseline excl growth</b>	<b>678,642</b>		<b>678,642</b>	<b>678,642</b>
Growth	28,774		28,774	28,774
B/f surplus		8,494	8,494	8,494
BCF	11,596		11,596	11,596
ETO Funding		2,300	2,300	2,300
Co -Commissioning	76,802		76,802	76,802
GPIT		1,622	1,622	1,622
Risk Share Agreement		1,430	1,430	1,430
Planned Surplus				(7,300)
MCD Adjustment				(1,427)
Waiting List validation/improving operational processes		22	22	22
Eating Disorders and Planning in 15/16		319	319	319
Transfer To Specialist Commissioning		(35)	(35)	(35)
<b>Last month total</b>	<b>795,814</b>	<b>14,152</b>	<b>809,966</b>	<b>801,239</b>
<b>Adjustments in month</b>				
Transfer to Specialist Commissioning		505	505	505
BCF Support		30	30	30
Liaison Psychiatry - Mental health		140	140	140
UEC Network		60	60	60
<b>Adjustments actioned in month</b>		<b>735</b>	<b>735</b>	<b>735</b>
<b>TOTAL NATIONALLY REPORTED LIMIT</b>	<b>795,814</b>	<b>14,887</b>	<b>810,701</b>	<b>801,974</b>

## NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

## Summary Financial Position

Overall financial position as at 31st October 2015 (Month 07)

	Year to Date			Forecast Outturn		
	Budget	Actual	(Under)/Over spend	Annual Budget	Forecast Outturn	(Under)/Over spend
	£000	£000	£000	£000	£000	£000
<b>Acute services</b>						
Acute contracts -NHS (includes Ambulance services)	204,988	197,902	(7,086)	347,416	347,378	(38)
Acute contracts - Other providers	9,094	15,033	5,939	15,590	14,522	(1,068)
Acute - NCAs	3,864	3,880	16	6,627	6,654	27
Pass-through payments						
<b>Sub-total Acute services</b>	<b>217,946</b>	<b>216,815</b>	<b>(1,131)</b>	<b>369,633</b>	<b>368,554</b>	<b>(1,079)</b>
<b>Mental Health Services</b>						
MH contracts - NHS	44,359	44,446	87	76,044	76,044	
MH contracts - Other providers	1,843	1,712	(131)	3,213	3,146	(67)
<b>Sub-total MH services</b>	<b>46,202</b>	<b>46,158</b>	<b>(44)</b>	<b>79,258</b>	<b>79,191</b>	<b>(67)</b>
<b>Community Health Services</b>						
CH Contracts - NHS	50,217	50,217		85,493	85,493	
CH Contracts - Other providers	(3,231)	(3,203)	29	(5,539)	(5,539)	
CH - Other						
<b>Sub-total Community services</b>	<b>46,986</b>	<b>47,014</b>	<b>29</b>	<b>79,953</b>	<b>79,953</b>	
<b>Continuing Care Services</b>						
Continuing Care Services (All Care Groups)	13,773	13,660	(114)	22,780	22,481	(299)
Local Authority / Joint Services	2,339	1,524	(815)	4,010	2,612	(1,398)
Free Nursing Care	5,550	5,346	(204)	9,515	9,163	(351)
<b>Sub-total Continuing Care services</b>	<b>21,663</b>	<b>20,530</b>	<b>(1,133)</b>	<b>36,305</b>	<b>34,257</b>	<b>(2,048)</b>
<b>Primary Care services</b>						
Prescribing	53,449	55,967	2,518	91,627	95,827	4,200
Co-Commissioning and Enhanced services	48,100	47,858	(243)	83,606	83,468	(139)
Other	5,662	5,583	(80)	9,707	9,652	(55)
<b>Sub-total Primary Care services</b>	<b>107,212</b>	<b>109,407</b>	<b>2,195</b>	<b>184,941</b>	<b>188,947</b>	<b>4,006</b>
<b>Other Programme services</b>						
Re-ablement funding						
Other	12,861	12,716	(145)	22,005	21,937	(67)
<b>Sub-total Other Programme services</b>	<b>12,861</b>	<b>12,716</b>	<b>(145)</b>	<b>22,005</b>	<b>21,937</b>	<b>(67)</b>
<b>Total - Commissioned services</b>	<b>452,869</b>	<b>452,640</b>	<b>(229)</b>	<b>772,093</b>	<b>772,839</b>	<b>746</b>
<b>Specific Commissioning Reserves</b> (Inc headroom and Contingency)	7,888	8,507	618	17,773	17,336	(437)
<b>Total - Programme Costs (excl Surplus)</b>	<b>460,757</b>	<b>461,147</b>	<b>389</b>	<b>789,867</b>	<b>790,175</b>	<b>308</b>
Running Costs (incl reserves) Quality Premium	7,893	7,504	(389)	13,534	13,226	(308)
<b>Total - Admin Costs (excl Surplus)</b>	<b>7,893</b>	<b>7,504</b>	<b>(389)</b>	<b>13,534</b>	<b>13,226</b>	<b>(308)</b>
<b>Surplus</b>	4,258		(4,258)	7,300		(7,300)
<b>Total Application of Funds</b>	<b>472,909</b>	<b>468,651</b>	<b>(4,258)</b>	<b>810,701</b>	<b>803,401</b>	<b>(7,300)</b>

#REF!

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP  
QIPP Programme 2015/16

Appendix 4

Theme	Planned Gross Savings 2015/16 £'000	Forecast £'000	Variance £'000
Urgent Care	7,433	5,498	(1,934)
Planned Care	2,910	2,998	88
Community	1,200	600	(600)
Prescribing	4,070	3,694	(376)
Transactional	1,430	1,930	500
Unidentified	0	0	0
<b>Grand Total</b>	<b>17,043</b>	<b>14,720</b>	<b>(2,323)</b>
Additional Schemes			0
Additional QIPP / Slippage / Contingent resources / Application of QIPP rule		2,323	2,323
<b>Grand Total</b>	<b>17,043</b>	<b>17,043</b>	<b>0</b>

Theme RAG	Savings RAG	Recurrent / Trend RAG
A	A	A
A	A	A
A	A	A
A	A	A
G	A	A
n/a	n/a	n/a

## Urgent Care Schemes

Project		
Integrated Community Teams (ICT)		
<p>Rapid Response Data is now being produced by GCS using the new clinical codes agreed with the CCG; this is currently being analysed by the finance and information team. This will assist commissioners to understand whether Rapid Response is focussing on the targeted patient cohort as identified in the 'Joint Case for Change'.</p> <p>The new governance arrangements for overseeing the performance of ICTs have been established and the ICT Performance &amp; Delivery Group has met on two occasions (3/09/2015 &amp; 2/10/2015). An ICT risk register has been produced and jointly reviewed and an ICT Delivery work plan is being developed by GCS for monitoring by the ICT Performance &amp; Delivery Group.</p>		
Older People's Assessment Liaison (OPAL)		
<p>A total of 75 patients in total have been discharged from ED and ACU via the OPAL service in September 2015; 69 at GRH and 6 at CGH.</p> <p>Recruitment is an ongoing issue but not currently a major concern; GHFT are reviewing feasibility of a single site option for OPAL which could resolve this. Awaiting proposal for consideration by the CCG but this will need to provide assurance of continued activity delivery if agreed for implementation. The OPAL service is currently available at both GRH and CGH. Both sites are working towards the consistent delivery of a 5-day week service and on the whole this is being achieved, but is reliant on locum cover and backfill from the General Older Age Medicine wards.</p>		
Integrated Discharge Team (IDT)		
<p>GHFT are starting a weekly review of patients on the medically stable list and Debbie Grey is working with GHFT on reducing length of stay. An IDT action plan has been produced and is being reviewed through the project board. Recruitment is an ongoing issue.</p>		
Ambulatory Emergency Care (AEC)		
<p>The AEC has an activity target to review 16.4 new patients daily (classed as an avoided admission) and currently the service is averaging 16 new patients a day according to the Alamac Kitbag, this target will increase to 21.6 new patients per day in January 2016 so throughput will need to increase.</p> <p>GHFT are going to operate a single AEC site from the 2nd November for longer hours 08.00-21.00 Monday – Friday during the winter period however this still does not cover the originally planned 7 day service coverage. The CCG have fed back the following points for consideration; impact on trajectory, single site demand and capacity, consideration to be taken in line with OPAL reconfiguration, incorporation of other pilots such as chest pain.</p>		
Urgent Care Respiratory Pathways		
<p>The Chronic Obstructive Pulmonary Disease (COPD) pathway and guidance developed is now in circulation for comment with anticipated sign-off and launch expected by early November 2015. Consideration being given to COPD Management Plan.</p> <p>COPD are also linking in with the JUPAC (Joined Up Proactive Care) work stream to support primary care healthcare teams in the effective case-management of those with COPD and who are at risk of admission i.e. live alone/elderly.</p>		
Mental Health Liaison		
<p>The night service within ED has commenced, with the Crisis team now providing late night cover from 10pm to 7am (for 16 years of age and above).</p> <p>It is intended to pilot the lowering of the age for ED liaison down to 12 years. Plans have been received from 2gether and will be reviewed by Commissioners.</p>		
Community Hospitals (Investment in relation to Medworxx)		
<p>SystemOne rollout continues and will finish with roll out to Tewkesbury in October 2015.</p> <p>However there are integration issues between Medworxx and SystemOne, which will therefore impact achievement of the £500K QIPP saving. Discussions have taken place with GCS and they are working with the two system providers on a solution and expect to still implement Medworxx on time.</p>		

<b>Project</b>	Maternity Triage	
<p>The 'midwife in the hub' project went live on the 2nd September 2015. Initial activity data is expected by the end of October. Good feedback has been received from clinicians in GHT and it is reported that women are now being effectively triaged, with triage seeing a decline in activity. Discussions are taking place regarding the evaluation of this pilot and KPIs are being developed.</p>		

<b>Project</b>	Signposting	
<p>GCCG alongside other CCGs are working with South West Ambulance Foundation Trust and 111 to identify ways in which a clinical hub can be established which will impact on dispositions to Emergency Department and 999. Work to date includes 111 incorporating floor walkers into the service. This has had positive impact on 999 dispositions which have seen a significant reduction and delivery of Key Performance Indicators. However this has had a knock on effect with some cases that would have had a 999 disposition are now going to ED. The ED impact is now being reviewed.</p>		

<b>Project</b>	Single Point of Clinical Access (SPCA)	
<p>The SPCA Service specification has now been agreed. GCS have also produced costings for the service which have identified a funding gap of £290K recurrently. A contract variation is being carried out to cover this and the new service specification. Requirements for a Business Continuity plan are being discussed</p>		

<b>Project</b>	Falls and Bone Health	
<p>Business Case approved by QIPP Assurance Group and Core Group for additional resource to capacity build within the community and develop proactive prevention working closely with ICTs and the Fire Service. A longer-term strategy is being developed and implemented to shift the focus of care to earlier in the pathway. Discussed at Falls Working Group and presented to CCG Senior Managers.</p> <p>MOU with Fire Service in draft, to be finalised and agreed ahead of launch of Gloucestershire Fire and Rescue Service 'Winter Social Isolation' pilot in county.</p>		

**Planned Care Schemes**

<b>Project</b>	Direct Access Diagnostics	
<p>Following agreement to re-procure the current service for a further three years, a new service specification has been produced and revised QIPP milestones for delivery shared with GHT. GHT are generally in agreement and have proposed a few minor revisions and points for clarification. Signoff from GHT is expected shortly, and work to review pathway actions to start next month.</p>		

<b>Project</b>	Care UK ISTC Utilisation	
<p>A general downward trend in GP referrals during this financial year, despite communication and promotion of Care UK's services, indicates that utilisation during the final month of the contract is likely to be much lower than expected. Waiting list transfers from GHFT to Care UK have been minimal with very little positive impact made towards increasing contract utilisation.</p>		

<b>Project</b>	Diabetes Enhanced Service	
<ul style="list-style-type: none"> <li>• Reminder has been sent to all GPs around diabetes OP referral criteria and support offered by the Community Diabetes Team. All forms and relevant guidance uploaded on and with links to G-Care (Sept. 17th edition of WNTW)</li> <li>• Reduction in 1st OP referrals - feedback from the lead consultant is that the increase in referrals does not match the current levels of activity seen in clinic; therefore some additional analysis of GP referrals is recommended in order to inform the underlying picture.</li> <li>• Capacity of Community Diabetes Team has been reduced due to staff shortages, which may be the cause of a spike in referrals to secondary care during May -July</li> <li>• Further reiteration of eligibility criteria at key locality meetings and forthcoming Diabetes Interest Group meeting (18th November)</li> <li>• Launch of the Diabetes and Frailty Guideline (18th November DIG meeting)</li> <li>• Identification of training needs, particularly in those practices where referrals are high</li> <li>• Recent launch of new structured Diabetes Education Programme which confers increased self-management skills to patients (early evidence of increased uptake and compliance)</li> </ul>		

<b>Project</b>	Respiratory Pathways	
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Outpatients – first and follow ups

- Awaiting primary care guidelines/top-tips for the management of intractable/persistent cough
- Service specification being developed for management of Pulmonary Nodules (reduced follow-ups)
- The self-management plan pilot for Bronchiectasis is well underway and positive feedback has been received from staff and patients alike. Business case from GCS for additional physiotherapy resource still awaited; this will provide capacity for the repatriation of some bronchiectasis activity as well as increasing the capacity of the Pulmonary Rehabilitation service.

