NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 26th January 2017 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1	Apologies for Absence	Chair	
2	Declarations of Interest	Chair	
3	Minutes of the Meeting held on 24th November 2016 and 22nd December 2016	Chair	Approval
4	Matters Arising	Chair	
5	Public Questions	Chair	
6	Chair's Update	Chair	Information
7	Accountable Officer's Update	Mary Hutton	Information
8	Performance Report	Cath Leech	Information
9	Gloucestershire Sustainability and Transformation Plan	Mary Hutton	Information
10	Operating Plan 2017/18 Update	Ellen Rule	Information
11	Social Prescribing	Ellen Rule	Approval
12	Assurance Framework	Cath Leech	Information
13	An Open Culture: Engagement, Equality and Experience Annual Report 2016	Marion Andrews-Evans	Approval
Items to Note:			
14	West of England Academic Health Science Network Board Report	Mary Hutton	Information

15	Integrated Governance and Quality Committee Minutes	Julie Clatworthy	Information
16	Audit Committee Minutes	Colin Greaves	Information
17	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
18	Priorities Committee Minutes	Chair	Information
19	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 30th March 2017 at 2pm in Board Room at Sanger House			

A recording will be made of this meeting to assist with the preparation of the minutes. This recording will be made on an encrypted device owned by the CCG and will be held securely for a maximum of one week before being deleted.

NHS
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Governing Body

Minutes of the Meeting held at 2.00pm on Thursday 24th November 2016 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Dr Andy Seymour	AS	Clinical Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Caroline Bennett	CBe	GP Liaison Lead – North Cotswolds
Dr Charles Buckley	CBu	GP Liaison Lead – Stroud and Berkeley Vale
Mark Branton	MB	Deputising for the Director of Adult Social Care, GCC
Julie Clatworthy	JC	Registered Nurse
Joanna Davies	JD	Lay Member – Patient and Public Engagement
Alan Elkin	AE	Lay Member – Patient and Public Engagement and Vice Chair
Helen Goodey	HG	Director of Locality Development and Primary Care
Colin Greaves	CG	Lay Member - Governance
Dr Will Haynes	WH	GP Liaison Lead – Gloucester
Mary Hutton	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Kelly Matthews	KM	Deputy Director of Transformation and Service Redesign
Dr Raju Reddy	RR	Secondary Care Doctor
Mark Walkingshaw	MW	Director of Commissioning Implementation and Deputy Accountable Officer
Dr Jeremy Welch	JW	GP Liaison Lead - Tewkesbury
In attendance:		
Helen Ford (Item 5)	HF	Lead Commissioner, Children and Maternity Services
Caroline Smith (Item 5)	CS	Senior Manager Engagement and Inclusion
Helen Edwards	HE	Associate Director of Locality Development and Primary Care
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 9 members of the public present.		

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1 Apologies for Absence

1.1 Apologies were received from Dr Malcolm Gerald, Dr Tristan Lench and Sarah Scott.

2 Declarations of Interest

2.1 All GPs declared a general interest.

3 Minutes of the Meeting held on Thursday 29th September 2016

3.1 The minutes of the meeting held on Thursday 29th September 2016 were approved.

4 Matters Arising

4.1 28.07.16 AI 9.15 – Performance Report – MAE advised that Becky Parish would be taking this action forward and would discuss the Patient Reported Outcome Measures (PROMs) with the Director of Patient Experience of GHFT.

4.2 29.09.2016 AI 10.8 – Performance Report – MW advised that a briefing on the clinical governance arrangements for the GP Care Community Urology Service would be presented to the December IGQC meeting. **Item Closed.**

4.3 29.09.2016 AI 12.11 – STP Update – AS advised that the detail relating to the role of the Responsible Clinician was still being clarified as part of the Memorandum of Understanding (MOU) discussions. It was also noted that this was being discussed as part of Agenda Item 10 - Gloucestershire Sustainability and Transformation Plan. **Item Closed.**

4.4 29.09.2016 AI 12.12 – STP Update – MH advised that the behaviour principles were covered within the Memorandum Of Understanding (MOU). **Item Closed.**

4.5 29.09.2016 AI 15.6 - Revision of the GCCG Constitution – This item was covered under Agenda Item 14. **Item Closed.**

5 Patient's Story

5.1 HE and CS provided a presentation and a patient's story relating

to mental health advice and support for young people in Gloucestershire.

5.2 The presentation covered:

- the vision;
- key feedback from children and young people;
- the message from stakeholders; and
- Gloucestershire Future in Mind;

5.3 The patient story could be accessed on the link below:

https://www.youtube.com/watch?v=PBhx2JceJJI

5.4 CS advised that a new website had been developed in collaboration with key stakeholders which provided local information and support for young people in Gloucestershire. The website could be accessed on the link below:

https://www.onyourmindglos.nhs.uk/

5.5 WH enquired if the above website could be linked with primary care websites. CS advised that the communication plan was being developed and agreed that this should also be linked into the website.

5.6 RESOLUTION: The Governing Body noted the patient's story.

6 Public Questions

6.1 The following questions were raised by a member of the public.

Q1 What is being done to raise GP awareness of muscular dystrophy (and other muscles wasting diseases)?

Q2 What is being done to raise awareness of the importance of physiotherapy for those with neuromuscular conditions?

6.2 The response below was read to the meeting:

Muscular Dystrophy is a specialised commissioning function undertaken and overseen by NHS England and is provided at regional specialist centres providing a suite of services. Each

region has a directory of services where referrals can be made from a number of sources, including GP's. Onward referrals to other related services can be made from these centres, depending upon clinical referral guidelines. The centres are staffed by multi-disciplinary teams specialising in over 60 different types of muscular dystrophy. Those patients whose needs are not specialist in nature can be cared for locally, not at the regional specialist centres.

The centres operate through a tiered clinical structure and each patient receives the appropriate level of integrated care, treatment, diagnostics, out patients, dietary and nutritional needs and end of life care.

Increasingly complex care packages and comprehensive local support for patients and their families requires specialist support.

As this is a service for people with long term, deteriorating conditions, discharge is rare. If patients feel they are sufficiently supported locally and are stable, they will be given open appointments for them to be reviewed as needed.

G-Care, our on-line system of clinical pathways, is used to promote awareness of Muscular Dystrophy to GP's and the wider health and social care community. G-Care is multifunctional and, in addition to providing information on pathways, has an educational element designed to provide a single source for all clinical support, including information published and disseminated by the CCG, and is accessible by all clinicians across the county.

G-Care enables GPs to provide patients with better quality information about how to manage their own condition, as well as details on how to access community resources that provide practical and emotional support. G-Care can also raise awareness of services, referral information and sources of support to ensure Gloucestershire clinicians have access to accurate information about a range of conditions. It also outlines how, when and where to refer patients for treatment and interventions and provides links to local, regional and national information. The information includes referral criteria and inclusion/exclusion criteria for access.

Through our G-care platform, we provide Gloucestershire GPs with access to clinical education resources, and we have

incorporated links to the Muscular Dystrophy UK e-learning module for GPs.

Regarding the query relating to physiotherapy, Gloucestershire Care Services employ Clinical Specialist Physiotherapists in Neurology who provide expertise for the most complex neurological conditions. These specialist members of staff are based within the local Integrated Community Teams and additionally act as a resource for the wider team of clinicians. Stroud Locality has a Clinical Specialist Physiotherapist who has expertise in Long Term Neurological conditions and acts as a countywide resource. Long term maintenance provision is not being delivered as Physiotherapy services are outcome-focussed interventions which are time limited with ongoing self-referral back into services if there is a change in clinical presentation or circumstances. Part of this intervention will be assessing how the person can self-manage their own condition. This may be by a home based exercise programme or accessing community assets such as local leisure centres.

Other expertise is available through Respiratory Clinical Specialist Physiotherapists who sit within Gloucestershire Care Services Specialist services. The wider provision of specialist respiratory Physiotherapy for Neuromuscular conditions is something that is under consideration by the Acute and Community providers as well as the CCG.

Specialist Services also include a Motor Neurone Disease Coordinator, whose role is the coordination of care by Integrated Community Team colleagues for this palliative group of 40-55 patients per annum.

Services for children and young people with neuromuscular conditions include the provision of ongoing Physio and Occupational Therapy to those who do not receive episodic care due to the need to support them in the home and school environment. They will have been assessed by therapists for inclusion in an Educational Health Care Plan which will state their medical and physical needs. Their equipment for home and school is assessed and issued by Physiotherapy, Occupational Therapy and wheelchair services and reviewed, either as required due to change in condition or, as a minimum, on an annual basis.

6.3 The member of the public was invited to make a comment at the meeting and she enquired if an event could be arranged which promoted further focus on this area. AS advised that the weekly GP bulletin was a good mechanism to communicate with the GPs and agreed that a further reminder should be circulated raising awareness. It was also noted that GPs were grouped into localities where local education events were held.

6.4 WH highlighted that the Cheltenham Sandford Education Centre held courses where neurological conditions were frequently discussed.

6.5 HLR advised that he was the Neurology Lead for the CCG and stated that he would be happy to meet the member of the public outside of the meeting to discuss this further.

7 Gloucestershire Clinical Commissioning Group (CCG) Clinical Chair's Report

7.1 AS presented this report that was taken as read and which highlighted a summary of key issues that arose during October and November 2016.

7.2 AS advised that work was progressing to implement the NHS GP Forward View (GPFV) and noted that the CCG Primary Care Strategy had been published which aligned with the GPFV. Members noted that the CCG had been contacting practices in order for them to start considering on how to access these national funds.

7.3 AS advised that practices had already formed into clusters to bid for these and CCG funds and that there were 16 clusters across the county and noted that the work of the clusters had also been aligned with the STP.

7.4 Members were advised that the CCG Quality Team hosted the 'Hot Topics in Health Care' event at Cheltenham Racecourse on the 21st October 2016. AS advised that the topics discussed included Flu Myth Busting, Infection Control, Dementia Training and Education, End of Life Strategy and Social Prescription. It was noted that the event was well supported with 228 delegates attending on the day and that feedback had been positive. It was proposed that this would be held as a regular annual event.

7.5 AS updated members on the Dementia workstream and advised that an inaugural Dementia Partnership Board meeting was held in September 2016.

7.6 Members were updated on the community eye health service which included provision for glaucoma referral enhanced case finding and repeat readings, cataract second eye follow up and minor eye conditions. It was noted that there were 67 sub-contractor practices signed up across the county, with 98 practitioners fully trained.