<b>Project</b>	Follow Ups	
<p>Meeting to discuss progress with this scheme was cancelled by GHFT due to unforeseen circumstances and is currently being rearranged. Additional information requested by the CCG in relation to the anticipated impact of the limited actions the GHFT planned to take has not yet been supplied however, activity data suggests that follow ups are higher than 2014/15 at month 5 so the actions do not appear to be having the desired effect. Dermatology has been excluded from the scheme as it will be picked up as part of the separate dermatology project. Therefore the only specialities currently included are Paediatrics and Neurology.</p>		

<b>Project</b>	Individual Funding Reviews (IFR)	
<p>The remaining policies are currently under review by the Effective Clinical Commissioning Policies Group, and most are likely to remain unchanged. The monthly Prior Approval and INNf challenge process has continued.</p>		

<b>Project</b>	Irritable Bowel Syndrome (IBS)	
<p>The service specification has been agreed and a contract variation order is being issued.</p> <p>The team are then starting the recruitment process with an aim to commencing the service January 2016.</p>		

<b>Project</b>	Cancer (Living with and Beyond)	
<p>Macmillan Next Steps financial agreement has now been signed off and recruitment of the team will commence next week. Secondment paperwork for the 2 service leads has been sent over to GCS for sign off. Still showing as Amber due to slippage of original service commencement milestone date.</p> <p>The Recovery Package, including Risk Stratified Pathways (RSPs), Treatment Summaries and Holistic Needs Assessments were discussed at the recent Gloucestershire Cancer Summit. Following these discussions, a phased approach to introducing the RSPs has been proposed at the Survivorship Steering Group and meetings are being set up with each tumour site lead to discuss and agree which one will be commence first.</p>		

<b>Project</b>	Dermatology	
<p>Tele dermatology solutions continue to be investigated – a meeting with Oxford was held to discuss their services &amp; tele dermatology, and the pilot was discussed at a Locality Executive meeting.</p> <p>Plans for a review of the Audit of skills &amp; equipment for dermatology GPs in Gloucester is in progress.</p>		

## Community Schemes

<b>Project</b>	Community Hospital Programmes	
<p>The original estimated savings of £500K will not be achieved and are to be re-estimated. Of the work undertaken by the Transforming Community Hospitals Groups 2 areas have relevance to the QIPP savings programme and these are below.</p> <ol style="list-style-type: none"> <li>1. Ambulatory Care - The Ambulatory Care Planning Group will meet monthly until the end of the calendar year with a brief to identify patient cohorts whose planned treatment could be delivered locally (Cirencester is the pilot scheme). A report on findings will be considered by GCCG/GCS in Jan 16.</li> <li>b. From 27th August former patients of the Ellie Lindsay leg club now receive their treatment in the ACU at Cirencester - (Target deadline achieved)</li> <li>2. Bed Utilisation and Rehabilitation - The exercise to identify the types of rehabilitation that will take place in community hospitals is underway.</li> </ol>		

<b>Project</b>	Rehabilitation Pathways	
<p>Meeting to be arranged with Attain who wrote the business case and the job description to be written for a lead therapist. Concern over resource has been escalated.</p>		

<b>Project</b>	Continuing Health Care (CHC)	
<p>This work is ongoing. Meeting has taken place with Care Track and there are proposed workshops for GCC purchasing staff to understand the rate card function. Following this GCC staff will set up rate cards for all new packages of care and the CHC team will do the retrospective packages of care. The workshops are possibly going ahead in December 2015, awaiting confirmation from Care Track.</p> <p>Delays in recruitment employment checks mean expected end date is now 31/03/2016.</p>		

<b>Project</b>	Leg Ulcers	
<p>Interim service lead and all band 6 Tissue Viability Nurses recruited.</p> <p>Project on target to 'go live' in Cheltenham and South Cotswolds localities 30th November 2015 and in Stroud and Berkley Vale locality in March 2016. A meeting to agree referral pathways with GHFT is scheduled to take place shortly. The Stroud and Berkley Vale go-live in March is dependent on remedial building work being completed on time.</p>		

## Prescribing Schemes

<b>Project</b>	Primary Care Prescribing	
<p>All practices are undertaking Prescribing Improvement Plan with the assistance of their prescribing support pharmacists. Concern around performance measurement as always working 3 months behind due to scheduling of ePACT data.</p>		

<b>Project</b>	Centralised Continence Supplies	
<p>The tender process is on hold as whole continence service is now under pathway review. Only then can tendering process can begin therefore this will add further delay to the start of the scheme. Therefore suggest chance of this being completed within this financial year are non-existent.</p>		

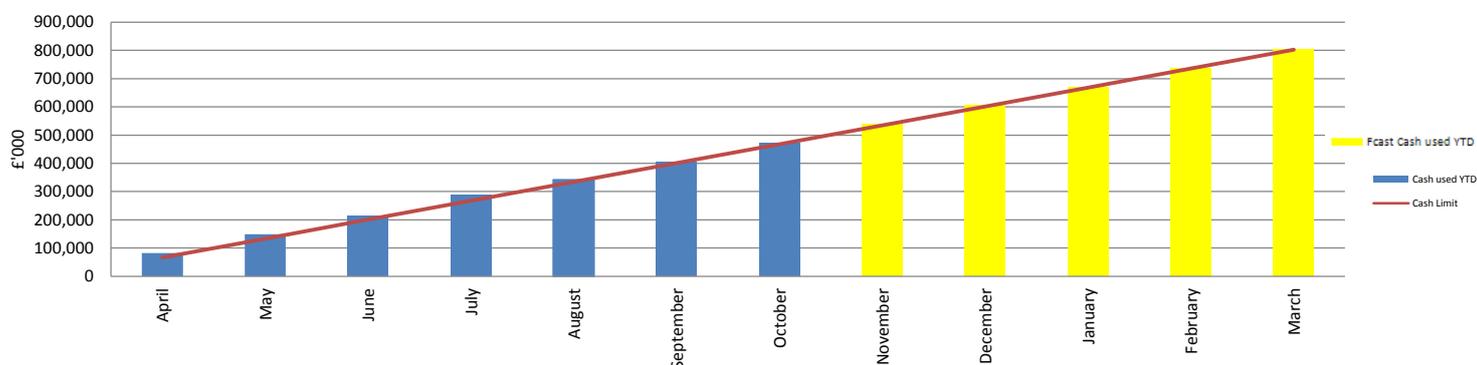
<b>Project</b>	Care Home Pharmacist medication reviews	
<p>Recruitment process for full service is commencing and anticipated recruitment is likely Dec15/Jan16.</p> <p>Care Home Pharmacists now attending higher priority care homes and delivering medicines optimisation services with close liaison with the attending GPs. Pilot 3 is continuing and findings have provided input to the business case for the next phase.</p>		

## NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 31st October 2015 (Month 07)

		Actual/Forecast Charges in Month							TOTAL	TOTAL	CASH	CASH AT	% CASH LIMIT	Bal/Cash
Month	Status	Drawn	Prescribing	Home Oxygen	Advance Drugs Payments	co Commissioning	CHC inc Risk pool contribution	Capital Allocation	MONTH	YTD	LIMIT 1/12ths	MONTH END	%	Limit
		£000	£000	£000	£000			£000	£000	£000	£000	%	%	
April	Act	70,000	6,364	82	80	6,244		82,770	82,770	66,831	1,460	10.32%	0.18%	
May	Act	50,000	7,149	89	(107)	9,169		66,300	149,070	133,662	2,429	18.59%	0.30%	
June	Act	51,000	6,887	91	93	6,385	1,154	65,610	214,680	200,494	1,133	26.77%	0.14%	
July	Act	60,000	6,756	87	(36)	6,232		73,039	287,719	267,325	3,735	35.88%	0.47%	
August	Act	46,000	7,147	91	19	1,460		54,717	342,436	334,156	802	42.70%	0.10%	
September	Act	49,000	7,392	90	(272)	6,079		62,289	404,725	400,987	6,747	50.47%	0.84%	
October	Act	55,000	6,652	89	278	5,657		67,676	472,401	467,818	211	58.90%	0.03%	
November	F'cast	53,000	6,997	89		5,889		65,976	538,377	534,649		67.13%	0.00%	
December	F'cast	53,000	6,997	89		5,889		65,976	604,352	601,481		75.36%	0.00%	
January	F'cast	53,000	6,997	89		5,889		65,976	670,328	668,312		83.58%	0.00%	
February	F'cast	53,000	6,997	89		5,889		65,976	736,303	735,143		91.81%	0.00%	
March	F'cast	52,695	6,997	89		5,889		65,671	801,974	801,974		100.00%	0.00%	

Proportion of Cash Limit Utilised  
Actual and ForecastOverview of current position

At the end of October £472m had been drawn down (58.9%) of the anticipated cash limit against 58.3% on a straight line basis for October.

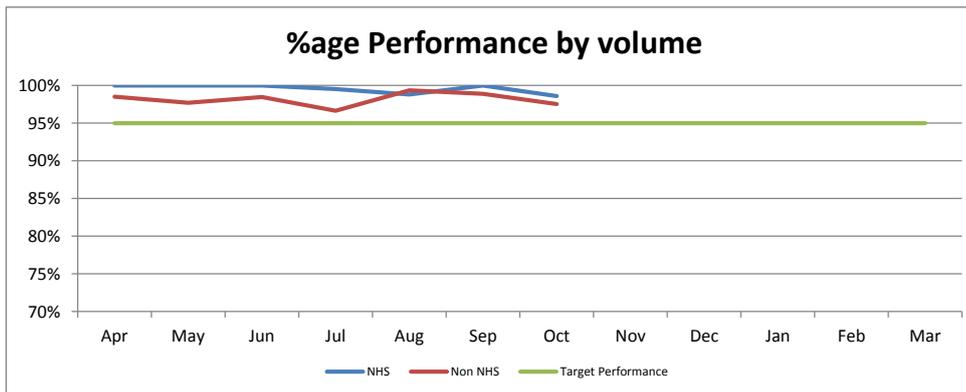
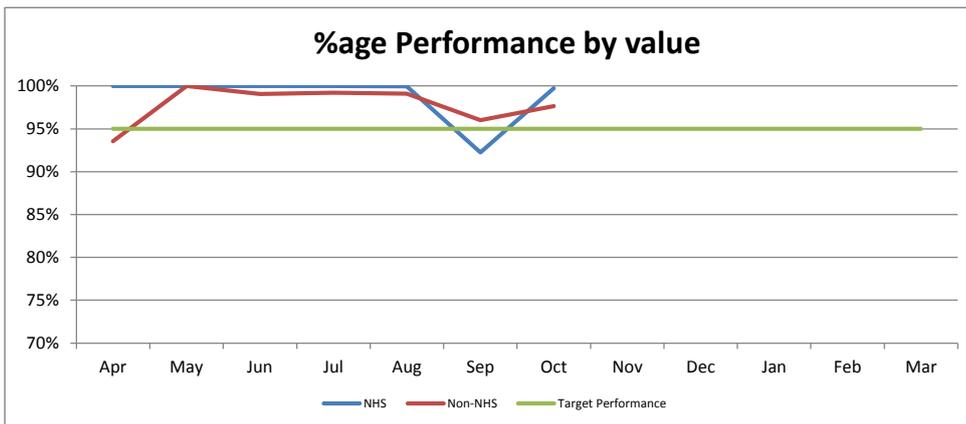
NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Performance against better payment practice code

As at 31st October 2015 (Month 07)

	In Month		Year to Date	
	NHS	Non NHS	NHS	Non NHS
<b>By volume</b>				
Total number of invoices	358	524	2,021	4,509
Number paid within target	353	511	1,992	4,390
<b>Performance</b>	<b>98.60%</b>	<b>97.52%</b>	<b>98.57%</b>	<b>97.36%</b>
<b>By value</b>				
Total value of invoices (£'M)	43.69	2.96	293.70	26.05
Value paid within target (£'M)	43.58	2.89	293.56	25.60
<b>Performance</b>	<b>99.75%</b>	<b>97.64%</b>	<b>99.95%</b>	<b>98.27%</b>

The target performance level is 95%



## NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Statement of Financial PositionAs at 31st October 2015 (Month 07)

	Opening Position as at 31 March 2015	Current Month end Position £000	Forecast Position as at 31 March 2016 £000
<b>Non-current assets:</b>			
Premises, Plant, Fixtures & Fittings	188	163	143
IM&T		0	0
Other		0	0
Long Term Receivables		0	0
<b>Total non-current assets</b>	<b>188</b>	<b>163</b>	<b>143</b>
<b>Current assets:</b>			
Inventories		0	0
Trade and other receivables	6,150	11,210	6,000
Cash and cash equivalents	104	211	1
<b>Total current assets</b>	<b>6,254</b>	<b>11,421</b>	<b>6,001</b>
<b>Total assets</b>	<b>6,442</b>	<b>11,584</b>	<b>6,144</b>
<b>Current liabilities</b>			
Payables	(40,361)	(43,924)	(40,000)
Provisions	(863)	(862)	0
Borrowings		0	0
<b>Total current liabilities</b>	<b>(41,224)</b>	<b>(44,786)</b>	<b>(40,000)</b>
<b>Non-current assets plus/less net current assets/liabilities</b>	<b>(34,782)</b>	<b>(33,202)</b>	<b>(33,856)</b>
<b>Non-current liabilities</b>			
Trade and other payables		0	0
Other Liabilities		0	0
Provisions		0	0
Borrowings		0	0
<b>Total non-current liabilities</b>		<b>0</b>	<b>0</b>
<b>Total Assets Employed:</b>	<b>(34,782)</b>	<b>(33,202)</b>	<b>(33,856)</b>
<b>Financed by taxpayers' equity:</b>			
General fund	(34,782)	(33,202)	(33,856)
Revaluation reserve			
Other reserves			
<b>Total taxpayers' equity:</b>	<b>(34,782)</b>	<b>(33,202)</b>	<b>(33,856)</b>

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>West of England Academic Health Science Network Board Report</b>
<b>Executive Summary</b>	The attached document is the ninth quarterly report produced by the West of England Academic Health Science Network.
<b>Key Issues</b>	The following key issues are referred to in the report: <ul style="list-style-type: none"> <li>• West of England Genomics Medicines Centre Partnership;</li> <li>• Visit of Sir Bruce Keogh, 21<sup>st</sup> August 2015;</li> <li>• Test Beds;</li> <li>• Design Together, Live Better;</li> <li>• Highlights from Quarter 2; and</li> <li>• Academic Health Science Network Stakeholder Survey.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	None
<b>Financial Impact</b>	None
<b>Legal Issues (including NHS Constitution)</b>	None
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note this report which is provided for information.
<b>Author</b>	Deborah Evans
<b>Designation</b>	WEAHSN Managing Director
<b>Sponsoring Director (if not author)</b>	Mary Hutton, Accountable Officer

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## Report from West of England Academic Health Science Network Board, 16 September 2015

### 1. Purpose

This is the ninth quarterly report for the Boards of the member organisations of the West of England Academic Health Science Network.

Board papers are posted on our website [www.weahsn.net](http://www.weahsn.net) for information.

### 2. West of England Genomics Medical Centre Partnership

Genomics England issued its “Invitation To Tender” documents for Wave 2 Genomics Medical Centres in August. The West of England Genomics Partnership, chaired by Tony Gallagher, Chair of Avon and Wiltshire Partnership Mental Health NHS Trust, responded by submitting a Pre-Qualification Questionnaire and the partnership has now heard that it is successfully through to the next stage.

There continues to be very strong involvement from clinicians across the West of England and initially, we are focussing on cancer and rare disease pathways. In parallel with the accreditation of Genomics Medical Centres, there is a national exercise to designate genetics laboratories and in the West of England, North Bristol NHS Trust is the lead laboratory services provider.

### 3. Visit of Sir Bruce Keogh, 21 August 2015

Sir Bruce Keogh, Medical Director, NHS England, returned to visit the Academic Health Science Network 18 months after we had first presented our work. We reported on our progress and demonstrated a number of our current exemplars. Sir Bruce thought that the PreCePT scheme on preventing cerebral palsy in pre-term babies was strong enough to be rolled out nationally, as was the Emergency Department Safety Checklist.

### 4. Test Beds

We continue to work very closely with NHS England on the “Test Bed” initiative. Around 450 companies expressed an interest across the country and over 30 potential Test Beds were registered. Over the coming months, the numbers will reduce and funding and procurement arrangements will be clarified. West of England member organisations and the Academic Health Science Network submitted five Test Bed proposals and discussions are now underway about whether these can be consolidated into two or three strong proposals. For more information, please contact Lars Sundstrom, Director of Enterprise and Translation ([lars.sundstrom@weahsn.net](mailto:lars.sundstrom@weahsn.net))

### 5. Design Together, Live Better

Over one hundred members of the public attended workshops across the West of England to share ideas about what would make daily living easier for people with impairments or long term conditions. These workshops were facilitated by a local charity called “Designability” which is a research and project development organisation. Following the workshops, a shortlisting process took place and Designability are now developing prototypes of the top three ideas which we hope to find SMEs who can turn them into products for the market.

Read the interim report [here](#).

### 6. Highlights from Quarter 2

Highlights from our work programme between July and September include:

- Atrial Fibrillation – the results of our pilot work with eleven GP practices were that 130 patients had a clinical review. A number of patients had their medication altered,

including those who were on Aspirin only, which is no longer recommended. The national evidence base suggests that seven strokes will have been prevented from this small sample. The next step is to roll the project out to all practices in Gloucestershire and then to the other Clinical Commissioning Groups. This pilot study suggests that our aim of preventing 200 strokes is feasible.

- We have developed an “Open Prescribing Platform” with Ben Goldacre and an SME called “Dark Greener”. It means that anyone can analyse GP prescribing information published by the Health and Social Care Information Centre. The tool is very easy to use and allows Clinical Commissioning Groups, GPs, researchers or lay people to look at quality or cost efficiency issues in prescribing. This will provide a good basis for quality improvement work. For further information contact Peter Brindle on ([peter.brindle@nhs.net](mailto:peter.brindle@nhs.net))
- We held our second Informatics workshop on 23 July and this event also saw the launch of the West of England Chief Clinical Information Officers Network. This will be an opportunity for this group of clinicians to work together on how to support their organisations to use data well to support the delivery of patient care, quality improvement, safety and improved communication. Contact Nina Cross for more information on ([janina.cross@weahsn.net](mailto:janina.cross@weahsn.net))
- Patient Safety Early Warning Score event. A hundred delegates attended the second in our series of workshops around using a common Early Warning Score across all settings and all organisations in the West of England Academic Health Science Network to improve Patient Safety and spot deterioration. This event focussed on understanding the outcomes we are trying to achieve and the measurement strategies to support them. We also looked at how the Early Warning Score work can help spot sepsis. For further information, please contact Ellie Wetz, Project Manager ([ellie.wetz@weahsn.net](mailto:ellie.wetz@weahsn.net))
- Primary care flow. The Academic Health Science Network is working with all seven Clinical Commissioning Groups on an exploratory study to assess approaches to measuring and understanding demand within primary care. A better understanding of demand in primary care could help us to manage patient flow, to predict workload pressures more effectively and develop solutions which are supportive to primary care, as well as the interface with acute hospitals. More information from Peter Brindle.

## 7. AHSN Stakeholder survey

- We have just received the results from this first national stakeholder survey. West of England attracted 125 responses, the second highest number out of the 15 Academic Health Science Networks. **Headlines are –**
  - 90% respondents would recommend working with the Academic Health Science Network
  - 70% say we have helped them to achieve their objectives
  - 85% say we provide good advice and are effective at building a culture of partnership and collaboration.

We are in the top five Academic Health Science Networks on 30 of 33 measures. There is a wealth of useful comment and feedback which we will use and make an action plan and feed into our Business Plan for 2016/17.

Thank you to everyone who took the time to comment.

**Deborah Evans**  
**September 2015**

**Agenda Item 16**

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Assurance Framework 2015/16</b>
<b>Executive Summary</b>	<p>The attached Assurance Framework for 2015/16 provides details of the assurances that will be provided to the Governing Body regarding the achievement of the CCG's objectives.</p> <p>The Assurance Framework identifies gaps in assurances and controls regarding the objectives along with details of the principal high-level risks that have been identified by lead managers.</p>
<b>Key Issues</b>	A number of risks have been identified which could adversely affect achievement of the objectives. Action plans have, however, been devised and are being implemented to minimise the effect of these risks.
<b>Risk Issues:</b>	The absence of a fit for purpose Assurance Framework could result in gaps in control or assurances not being identified and addressed.
<b>Original Risk</b>	8 (2x4)
<b>Residual Risk</b>	4 (1x4)
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None

<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note this paper and the attached Assurance Framework.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Cath Leech Chief Finance Officer

**Governing Body**

**Thursday 26<sup>th</sup> November 2015**

**Assurance Framework 2015/16**

**1. Introduction**

1.1 The Assurance Framework provides the Governing Body with a structure and process that enables the organisation to:

- focus on those high-level risks that could compromise achievement of the organisational objectives;
- map out the key controls in place to manage the objectives;
- identify the assurances that will be received by the Governing Body regarding the effectiveness of those controls.

1.2 The Assurance Framework is also a key source of evidence for the Annual Governance Statement.

1.3 The primary benefit of the Assurance Framework is that it provides a structure for individuals within the CCG to consider and plan for the achievement of the organisation's objectives in a proactive manner.

**2. The Assurance Framework**

2.1 The Assurance Framework is based upon the six summary objectives outlined in the 2 Year Plan for 2014/16.

2.2 The document outlines the principal high-level risks, control systems and assurances that will be provided to the Governing Body regarding the achievement of each summary objective. Details of the action plans to address the risks, gaps in controls or gaps in assurance are also provided.

2.3 Progress regarding the achievement of each annual objective is monitored separately through the performance management process.

### **3. Recommendation**

3.1 The Governing Body is invited to note this paper and the attached Assurance Framework.

### **4. Appendix**

Appendix 1: Assurance Framework

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
<b>Objective 1: Develop strong, high quality, clinically effective and innovative services.</b>								
L2	Risk to the Quality of Primary Care due to GP practices running at maximum capacity and certain practices not being financially viable.	Helen Goodey	12 (3x4)	4 (1x4)	Practice visits by Executive Team and CCG Lead GPs; Senior Locality Manager attendance at Locality Executive meetings; Implementation of Countywide Practice Manager Representative Group; Working closely with Area Team.	Primary Care Commissioning Committee, Risk and issues log for all member practices.		Ongoing monitoring, appointments made within Senior Management of Primary Care team, Investment to support unplanned admissions DES to practices, new ways of working pilot, funding identified in ORCP plan to support Primary Care initiatives.
Q3	Risk around the specialised services for children and young people with mental health problems due to specialised commissioning transferring to NHS England leading to fragmentation of pathways.	Kathryn Hall/Simon Bilous	12 (3x4)	16 (4x4)	Monitoring service provision with local providers and feedback to Area Team. Issue raised in CQC review report.	Assurance from Area Team		Raise the concerns with the Area Team and get feedback to ensure the lead commissioner is involved in this specific area. Work ongoing to review local services and identify opportunities and gaps for service improvement, including crisis support and hospital liaison services for young people (March 2015)
<b>Objective 2: Work with patients, carers and the public to inform decision making.</b>								
Q4	Failure to capture and ensure outcomes from patient, carer and public feedback and quality governance systems to inform commissioning and contracting arrangements resulting in failure to maintain and improve the quality of services.	Marion Andrews-Evans, Mark Walkingshaw, Becky Parish	9 (3x3)	6 (2x3)	Communications and Engagement Strategy, 4Cs Policy and Procedure, Provider Clinical Quality Review Groups, HSOSC, Healthwatch Gloucestershire (HWG) comments.	Commissioning for Quality Report, Outcome of Engagement/Consultation Reports, CPGs and other programme groups		Maintain mechanism for 'feeding back' impact of patient, carer public experience data. Make information available in the public domain.
Q11	Failure to implement Deprivation of Liberty Safeguards (DoLS) as per recent judicial review.	Helen Crystal/Mary Morgan	12 (4x3)	6 (2x3)	Adult Safeguarding Board and provider Clinical Quality Review Groups (CQRGs) in place to monitor.	Adult Safeguarding Board and CQRG meetings.		General awareness to be raised across the whole organisation with emphasis on Continuing Health Care (CHC) and Mental Health services (Oct 2014).  Expansion of the CCG Safeguarding team will allow greater focus on training and support across the health community
<b>Objective 3: Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation.</b>								

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
C5	(Discharge) Risk that the number of medically stable patients remaining in hospital exceeds agreed target.	Maria Metherall	16 (4x4)	12 (3x4)	GSRG, Urgent Care Delivery Group, 7 day services countywide group, ORCP schemes mitigated by fortnightly delivery calls and clear KPIs and milestones.	Performance Reports and dashboards, critical milestones reviewed, regular programme stocktake.		Whole system recovery plan agreed with focus upon ED staffing and rotas, bed capacity and flow, community capacity and weekend discharges. Daily monitoring of performance plan underway via whole system escalation calls.
C6	(Acute Care) Non-delivery of the Constitution standard for maximum wait of 4 hours within the Emergency Department.	Maria Metherall	12 (3x4)	16 (4x4)	GSRG, Weekly GHT, ECB, 7 day service project board and steering group. ORCP schemes mitigated by fortnightly delivery calls and clear KPIs and milestones.	Performance Reports, weekly situation report, project status updates.		Whole system recovery plan agreed with focus upon ED staffing and rotas, bed capacity and flow, community capacity and weekend discharges. Daily monitoring of performance plan underway via whole system escalation calls. Streamlining urgent care.
C15	Failure to comply with national and local access targets for planned care; including 2ww, over 52ww, 62 day cancer target, diagnostic 6-week target, planned follow-ups could result in inadequate and/or delayed care.	Annemarie Vicary	12 (3x4)	12 (3x4)	Acute provider contracts, including AQP.	Performance Reports		Performance calls in place to monitor action plans and trajectories with focus on services under pressure. Additional capacity is being sought from other providers for April 2015/16 contracts including both elective and diagnostic options. Ongoing work to assist with the transfer of patients to ISTC. Cancer CPGs actively working on patient pathways. Development of Urology outpatient service.
F11 - F16	Failure to deliver financial targets.	Cath Leech	12 (3x4)	12 (3x4)	Robust financial plan aligned to commissioning strategy.	Budgets approved by the Governing Body. Monthly reporting to CCG Governing Body.		Ongoing work to ensure financial commitments are affordable and CCG is achieving a recurrent balance (at least quarterly). Work on 5 year financial plan underway including growth estimates.
					Robust contract management and activity monitoring and validation (particularly at GHFT)	Monthly performance dashboard for larger contracts with robust out of county contract monitoring reflected within performance reports.		Monthly performance meeting which reviews all contracts (including out of county) together with Contract Boards and Finance & Information Groups for larger contracts.
					Financial procedure being refreshed.	Internal audit plan in place and internal audit reports and recommendations to be reported to Audit Committee.		Procedures are constantly under review and work is currently ongoing re: financial delegation limits

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
C26	There is a risk that the scale, complexity and unavoidable time constraints associated with the implementation of the agreed service model for strengthened health and social care integrated community teams across Gloucestershire means that the financial savings target allocated to this programme as part of 2013/14 Annual Operation Plan and prior to the completion of the case for change and return of investment are not realised along with the service objectives (given the significant change in the model of service delivery required).	Kim Forey/Andrew Hughes	12 (3x4)	12 (3x4)	ICT Programme Group, QIPP Board Reports, GCCG Board Reports	Report to IGC and Governing Body, ICT Steering Group	Implementation of integrated case management and model; Delivery of HIS functionality as part of day to day service. Finalised financial model. Impact of current DN working on programme development. Throughput of Rapid Response cases.	The performance of Rapid Response is gradually improving, consistently achieving the revised target of 60 cases per week e.g. weekly discharges from Rapid Response range from 58 cases a week (week commencing 31st Aug) to 61 cases a week (week commencing 21st September). Rapid Response referral activity continues to be closely monitored which will be strengthened by the introduction of new clinical codes for patient referrals (1st August). 'System Wide' KPI's have been agreed by GCCG, GCC, & GCS which ICT KPIs will be aligned – These 'System Wide' KPIs are based on BCF KPI metrics. The draft ICT Service Specification which includes these 'System-Wide' KPIs is in the final stages of negotiation. Opportunities to establish the links between the ICT Integrated Case Management model, ICT Phase 2 and 'Joining up Your Proactive Care' are being actively explored. New governance arrangements for ICT are in place which includes the establishment of an ICT Performance & Delivery Group which is responsible for providing closer scrutiny of the performance of all ICT functionalities (Rapid Response, HIS, Core ICT).

**Objective 4: Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.**

F8	Insufficient capacity and/or capability within the CSU as a result of the proposed merger could adversely affect the organisation's ability to adequately support the CCG during the transitional period.	Cath Leech	12 (3x4)	8 (2x4)	Contract/service level agreement signed between the CCG and CSU specifying the services to be delivered.	Monthly meetings between the CCG and the CSU to review service delivery. CCG service leads meet with their counterparts in the CSU to review more detailed aspects of delivery.		Most services are now being provided in-house and the remaining CSU services are subject to a tender (lead provider framework) with any new arrangement being implemented in 2016/7
L5	Delegated commissioning arrangements create a cost pressure on the CCG through overspent primary care budgets, resulting in the CCG being unable to deliver against its statutory financial requirements.	Helen Goodey	12 (4x3)	9 (3x3)	Transition Group in place.	Regular progress reports to Governing Body. Monitoring of budgets.		Due Diligence undertaken prior to submission. Budgets will be monitored through 2015/16.