7.7 AS advised that as part of the AHSN Diabetes Digital Coach programme, the Mapmydiabetes project, which enabled patients in Gloucester City and Forest of Dean to access online, NICE approved, diabetes structured education and self-management resources, was well underway. It was noted that 100 patients had been set up by practices and over half of those had been actively accessed.

7.8 Members were updated on the Cancer Work Programme and advised that the Macmillan GP Master Classes were progressing with events on Prostate Cancer, Lung Cancer and Living with and Beyond cancer.

7.9 JC enquired if the Primary Care Strategy had been shared with the local providers and it was confirmed that it had been shared.

7.10 <u>RESOLUTION:</u> The Governing Body noted the contents of this report.

8 <u>Gloucestershire Clinical Commissioning Group Accountable Officer's Report</u>

8.1 The Accountable Officer introduced this report which was taken as read, and provided a summary of key issues arising during October and November 2016.

8.2 MH provided a summary of progress of the development of the ICT Rapid Response pathway for Care Homes in avoiding hospital admissions. MH drew attention to Section 2.2 of the report which provided details of the phase one pilot. Section 2.3 provided details of the phase two pilot.

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8.3 MH drew attention to Section 3 of the report which updated members on the Patient Activation Measures (PAM). MH explained that Section 3.2 outlined how PAMs were used and noted that they were a measure of a person's skills, confidence and knowledge to manage their own health. MH advised that three initial areas had been identified to pilot the tool. These were:

- frailty project in South Cotswolds;
- winter pressures Chronic Obstructive Pulmonary Disease (COPD) in Gloucester City; and
- Macmillan Next Steps Programme.

8.4 MH updated members on the prevention and self-care programme and advised that work with wider communities on the Workplace Wellbeing Charter was progressing. MAE added that Gloucestershire CCG were working towards achieving the accreditation and that a report would be presented at a further meeting. MAE

8.5 CBu encouraged members to visit the Facts4Life website and noted that it had been updated recently. CBu felt that this was a useful tool which provided schools with useful health education programme.

8.6 <u>RESOLUTION:</u> The Governing Body noted the contents of this report.

9 <u>Performance Report</u>

9.1 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 October 2016.

9.2 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.

Clinical Excellence

9.3 MW advised that the year to date performance for the 4 hour Emergency Department (ED) target was 87.4% which was above the agreed STP trajectory although noting the emerging winter

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pressures. Members noted the additional actions being undertaken to reduce emergency admissions.

9.4 Members were updated on the cancer performance target and noted that the delivery of cancer targets continued to be a challenge. MW informed members of the mitigating work to address the issues in the cancer service, particularly focusing on the urology service. Key actions included the implementation of one stop clinics and utilising the community based services.

9.5 MW advised that there had been significant pressure on the 6 week diagnostic waiting time target, with performance challenged in particular within the Audiology service. MW advised that the CCG was working closely with GHFT to review the process in order to release capacity within the system.

9.6 MW updated members on the 18 week Referral to Treat (RTT) target and advised that the year to date was on track noting the pressures within a number of key specialities. Members noted that the monthly position had decreased and noted the additional work being undertaken to recover performance i.e. promoting the choice to patients to be transferred to other hospitals.

9.7 JC requested further clarity of the GP in ED Scheme and was advised that there were a number of schemes operating within the ED. These included GPs working within the ED supporting admissions (front door) and discharges (back door).

Patient Experience

9.8 MAE updated members on the Friends and Family Test (FFT) for GHFT and noted that the response rate was improving. MAE advised that GHFT had recently changed providers and were trialling different methodologies such as text messaging. It was noted that this had been successfully implemented within the Emergency Department with a good response rate and was being rolled out to other departments.

9.9 MAE advised that GHFT had been requested to undertake focused work on patient experience for people using urgent care services in the Trust as this has not previously been systematically monitored.

9.10 MAE informed members that the CCG had won a Nursing Times

Award for Patient Safety Improvement for its work to raise awareness of sepsis and support frontline clinical decisions. The Governing Body thanked HLR and Kay Haughton for their work in tackling sepsis and improving patient safety.

Partnerships

9.11 MW highlighted the strong partnership working and advised that the system resilience plan had been agreed for 2016/17 including a series of investments to improve system performance this winter.

9.12 MW highlighted the work being undertaken in the development and implementation of the Sustainability and Transformation Plan by partners.

9.13 Members noted that a discharge summit was held which was attended by key operational teams, CEOs and lead Directors to agree a number of system wide actions necessary in order to address the current pressures on the urgent and emergency care system.

Staff

9.14 MW provided a brief update on the Staff Perspective and advised that this was rated as green and that there were no particular issues to be raised.

Finance and Efficiency

9.15 CL provided a brief summary of the 2016/17 financial performance and reported that the CCG was forecasting to deliver a surplus of £9.456m which was in line with plan although noting that there were risks identified within this position.

9.16 CL advised that there was significant over performance in emergency activity against contracted levels and noted that the Emergency Department attendances were above the planned levels at GHFT.

9.17 Members noted that there was slippage in the QIPP programmes particularly within Urgent Care and Planned Care schemes and noted the risk and mitigating actions associated with the schemes. It was noted that this was considered within the overall financial position.

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9.18 CL advised that there was significant over performance on a number of contracts primarily within Elective Care at the Great Western and Winfield hospitals.

9.19 Members noted that there was considerable pressure on the prescribing budget although the position was positive which was due to the national changes to category M drug prices and other initiatives within the CCG.

9.20 CL updated members on the number of actions being undertaken to mitigate any risks which impact on the achievement of the financial plan.

9.21 CL advised that the CCG achieved the better payment practice code performance which was in line with the 95% performance target.

9.22 CL drew attention to the GHFT financial position. The Trust was in financial special measures and were working with NHS Improvement on a plan to return to a balanced position.

9.23 JC queried if the performance report for community providers was available in order to provide an overall view of system performance. MW advised that the CCG monitored performance closely in particular length of stays and delays in discharge from community hospitals and agreed that this could be included in future reporting. MW

9.24 JC sought assurance that there was resilience within the plan to reduce any mixed sex accommodation breaches. MW advised that a system resilience plan had been agreed for 2016/17 including a series of investments to improve system performance this winter. MW also updated members on the process prior to any mixed sex accommodation breaches occurring within the system which included advice being sought from the Trust Director of Nursing.

9.25 JC also queried the lack of improvement in the Learning Disability performance although Gloucestershire benchmarked well nationally. AS considered that this may be due to reductions in the take up of annual health checks and advised that work was being undertaken to promote this.

9.26 JC requested if the Out of Hours performance could also be included within the Performance Report. MW advised that this information was reported to the Delivery Board and agreed for this to be included within the Performance Report. MW

9.27 <u>RESOLUTION:</u> The Governing Body:

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

10 Gloucestershire Sustainability and Transformation Plan

10.1 MH presented the report and advised that the final Gloucestershire Sustainability and Transformation Plan and short guide was published on the 11th November 2016.

10.2 MH advised that the accompanying short guide and survey can be accessed by visiting the following link:

www.gloucestershireSTP.net

10.3 Members also noted that a communication and engagement strategy and plan had been developed to support the STP approach and to ensure that comprehensive and planned engagement and communication was undertaken with interested parties. It was noted that the engagement events would be commencing shortly.

10.4 MH emphasised the importance of partnership working and highlighted that the STP framework did not replace existing local bodies, or change local accountabilities and that it was a shared endeavor to work together and improve future care.

10.5 Members were advised that the work on urgent care would be commencing imminently and informed members that a presentation on urgent care was being presented at the Health and Care Overview and Scrutiny Committee in December 2016.

10.6 MH drew attention to the ASAP software application and the work

being undertaken to promote the use of this application.

10.7 MH advised that the Memorandum of Understanding (MOU) should now been agreed and invited final feedback from members. It was noted that the MOU was being agreed by the Boards of all the other partner organisations.

10.8 Members noted that the Operational Plan would link with the STP and should be ready within the next two months.

10.9 AS drew attention to the Section 8.1.3 of the MOU regarding definition of the Lead Clinician and advised that this was subject to change following further guidance being received.

10.10 CG expressed concerns regarding the governance arrangements in particular in relation to lay member and non-executive director involvement although recognising the challenges for agreeing the MOU. MH advised that there were lay member representations on the STP Advisory Group.

10.11 <u>RESOLUTION:</u> The Governing Body:

- **noted the final Gloucestershire STP plan, which was now in the public domain alongside the Short Guide and Survey; and**
- **noted revised Governance Structure and Memorandum of Understanding (MOU).**

11 <u>2017/18 Planning Round Update</u>

11.1 KM presented the report which provided an update on the progress of the 2017/18 Planning Round.

11.2 KM advised that work was progressing on developing the Operational Plan and noted that the timescales for delivering the Operational Plan and agreeing provider contracts had been brought forward to the 23rd December 2016.

11.3 Members were advised that an overview of the delivery against the 2016/17 operational plan priorities was outlined within the report. It was noted that there were two priorities that were risk assessed as 'Red' and that these related to; Improving Access to Psychological Therapies (IAPT) and the achievement of the Constitutional Standards. Members also noted that 26 priorities

were risk assessed as 'Amber'.

11.4 KM informed members that an updated procedures and tools for supporting business case review and approval had been developed as a result of the new ways of working required to deliver the STP which included a revised Business Case template and new business case approval process.

11.5 JC felt that the business case template was weak in terms of ensuring the quality and effectiveness of services and questioned how the CCG sought assurance regarding this. KM considered that this would be addressed via the impact assessment process and agreed that this would be reviewed.

11.6 CG drew attention to page 5 of the executive summary report regarding the 5th December 2016 timeline in terms of mediation and queried if the CCG had resolved any issues in order to avoid the mediation process. MH advised that significant progress was being made and that this would be understood within the next six days.

11.7 RESOLUTION: The Governing Body noted:

- **the progress made in delivering the 2016/17 Operational Plan;**
- **the 2017/18 planning timetable and key activities to date;**
- **the revised business case approval process; and**
- **the revised business case template.**

12 Social Prescribing Procurement

12.1 HE presented the Social Prescribing Procurement report and provided a background context to the report.

12.2 HE advised that Governing Body members recently saw a film containing three case studies of people who had been supported by Social Prescribing Hub Coordinators in the Forest of Dean and Tewkesbury. In addition, at a Governing Body development session on 10th November 2016, the impacts of the findings of the external evaluation of Social Prescribing had been presented to members.