**Objective 5: Work together with our partners to develop and deliver ill health prevention and care strategies designed to improved the lives of patients, their families and carers.**

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
A1	Failure to build positive relationships with the local health community and other commissioners could impact on joined-up service delivery and transformation.	Mary Hutton, Helen Miller	12 (3x4)	8 (2x4)	Joint Commissioning posts, Joint Commissioning Boards and Executives in place between the CCG and the Local Authority. System vision agreed and Joining Up Your Care implementation with key members of the healthcare community established. GSF programme of work established to deliver on system vision.	Performance reports	Risk to partner engagement due to austerity measures	Continued engagement with all partners.
A2	Failure to build positive relationships with key stakeholders (HCOSC, HWG) could impact on implementation of service delivery and transformation.	Mary Hutton, Helen Miller, Becky Parish, Anthony Dallimore	12 (3x4)	8 (2x4)	Attend HCOSC meetings. NHS Reference Group 'No surprises' discussions. Attend HWG Meetings. Timely written briefing of stakeholders. Joint Health and Well Being Strategy agreed. Membership of Health and Well Being Board.	C4Q reports, Outcome of Engagement/Consultation reports, Written stakeholder briefings as part of integrated communication plans	Communications and Engagement Strategy requires revision	Development of BCF to act as a catalyst for transformation. (Ongoing).
A3	Failure to build positive relationships with local media could impact on the ability of the CCG to promote engagement opportunities.	Anthony Dallimore, Helen Miller, Mary Hutton	12 (3x4)	8 (2x4)	CCG Communication and Engagement Strategy. Quarterly meeting with editors. 'No Surprises' briefing on key announcements.	Sponsorship/partnership agreements, briefing arrangements within individual communication plans.	Communications and Engagement Strategy requires revision	Implementation of GCCG Communications and Engagement Strategy (Ongoing).
Q7	Lack of compliance with national targets for <i>C Difficile</i> and MRSA could result in a lower quality of care for some patients.	Teresa Middleton, Karyn Probert	12 (4x3)	6 (2x3)	Countywide HCAI action plan. Monthly monitoring of incidents of <i>C Difficile</i> and MRSA. Countywide HCAI Committee oversees action plan implementation and monitors progress.	Performance reports, Bimonthly <i>C Difficile</i> working group, Strategic Countywide HCAIs group.		Bi-monthly Strategic Countywide Healthcare Acquired Infections (HCAIs) Group. Ribotyping all <i>C Difficile</i> cases. Annual review of Countywide Antibiotic Formulary. Bimonthly CCG <i>C Difficile</i> working group. Regular communications with all prescribers. Involvement in sharing good practice with Area Team Workshop. Explore faecal transplantation as a method to reduce relapse of <i>C Diff</i> in patients as per NICE interventional procedures guidance (IPG) (March 2015).
C32	<b>2015/16 Impact of Care Act 2014:</b> 1) Significantly reduced social care capacity within ICTs associated with early assessment and review for national eligibility criteria. 2) Predicted increased demand on service (information, advice & advocacy), focus on early intervention and prevention and promotion of independent advocacy. 3) GCC new duties for managing provider failure and other service interruptions. CQC new duties for managing 'hard to replace' provider failure. New arrangements with prisons, approved premises and bail accommodation. 4) Equal rights for carers - assessments and duty to meet assessed needs	Donna Miles	12 (3x4)	12 (3x4)	Maintain regular monitoring of performance/progress at quality groups. Active participation from joint commissioners into new contractual arrangements, input into market management (via Commissioning Intentions / safeguarding / compliance)	Reports to Governing Body		NHS engaging fully with GCC Implementation Plan (March 2015)

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
C33	<b>Impact of Children &amp; Families Act 2014:</b> GCCG new duties associated with assessment, planning and provision of services for children and young people up to age 25 who have special educational needs and disabilities, and their families. New provisions for these duties to be challenged and potentially taken to tribunal / tested by case law.	Simon Bilous	12 (3x4)	8 (2x4)	Maintain regular monitoring of performance/progress at quality groups. Active participation from joint commissioners into new contractual arrangements, input into market management (via Commissioning Intentions / safeguarding / compliance)	Reports to Governing Body		NHS engaging fully with GCC Implementation plan. Interim champion arrangements. QIPP to formalise contracted capacity to ensure NHS Trusts are enabled to discharge their duties. (March 2015)
<b>Objective 6: Develop strong leadership as commissioners at all levels of the organisation, including localities.</b>								
F9	Lack of staff engagement and staff development could limit the achievement of financial balance.	All Directors	6 (2x3)	6 (2x3)	Organisational Development Plan progress reports.	Organisational Development Plan progress reports.	Organisational development plan update needed to reflect new information. Appraisal process needs to be developed to fit the organisation's needs.	Refresh of the Organisational Development Plan. Senior Manager's Group developing an appraisal process (March 2015).

**Agenda Item 17**

**Governing Body**

<b>Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Auditor Panels</b>
<b>Executive Summary</b>	<p>From 2017/18, clinical commissioning groups and NHS trusts must have an ‘auditor panel’ to advise on the appointment of their external auditors.</p> <p>As the 2017/18 appointment must be made by the end of the preceding calendar year (i.e. by 31st December 2016), auditor panels need to be in place early in 2016.</p> <p>CCGs are able to nominate their Audit Committees to fulfil this function.</p>
<b>Key Issues</b>	An independent company created by the Local Government Association (Public Sector Audit Appointments Limited) will be responsible for overseeing the Audit Commission’s current external audit contracts with audit firms from 1 April 2015 until December 2017 or up to 2020.
<b>Risk Issues:</b>	The appointment of external auditors for the CCG is not independent.
<b>Original Risk (LxC)</b>	12 (3x4)
<b>Residual Risk (LxC)</b>	8 (2x4)
<b>Financial Impact</b>	Lack of independence in the appointment of external auditors could mean that the audit of the accounts and associated opinion do not give a true and fair view of the organisation.
<b>Legal Issues</b>	The legislation in relation to this issue is covered by the Local Audit and Accountability Act 2014.

<b>Impact on Health Inequalities</b>	Not applicable
<b>Impact on Equality and Diversity</b>	Not applicable
<b>Impact on Sustainable Development</b>	Not applicable
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is asked to approve: <ul style="list-style-type: none"> <li>• the proposal that the CCG Auditor Panel is created as a distinct part of the Audit Committee; and</li> <li>• the amendments to the Audit Committee Terms of Reference to include the Auditor Panel functions.</li> </ul>
<b>Author</b>	Cath Leech
<b>Designation</b>	Chief Finance Officer
<b>Sponsoring Director (if not author)</b>	

**Governing Body**  
**Thursday 26<sup>th</sup> November 2015**  
**Auditor Panels**

**1. Background**

1.1 The Local Audit and Accountability Act 2014 (the 2014 Act) brings in significant changes to the local public audit regime in England by replacing centralised arrangements for appointing external auditors to clinical commissioning groups with a system that allows each body to make its own appointment.

1.2 The key provisions set out in the 2014 Act were that:

- The Audit Commission closed on 1st April 2015 and so is no longer responsible for the centralised system of appointing external auditors to local authorities and health service bodies (Part 1 of the 2014 Act abolishes the Commission and repeals the Audit Commission Act 1988).
- The Commission's ongoing functions transferred to a variety of other bodies (Part 5, section 19 and Schedule 6 of the Act). Of particular importance is the Code of Audit Practice which defines the scope, nature and extent of local public audit work. Since 1st April 2015, the Code has been issued by the Comptroller and Auditor General and applies to all audits from 2015/16 onwards
- There is a new approach to the regulation of local public audit and eligibility of local auditors (Part 4 and Schedule 5 of the Act)
- Local public bodies select and appoint their own auditors on the advice of auditor panels (see later in this briefing for detailed legislative references).

This paper sets out the requirements relating to the last of the points above.

1.3 Existing contracts are managed a 'transitional body' (Public Sector Audit Appointments Ltd – PSAA – a Local Government

Association company set up for the purpose).

- 1.4 During this transition period, PSAA is therefore responsible for:
- regulating auditors' work;
  - monitoring quality;
  - managing audit relationships;
  - making any new auditor appointments;
  - approving any non-audit work (above a de minimis level); and
  - setting audit fees.
- 1.5 The legislation and guidance underpinning the new arrangements is listed at Appendix A. An analysis of the CCG's current arrangements and the changes required to achieve full compliance with 'The Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015', as encapsulated by the proposals contained within this paper, are shown at Appendix B. The proposals contained within this paper also fully comply with all other relevant legislation and guidance.

## **2. Auditor Panels**

- 2.1 From 2017/18 onwards, CCGs will appoint their own external auditors and directly manage the resulting contract and relationship. The 2014 Act specifies that **all** local public bodies covered by the legislation must have auditor panels to advise on the selection, appointment and removal of external auditors and on maintaining an independent relationship with them.
- 2.2 An auditor panel must be appointed by the CCG (or jointly with another organisation) and be either a specially appointed panel or an existing sub-committee, provided it complies with the regulations on auditor panels. The guidance anticipates that it is highly likely that Audit Committees will be used to fulfil these functions. In this case, the Auditor Panel will either be the Audit Committee or a sub-set of the Audit Committee.

## **3. Main Functions of an Auditor Panel**

- 3.1 The Auditor Panel must advise the CCG on:
- the selection and appointment of the external auditor;

- the maintenance of an independent relationship with the appointed auditor; and
- the purchase of 'non-audit services' from the external auditor.

#### **4. Key Requirements**

4.1 The key requirements of Auditor Panels are as below:

- must comprise at least three members, including a Chair who is an independent non-executive member of the CCG Governing Body;
- a majority of the Auditor Panel must be independent and non-executive members of the Governing Body; and
- to be quorate, there must be a majority of independent members (and at least 2)

#### **5. Timeline**

5.1 Appointments to external audit contracts must be made by the 31<sup>st</sup> December 2016. Therefore, the Auditor Panel needs to be in place by early 2016.

#### **6. Proposal**

6.1 The CCG is proposing that the Auditor Panel is a distinct part/sub-set of the Audit Committee for the following reasons:

- the Audit Committee is independent;
- there is an established relationship with the external auditors;
- the Audit Committee receive the external auditor's reports throughout the year; and
- the Audit Committee is already involved in reviewing external auditor's work.

6.2 A revised Terms of Reference for the Audit Committee, incorporating this proposal, is attached at Appendix C. The principal change is the addition of Section 11.

## **7. Recommendation**

The Governing Body is asked to approve:

- the proposal that the CCG Auditor Panel is created as a distinct part of the Audit Committee; and
- the amendments to the Audit Committee Terms of Reference to include the Auditor Panel functions.

### **Appendices**

**Appendix A - Legislation and Guidance regarding Auditor Panels**

**Appendix B – Analysis of the Regulations**

**Appendix C – Revised Audit Committee Terms of Reference**

## Appendix A

### Legislation and Guidance regarding Auditor Panels

#### Legislation

There are two key legislative sources underpinning the new arrangements:

- The Local Audit and Accountability Act 2014
- The Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 which came into force on 1st April 2015 (SI 2015 No. 18).

Three other sets of regulations have also been issued that are relevant to health bodies:

- The Local Audit (Auditor Resignation and Removal) Regulations 2014 (SI 2014 No.1710) which came into force on 1st April 2015
- The Local Audit (Liability Limitation Agreements) Regulations 2014 (SI 2014 No.1628) which came into force on 1st April 2015
- The Local Audit (Appointing Person) Regulations 2015 (SI 2015 No.192) which came into force on 10th February 2015.

#### Guidance

The following guidance has been produced jointly by the Department of Health and the HFMA (Healthcare Financial Management Association):

Auditor Panels – Guidance to help Health Bodies meet their Statutory Duties, September 2015.

## Appendix B

Regulatory Requirements	Gloucestershire CCG	Changes required
Regulation 2: An auditor panel member may receive remuneration.	Audit Committee members are remunerated.	No changes required. Audit Committee members proposed to form the Auditor Panel.
Regulation 3: the quorum is two members or 50% of the membership of the panel (whichever is the greater). The proceedings of the meetings are valid if a majority of members present are independent.	The current Audit Committee terms of reference state:  Membership: Three Lay Members and two GP Governing Body members.  Quoracy: Three members, two of whom should be Lay Members.	The revised Audit Committee Terms of Reference indicate that quoracy of the Auditor Panel is the same as the current Audit Committee.
Regulation 4: the auditor panel should advise the health service body on the purchase of 'non-audit services' from the auditor.	The CCG policy on the Engagement of Internal and External Auditors for Non-Audit Work states that the Audit Committee will have oversight of the appointment and approval of the appointment of auditors for non-audit work.	This has been reinforced in the revised Audit Committee Terms of Reference where it is specifically referenced in the section on the Auditor Panel.
Regulation 5: an auditor panel must have at least three members, including a Chair who is an independent non-executive member of the health service body's governing board/ body. A majority of the panel's members must also be independent and non-executive members of the governing board/ body	The current Audit Committee terms of reference state:  Membership: Three Lay Members and two GP Governing Body members.  Quoracy: Three members, two of whom should be Lay Members.	See Regulation 3, above. No further changes required.