12.3 HE advised that the external evaluation undertaken over the

summer of 2016 by the University of the West of England (UWE) demonstrated key beneficial impacts.

12.4 HE advised that the evaluation identified that 78% of service users found a significant benefit in their wellbeing. It also identified a reduction in the use of primary care by the service user in particular:

- GP appointments declined by 21%;
- number of GP home visits declined by 26%; and
- number of GP telephone calls declined by 6%.

12.5 HE explained that a component of the Enabling Active Communities joint action plan was a commitment to develop a new service specification which jointly commissioned the current Social Prescribing programme, the Community and Village Agent service and the GCC project entitled 'InTouch'.

12.6 Members were advised that GCC and the CCG were seeking a contract term of five years with an option to extend for a further two years. It was felt that the longer contract duration would enable successful providers to fully embed, and subsequently develop their service proposals and to establish positive working relationships with other service providers.

12.7 Members noted that the indicative procurement timetable was outlined within Section 5.2 of the report. HE advised that the approval of the contract award recommendation would require an extraordinary Governing Body to be convened in January 2017 or that delegated authority was sought.

12.8 HE provided details of the financial element of the contract and advised that funding investment of £599K per annum was required for up to 7 years.

12.9 JC felt that there was a low return on investment considering the cost of the investment recognising the huge financial challenges and questioned if the focus should be on the 'must do's'. HE advised that the evaluation report by the University of the West of England outlined the key benefits although recognising that the reduction in GP time was not a cashable saving. However, it contributed to the sustainability of primary care.

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12.10 JC also queried the level of investment provided by GCC and was advised that GCC was funding £260K per annum for each year and up to 7 years.

12.11 HG advised that she had received positive feedback from practices and had requested to work with the new service provider. HG considered that savings would initially be intangible and that this would be captured as the programme progresses further.

12.12 WH highlighted that, as a GP working in a deprived area within Gloucester City, he had seen significant improvements and that the benefits gained from this programme had been positive.

12.13 JW read out some statements from patients providing feedback of the service. JW also provided the statistical figures for the Tewkesbury Locality. These were:

- 73% of patients reported a positive difference in their life;
- 73% of patients required less need for medical access; and
- 92% of patient would recommend this service to friends and family.

12.14 CBu concurred with JC views and acknowledged the intangible savings associated with the investment. However, he stated that if he considered it was the 'right thing to do' in terms of embedding within the community and services although recognised the financial risk associated with this.

12.15 MH highlighted the positive feedback from previous patient stories and that Gloucestershire needs to consider new ways of working in order to manage demand.

12.16 AE questioned how the procurement process would measure quality. HE agreed that she could share the evaluation framework to members to comment on. **HE**

12.17 JD enquired if there were breaks or checkpoints within the contract to review the effectiveness of the service. HE confirmed that there were breaks within the contract and that there was an opportunity to revise the contract price if it was required.

12.18 MAE enquired on the target number of people entering the

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programme each year. MAE highlighted that the cost of the contract was the same each year and queried if the service was expecting similar level of users per year and probed if this should increase each year particularly recognising the ambitions of the service. MAE also debated if the level of funding requested had been sufficient to meet the needs of the service. HE advised that there were 100 new patients each month and that the figures had been based on this projection. However, it was noted that if referrals significantly increased then this would be subsequently reported to the Governing Body although noting that referrals had been steady over the previous year.

12.19 <u>RESOLUTION:</u> The Governing Body (JC and CBu abstained) voted in favour of the proposals and agreed:

- **CCG funding approval of £599K each year for up to 7 years (5 years + 2 years);**
- **that an extraordinary Governing Body meeting was convened on Tuesday 31st January 2017 to ratify the award decision.**

13 Out of Hours (OOH) Procurement

13.1 MW presented the report which provided an update on the procurement to secure a short-term contract required for the provision of OOH primary care services from 1st June 2017 to 31st March 2018.

13.2 MW provided a background context to the procurement and advised that earlier this year, South Western Ambulance Service NHS Foundation Trust (SWASFT) served 12 months' notice on its current contract to cease the provision of Primary Care OOH services in Gloucestershire from the 31st May 2017.

13.3 MW advised that the CCG explored the options and were undertaking a two stage procurement process. The first stage included a short term 10 month contract and noted that this was to ensure that the OOH contract end date aligned with the end of the existing Care UK NHS 111 contract which expired on the 31st March 2018.

13.4 Members noted that this would enable the CCG to combine the service requirements into a new integrated model with a single contractual arrangement from April 2018.

13.5 MW updated members on the procurement of Project A and advised that adverts had been issued and that the deadline for bids was the 25th November 2016. MW informed that five expressions of interests had been received from potential providers and highlighted that the majority of the bidders had significant experience in this subject area. It was noted that the contract would be awarded to the preferred bidder in January 2017.

13.6 MW also updated members on Project B which included a separate procurement process being undertaken which would include Primary Care OOH and NHS 111 service and an Integrated Clinical Hub. Members noted that further work was required to agree and scope the full specification and the financial envelope.

13.7 MW advised that this would also provide the CCG with an opportunity to consider what was needed from the service over the longer term, alongside the work on reviewing the urgent care system in Gloucestershire. It was noted that the first stage of the engagement process for reviewing the urgent care strategy was being undertaken during December 2016.

13.8 AE enquired on how conflict of interests would be managed for the procurement of project B. MW acknowledged that the Governing Body GPs had direct conflicts of interests and advised that legal advice had been sought. Members were informed that GPs could provide input in scoping the service model, however, they, would be excluded following the invitation to tender and evaluation process.

13.9 RR referred to a procurement process undertaken in a different area where the provider withdrew from the process one day prior to contract signoff. RR sought assurance that the procurement process considered this issue and queried if this could be built into the process. MW advised that a key part of the evaluation process included undertaking a due diligence process of the potential provider and highlighted that providers with proven track record were being sought.

13.10 JW enquired if GPs could be involved in the final evaluation of the bidders and was advised that this was not possible due to

potential conflicts of interests. JW also queried if input from independent GPs would be included in the procurement process and was advised that these were currently being pursued. CBu suggested using a retired GP from Gloucestershire as part of the process.

13.11 WH emphasised the importance of ensuring that the right level of expertise was involved in the procurement process in particular ensuring that a secure and safe service was procured for the local population.

13.12 <u>RESOLUTION:</u> The Governing Body noted the progress made on Project A and the timeline for Project B Out of Hours NHS 111 procurement.

14 <u>Constitution Update</u>

14.1 AP presented the document and advised that the document had previously been reviewed at the September Governing Body meeting.

14.2 AP explained that the document had been reviewed to ensure that it remained relevant and suitable for the organisation and in accordance with the advice received from NHS England to reduce the size of the Constitution, a number of documents that were previously appended had now been extracted and collected into a supporting documents volume 'Supporting Documents to the Constitution'.

14.3 AP advised that all changes made, other than minor typographical corrections, were shown by way of 'tracked changes' in both documents.

14.4 Members were also advised that a number of changes had been proposed to clarify the document in certain areas. These principally include:

- the processes for the appointment of the Clinical Chair, the Deputy Clinical Chair and the GP Locality Leads; and
- the standards of business conduct processes, to reflect the recently issued national guidance.

14.5 AE highlighted Section 7.14.1 regarding the role of Lay Members

and requested that these were amended to reflect the current structure and responsibilities.

14.6 JC drew attention to Section 7.14.4 and highlighted that a named Lay Member for Equalities was required. It was agreed that the new Lay Member for Business would cover this role.

14.7 CG highlighted a typographical error in the IGQC Terms of Reference regarding responsibilities for quality. AP agreed to amend. **AP**

14.8 AS advised that the eligibility criteria for all GPs on the Governing Body had also been widened to include clinicians working regularly in Gloucestershire member practices.

14.9 Members were informed that the newly established Director of Integration had been added to the Governing Body membership and noted that this would be a non-voting member.

14.10 AS advised that an additional member had also been included in the Primary Care Commissioning Committee membership which related to a GP not currently working in primary care within Gloucestershire or who could be retired.

14.11 AP advised of the ratification process and advised that a letter would be sent to all member practices advising of the changes to the constitution and inviting any feedback.

14.12 <u>RESOLUTION:</u> The Governing Body:

- **approved the proposed changes to the Constitution;**
- **recommended the ratification of the Constitution changes by member practices and subsequent formal approval by NHS England; and**
- **approved the 'Supporting Documents to the Constitution.**

15 <u>Standards of Business Conduct Policy</u>

15.1 AP presented the Standards of Business Conduct Policy and provided a background context. AP advised the NHS England commissioned an audit review of the practices for managing conflicts of interest within CCGs in 2015.

15.2 It was noted that in response to the audit review, and following consultation, NHS England issued the document: 'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs'.

15.3 AP explained that the document outlined a framework that CCGs were expected to follow to ensure that conflicts and perceived conflicts were appropriately identified and managed.

15.4 AP advised that as a result, the CCG's Standards of Business Conduct Policy had been reviewed and revised in order that it complied with NHS England guidance.

15.5 Members were advised that the changes proposed to the Policy were outlined in Section 2 of the report.

15.6 AE drew attention to a typographical error at section 3.1.8 relating to '*Further information about how the PCCC will manage conflicts can be found at point **4.3.12***'. AE highlighted that section 4 concluded at 4.3.9. AP agreed to correct this. **AP**

15.7 <u>RESOLUTION:</u> The Governing Body approved the revised Standards of Business Conduct Policy subject to the above comments.

16 <u>Assurance Framework</u>

16.1 CL presented the Assurance Framework for 2016/17 which was taken as read. The Assurance Framework identified gaps in assurances and controls regarding the organisational objectives, along with details of the principal risks that have been identified by lead managers.

16.2 CL highlighted that one red risk remained on the framework and that this related to Risk No T13 regarding the specialised services for children and young people with mental health problems

16.3 <u>RESOLUTION:</u> The Governing Body noted the paper and the attached Assurance Framework.

17 <u>Integrated Governance and Quality Committee Minutes</u>

17.1 The Governing Body received the minutes of the meeting of the Integrated Governance and Quality Committee held on the 18th

August 2016.

17.2 <u>RESOLUTION:</u> The Governing Body noted these minutes.

18 <u>Primary Care Commissioning Committee Minutes</u>

18.1 The Governing Body received the minutes of the meeting of the Primary Care Commissioning Committee held on the 28th July 2016.

18.2 <u>RESOLUTION:</u> The Governing Body noted these minutes.

19 <u>Priorities Committee Minutes</u>

19.1 The Governing Body received the minutes of the meeting of the Priorities Committee held on the 7th July 2016.

19.2 <u>RESOLUTION:</u> The Governing Body noted these minutes.

20 <u>Joint Commissioning Partnership Board (JCPB) Minutes</u>

20.1 The Governing Body received the minutes of the meeting of the JCPB held on the 7th June 2016.

20.2 MH highlighted that JCPB did not hold any decision making powers and was a partnership between the GCC and GCC whose aim was to work together to jointly commission services in order to achieve better integration. It was noted that the JCPB reported to the Health and Wellbeing Board.

20.3 <u>RESOLUTION:</u> The Governing Body noted these minutes.

21 <u>Any Other Business</u>

21.1 There were no items of any other business.

22 The meeting closed at 15:55.

23 Date and Time of next meeting: Thursday 26th January 2017 at 2pm in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

DRAFT

Signed (Chair):_____ Date:_____

DRAFT

NHS
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Clinical Commissioning Group

Governing Body

Minutes of the Extraordinary Meeting held at 3.00pm on Thursday 22nd December 2016 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Dr Andy Seymour	AS	Clinical Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Andrew Beard	AB	Deputy Chief Finance Officer
Dr Caroline Bennett	CBe	GP Liaison Lead – North Cotswolds
Dr Charles Buckley	CBu	GP Liaison Lead – Stroud and Berkeley Vale
Julie Clatworthy	JC	Registered Nurse
Alan Elkin	AE	Lay Member – Patient and Public Engagement and Vice Chair
Kim Forey (Non-Voting)	KF	Joint Director of Integration
Dr Malcolm Gerald	MGe	GP Liaison Lead – South Cotswold
Colin Greaves	CG	Lay Member - Governance
Dr Will Haynes	WH	GP Liaison Lead – Gloucester
Mary Hutton	MH	Accountable Officer
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Dr Tristan Lench	TL	GP Liaison Lead – Forest of Dean
Ellen Rule	ER	Director of Transformation and Service Re-Design
Mark Walkingshaw	MW	Director of Commissioning Implementation and Deputy Accountable Officer
Margaret Willcox	MWi	Director of Adult Social Care, GCC
In attendance:		
Ian Goodall	IG	Associate Director of Operational Planning and Programme Management
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were no members of the public present.		

1 Apologies for Absence

1.1 Apologies were received from Helen Goodey, Cath Leech, Dr Raju Reddy, Joanna Davies, Dr Jeremy Welch and Sarah Scott.

2 Declarations of Interest

2.1 All GPs declared a general interest.

DRAFT

3 Operational Plan 2017/18-2018/19

3.1 IG presented the final draft of the two year Operational Plan (2017 – 2019) prior to the final plan being submitted to NHS England on the 23rd December 2016. Members noted that the first draft had been presented at the November Governing Body meeting. The paper was taken as read.

3.2 IG advised that positive feedback had been received to date on the Plan with particular comments relating to providing additional information on managing demand and noted that an additional section had been added to page 12 of the document reflecting this. IG also noted that the planned management of demand was summarised in the Solutions Analysis which was outlined in Appendix 9 of the document.

3.3 Members were advised that the Operational Plan also included the General Practice Forward View Key Lines Of Enquiry. Members noted that this had also been reviewed by the Primary Care Commissioning Committee.

3.4 The Governing Body discussed the formal wordings of the prioritisation process and agreed to delegate authority to MH and AS to formally sign off the document.

3.5 RESOLUTION: The Governing Body:

- **approved the Operational Plan 2017/18-2018/19 ahead of submission to NHS England on the 23rd December 2017 subject to the document being signed off by the Accountable Officer and Clinical Chair;**
- **noted the amendments to the draft shared on the 24th November 2016;**
  - **Demand Section – 2.4.1**
  - **Annex 9 STP Solutions Overview.**
- **noted the General Practice Forward View Key Lines Of Enquiry (KLOE) ahead of submission to NHS England on the 23rd December 2017.**

4 The meeting closed at 15:49.

5 Date and Time of next meeting: Thursday 26th January 2017 at 2pm in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair):_____ Date:_____

DRAFT

NHS
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Agenda Item 4

Matters arising from previous Governing Body Meetings – November 2016

Item	Description	Response	Action with
28.07.2016 Agenda Item 9.15	Performance Report	RR understood that surgeons felt that the PROMs were reported on prematurely in order to judge any true outcome measures and enquired if this could reported further down the line. MAE advised that the national response period was 6 months and agreed that a local benchmark should be established. MAE agreed to discuss. *24/11/16 Becky Parish to discuss this with the Director of Patient Experience of GHFT*.	MAE
24.11.2016 Agenda Item 8.4	Accountable Officer's Report	MH updated members on the prevention and self-care programme and advised that work with wider communities on the Workplace Wellbeing Charter was progressing. MAE added that Gloucestershire CCG were working towards achieving the accreditation and that a report would be presented at a further meeting.	MAE
24.11.2016 Agenda Item 9.23	Performance Report	JC queried if the performance report for community providers was available in order to provide an overall view of system performance. MW advised that the CCG monitored performance closely in particular length of stays and delays in discharge from community hospitals and agreed that this could be included in future reporting.	MW

Item	Description	Response	Action with
24.11.2016 Agenda Item 9.26	Performance Report	JC requested if the Out of Hours performance could also be included within the Performance Report. MW advised that this information was reported to the Delivery Board and agreed for this to be included within the Performance Report.	MW
24.11.2016 Agenda Item 12.16	Social Prescribing Procurement	AE questioned how the procurement process would measure quality. HE agreed that she could share the evaluation framework to members to comment on.	ER / Helen Edwards

NHS
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Agenda Item 6

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Gloucestershire Clinical Commissioning Group Clinical Chairs Report**
Executive Summary	This report provides a summary of key updates and issues arising during December 2016 and January 2017.
Key Issues	The key issues arising include: • Primary Care and Locality Development Update • Clinical Programmes
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	None
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note this report which is provided for information.
Author	Dr Andy Seymour
Designation	Gloucestershire CCG Clinical Chair
Sponsoring Director (if not author)	Not applicable

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 6

Governing Body

Clinical Chairs Report

1 Introduction

1.1 This report provides a summary of key updates and issues arising during December 2016 and January 2017.

2 Primary Care and Locality Development Update

GCCG's General Practice Forward View (GPFV) Plan, a requirement of NHS England (NHSE), was signed off by Governing Body at the end of December and subsequently submitted to NHSE. The plan details ways in which GCCG will deliver the Forward View in addition to the other two requirements improving access and practice transformational support. In addition the public facing version of our Primary Care Strategy is about to be published.

Good progress has been made across the county in terms of transformation. All 81 Practices are now part of 16 cluster groups. Fourteen bids from the clusters were received with the majority of clusters requesting clinical pharmacists. Recruitment to these additional posts (15.6wte new posts) has commenced as have schemes to offer mental health staff in primary care and a frailty service. Other bids for repeat prescribing and urgent care are being progressed.

Funding has already been offered to clusters for staff training in signposting and correspondence management. Whilst some clusters have requested this, others are choosing to wait until the end of January, when GCCG is hosting an event for GPs and Practice Managers on the GPFV. Dr. Robert Varnam, GP and Head of General Practice Development at NHS England is our keynote speaker. In addition we have a range of national and local speakers delivering workshops in the afternoon, including one on active signposting.

Practices who consider themselves vulnerable or wished support for ongoing sustainability and resilience, have identified themselves.

Common reasons for requesting support were the recognition of the need to develop the workforce, to investigate options for working at scale and more effective working generally across clusters. This included requests for specialist advice and guidance, for example Human Resource and financial expertise. Thirty three bids (covering 59 practices) were received and were prioritised using NHSE criteria, and with the support of the LMC and the RCGP GP Ambassador. Support to practices, who scored most highly, has commenced.

To further support our primary care workforce, the GCCG, alongside the other main Gloucestershire Health and Social Care providers, held a recruitment event to support promotion of the health and social care job opportunities in the county in November 2016. Whilst too early to evaluate the effect on recruitment the event was a good opportunity for all providers to work together and we plan to hold another in the future to support Gloucestershire providers including General Practice.

GCCG is a General Practice Access Fund (GPAF) Wave 2 pilot; offering “Choice Plus” appointments across weekdays, evenings and weekends, which are available to patients registered at all our practices across the seven localities. This pilot has been extended to March 2017 with a focus on ensuring the appointments are provided based on population need and demand and to increase utilisation of the appointments offered. GCCG will continue to commission extended access through 2017 – 2020 in line with national guidance. A full options appraisal is being developed to support the consideration of the seven day model to be commissioned post March 2017 and the CCG will be imminently seeking views and opinions from stakeholders to develop the specification for future procurement.

To further support winter resilience for primary care the CCG has written to Practices seeking expressions of interest from those who would be interested in undertaking additional appointments on a Saturday morning. These would be provided from January to April 2017.

In conjunction with the recommissioning of OOH and 111, GCCG is undertaking a review of primary and community urgent care which is considering how these services fit together to ensure patients are seen by the right professional at the right time to reduce duplication and better manage urgent, same day, demand within an integrated urgent

care system for Gloucestershire.

3 Clinical Programmes

We are pleased to report encouraging progress with our Clinical Programmes. Some programmes are already launching new service models that offer patients streamlined, accessible and high quality care. Other programmes are now bringing together partners to collaborate on new work to improve the health of our population and ensure sustainable services.

3.1 Respiratory

We continue to progress an integrated model across specialist respiratory services. In the meantime 62 practices across Gloucestershire have signed up to provide an additional annual review for identified Chronic Obstructive Pulminary Disease (COPD) patients, ensuring a self-management plan is in place to support respiratory patients through the winter months.

3.2 Circulatory

To understand the required levels of service provision for Cardiology and coronary artery disease a “Deep Dive” review is planned for February 8th 2017 to provide a robust understanding and review of demand and capacity. In addition to progress the use of highly sensitive troponin testing in Emergency Departments, a specialist nurse role within Accident & Emergency has now been approved.

The Familial Hypercholesteraemia (FH) testing service has now started within Gloucestershire Hospitals NHS Foundation Trust, which will allow patients that are genetically affected by high cholesterol levels to be actively picked up and treated hence reducing cardiac events for this high risk group.