<p>but the panel may include a minority of members who are not members of the governing board/ body or who are not considered independent.</p>		
<p>Regulation 6: the governing board/ body must assess a prospective auditor panel member's independence by considering whether his or her circumstances could affect his or her judgement and by a number of factors – for example, recent employment with the health service body, close family ties to its directors, members, advisors or senior employees or a material business relationship with the health service body.</p>	<p>Appointment of Governing Body Lay Members is made in accordance with guidance issued by NHS England (and formerly, the NHS Commissioning Board) with all appointments made following external advert with candidates required to complete an application form and attend an interview.</p> <p>The CCG's Standards of Business Conduct Policy outlines the processes for managing conflicts of interest.</p>	<p>No changes required.</p>

**NHS Gloucestershire Clinical Commissioning Group**

**Governing Body Audit Committee  
(Incorporating the Auditor Panel)**

**Terms of Reference**

## **1. Introduction**

- 1.1. The Audit Committee (the Committee) is established in accordance with Gloucestershire Clinical Commissioning Group's Constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

## **2. Membership**

- 2.1. The Committee shall be appointed by the Clinical Commissioning Group as set out in the Clinical Commissioning Group's Constitution and may include individuals who are not on the Governing Body.
- 2.2. The membership of the Audit Committee shall include:-
- the lay member of the Governing Body with a lead role in overseeing key elements of governance
  - two other lay members
  - two GP Governing Body members
- 2.3. The lay member on the Governing Body, with a lead role in overseeing key elements of governance, will chair the Audit Committee.
- 2.4. In the event of the Chair of the Committee being unable to attend all or part of the meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.
- 2.5. The Chair of the Governing Body shall not be a member of the Audit Committee.
- 2.6. Members of the Committee shall cease to be members of the Committee if they are no longer members of the Governing Body.
- 2.7. The members from the GP member practices of the Governing Body shall not be in the majority.

## **3. Attendance**

- 3.1. The Committee shall invite the Chief Finance Officer, the respective internal and external auditors and a representative of NHS Protect/Counter Fraud to attend meetings of the Committee.
- 3.2. Additionally the Committee may invite any individual to attend any or part of its meetings.
- 3.3. The Committee may invite any person to attend meetings to provide advice and/or expertise as required. Any such person shall not be a member of the Committee and shall withdraw upon request.

3.4. Any individual invited to attend the Committee may contribute to the proceedings and provide advice and/or guidance to the Committee as requested.

3.5. Notwithstanding the above provisions, external audit, internal audit and local counter fraud and security management providers will have full and unrestricted rights of access to the committee in respect of their **audit** functions.

#### **4. Secretary**

4.1. The Committee Secretary shall be the Associate Director of Corporate Governance.

#### **5. Quorum**

5.1. The quorum of the Committee shall be three members, two of whom must be lay members.

#### **6. Frequency and notice of meetings**

6.1. The Committee shall meet not less than four times each financial year.

6.2. The Chair of the Committee may convene additional meetings as required.

6.3. The external auditor or internal auditor may requisition a meeting of the Committee if it is deemed necessary.

6.4. Written notice of meetings and the agenda shall be provided to Committee members not less than 5 working days before the meeting.

6.5. Notice of Committee meetings and the agenda shall also be provided to the Accountable Officer, Chief Finance Officer and the Clinical Commissioning Group employee responsible for internal audit.

6.6. The Committee shall meet in private with the internal and external auditors not less than annually.

6.7. The Committee shall meet with the Accountable Officer not less than annually to discuss and consider the process for assurance that supports the Governance Statement.

#### **7. Remit and responsibilities of the Committee**

7.1. The Committee shall critically review the Clinical Commissioning Group's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

7.2. The key duties of the Committee are:-

##### ***Integrated governance, risk management and internal control***

7.3. The Committee shall review the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities that support the achievement of the Clinical Commissioning Group's objectives.

- 7.4. In particular, the Committee will review the adequacy and effectiveness of:
- all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the Clinical Commissioning Group.
  - the underlying assurance processes that indicate the degree of achievement of the Clinical Commissioning Group's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
  - the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
  - the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
- 7.5. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.
- 7.6. This will be evidenced through the Committee's use of an effective assurance structure to guide its work and that of the audit and assurance functions that report to it.

***Internal Audit***

- 7.7. The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the audit committee, Accountable Officer and the Clinical Commissioning Group. This will be achieved by:
- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
  - Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.
  - Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
  - Ensuring that the internal audit function is adequately resourced and has appropriate standing within the clinical commissioning group.
  - An annual review of the effectiveness of internal audit.

***External audit***

- 7.8. The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Clinical Commissioning Group and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Clinical Commissioning Group and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- To review advice received from the external auditors regarding regulatory issues.

***Other assurance functions***

- 7.9. The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the Clinical Commissioning Group.
- 7.10. These will include, but will not be limited to, any reviews by Department of Health arms-length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

***Counter fraud***

- 7.11. The Committee shall satisfy itself that the Clinical Commissioning Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

***Management***

- 7.12. The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 7.13. The Committee may also request specific reports from individual functions within the Clinical Commissioning Group as they may be appropriate to the overall arrangements.

***Financial reporting***

- 7.14. The Audit Committee shall monitor the integrity of the financial statements of the Clinical Commissioning Group and any formal announcements relating to the Clinical Commissioning Group's financial performance.

- 7.15. The Committee shall ensure that the systems for financial reporting to the Clinical Commissioning Group, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Clinical Commissioning Group.
- 7.16. The Audit Committee shall review the annual report and financial statements before submission to the Clinical Commissioning Group, focusing particularly on:
- The wording in the governance statement and other disclosures relevant to the terms of reference of the committee;
  - Changes in, and compliance with, accounting policies, practices and estimation techniques;
  - Unadjusted mis-statements in the financial statements;
  - Significant judgements in preparing of the financial statements;
  - Significant adjustments resulting from the audit;
  - Letter of representation; and
  - Qualitative aspects of financial reporting.

## **8. Relationship with the Governing Body**

### ***Authority***

- 8.1. The Committee is authorised by the Governing Body to obtain professional advice, including the appointment of external advisor and/or consultants, related to its functions as it deems fit at the expense of the Clinical Commissioning Group.
- 8.2. The Committee shall recommend appropriate action(s) should be taken by the Governing Body in allowing the Committee to fulfil its terms of reference.

### ***Monitoring and Reporting***

- 8.3. The minutes of each meeting of the Committee shall be formally recorded and retained by the Clinical Commissioning Group. The minutes shall be submitted to the Governing Body.
- 8.4. The Chair of the Committee shall report the outcome and any recommendations of the committee to the Governing Body.
- 8.5. The Committee shall report to the Governing Body annually on its work in support of the Statement of Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework process. The Assurance Framework is presented regularly to the Governing Body.

## **9. Policy and best practice**

- 9.1. The Committee shall have regard to current good practice, policies and guidance issued by the NHS England, the Clinical Commissioning Group and other relevant bodies.

## **10. Conduct of the Committee**

- 10.1. The Committee shall conduct its business in accordance with these terms of reference and the Clinical Commissioning Group's governance arrangements.

## **11 Auditor Panel**

- 11.1 The Audit Committee will fulfil the role of 'Auditor Panel', as defined in the Local Audit and Accountability Act 2014 and in accordance with the Department of Health publication 'Auditor Panels – Guidance to help Health Bodies meet their Statutory Duties, September 2015'.
- 11.2 The principal role of the Auditor Panel is to advise the Governing Body on the selection, appointment and removal of the Clinical Commissioning Group's external auditors. The Auditor panel is also responsible for advising the Governing Body on the purchase of 'non-audit services' from the external auditor.
- 11.3 The Auditor Panel will take the form of a separate section of the Audit Committee meeting and will be minuted separately.

### ***Membership, Attendance, Secretary and Quorum***

- 11.4 The membership, secretary and quoracy will be as per the Audit Committee and outlined in Sections 2, 4 and 5 above.
- 11.5 The Chief Finance Officer will be invited to attend the meetings. In addition, the Panel may invite any other individual to attend the meetings, as appropriate.

### ***Frequency and notice of meetings***

- 11.6 The Panel will meet as and when required.
- 11.7 Written notice of the meetings and agendas will be provided, as part of the normal Audit Committee processes, to Panel members not less than 5 working days before the meeting.

### ***Remit and responsibilities of the Panel***

- 11.8 The key duties of the Panel are to advise the Governing Body on:
1. the selection, appointment and removal of the Clinical Commissioning Group's external auditors;
  2. the maintenance of an independent relationship with the appointed external auditor; and
  3. the purchase of 'non-audit services' from the external auditor.

***Monitoring and reporting***

- 11.9 The minutes of each meeting of the Panel will be formally recorded and retained by the Clinical Commissioning Group and submitted to the Governing Body.
- 11.10 The Chair of the Panel shall report the outcome and any recommendations of the Panel to the Governing Body.

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Integrated Governance and Quality Committee (IGQC) minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the IGQC meeting held on the 20 <sup>th</sup> August 2015.
<b>Key Issues</b>	<p>The following principal issues were discussed:</p> <ul style="list-style-type: none"> <li>• Experience and Engagement Report</li> <li>• CQC Inspection of GHFT</li> <li>• Quality Report</li> <li>• Future arrangements for the Clinical Effectiveness Group</li> <li>• Effective Clinical Commissioning Policies</li> <li>• Assisted Conception Policy</li> <li>• Section 117 Aftercare</li> <li>• Dispute Resolution Policy for NHS Continuing Healthcare and NHS Funded Nursing Care</li> <li>• Risk Register</li> <li>• Assurance Framework</li> <li>• Governance Policies for approval</li> <li>• Information Governance Update</li> <li>• Briefing on Suicides and Attempted Suicides</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None

<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Julie Clatworthy IGQC Chair and Registered Nurse

## Integrated Governance and Quality Committee (IGQC)

**Minutes of the meeting held on  
Thursday 20<sup>th</sup> August 2015, Board Room, Sanger House**

<b>Present:</b>		
Dr Charles Buckley	CBu	Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Caroline Bennett	CBe	GP - North Cotswolds Locality
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Cath Leech	CL	Chief Finance Officer
Colin Greaves	CG	Lay Member – Governance
Sarah Scott	SS	Interim Director of Public Health
Valerie Webb	VW	Lay Member - Business

<b>In Attendance:</b>		
Teresa Middleton	TM	Deputy Director of Quality
Rob Mauler	RM	Patient Experience and Safety Manager
Richard Thorn	RT	Commissioning Manager (Planned Care)
Liz Ponting	LP	Senior Medicines Management Pharmacist
Karl Gluck	KG	Interim Joint Commissioning Manager
Kim Forey	KF	Associate Director, Partnerships, Joint Commissioning and Community Services
Cate White	CW	Project and Business Manager Quality Team
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator

### **1. Apologies for Absence**

- 1.1 Apologies were received from Mary Hutton, Dr Helen Miller, Dr Tristan Lench, Mark Walkingshaw and Julie Clatworthy.

## 2. **Declarations of Interest**

2.1 There were no declarations of interest received.

## 3. **Minutes of the meeting held on 18<sup>th</sup> June 2015**

3.1 The minutes of the meeting were accepted as a true and correct record, subject to the following amendments:

- Section 9.1.10.1 to be amended to read '*JC queried if there was any local evidence to indicate that varicose veins led to limb loss.*'
- Section 9.2.3 to be amended to read '*GB advised that the new policy was shared with other commissioners and they were considering adopting this Policy.*'

## 4. **Matters Arising**

### 4.1 **IGQC97 Information Governance Update**

AP advised that the Information Governance training had been organised for members on the 3<sup>rd</sup> December 2015.

### 4.2 **IGQC108 Quality Report**

AP advised that the Perinatal Mental Health Improvement Seminar Presentation had been located. However, confirmation that this was the correct presentation from Dr Helen Miller was required. CBu suggested that Dr Hein Le Roux was approached as he had met with the CQC regarding Mental Capacity Act (MCA) and if any information could be shared.

### 4.3 **IGQC110 and IGQC126 Quality Report**

The feedback from the CQC inspection of GHFT was covered under Agenda Item 15. **Item Closed.**

### 4.4 **IGQC112 Quality Report**

Themes from the Clinical Quality Review Group meeting were covered within the Quality Report. **Item Closed.**

- 4.5 **IGQC116, 117 and 118 Safeguarding Children Policy**  
The minor corrections regarding the Safeguarding Children Policy had been actioned. **Item Closed.**
- 4.6 **IGQC121 Assisted Conception Policy**  
The Policy was covered under Agenda Item 10. **Item Closed.**
- 4.7 **IGQC122 NHS England Peer Review**  
MAE clarified that the issues regarding the review of the Trauma unit were recorded on the GHFT Risk Register. **Item Closed.**
- 4.8 **IGQC123 GHFT Dr Foster Mortality Data**  
MAE advised that the Fracture Neck of Femur issue raised in the report was included in the GHFT Risk Register. **Item Closed.**
- 4.9 **IGQC125 Any Other Business**  
CBu highlighted that the CCG had invested in an alternative clinical reference tool called 'DynaMed'. **Item Closed.**
- 4.10 **IGQC127 Quality Report**  
The Committee received the Public Health response to the Dr Foster Mortality Data. SS highlighted that further clarity on the metrics was required in order to provide a sufficient response. **Item Closed.**
- 4.11 **IGQC129 Health and Safety Policy**  
MAE advised that she had received guidance from the CSU and it was identified that a board level Health and Safety Champion was required although there were no specific requirements on the training for the champion. It was noted that the CCG commission the CSU to provide expert advice. **Item Closed.**
- 4.12 **IGQC130 Assurance Framework**  
AP advised that Risk No F8 had not been removed as it had been reassessed as amber. **Item Closed.**

#### 4.13 **IGQC131 Information Governance Update**

CL provided an update on the proposed patient consent model and advised that she would provide a briefing report on audit, access, safeguard and controls.

### **5. Experience and Engagement Report**

5.1 RM introduced the report which provided an overview of key experience and engagement activity undertaken by the CCG during 2015/16 Quarter 1. The report was taken as read.

5.2 The Committee were informed that complaint numbers had risen overall. However, this increase was largely due to a series of historical Continuing Health Care (CHC) assessment complaints. RM highlighted that complaints were being generated by claims management companies and it was noted that the Ombudsman had established a dedicated team to review the CHC claims.

5.3 RM advised that a conference was being held the following week regarding the future of PALs.

5.4 It was reported that the Friends and Family Test response rate for June 2015 was 0.9% and that this equated to 54 responses from 5688 individuals who were eligible to respond to the 'test'. RM advised that the low response rate was discussed with GHFT who advised that they were considering changing the methodology used. RM stated that this would be an area of focus going forward. MAE advised that an extraordinary Clinical Quality Review Group meeting with GHFT was being convened to discuss patient experience. MAE indicated that further measures on patient experience would be included in the following year's contract.

5.5 RM advised that NHS England were developing a complaints policy for primary care complaints and it was noted that NHS England would remain responsible for complaints management.

5.6 The Committee were informed of the key engagement activities undertaken relating to the Choose Well campaign. Events included attendance at Lydney Community Hospital Fete, Gloucester Royal Hospital Fete, Longlevens School Health and Wellbeing Day and Oakley Fun Day in Cheltenham.

**5.7 RECOMMENDATION: The Committee noted the contents of this report.**

## **6. CQC Inspection of GHFT**

6.1 MAE advised that the presentation, which was produced by GHFT in relation to the CQC report, was included in the report. The report was taken as read.

6.2 MAE drew attention to the ratings awarded to Gloucestershire Royal Hospital and it was emphasised that improvements were required overall. MAE articulated that the CQC inspection identified that safety required improvement specifically in the Emergency Department.

6.3 MAE highlighted that the Trust were scored as 'good' for caring and that the caring provided by staff was 'good' across all hospitals inspected, with 'outstanding' in critical care.

6.4 The Committee were advised that the Trust had a low rate of incident reporting which had not been previously identified. It was highlighted that the CCG does not have access to the National Reporting and Learning System.

6.5 Issues were also identified with the child protection training for doctors as this was considered low and not robust.

6.6 MAE advised that the CQC inspection also identified that improvements were required to End of Life Care and to distinguish patients who were potentially in their last year of life in order to plan care better. It also

suggested that a strategy for End of Life Care was developed. MAE advised that an End of Life Care working group had been established to review this area and to develop a countywide strategy.

- 6.7 The CQC felt that the bed occupancy was too high at average 91%, which was above the England average of 88% and that 85% was generally the accepted level. MAE highlighted that this level was common across many acute sector hospitals.
- 6.8 MAE highlighted that the CQC identified that the leadership of the Medical Directorate required improvement. MAE acknowledged the issues particularly as there had been issues with cardiology letters.
- 6.9 Reports to the CQC of bullying were not substantiated on inspection, but evidence of bullying raised by staff to management was found but had been appropriately managed. The Trust also scored poorly on engagement in the staff survey although this was not demonstrated when talking to staff.
- 6.10 The Committee were advised that an action plan had been developed by GHFT and it was felt that this was not comprehensive. MAE advised that further information had been requested from GHFT to ensure that the plan could be monitored effectively and that this was still awaited. CL advised that contract leverage could be applied if co-operation could not be sought.
- 6.11 The Committee felt that high level discussions were required regarding the outcome of the report. CBU suggested that a report outlining the issues was prepared and discussed at the forthcoming Development Session to be attended by Frank Harsent. CL suggested that, a preliminary discussion was held at the Core Directors meeting.
- 6.12 **RECOMMENDATION: The Committee noted the contents of this report.**

## **7. Quality Report**

- 7.1 MAE presented the Quality Report which provided assurance to the Committee that quality and patient safety issues were given the appropriate priority and that there were clear actions to address them. The report was taken as read.
- 7.2 Members were informed that the report included the Quality Dashboard which provided an overview of performance within the provider organisations. MAE highlighted that this was a developing framework.
- 7.3 MAE highlighted the performance figures relating to GCS inpatients receiving Venous Thromboembolism (VTE) risk assessment and it was reported that it had fallen to 77.7% against a target of 90%. MAE advised that GCS advised that there had been issues with the implementation of SystemOne and that data was not captured from Cirencester Hospital. Members were assured that this should now be on trajectory.
- 7.4 The performance regarding GHT patients who were assessed and treated within 24 hours following a Transient Ischaemic Attack (TIA) or are at high risk of a stroke had improved and it was reported that performance was at 58.7% in June 2015 against the target of 60%.
- 7.5 MAE informed members that there was an increasing concern around the C.Difficile rates across the community (acute and community sector). It was highlighted that although it was currently below target, if the trend continued, then the target threshold could be exceeded.
- 7.6 RM informed members that he was currently working on developing two new policies regarding serious incidents within the CCG and the other within secondary care providers.
- 7.7 RM advised that Quality Alerts identified an emerging concern relating to anomalies with patient data being

provided to primary care following discharge. It was noted that discharge was an area of focus for Healthwatch.

- 7.8 MAE indicated that there was an issue with GHFT reporting details of Serious Incidents on the Strategic Executive Information System (STEIS). However, it was confirmed by RM that issues had been resolved.
- 7.9 CG highlighted the incident where a patient suffered burns after lighting a cigarette whilst using oxygen. The Committee deliberated if a patient should be offered oxygen therapy if they continued to smoke. MAE advised that support was available to quit smoking i.e. smoking cessation, nicotine patches. It was noted that the fire service would undertake a risk assessment of the home where oxygen was provided to a patient.
- 7.10 The minutes of the 2gether Trust Clinical Quality Review Group meeting held on the 27<sup>th</sup> July 2015 were tabled at the meeting. MAE highlighted the key themes from this meeting and advised that there was a significant reduction in the waiting list for the Eating Disorder service. It was also noted that the report on the outcome of a homicide investigation was still awaited.
- 7.11 MAE advised that 'Fractured Neck of Femur' would be an area of focus going forward and it was confirmed that this had been added to the GHFT risk register.
- 7.12 Members were informed that the Director of Nursing for GCS had been seconded to Health Education England and that her post was being advertised on NHS Jobs.
- 7.13 MAE reported that a draft report from the CQC inspection of GCS that took place in June 2015 would be received at a formal CQC summit planned for the 29<sup>th</sup> September 2015.
- 7.14 MAE updated members on the progress of the District Nurse recruitment. It was confirmed that GCS had recruited all Band 5 positions and were now in the

process of 'over recruiting' so that they could provide 'like for like' backfill from September 2015 while they support Band 6 staff members to undertake their Specialist Practitioner Qualification in District Nursing. The CCG supported this approach and had agreed to fund the backfill.

7.15 Members noted that a 'Keep Well' campaign was being arranged on the 21<sup>st</sup> October with the support from Public Health and the Local Authority particularly targeting nursing homes in order to enable staff to effectively manage the symptoms of diarrhoea and vomiting of patients and to avoid hospital admissions.

**7.16 RECOMMENDATION: The Committee noted the contents of this report.**

## **8. Future arrangements for Clinical Effectiveness Group**

8.1 CBu provided a verbal update regarding the role of the Clinical Effectiveness Group. CBu felt that the scope for the group was potentially huge and there was a danger of it adding little value. He felt that the Group required a refresh of roles, tasks and operation and welcomed any ideas for improvement.

8.2 CBu suggested there were three major roles that the Group could perform. These were:

- assure the CCG Board and Membership, via the IGQC, that current best practice, clinical guidance and evidence – particularly from NICE and other national bodies – had been reviewed by relevant components of the CCG and its partners;
- promote and support the gaining and use of evidence from Research, Audit, Service Evaluation, Patient Experience and Incident Reporting in improving patient care. This means actively looking for gaps and omissions rather than just being reactive; and

- promote and support knowledge management within the CCG so it was an effective learning organisation. This means helping with connecting and networking, signposting, assisting when needed in developing and improving the range of tools the CCG used to deliver quality. Much of the 'doing' was already happening in Clinical Programme Groups, Clinical Pathways Group and G-Care.

8.3 CBU suggested that there were linkages with other groups and that close working with the following was required:

- Clinical Quality Review Groups
- Clinical Programme Groups
- Medicines Management Interface Group
- Clinical Pathways Group/G-Care

8.4 CBU advised that a familiar way of setting agendas and managing a work programme was producing a checklist and explained that he had produced a checklist for the Group.

8.5 CBU suggested that the following areas were reviewed under the checklist:

- NICE TAs;
- NICE Quality Standards;
- NICE guidelines;
- other guidance;
- audit reports and activity;
- research updates;
- low value healthcare;
- knowledge management; and
- CCG Outcome Indicate Set metrics

8.6 CBU highlighted that useful summaries and reports were issued from the CSU on recent NICE and other guidance and noted that these would be a vital consideration when completing the checklist.

- 8.7 CBe queried the assurance process for covering the gap where there were no specific CPGs. It was agreed that this required further clarity. It was also agreed that the role of the CPGs would require further clarity to ensure that the remit was clearly defined.
- 8.8 It was noted that the Terms of Reference would be reassessed and revised. AP advised that revised Terms of Reference should be endorsed by the Committee.
- 8.9 CG queried the process of updating the changes to the CPGs formally. CBu advised that it was being reviewed and that a discussion with the CPGs was required in order to ensure a joined up approach. CG suggested that a discussion with Graham Mennie was held as he was the newly appointed lead for Clinical Programmes.
- 8.10 RECOMMENDATION: The Committee noted the verbal update.**

## **9. Effective Clinical Commissioning Policies**

- 9.1 RT presented the Effective Clinical Commissioning Policies (ECCP) and provided a background context underpinning the review to the policies on the current ECCP list.
- 9.2 The Committee were presented with a proposal for 31 policies which had been reviewed in the second stage of the process. RT advised that 22 of the existing policies had no changes to the clinical criteria.
- 9.3 The 21 policies where no changes were proposed to the current criteria were approved by the Committee. These were:
- Discectomy for lumbar disc prolapse;
  - Ganglia;
  - Hip impingement surgery;
  - Hip resurfacing techniques;
  - Hyalurons, Hyaluronic acid or

viscosupplementation;

- Trigger Finger;
- Bevacizumab for choroidal neovascularisation;
- Bevacizumab for iris rubeosis and rubeotic/neovascular glaucoma;
- Bevacizumab for neovascular glaucoma;
- Cataract;
- Excimer laser eye surgery;
- Intravitreal anti VEGF in diabetic macular oedema;
- Minor eyelid surgery;
- Hysterectomy for heavy menstrual bleeding
- Ranibuzumab for wet AMD;
- Bobath therapy;
- Botulinum toxin for treatment of chronic anal fissure;
- Cannabinoids for spasticity associated with multiple sclerosis;
- Chronic fatigue syndrome – residential treatment
- Lycra splinting for paediatric patients with cerebral palsy; and
- Interventions that are not covered by a CCG policy that are not already well established and commonly provided on the NHS.

9.4 SS highlighted the Long Acting Reversible contraceptive in Secondary Care Policy and queried in what circumstances would this apply as it was highlighted that Public Health commissioned a specialist unit with GCS. The Committee agreed that further discussion was required and that the policy should not be considered for approval at this stage.

9.5 RT presented three policies where minor changes were proposed and it was noted these changes were primarily rewording elements to improve clarity. These policies which were approved by the Committee were:

- Dupuytren's surgery;
- Non-specific low back pain; and
- Circumcision.

9.6 The five policies where major changes were proposed that altered the commissioning criteria or funding process were approved by the Committee. These were:

- Carpal Tunnel Syndrome;
- Epidural injections for lumbar back pain;
- Facet Joint Injections;
- Medial branch blocks; and
- Radiofrequency denervation.

9.7 RT advised that one additional policy was being proposed for a procedure that was identified as a result of the clinical discussions that took place during the review process. This related to Xiapex for dupytrens contracture.

**9.8 RECOMMENDATION: The Committee approved the above policies with the exception of the Long Acting Reversible contraceptive in Secondary Care Policy**

## **10. Assisted Conception Policy**

10.1 MAE presented the revised Assisted Conception Policy and advised that a cost benefit analysis had been undertaken. MAE advised that treatments would be commissioned for couples who adhere to the eligibility criteria as outlined within the Policy.

10.2 CG highlighted that an Equalities Impact Assessment had been undertaken.

10.3 VW highlighted Section 10 of the Policy regarding Childlessness and felt that it required further clarity. MAE agreed that the criteria would be amended to read 'no living children from either partner from a previous relationship'.

10.4 LP gave a comparative overview to the changes that were being proposed from the current Policy. It was

noted that the main changes were endorsed by the Priorities Committee on the 16<sup>th</sup> July 2015.

- 10.5 The Committee highlighted the section relating to the age of the female partner at the time of referral and requested the sentence 'so that treatment can commence before the woman's 40<sup>th</sup> birthday' was removed.
- 10.6 CBe felt that consuming high levels of alcohol was considered to be harmful and suggested that known/suspected alcohol misuse was also added to the Policy.
- 10.7 LP informed members on the access of choice arrangements and advised that treatment would be provided at Cotswold Fertility Unit and Oxford Fertility Unit. It was noted that if there was a request for any treatment to be provided out of county, then funding approval must be sought from the CCG via the Individual Funding Request process prior to treatment.
- 10.8 RECOMMENDATION: The Committee approved the Assisted Conception Policy, subject to the above amendments.**
- 11. Section 117 Aftercare (Mental Health Act 1983)**
- 11.1 KG presented the revised draft policy and provided a brief context to this policy. KG explained the details regarding Section 117 and advised that Section 117 aftercare was a legal duty that was placed on health and social services to provide for individuals who had been detained under Section 3 of the Mental Health Act. The duty that comes into effect once the person had been discharged from the hospital.
- 11.2 KG advised that the existing Policy had been revised to align with current legislation and to provide specific details in relation to joint funding arrangements.
- 11.3 KG informed members that a 12 week consultation process was undertaken which was led by GCC. The

Policy was revised based on the feedback received from the consultation process.

- 11.4 It was noted that following the consultation, the draft policy was taken to Joint Commissioning Partnership Executive (JCPE) in October 2014 and that JCPE did not feel able to agree to the policy due the lack of detailed financial modelling and the potential impact on both organisations with regards to agreeing a formal position on joint funding.
- 11.5 It was noted that a further financial analysis was undertaken which considered several potential scenarios.
- 11.6 KG informed members that the revised Policy had now been approved by JCPE and GCC. The Committee noted that some areas of expenditure were not quantifiable, i.e. dementia cases, and there remained a potential risk to both the CCG/GCC in respect of joint funding.
- 11.7 CG expressed concerns regarding the financial implications and was assured by CL that it was equitable.
- 11.8 CBU queried how a care package would be monitored following the patient's discharge from hospital. CBU also queried how the carer's needs would be taken into account and if that was covered under Section 117. KG advised that it was not covered and recognised that it should be considered. It was noted that the discharge planning meeting prior to the patients discharge included carer's arrangements which was also articulated in the Code of Practice. KG proposed that an audit should be undertaken within 6 months after policy implementation to review discharge planning and subsequently re-audited within a year.
- 11.9 KF indicated that due to the Deprivation of Liberty, there could be an increase in the use of the Mental Health Act, particularly with regards to dementia cases, which would increase the numbers of people to whom

Section 117 applied.