3.3 Eye Health

Four projects in the Eye Health Programme have now gone live as follows:

- Glaucoma Referrals/repeat readings
- Cataract second eye follow up
- Minor Eye Conditions
- School Vision Screening

There are now 104 Eye Specialist Practitioners trained up in 67 practices across the county providing good geographical coverage and performance will be monitored against agreed contracts.

3.4 Diabetes

The implementation of Mapmydiabetes in Gloucester and Forest of Dean continues. There are now 29 practices with accounts, 112 primary care healthcare professionals with accounts and 261 patients with accounts. The patient activation rate (number of patients who have accessed their accounts already) is over 50% which is considered to be very good at this stage.

NHS England has recently launched a National Diabetes Treatment and Care programme. It has asked STP areas to bid for resources to fund transformational change in four specific diabetes areas: Structured education, treatment targets, multidisciplinary foot care teams and inpatient specialist diabetes nurses. At the last Diabetes and Endocrinology Clinical Programme meeting, a decision was made to submit bids relating to the increase in provision of structured education in the county and to implement an acute multidisciplinary footcare team (MDFT) with associated pathway redesign. The bids are being finalised (to be submitted on January 18th). There has been close collaboration between the CCG, GHT and GCS to ensure the bids are accurate and all parties are signed up to delivering the transformational change. We are expected to hear if we have been successful in securing funding in March this year.

After our success in securing funding to deliver the National Diabetes Prevention Programme (NDPP), we have begun the process of planning for mobilisation. This programme identifies people at risk of developing type 2 diabetes and works with them to lose weight and become more active in a structured way. In the next few weeks, following a mini tender process, we will know who the local provider of these interventions will be and we can begin working with them to develop a local pathway. In the meantime, a stakeholder group has been identified and initial meetings have been arranged. We are

planning on holding a launch event in April to promote the programme and generate enthusiasm for the programme.

4 Meetings

5th December- GP Practice Visit, Blakeney Surgery

15th December- Leadership Gloucestershire, Shire Hall

15th December- Extra HCOSC meeting, Shire Hall

19th December- GP Practice Visit, Frampton Surgery

22nd December- LMC Negotiators Committee, Sanger House

10th January- GP Practice Visit, Minchinhampton Surgery

12th January- LMC, Farmers Club

17th January- HFMA Annual NHS Chairs Conference, London

23rd January- GP Practice Visit, Winchcombe Medical Centre

24th January- Primary Care Event, Gloucester Rugby Club

5 Recommendations

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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 7

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Gloucestershire Clinical Commissioning Group Accountable Officer's Report**
Executive Summary	This report provides a summary of key update and issues arising during December 2016 and January 2017.
Key Issues	The key issues arising include: • **Urgent & Emergency Care Update** • **Strategy & Planning** • **Meetings attended**
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	None
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note this report which is provided for information.
Author	Mary Hutton
Designation	Accountable Officer
Sponsoring Director (if not author)	Not applicable

Agenda Item 7

Governing Body

Accountable Officer's Report

1. Introduction

1.1 This report provides a summary of key updates and issues arising during December 2016 and January 2017.

2. Urgent & Emergency Care Update

In common with other parts of the country the urgent and emergency care system within Gloucestershire has been under significant pressure during the winter period.

We monitor the pressure on the system during the winter in line with the new national escalation policy. Levels of escalation are now defined within the Operational Pressures Escalation Framework (OPEL) issued by NHS England in October 2016. This rates levels of escalation as follows:

Operational Pressures Escalation Levels

OPEL 1:

The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.

OPEL 2:

The local health and social care system is starting to show signs of pressure. The local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will

alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.

OPEL 3:

The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub- regional teams through internal reporting mechanisms

OPEL 4:

Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required.

The levels mirror systems already in use around the country, and aligns with the national Resource Escalation Action Plan2 (REAP) used by Ambulance Trusts.

In Gloucestershire the system has been under significant pressure. However, our level of escalation has been maintained at OPEL 2 for the majority of this period but has increased to OPEL 3 when under particular pressure (largely due to bed capacity).

Overall demand into the system has been slightly lower than the same period last year. In particular, the level of Ambulance responses to 999 calls has seen a daily average of 222 from the 1st December 2016

(against a daily average of 235 in December 2015). There is also some evidence that ambulances are arriving at hospital earlier in the day.

The CCG and system partners have implemented a number of actions in order to achieve this. These include:

- earlier GP visits;
- 'hot' clinical advice from secondary care to primary care to support alternative pathways to hospital admission;
- 999 utilisation of the Single Point of Clinical Access to support admission avoidance;
- support to frequent callers in care homes provided by the 999 service;
- additional support for frequent attenders provided by mental health and community services;
- clear communication to the public on use of appropriate services.

The county is also well served through the provision of urgent care in Minor Injury and Illness Units, increased availability of primary care appointments ('Choice Plus') and Community Pharmacy based minor ailment services.

Attendances at the two Emergency Departments have also slightly reduced from last year, daily December A&E attendances this year were on average 12 less (-0.11%) than last year. The daily average for December to date was 347 attendances, with the last week (at time of writing 9th January to 16th January) averaging at 321 attendances.

The week commencing the 9th January, saw system commitment to a "Breaking the Cycle together" event, this week long event identified key barriers in the system which partners have committed to change and action in January. Key areas identified include the development of "red and green" days across the acute and community system and embedding professional accountability for delivery at ward level. Whilst 4 hour performance did not significantly improve, bed capacity at the end of the week was good with a reduction in escalation to Amber

Trust and system wide. The team will support delivery of the “top five” actions to be implemented on Friday 20th January 2017 to maintain focus.

Our focus in Gloucestershire has been on putting in place practical measures as part of our system wide winter plan and escalation framework. Key actions include:

- ‘Breaking the Cycle Together’ events (see below).

- Additional investment in Rapid Response and the refocussing of the front door Integrated Discharge Team.

- Development of a new ‘pull model’ to reduce discharge delays from hospital by actively ‘pulling’ patients through the system from acute to primary and community based care.

- Implementing a new ‘Onward Care Procedure’ supported by the Onward Care Team

- Implementing a new ‘Discharge Decision Support Tool’ supported by a new Care Navigator post.

Staff within the CCG have been working alongside all system partners on site during the ‘Breaking the Cycle Together’ events. These weeks have had a particular emphasis on supporting timely discharge from hospital through supporting the red and green day approach and the implementation of the onward care procedure.

Red and green days are a visual management system to assist the system in identifying wasted time in a patient’s journey. A green day is defined as when a patient received an intervention that supports their pathway of care through to discharge. A red day is defined as when a patient is waiting for an action to progress their care and/or this action could take place out of the current setting or that an action required within hospital could not be achieved.

3. Strategy & Planning

3.1 Prevention & Self-Care

Social Prescribing and Village Agents

A new Social Prescribing and Community Agents service is currently being jointly procured with Gloucestershire County Council. The aim of the new service will be to increase the wellbeing and resilience of the local community and reduce the reliance on statutory services. This will be achieved through employing person and community centred approaches that connect individuals to local community services and organisations. The new service will commence from the 2nd June 2017.

Health Coaching

A Health Coaching workshop has been commissioned to support the new frailty model in the South Cotswolds. Training will be provided for 20 practitioners (including District Council reps) with aim to increase knowledge and competencies in delivering person-led care. Training will also support roll out of Patient Activation Measure (PAM) and understanding how it can be used to increase the knowledge, skills and confidence in patients to promote self-care.

Workplace Wellbeing Charter

The workplace wellbeing charter is continuing to progress well. Twenty one organisations have currently committed and are working toward accreditation. These organisations employ approximately 16,000 staff between them and include Gloucestershire County Council, Gloucestershire Hospital NHS Foundation Trust, Ecotricity, UCAS and EDF Energy. The charter is a way of giving employers a checklist, or toolkit, for improving and embedding good workplace health practice. It has been backed by the Government's former National Director for Health and Work, Dame Carol Black, who has described it as being an "opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce."

3.2 Cultural Commissioning

Gloucestershire continues to share learning from the cultural commissioning programme and inform national policy. This includes speaking at the Art and Health South West Conference in November and attendance at the All Party Parliamentary Group for Arts, Health and Wellbeing.

The CCG is continuing to work in partnership with University of Gloucestershire to evaluate the programme and an Evaluation Workshop is planned for 9th February to explore emerging themes from the qualitative analysis.

3.3 Meetings attended

25 Nov	Carers Rights Day, Gloucester
29 Nov	Gloucester Health & Wellbeing Board, Gloucester
29 Nov	Healthy Weight Core Group, Gloucester
29 Nov	Quarter 2, Healthwatch Partners Meeting
2 Dec	Stroud District LSP, Stroud District Council
5 Dec	Blakeney Surgery Practice Visit
6 Dec	GHWB Provider Forum
6 Dec	Gloucestershire Strategic Forum (GSF)
7 Dec	West of England Academic Health Science Network (WEAHSN) Board Meeting, Gloucester
7 Dec	Joint Commissioning Partnership Executive (JCPE)
13 Dec	Grant Thornton STP Day, Bristol
14 Dec	Enabling Active Communities Commissioning Group Meeting, Tewkesbury
15 Dec	STP Delivery Board
15 Dec	Additional HCOSC
19 Dec	Frampton Surgery Practice Visit
22 Dec	LMC Negotiating Committee
10 Jan	Health & Care Scrutiny Committee
10 Jan	Minchinhampton Surgery Practice Visit
11 Jan	Gloucestershire Q3 IAF meeting

12 Jan	NMOC Board
16 Jan	Additional JCPE Budget meeting
17 Jan	Gloucester Health & Wellbeing Board
18 Jan	Gloucester Health & Wellbeing Board – Development Session
19 Jan	NHSCC board day, London
23 Jan	Joint Roundtable on STP Governance, London
24 Jan	Primary Care Event, Gloucester

4. Recommendations

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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 8

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Performance Report**
Executive Summary	This performance report provides an overview of Gloucestershire CCG performance against organisational objectives and national performance measures for the period to the end of December 2016.
Key Issues	These are set out in the executive summary within the report.
Risk Issues: **Original Risk** **Residual Risk**	All risks are identified within the relevant sections of this report.
Management of Conflicts of Interest	None declared.
Financial Impact	This report gives detail on the financial position to the end of December.
Legal Issues (including NHS Constitution)	These are set out in the main body of the report.
Impact on Health Inequalities	Not applicable.
Impact on Equality and Diversity	There are no direct health and equality implications contained within this report.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	These are set out in the main body of the report.
Recommendation	The Governing Body is asked to: • Note the performance against local and national targets and the actions taken to remedy the current performance position.