**11.10 RECOMMENDATION: The Committee approved the Policy.**

**12. Dispute Resolution Policy for NHS Continuing Healthcare and NHS Funded Nursing Care**

12.1 KF presented the above Policy which provided a mechanism to be applied for the purposes of resolving disputes regarding the eligibility of a service user for NHS Continuing Health Care (CHC) in accordance with the national framework.

12.2 KF highlighted that the framework had been used in various other health and social care communities across the country.

12.3 KF articulated that the Policy had never been exercised due to the positive working relationship between the CCG and GCC.

12.4 CG queried the governance process for the authorisation of the policy as it stated that Margaret Willcox would sign off this policy on behalf of the GCC and noted that she was also a member of the CCG Governing Body and felt that this caused a potential conflict of interest.

12.5 CL expressed concerns regarding the stages within the dispute panel escalation process as it stated that Margaret Willcox was responsible for stages two, three and four of the dispute process and felt that it should be independent at each stage. MAE felt that MW should replace MH at stage four. KF agreed that she would amend this. KF

12.6 The Committee agreed that the Policy should be reviewed in three years.

12.7 CBu queried if legal advice was sought and was advised that the standard pro-forma template provided by NHS England had been used. NHS England had

agreed this approach with their legal advisors. KF advised that it was routine practice for her team to seek legal advice if it was necessary.

**12.8 RECOMMENDATION: The Committee approved the Policy.**

**13. Risk Register**

13.1 AP presented the Risk Register which provided details of those risks identified by the responsible managers that currently face the CCG and which could affect the achievement of the organisational objectives.

13.2 The Risk Register currently comprised a total of 47 risks, three of which were graded as 'red' as outlined in Appendix 1. AP advised of the addition of eight new risks detailed on Appendix 2

13.3 AP confirmed that details of all risks for consideration to be removed from the Risk Register had been provided at Appendix 3. These were Risk No L1 and Q15.

13.4 CG highlighted Risk No F17 and stated that the calculation of the current risk was incorrect. AP agreed to correct this.

**13.5 RECOMMENDATION: The Committee**

- **noted the paper and the attached Risk Register; and**
- **approved the addition of the eight risks detailed on Appendix 2; and**
- **approved the closure of the two risks detailed on Appendix 3.**

**14. Assurance Framework**

14.1 AP presented the Assurance Framework for 2015/16 which provided details of the assurances that will be received by the Governing Body regarding the achievement of the CCG's Objectives. The paper was

taken as read.

14.2 CBU felt that there should be a tracker to summarise the changes and updates in order to understand it effectively. AP responded that a review of the format of the Risk Register and Assurance Framework was being undertaken.

14.3 VW highlighted the target date specified for Risk No Q3 relating to specialist commissioning and noted that this was stated at March 2015. MAE advised that the concerns were formally raised with the Area Team and the risk still remained.

14.4 **RECOMMENDATION: The Committee noted this paper and the attached Assurance Framework.**

## 15. Policies for Approval

### 15.1 Harassment and Bullying

15.1.1 AP presented the Harassment and Bullying Policy and advised that it had been reviewed by the Policy Working Group and the Core Executive Team.

15.1.2 AP advised that this policy had been reformatted to align with the CCG format.

15.1.3 **RECOMMENDATION: The Committee approved the Policy.**

### 15.2 Whistleblowing

15.2.1 AP presented the Whistleblowing Policy and advised that this was a minor revision to the existing policy.

15.2.2 **RECOMMENDATION: The Committee approved the Policy.**

### 15.3 Intellectual Property Rights

15.3.1 AP presented the Intellectual Property (IP) Rights Policy which was a new Policy being implemented by

the CCG.

15.3.2 It was noted that the policy outlined the effective management of IP and provided a brief definition of what IP was. It also had information on who to contact if staff have an invention/idea/innovation that they think may need to be protected, or if they required general advice on IP arising from their work.

**15.3.3 RECOMMENDATION: The Committee approved the Policy.**

## **16. Records Disposal Schedule**

16.1 AP presented the Records Disposal Schedule which identified the classification of records and information held by the CCG and provided retention rules for which individual records should be held. AP advised that this was based upon national guidance.

**16.2 RECOMMENDATION: The Committee approved the attached disposal schedule for use within the CCG.**

## **17. Information Governance Update**

17.1 The paper provided an update on the organisation's information governance arrangements. The paper was taken as read.

17.2 CL informed members that organisations within the County agreed at the previous County Wide Information Governance meeting to sign the Gloucestershire Information Sharing Agreement. Work was now underway between information governance leads to agree on a common format for the specific information sharing agreements.

**17.3 RECOMMENDATION: The Committee:**

- **noted the 15th July 2015 minutes from the Information Governance Group meeting;**
- **noted the 13<sup>th</sup> May 2015 notes from the County Wide Information Governance Working Group;**

and

- noted the contents of this report.

## **18. Briefing on Suicides and Attempted Suicides**

- 18.1 This paper was presented to the Committee which was provided for information. The paper was taken as read.
- 18.2 CBU highlighted the recent finding that statistically men were more at risk of suicide and probed if there were opportunities to engage and target this group via other mechanisms and with Public Health support i.e. self-harm helpline, NHS Health Checks.
- 18.3 CBU indicated that the self-harm helpline was underutilised due to the low exposure of the service particular within primary care. SS agreed that she would address this issue. It was also highlighted that a strategy had been produced and that reaching the group was challenging as generally they were not known to frontline services.
- 18.4 SS suggested that an update on the delivery plan around the work of the suicides prevention strategy and how men were being targeted was presented at the next Committee meeting. SS
- 18.5 SS clarified that deliberate self-harm was not the same as attempting suicide and that there was not necessarily a link between the two.
- 18.6 RECOMMENDATION: The Committee noted the report.**

## **19. Any Other Business**

- 19.1 There were no items of any other business.

## **20. The meeting closed at 12.15pm.**

***Date and time of next meeting: Thursday 22<sup>nd</sup> October 2015 in the Board Room at 9am.***

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Audit Committee minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the Audit Committee meeting held on the 7 <sup>th</sup> July 2015.
<b>Key Issues</b>	The following principal issues were discussed: <ul style="list-style-type: none"> <li>• Internal Audit</li> <li>• External Audit</li> <li>• Counter Fraud</li> <li>• QIPP</li> <li>• Procurement decisions</li> <li>• Waivers of Standing Orders</li> <li>• Aged Debt Report</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Colin Greaves Audit Committee Chair and Lay Member

**NHS Gloucestershire CCG**  
**Audit Committee**

**Minutes of the meeting held on Tuesday 7<sup>th</sup> July 2015**  
**Bartlett Room, Sanger House**

<b>Present:</b>		
Colin Greaves (Chair)	CG	Lay Member, Governance
Valerie Webb	VW	Lay Member, Business
Alan Elkin	AE	Lay Member, Patient and Public Experience
Dr Andy Seymour	AS	Deputy Clinical Chair

<b>In Attendance:</b>		
Cath Leech	CL	Chief Finance Officer
Alan Potter	AP	Associate Director, Corporate Governance
Paul Dalton	PD	Audit Manager, PWC
Ashley Allen	AA	Audit Manager, Grant Thornton
Laura Hallez	LH	Audit Manager, Grant Thornton
Andrew Beard	AB	Deputy Chief Finance Officer
Lee Sheridan	LS	Local Counter Fraud Specialist
Zoe Barnes	ZB	Corporate Governance Officer

**1. Apologies**

1.1 Dr Hein Le Roux

**2. Declarations of Interests**

2.1 There were no relevant interests declared.

**3. Minutes of the Meeting held 26<sup>th</sup> May 2015**

3.1 The minutes were approved subject to the following changes:

3.1.1 Point 4.3.3 – Sentence to read ‘CG queried why IT costs were included if these had been fully depreciated in 2013/14’ only.

3.1.2 Point 7.2 – Sentence to read ‘Following a query raised by LC

it was confirmed that external audit were not required at the Governing Body meeting on the 28<sup>th</sup> May 2015'.

**3.2 Recommendation: The Committee approved the minutes from 26<sup>th</sup> May 2015 subject to the above changes.**

**4. Matters Arising**

4.1 Please see attached matters arising log.

4.2 11.03.14 Item 5.4 – It was noted that the counter fraud training session had been scheduled for the 27<sup>th</sup> August 2015 during a development session and required communicating to the Governing Body beforehand to encourage attendance.

4.3 26.05.14 Item 6.2 – CG advised this should include bringing the assurance framework to Audit Committee meetings, and was not just about areas that the Integrated Governance and Quality Committee (IGQC) oversee but broader governance matters. CL advised that the internal audit plan could pick up these issues.

**5. Internal Audit**

**5.1 Final Annual Report 2014/15**

5.1.1 PD presented the final internal audit report and advised that no changes had been made following the draft report presented in May.

5.1.2 PD requested comments from the members. AE queried the description and detail columns regarding internal control issues as the statements in each column appeared to be conflicting. PD confirmed that there had been no specific weaknesses considered to be reported in the annual governance statement and that the description column had not been updated which was an error.

5.1.3 CG requested an update on the business intelligence tool, given the reporting issues raised in the previous year. CL gave an overview of how the tool works and confirmed that it would be rolled out this year.

**5.1.4 Recommendation: The Committee noted the contents of the report.**

**5.2 Internal Audit Action Tracker**

5.2.1 PD outlined the purpose of the development of the tracker and drew attention to the table on page two – risk management. PD requested views from the members and AE agreed that the context was helpful. CG requested that trend information was included.

**5.2.2 Recommendation: The Committee accepted the tracker for inclusion at future meetings.**

**5.3 Corporate Governance Review – Final Report**

5.3.1 PD advised the review presented a low overall risk rating.

5.3.2 PD outlined the three advisory findings which related to staff engagement, constitution appendices and the training and development of internal stakeholders.

5.3.3 CG noted that some points within the report were historical.

5.3.4 AP advised that work around policy development had been completed and he was confident that the CCG had appropriate policies in place. VW discussed policy development further and advised of the work of the policy working group and discussions held with the CSU around formatting.

5.3.5 AE highlighted point five regarding training and development and queried how the Organisational Development group would be scrutinised. CL advised that the attendees are self-selected staff and that minutes from the meeting would go to Core Team meetings. VW noted that this links to the staff survey and CL advised that the Executive Nurse and Quality Lead was setting up a staff forum to address these kind of matters.

**5.3.6 Recommendation: The Committee noted the contents**

**of the report.**

5.4 Communications Review – Final Report

5.4.1 PD gave an outline into the review and advised that no risk rated findings had been found. It was noted that communications was a good area within the CCG.

**5.4.2 Recommendation: The Committee noted the contents of the report.**

5.5 Annual Plan 2015/16

5.5.1 PD presented the annual plan for 2015/16 and highlighted page three, auditable areas.

5.5.2 PD advised he had met with CL to discuss the procurement project. CL confirmed that internal audit would be assisting during the project as good practice rather than an audit of the completed work.

5.5.3 VW queried how any slippage would be reported and it was confirmed that this would be brought to Audit Committee meetings as appropriate.

5.5.4 CG queried the governance arrangements around primary care commissioning procurement. CL confirmed that two audits for primary care commissioning would be organised for 2015/16, with a few areas of focus identified already. It was advised that discussion would be held next week to pick this up.

5.5.5 CG thanked PWC for their work over the last year.

**5.6 Recommendation: The Committee accepted the internal audit plan for 2015/16.**

**6. External Audit**

6.1 Update Report

6.1.1 AA presented the attached reports and noted that LH would be taking over the management of external audit for

GCCG moving forward.

6.1.2 AA advised that the report was an update on progress and drew attention to the following key points from the report:

- 2014/15 audit work now complete
- NHS Governance review
- Bespoke review on GCCG – It was noted that CL held a copy of the report and had shared with teams
- NHS financial resilience review – AA advised this was the second annual review and copies were made available
- CQC mental health review
- New models of care – It was noted that there would be opportunities in the future for the CCG to take part and the timescale for completing this time was limited. CL advised that the CCG had completed a vanguard application but was not successful.

## 6.2 Annual Audit Letter

6.2.1 AA presented the letter which was a public version of the audit findings report. It was noted that there was one new part of the report as this related to looking forward.

6.2.2 CG queried the wording regarding surplus on page five, as although this was factually correct, it appeared to be misleading. AA agreed to adjust the wording to reflect the discussion.

6.2.3 AA highlighted the acknowledgements on page five.

6.2.4 AA briefly discussed the audit of the accounts including financial performance and looking forward.

6.2.5 AA invited comments from the members. CG noted that this was a good report and recognised the work of the finance team in the production of the accounts.

## 6.3 **Recommendation: The Committee noted the contents of the report.**

## 7. Counter Fraud update

7.1 LS presented the report and noted that the May report had now been updated and an additional paragraph added. LS highlighted the following key points from the report:

7.1.1 It was advised that the action plan had been agreed with CL prior to forwarding to the Committee.

7.1.2 Counter Fraud training in primary care – current issues regarding overseas patients in Gloucestershire was discussed. AS advised that practice managers would be appropriate to attend this training.

7.1.3 LS advised of two recent arrests regarding the inappropriate use of blank prescription forms.

7.1.4 An ongoing case regarding a regular direct payment was discussed. CL advised that this was a joint case with the County Council and joint working was taking place to address. It was noted that the case may be relevant for criminal proceedings. CL advised that the CCG was taking the learning even though the case had not been finalised.

7.1.5 CG queried if the CCG would have access to figures of cases that have resulted in court proceedings. LS advised that the LCFS now has direct access to the CPS.

7.1.6 CG requested clarity with regard to point 1.2 as LS felt that the report had been submitted to NHS Protect. It was agreed that LS would confirm with SC.

7.1.7 CL advised that she would be meeting with SC to discuss the self-review tool. It was noted that SC would be attending an event in July.