	• Note the financial position as at month 9. • Note the risks identified in the Finance and Efficiency report. • Note progress on the QIPP schemes.
Author & Designation	Sarah Hammond, Head of Information and Performance Andrew Beard, Deputy CFO Ian Goodall, Associate Director of Strategic Planning
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

Agenda Item 8

Performance Report

1. 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 2016/17 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 2016/17 – up to 31st December 2016

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

Clinical Excellence – **Amber**,

Clinical excellence - Perspective highlights:

- Progress is being reported across all active clinical programme groups with good clinical engagement across the system
- The Primary Care Clinical Quality Review Group have established a quality assurance framework for primary care. The group has met on several occasions and has considered the outcomes of practice Care Quality Commission (CQC) inspections. It is also monitoring 2016/17 seasonal flu vaccination performance, medicines optimisation, QOF and primary care staffing including training and recruitment. Patient experience including the progress with patient participation groups and Friends and Family test (FFT) was also an agenda item.
- Improvement and Assessment Framework (IAF) indicators show 3 Performing well & 3 Needs Improvement
- The Care Quality Commission has completed 79 inspections of the GP practices and 3 was rated outstanding, 72 as good, 3 requires improvement and 1 meeting the 2013 standard. 2 practices have not had an inspection.

Good performance:

- 2 week cancer wait performance in November was 93.5%, meeting the national standard (target 93%)

Challenging performance:

- Delivery of cancer targets continues to be challenging.
  - 62 days cancer is below STF target at 79.8% for November and 78.1% YTD
- IAPT – the impact of the recent NHSE Intensive Support Team has resulted in improved compliance with IAPT recovery standard; however access rates have dropped following the decision to not count the nursing element of the service. IAPT access is currently 5.08% against a target of 10%
- RTT has fallen below the 92% target and is currently at 91.7% YTD
- 4 hr A&E target has slipped 1.1% below STF target for December (85.8%)

Patient experience – **Green**.

Patient Experience - Perspective highlights:

- The Practice Participation (PPG) Group network held a successful meeting in October 2016. The meeting focussed on reducing stigma in mental health, patient facing website and social prescribing and working with the community and voluntary sector. In response to requests from PPG members, two workshops have been arranged, facilitated by PPG members themselves, on the topics of 'Developing your PPG' and 'Using online forums'.

- Patient Engagement and Experience continues to develop across a wide range of GCCG projects – a particular recent focus has been Renal, Respiratory and Diabetes.

- A wide range of engagement activity to support GCCG projects. In particular over 100 semi-structured interviews with renal dialysis patients in three units across Gloucestershire.

Good performance

- Comprehensive experience and engagement activity supporting CCG work programme.
- Most GP practices in Gloucestershire now have a Patient Participation Group (PPG).
- GP Patient Survey, (July 2016 publication) CCG average satisfaction with GP services remains above national average.

Challenging performance:

- FFT - Results remain amber overall due to a Red rating for response rate for the Inpatient FFT. However, results are green for ED response rate and %recommend for both ED and Inpatients. This is a marked improvement.

- GHFT have been requested to undertake focused work on patient experience for people using urgent care services in the Trust as this has not previously been systematically monitored.

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

Partnerships - Perspective highlights:

- Gloucestershire is working to a local footprint for the development and implementation of the Sustainability and Transformation Plan. Our system published our plan and accompanying short guide and survey on 11/11/2016. A communication and engagement plan has been developed to support the STP approach, to ensure comprehensive and planned engagement and communication with the public and key stakeholders. The plan takes a two phase approach; with Phase One covering our new models of care and new ways of working from autumn 2016 to spring 2017 and Phase Two covering more detailed proposals for service change to commence during the summer 2017.

- A system resilience plan has been agreed for 2016/17 including a series of investments to improve system performance this winter.

- Discharge summit – A summit has taken place attended by key operational teams, CEOs and lead Directors to agree a number of system wide actions necessary in order to address the current pressures on the urgent and emergency care system (with a particular emphasis upon addressing potential barriers to timely discharge from hospital).

Staff – **Green**

Staff - Perspective highlights:

- Staff sickness level for December is 2.43% against a target of 3%.

- A working group is progressing the organisational development plan and will complete a refresh for 2016/17.

Finance and efficiency – Amber

Finance and Efficiency - Perspective highlights:

- The overall assessment for the finance and efficiency perspective against the NHS England criteria is amber. The CCG is forecasting to deliver a surplus of £9.456m, however, there remain risks to achieving this position.
- Further updated plans for 17/18 & 18/19 were submitted to NHS England on the 23rd December which showed a planned £9.456m surplus in line with the anticipated control total. There is anticipation that there will be a further submission but no date as yet.

Good performance

- The CCG is forecasting to deliver a surplus of £9.456m
- The better payment practice code performance for the year to date (for non-NHS invoices by value) is 98.62% which is above the target figure of 95%.
- Prescribing continues to show signs of negative growth from the same period last year and in conjunction with reductions in Category M pricing in this area is reporting a forecast underspend of £1,263k.

Challenging performance:

- Activity in other Trusts is showing significant pressures, particularly North Bristol & Winfield.
- QIPP schemes for 16/17 total £18.042m. Currently reporting slippage of £3.23m.

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 2016/17 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 31st December 2016

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

<table>
<tr><th>PERSPECTIVE 1</th><th>Clinical Excellence</th><th>Amber</th></tr>
<tr><td colspan="2">Success criteria: 1. Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.</td><td>Green</td></tr>
<tr><td colspan="3">Key performance indicators</td></tr>
<tr><td colspan="2">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).

Number of NICE TAs published and relevant to CCG
<table>
<tr><th></th><th>Q1 (April - Jun 15)</th><th>Q2 (July- Sept 15)</th><th>Q3 (Oct- Dec 15)</th><th>Q4 (Jan -Mar 16)</th><th>Total</th><th>Q1 (Apr - Jun16-</th><th>Q2 (Jul - Sept 16)</th><th>Q3 (Oct - Dec 16)</th><th>Q4 (Jan - Mar 16)</th></tr>
<tr><td>Number issued</td><td>6</td><td>12</td><td>18</td><td>12</td><td>48</td><td>9</td><td>14</td><td>14</td><td></td></tr>
<tr><td>Number relevant to GCCG</td><td>4</td><td>7</td><td>5</td><td>3</td><td>19</td><td>5</td><td>2</td><td>4</td><td></td></tr>
</table></td><td>Green</td></tr>
<tr><td colspan="2">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.
The Clinical Effectiveness Group (CEG) is a sub group of CCG Integrated Governance and Quality Committee (IGQC). The CEG meets bi-monthly and identifies areas of best practice or concern in relation to quality outcomes or evidence based practice. It also monitors compliance or deviations from published NICE Guidance. Where concerns are identified a ‘Pink Slip’ is sent to the provider (via the appropriate CQRG) which asks for information and highlights the area of concern. On behalf of the CCG it seeks assurance that these are being addressed by appropriate action plans. These together facilitate an auditable process around ensuring best practice.
The National Audit Review Group (NARG) is a sub group of the CEG which enables the CCG to review national clinical audit results and to gain assurance that providers of these services conform to these recognised standards of care (also by means of a ‘Pink Slip’).</td><td>Green</td></tr>
</table>

Success criteria: 2. *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 2016/17 that focuses on clinical quality improvement, reduces variation, tackles health inequalities and promotes innovation	Green
Set-up and implement a Primary Care Clinical Quality Review Group (CQRG) and develop a set of indicators to measure primary care quality	Green
Success criteria: 3. *Progress in developing and implementing locality plans*	Green
Key performance indicators	
Reporting progress on implementation of the seven Locality Development Plans for 2015-2017.	Green
Success criteria 4. 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
Success criteria: 5*. Key local and National standards relating to Patient Experience*	Amber
Key performance indicators	
Achievement of key local and National standards relating to Clinical Excellence – see section 2.2 to 2.9	Amber

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, 2G NHSFT and Gloucestershire Care Services Trust. Further CQRG's are held for Care Homes and Primary Care. 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.

CQRG's have the ability to escalate any issues to the full contract board, and where necessary to the regular wider NHS England Quality Surveillance Group

meetings. Updates and minutes from CQRG's are routinely reported to IGQC for assurance purposes.

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.

Since April 2015, GCCG have been responsible for commissioning primary medical care services through a delegation agreement with NHS England. The Primary Care and Localities Directorate, working with the Primary Care Operational Group (PCOG) and the Primary Care Commissioning Committee (PCCC), manage this within a good governance process that minimises any real or perceived conflicts of interest.

In the Quarter 4 2015/16 NHS England assurance, Gloucestershire received an 'Outstanding' rating for exercising delegated commissioning arrangements.