7.2 **Recommendation: The Committee accepted the contents of the report.**

## 8. QIPP Report

- 8.1 CL presented the report which provided an overview of the 2015/16 programme delivery at month two.
- 8.2 The report presented an assessment of areas of shortfall at the present time. CL advised that the care homes work would be extended and that some schemes would offset the shortfall.
- 8.3 AE noted that the care homes work was good and that the CCG should celebrate success. AE advised that the report was useful in terms of seeing progress.
- 8.4 CG queried the QIPP target as there was conflicting information within the report. CL confirmed that the target was £17,043 and apologised for the confusion. It was noted that the variation was the correct figure.
- 8.5 CG noted that the report was positive.
- 8.6 **Recommendation: The Committee noted the QIPP delivery position at month two.**

## **9. Summaries of Procurement Decisions**

- 9.1 It was noted that the appendix had been corrected following the initial distribution of the papers.
- 9.2 **Recommendation: The Committee noted the paper which was presented for their information.**

## **10. Register of Waiver of Standing Orders**

- 10.1 There were a number of waivers to report and it was noted that the waiver number 161/04/2015 had been used twice within the table which was an error.
- 10.2 CL advised that waiver 156/02/2015 would be evaluated in year and a procurement decision paper taken forward when an outcome was reached.
- 10.3 It was confirmed that a plan was in place with the CSU with regard to waiver 163/04/2015.

10.4 AE queried the reason for the funding of the Gloucestershire Royal Hospital A&E project and it was confirmed that this matter was addressed at a development session where it was agreed that assisting with the gathering of information would be of overall health benefit for the Gloucestershire community. CL confirmed that the CCG are legally empowered to fund this work.

**10.5 Recommendation: The Committee accepted the report and the attached waivers which were presented for their information.**

## **11. Aged Debtor Reports**

11.1 AB discussed the report and advised that it was produced in June and therefore some updates were given to the Committee.

### NHS Debtors

11.2 It was advised that the outstanding debt relating to South Worcestershire had now been paid. Gloucestershire Hospitals NHS Foundation Trust (GHT) had now agreed to pay and this was now more of a timing issue.

### Non NHS Debtors

11.3 An update was given regarding non NHS debtors:

- The County Council debt had been paid as of the date of the meeting
- The Boehringer Ingelheim payment now authorised and agreed
- It was noted that issues regarding Arriva debt were being worked through and the majority of the debt would be recoverable
- It was advised that the business status of Francis and Co was now 'dissolved'. The CCG had accepted a monthly payment from them for the debt to commence from July. Costs of debt agents were queried and it was confirmed this would be a very small amount.

11.3.1 AE queried the relationship with Aneurin Bevan Health

Board in terms of how many patients were being assisted by the community equipment store. CL advised that work was ongoing regarding the care of cross border patients and confirmed that the care would be given by residency rather than the location of the GP surgery.

**11.4 Recommendation: The committee noted the paper on the current level of invoices on the Sales Ledger of NHS Gloucestershire CCG, and the actions being taken to recover the outstanding debts.**

**12. Debts proposed for write-off**

12.1 It was reported that there were no debts proposed for write-off.

**13. Losses and Special payments register**

13.1 Was reported that there were no losses and special payments as at the meeting date.

**14. Any Other Business**

14.1 CG advised that a self-assessment of the Committee using the latest information from HFMA would be completed by him and forwarded to the Committee for comment. It was also planned to be an agenda item at the next meeting.

**The meeting closed at 10:25am.**

**Date and time of next meeting: Tuesday 29<sup>th</sup> September 2015, 9:00 – 12:00pm in the Prout Room, Sanger House**

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Primary Care Commissioning Committee (PCCC) minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the PCCC meeting held on the 30 <sup>th</sup> July 2015.
<b>Key Issues</b>	The following principal issues were discussed: <ul style="list-style-type: none"> <li>• Prime Minister's Challenge Fund</li> <li>• GP Premises</li> <li>• National GP Patient Survey</li> <li>• Locality Development and Primary Care Structure</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Alan Elkin PCCC Chair and Lay Member

## Primary Care Commissioning Committee

**Minutes of the Meeting held on Thursday 30<sup>th</sup> July 2015  
in the Board Room, Sanger House, Gloucester GL3 4FE**

<b>Present:</b>		
Alan Elkin	AE	Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Colin Greaves	CG	Lay Member - Governance
Julie Clatworthy	JC	Registered Nurse
Helen Goodey	HG	Director of Locality Development and Primary Care
Mary Hutton	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Andy Seymour	AS	Deputy Clinical Chair
<b>In attendance:</b>		
Debra Elliott	DE	Director of Commissioning, NHS England Area Team
Andrew Hughes	AH	Locality Implementation Manager
Becky Parish	BP	Associate Director, Engagement and Experience
Anthony Dallimore	AD	Associate Director, Communications
Barbara Piranty	BPi	Chief Executive of Healthwatch Gloucestershire
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 3 members of the public present.		

### **1 Apologies for Absence**

1.1 Apologies were received from Dorcas Binns.

### **2 Declarations of Interest**

2.1 There were no declarations of interests.

### **3 Minutes of the Meeting held on Thursday 7<sup>th</sup> May 2015**

3.1 The minutes were approved.

#### **4 Matters Arising**

4.1 07.05.15 AI 5.5 – MH provided an update regarding the delegation agreement arrangement. Action has been completed. **Item Closed.**

4.2 07.05.15 AI 6.4 - National Updates – The premises presentation was covered under Agenda Item 6. **Item Closed.**

4.3 07.05.15 AI 8.1.7 – Primary Care Governance Structure – The Locality Development and Primary Care Team organisational structure was covered under Agenda Item 8. **Item Closed.**

#### **5 Prime Minister's Challenge Fund Presentation**

5.1 AH provided a presentation regarding the Prime Minister's Challenge Fund programme in Gloucestershire. AH advised that the CCG worked closely with the Gloucestershire GP Provider Company (G-Doc) to produce a countywide bid for the second wave of the Prime Minister's Challenge Fund and reported that Gloucestershire was successful in securing £4m of national funding to provide local people with better and more flexible access to GP services.

5.2 The presentation covered:

- overview of bid;
- how does the money breakdown;
- choice+ overview;
- choice+ the figures;
- what do we expect to achieve;
- key challenges; and
- conclusion.

5.3 DE felt it would be useful that the learning from this programme was reflected within the whole system.

5.4 AE queried the period of the funding and what happens after it

ends. AH advised that the £4m would be for funding over 12 months and that the business case proposed a return on investment approach for seeking recurrent investment. MH highlighted that the reason for a rapid implementation plan was to ensure that there was sufficient experience over a period of time to be able to be clear about the impact. It was noted that G-Doc had already moved ahead of pace which would enable an impact assessment to be undertaken during the winter period. The Committee recognised the short term funding period.

**5.5 RESOLUTION: The Committee noted the presentation.**

**6 Premises Presentation**

6.1 DE/AH provided a joint presentation regarding the Primary Care Estates Developments for Gloucestershire.

6.2 The presentation covered:

- key considerations;
- new builds and new models of care;
- improving existing estate;
- legacy developments;
- other new builds planned;
- impact of spatial plans;
- new funding for NHS England;
- local estates strategy; and
- CCG approach.

6.3 BPi queried on the arrangements to establish the engagement plans for patients and was advised that this would be embedded as part of the development process.

6.4 AE understood that the 'model' was a critical element of the process and queried if there was any indication on how it was being formulated. HG advised that infrastructure was fundamental in driving forward the model of delivery for primary care. It was noted that a workshop was being organised for the 3<sup>rd</sup> September with member practices where the primary care strategy would be discussed. It was emphasised that GP practices would need to participate and indicate what in their view the future of primary care should look like.

6.5 BP advised that a workshop was being organised for the practice participation groups on the 3<sup>rd</sup> September where the Estates Strategy would be discussed.

6.6 AH informed members that a new initiative had been launched relating to registering an interest in the healthy new towns programme and Cirencester practices were being encouraged to join this programme.

6.7 **RESOLUTION: The Committee noted the presentation.**

## 7 **National GP Patient Survey**

7.1 BP introduced this item which concerned a national survey providing practice level data about patients' experiences of their GP practices. It was noted that Ipsos MORI administered the survey on behalf of NHS England.

7.2 BP indicated that where the response rates in respect of particular practices were so low as to affect their significance, the data was not included in the survey results.

7.3 BP highlighted that the survey identified a high overall level of satisfaction in respect of GP practices in Gloucestershire. It was noted that Healthwatch Gloucestershire had conducted a survey within a similar period which also identified a high overall level of satisfaction.

7.4 BP advised that the CCG would be following through on the results with individual practices as part of performance review.

7.5 BP highlighted that the survey provided quantitative not qualitative information although the information would be triangulated with the other key sources of data such as that provided by Healthwatch. HG added that a Primary Care Quality Working Group had been established which would consider any quality issues.

7.6 DE felt that this would be a useful mechanism and could act as an early indicator of practices that could be at risk of

underperforming.

**7.7 RESOLUTION: The Committee noted the report.**

**8. Locality Development and Primary Care Structure**

8.1 HG presented the report which provided an overview of the structure of the Locality Development and Primary Care Team.

8.2 HG advised that the Locality Managers supported the seven GP localities as commissioners of local service provision. Members were informed that the Primary Care Project Support Manager would be leading on risk stratification for the organisation as well as primary care premises.

8.3 It was highlighted that the Variance Manager would be responsible for reviewing the use of NHS services by individual GP practices. HG advised that the previous few months had been focused on developing taxonomy groups for practices in order to better identify and understand variation.

8.4 HG clarified that the following additional posts had been created.

- Head of Primary Care Contracting;
- Primary Care Project Support Manager; and
- Assistant Contracts Manager.

8.5 The Committee requested an updated structure to reflect the relationship between other joint roles relating to Localities within the organisation. HG

8.6 AS advised that the benchmark data regarding variance would be circulated that week and it was proposed that the practices should review the data, identify two outliers and develop an action plan to address this.

**8.7 RESOLUTION: The Committee noted the report.**

**9 Any Other Business**

9.1 There were no items of any other business.

**10 The meeting closed at 12:53.**

**11 Date and Time of next meeting: Thursday 24<sup>th</sup> September 2015 in the Board Room at Sanger House.**

Minutes Approved by Gloucestershire Clinical Commissioning Group  
Primary Care Commissioning Committee:

Signed (Chair):\_\_\_\_\_ Date:\_\_\_\_\_

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 26<sup>th</sup> November 2015</b>
<b>Title</b>	<b>Priorities Committee minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the Priorities Committee meeting held on the 16 <sup>th</sup> July 2015.
<b>Key Issues</b>	The meeting focused on a consideration of the revised Assisted Conception Policy.
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Andy Seymour Deputy Clinical Chair

## Gloucestershire Clinical Commissioning Group

Minutes of the Priorities Committee held at 4.30 p.m.  
on Thursday 16<sup>th</sup> July 2015 in the Board Room, Sanger House

### Present:

Dr Andrew Seymour (AS)	Deputy Clinical Chair
Marion Andrews-Evans (MAE)	Executive Nurse & Quality Lead
Cath Leech (CL)	Chief Finance Officer
Dr Tristan Lench (TL)	Forest Locality
Colin Greaves (CG)	Lay Person, Governance
Dr Charles Buckley (CBu)	Stroud & Berkeley Vale Locality
Mark Walkingshaw (MW)	Director, Commissioning Implementation
Dr Jeremy Welch (JW)	Tewkesbury Locality
Dr Caroline Bennett (CBe)	North Cotswolds Locality
Dr Malcolm Gerald (MGe)	South Cotswolds Locality
Julie Clatworthy (JC)	Registered Nurse
Valerie Webb (VW)	Lay Member, Business
Alan Elkin (AE)	Lay Member, PPE
Ellen Rule (ER)	Director of Transformation and Service Redesign
Dr Sadaf Haque (SH)	Cheltenham Locality

### Apologies:

Dr Hein Le Roux (HLR)	Stroud and Berkeley Vale Locality
Dr Helen Miller (HM)	Clinical Chair
Mary Hutton (MH)	Accountable Officer
Dr Will Haynes (WH)	Gloucester City Locality
Margaret Wilcox (MWi)	Director of Adult Social Care (GCC)
Sarah Scott (SS)	Interim Director of Public Health (GCC)

### In Attendance:

Zoe Barnes (ZB)	Corporate Governance Support Officer
Teresa Middleton (TM)	Head of Medicines Management
Liz Ponting (LP)	Medicines Management Pharmacist

## 1. Apologies for Absence

- 1.1 Apologies were noted as above.

## 2. Declarations of Interest

- 2.1 JC declared an interest in agenda item 5 as she was a member of

the NICE Quality Standards Advisory Committee which developed guidance for IVF.

### **3. Minutes of the Extraordinary Meeting held on the 16<sup>th</sup> April 2015**

3.1 AS highlighted the key points from the minutes of the last meeting as a recap on the policy. Point 2.3 regarding the number of cycles offered was the required decision carried forward for this meeting.

### **4. Matters Arising**

4.1 The matters arising were covered within the minutes and on the agenda.

### **5. Revised Assisted Conception Policy**

5.1 ER gave an update on the changes to the policy that have been incorporated since the last meeting including:

- Timing of referral
- Family structure

5.2 ER presented the cost analysis of success rates (appendix 2) based on the published national average live birth rate.

5.3 ER outlined the proposal regarding the cycles to be funded as described at point 3.1 of the paper.

#### Resource Implications

5.4 ER advised that estimates and analysis of past trends indicate that there will continue to be growing demand for assisted conception services in Gloucestershire.

5.5 It was advised that the policy amendments mean that the CCG could continue to offer three implantation opportunities for women eligible under the new policy.

5.6 It was noted that the impact of the changes was expected to result in a broadly cost neutral position against existing resources committed to this service.

5.7 JC requested confirmation of accreditation of the laboratory and it

was confirmed this had been sought appropriately and it was felt this was sufficient.

5.8 JC requested that the EIA for the policy would be completed and MAE advised that this would be included within the full policy which would be forwarded to the Integrated Governance and Quality Committee where the policy would be formally approved.

5.9 AS highlighted the descriptions as outlined at point 3.1 within the paper which required the Committee's decision:

- 1) All eligible women will continue to receive three opportunities to have an embryo implanted.
- 2) Where frozen embryos can successfully be developed, the CCG will now fund implantation of these in preference to new fresh embryos, for a second or third cycle.
- 3) If no frozen embryos were available, women will receive one or two further fresh cycles to ensure they receive three implantation attempts.

5.9.1 It was confirmed that these three points would be included within the final draft of the policy.

**5.10 Recommendation: The Committee voted unanimously in favour of the policy amendments as described above.**

**The meeting closed at 4:40pm**

**Date and time of next meeting:** to be confirmed

**Circulation:** GCCG Governing Body and attendees and at today's meeting