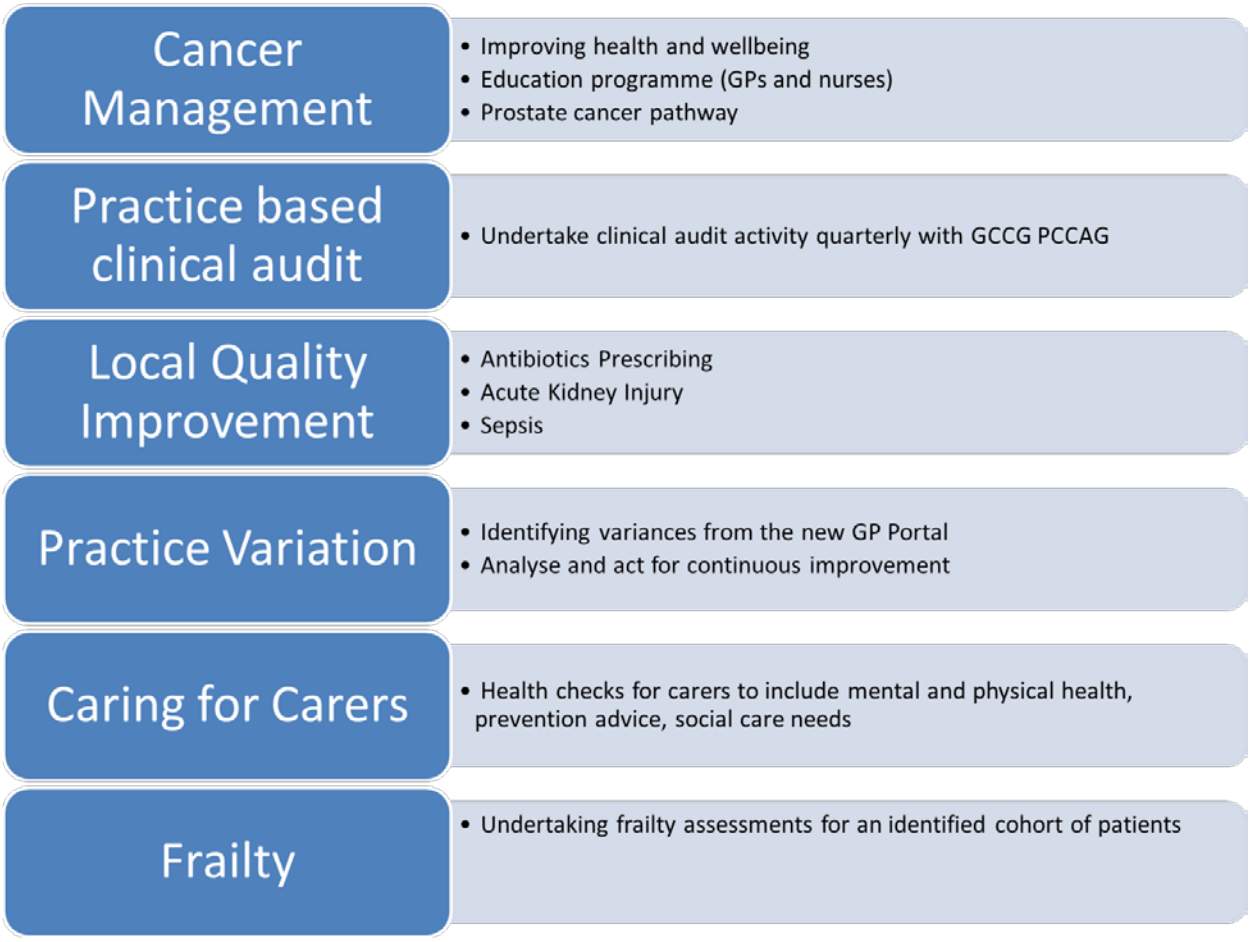
The CCG's Primary Care Strategy for Gloucestershire: Joining Up Your Primary Care was approved in September 2016. The Strategy sets out a draft vision for Primary Care, with a plan to achieve it over the next five years:

"So patients in Gloucestershire can stay well for longer and receive joined-up out of hospital care wherever possible, we need to have a sustainable, safe and high quality primary care service, provided in modern premises that are fit for the future. To do this, we will:

- Attract and retain the best staff through promoting Gloucestershire as a great place to live and work, and offering excellent training opportunities;
- Ensure good access to primary care 7 days a week;
- Create a better work-life balance for our staff;
- Maximise the use of technology;
- Reduce bureaucracy;
- Support practices to explore how they can work closer together to provide a greater range of services for larger numbers of patients."

GCCG's General Practice Forward View (GPFV) Plan, a requirement of NHSE, was signed off by Governing Body at the end of December and subsequently submitted to NHSE. The plan details ways in which GCCG will deliver the Forward View in addition to the other two requirements Improving access and Practice transformational support. In addition our public facing version of our Primary Care Strategy is about to be published.

The Primary Care Offer for 2016/17 builds on the success of the previous two years. The key activity themes are (over page):



Activity against these themes has commenced as has planning the Primary Care Offer for 2017/18

GCCG is a General Practice Access Fund (GPAF) Wave 2 pilot; offering "Choice Plus" appointments across weekdays, evenings and weekends, which are available to patients registered at all our practices across the seven localities. This pilot has been extended to March 2017 with a focus on ensuring the appointments are provided based on population need and demand and to increase utilisation of the appointments offered. GCCG will continue to commission extended access through 2017 – 2020 in line with national guidance. A full options appraisal is being developed to support the consideration of the seven day model to be commissioned post March 2017 and the CCG will be imminently seeking views and opinions from stakeholders to develop the specification for future procurement.

To further support winter resilience for primary care the CCG has written to

Practices seeking expressions of interest from those who would be interested in undertaking additional appointments on a Saturday morning. These would be provided from January to April 2017.

In conjunction with the recommissioning of OOH and 111, GCCG is undertaking a review of primary and community urgent care which is considering how these services fit together to ensure patients are seen by the right professional at the right time to reduce duplication and better manage urgent, same day, demand within an integrated urgent care system for Gloucestershire.

2.1.4 Success criteria 3. Progress in developing and implementing locality plans

All seven CCG localities have developed two year Locality Development Plans running from 2015-2017. Each plan was developed in conjunction 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 have been shared with a wide range of stakeholders across the county, including practice Patient Participation Groups (PPGs).

Progress against all seven Locality Development Plans is being reported six monthly to the GCCG Governing Body, with in-depth reporting on individual localities quarterly to the CCG Development Session.

In addition, across the county, the GCCG Primary Care and Localities Directorate have been supporting localities in formulating the vision for primary care in the future. Given the current resilience and sustainability issues being experienced within General Practice, along with the latest national policy direction of primary care working 'at scale' to lead an integrated out-of-hospital care system, the locality infrastructure is well placed to organise and co-ordinate events to help develop the ideas locally. These events have now led to the development of a GP Provider Leadership Development programme, with identified leads from each locality. This GP membership has formed the basis of the 'New Models of Care Board', along with the Chief Executives of our Provider organisation partners. Good progress has been made across the county in terms of transformation. All 81 practices are part of 16 cluster groups.

Fourteen bids from the clusters were received with the majority of clusters requesting clinical pharmacists. Recruitment to these additional posts (15.6wte new posts) has commenced as have schemes to offer mental health staff in primary care and a frailty service. Other bids for repeat prescribing and urgent care are being progressed.

2.1.5 Funding has already been offered to clusters for staff training in signposting and correspondence management. Whilst some clusters have requested this, others are choosing to wait until the end of January, when GCCG is hosting an event for

GPs and Practice Managers on the GPFV in January. Dr. Robert Varnam, GP and Head of general practice development at NHS England is our keynote speaker. In addition we have a range of national and local speakers delivering workshops in the afternoon, including one on active signposting.

2.2 Practices who are vulnerable or wished support for ongoing sustainability and resilience identified themselves. Common reasons for requesting support were the recognition of the need to develop the workforce, to investigate options for working at scale and more effective working generally across clusters. This included requests for specialist advice and guidance, for example Human Resource and financial expertise. Thirty three bids (covering 59 practices) were received and were prioritised using NHSE criteria, and with the support of the LMC and the RCGP GP Ambassador. Support to practices, who scored most highly, has commenced.

To further support our primary care workforce, the GCCG, alongside the other main Gloucestershire Health and Social Care providers, held a recruitment event to support promotion of the health and social care job opportunities in the county in November 2016. Whilst too early to evaluate the effect on recruitment the event was a good opportunity for all providers to work together and we plan to hold another in the future to support Gloucestershire providers including General Practice.

2.2.1 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)

Please see section 3.1.6

2.3 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. Sections 2.2.1 to 2.8 covers constitutional targets and local key performance indicators. Section 2.9 looks at the Improvement and Assessment Framework (IAF). This has been introduced by NHS England to replace the existing CCG framework. It is designed to fit in with the STP plans and supplies metrics for adoption in the plans as markers for success.

Issues identified in the following areas:

- Cancer 62 day GP referral
- Incomplete RTT performance
- A&E 4 hour target

As part of the 2016/17 planning cycle and in support of the sustainability and transformation plan for Gloucestershire, the CCG and GHNHSFT have been required to submit agreed performance trajectories for the following constitutional standards.

A&E – 4 hours: National standard 95%

A&E	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed trajectory	80.0%	85.0%	85.0%	87.0%	87.0%	91.9%	89.1%	91.2%	85.7%	85.1%	80.1%	89.6%

RTT incomplete pathways: National standard 92%

RTT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed trajectory	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Diagnostic 6 week: National standard 1%

Diagnostics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed trajectory	2.7%	2.2%	1.5%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

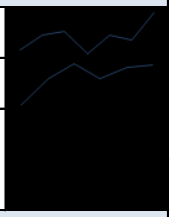
62 Day cancer: National standard 85%

Cancer 62 days	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed trajectory	77.2%	80.4%	82.6%	82.9%	84.4%	85.3%	85.0%	85.2%	85.0%	85.0%	85.1%	85.6%

The finalised trajectories were submitted on the 23rd May, for the purposes of this report the RAG rating applied to the above metric will be based on achievement of the trajectory as opposed to the national performance standard.

2.3.1 Unscheduled care:

The following dashboard provides a 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							
Ambulance Category 1 response	75%	Nov	72.9%	■	71.7%	■	
Ambulance Category 1 T response	75%	Nov	81.8%	●	81.5%	●	
Over 30 minute ambulance handover delays (GHNHSFT)		CCG / SWAST/ GHNHSFT are undertaking some additional validation of handover numbers for 2016/17					
Over 1 hour ambulance handover delays (GHNHSFT)							
A&E							
4-hour A&E target GHNHSFT	85.7%	Dec	73.9%	◆	85.8%	◆	
4-hour A&E target GCS MIU	95%	Dec	99.6%	●	99.6%	●	
12 hour trolley waits	0	Dec	1	◆	2	◆	

SWAST Ambulance indicators

Key performance and activity indicators:

- At the end of November, the SWAST Category 1 year to date position was 71.7% (Ambulance Response Programme was initiated 18/04 & ARP v2.2 started on the 15th Oct 16.)
- Ambulance incidents with response indicate a decrease for months April to November 2016, with 333 fewer incidents than during the same period in 2015/16.

- Gloucestershire Conveyance to A&E has increased compared to 2015/16 (38%), with 44.7% of incidents resulting in conveyance to A&E. However due to the implementation of the new Ambulance response programme, caution should be applied when comparing the data as they use differently models of dispatch.

A demand management plan for Gloucestershire is in place with SWASFT and identified as part of the Improvement Plan and the Right Care 2 Programme.

SWASFT is participating in the Ambulance Response Programme Code Set Trial (ARP) which has seen a change to the way in which ambulance responses are measured. The ARP trial is now evolving and entering a new phase following a formal review process and staff feedback. SWASFT have migrated to ARP 2.2 on 25 October 2016. The objective of ARP is to enhance the management of demand and ensure that resources are appropriately deployed to patients commensurate with their clinical need. The main change of ARP2.2 is the introduction of a new Purple category ARP 2.2 will require a blue light emergency response for all Purple, Red and Amber categories of call. There is an expectation that the timely allocation and mobilisation for PURPLE (category

1) and RED (category 2) incidents will be beneficial to the clinical pathway of the patient. A breakdown of the new categories are:

The new call type definitions

Category		
Category 1	Time critical life threatening event needing immediate intervention and/or resuscitation EG: cardiac/respiratory arrest, airway obstruction, ineffective breathing, unconscious with abnormal or noisy breathing, hanging. Mortality rates high where a difference of one minute in response time is likely to affect outcome and there is evidence to support the fastest response	
Category 2 Response	EG: Probable MI, serious injury	Potentially serious conditions that may require rapid assessment, urgent on-scene intervention and/or urgent transport. Mortality rates are lower; a difference of an extra 15 minutes response time is likely to affect outcome and there is evidence to support early dispatch.
Category 2 Transport	EG: Stroke, major burn, sepsis	
Category 3 Response	EG: Hyperglycaemia	Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe. Mortality rates are very low or zero; a difference of one hour or more might affect outcome and there is evidence to support alternative pathways of care.
Category 3 Transport	EG: isolated limb fractures, non-major burns, abdominal pain	
Category 4 Transport	999 calls that may require a face to face ambulance clinician assessment	Problems that are not urgent but need assessment (face to face or telephone) and possibly transport within a clinically appropriate timeframe.
Category 4 Hear & Treat	EG: Home management advice or referral	Calls which do not require an ambulance response but do require onward referral or attendance of non-ambulance provider in line with locally agreed plans or dispositions, or can be closed with advice (Hear & Treat)

Performance is now measured against the Category 1 8 minute response, which in November was 72.9%, with a year to date of 71.7%. Category 1 T 19 minute response was 81.8% with a year to date of 81.5%

The SWAST contract position which includes growth on 2015/16 shows ambulance incidents -3.21% on contract (-2012 incidents) for the period April to November. The level of growth within the 2016/17 contract was 3%.

Across the first 8 months of 2016/17, hear and treat cases accounted for 12.4% of activity, conveyance to A&E continues increased by 2.35% compared to 2015/16. Conveyance rate for 2016/17 is 44.7% with 27,083 of incidents resulting in an A&E attendance.

Ambulance activity and outcome variance 2016/17 (compared to same period in 2015/16):

Ambulance outcome*

	M8 2015/16	M8 2016/17	Change	%
Total Incidents	62034	60610	-1424	-2.3%
Hear and Treat	8610	7588	-1022	-13.5%
See and Treat	22486	19804	-2682	-13.5%
See and Convey (Total)	30938	33218	2280	6.9%
See and Convey (A&E Department)	25028	27083	2055	7.6%
See and Convey (Other Destination)	5910	6135	225	3.7%

**NB: The rise in A&E conveyance can be linked to the change in the CAD system within the SWAST North Division.(see 2.3.1)*

2.3.2 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 (STP trajectory for December – 85.7%).

- ED Performance year to date was 85.8%, which is 1.1% below the STP YTD trajectory (86.9%). December performance was 73.9% (STP trajectory was 85.7%).

- ED Attendances at GHFT have also slightly reduced from last year, daily December A&E attendances this year were on average 12 less (-0.11%) than last year. The year to date position is +4.7% (3,960 attendances).
- Self-referral is the biggest growth areas for ED attendances in 2016/17 with an additional 9.9% (3,570 attendances).
- The proportion of patients admitted when attending ED in 2016/17 stands

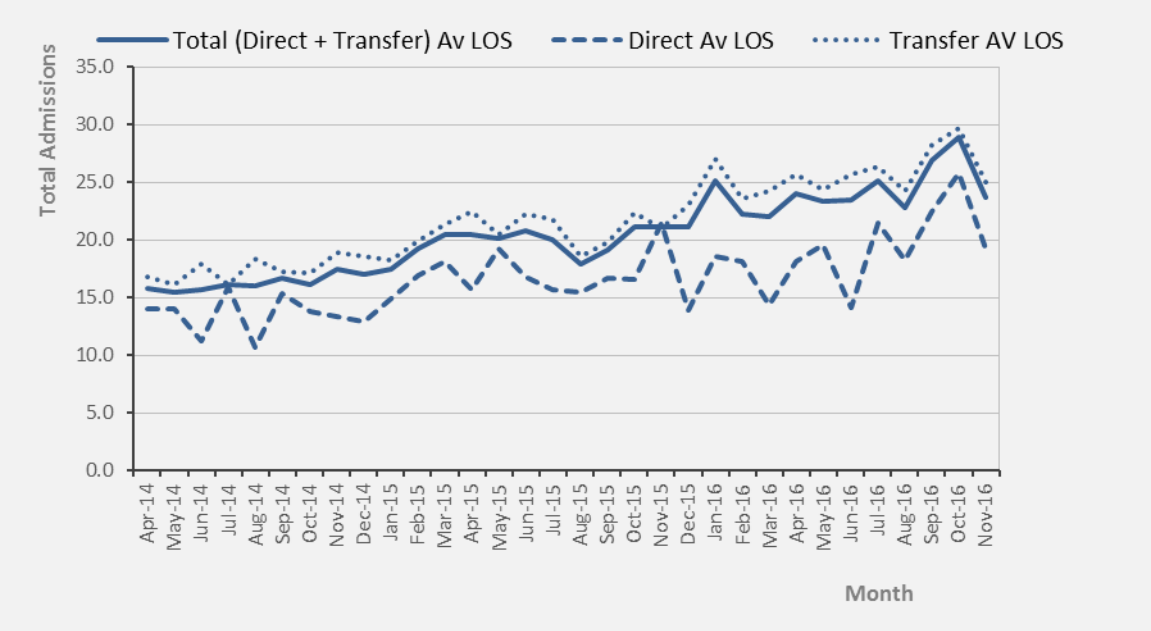
at 31.8%, below 2015/16's proportion of 33.7%.

The system have an agreed improvement plan for 4 hours, this is supported 11 work programmes within the Trust. Specific areas of focus are the reduction in emergency admissions and a reduction in acute bed base capacity. Key actions include:

- GP In ED (Front and back door) – supporting attendance/ admittance avoidance.
- Pathway compliance including enhanced utilisation of AEC/OPAL
- Development of new pathways for patients direct to assessment units.
- Reviewing primary care and work that may impact on surge
- Working with 111 on enhanced clinical validation to reduce 999/ED dispositions
- Reviewing staffing model to provide enhanced mental health liaison service in ED
- Reviewing staffing models and corresponding capacity within SWASFT to enhance 999 service offer.
- Working with community provider to actively reduce current community hospital length of stay
- Development of community based IV service
- Enhancing role of single point of clinical access to support admission avoidance including access to specialised advice line within the acute trust
- Ongoing work within the acute trust to deliver SAFER principles of discharge
- Development of discharge to assess beds with progression on home-based pathways
- Providers developing a plan for reduction in Length of Stay

2.3.3 Community Hospitals Length of Stay (LOS)

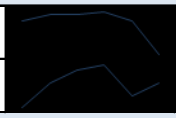
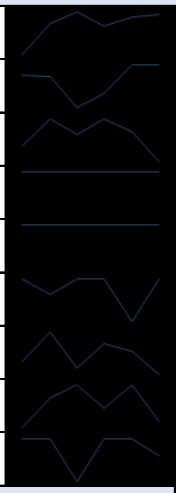
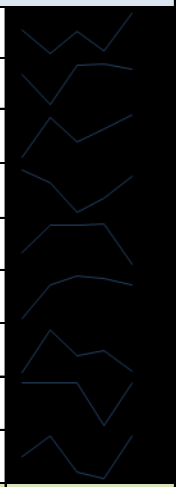
- Admissions to community hospitals have seen a decrease this year -12.9% (-301 admissions).
- 77.2% of admissions to community hospitals have been transfers, this has resulted in an overall longer length of stay for these patients which has increased from 20.5 days in 2015/16 to 24.9 days for the same period in 2016/17.



A pilot to 'hold' 3 beds every day for direct admissions from the primary Care community has been trialled in the autumn of 2016. The pilot's objective was to address the increase in transfers than direct admissions.

2.4 Planned care:

The dashboard provides a 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	Month	Latest Performance		YTD performance		6 month trend
Referral to treatment (RTT)							
% of incomplete Pathways that have waited less than 18 Weeks	92%	Nov	88.3%	◆	91.7%	■	
Zero RTT pathways greater than 52 weeks	0	Nov	8	◆	81	◆	
Cancer waiting times							
% of patients seen within 2 weeks of GP referral for suspected cancer	93%	Nov	93.5%	●	87.8%	◆	
% of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected	93%	Nov	92.1%	■	93.6%	●	
Cancer - first definitive treatment within 31 days of a cancer diagnosis	96%	Nov	95.4%	■	98.4%	●	
Cancer - subsequent treatment for cancer within 31 days - surgery	94%	Nov	91.8%	■	98.9%	●	
Cancer - subsequent treatment for cancer within 31 days - Drug Regime	98%	Nov	100.0%	●	99.8%	●	
Cancer - subsequent treatment for cancer within 31 days - Radiotherapy	94%	Nov	100.0%	●	99.2%	●	
Cancer - first definitive treatment within 62 days GP referral	85.2*%	Nov	79.8%	◆	78.1%	◆	
Cancer - first definitive treatment within 62 days screening service	90%	Nov	100.0%	■	93.6%	●	
Cancer - first definitive treatment within 62 days upgrade	85%	Nov	100.0%	●	94.2%	●	
Diagnostic waiting times							
% of patients waiting more than 6 weeks diagnostic test	1.0%	Nov	1.01%	■	1.8%	■	
Local community waiting times							
% referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	95%	Nov	98.8%	●	97.7%	●	
% referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	95%	Nov	96.9%	●	97.1%	●	
% referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	95%	Nov	87.9%	◆	95.6%	●	
% referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	95%	Nov	98.7%	●	95.0%	●	
% referred to the Podiatry Service who are treated within 8 Weeks	95%	Nov	96.6%	●	96.7%	●	
% referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	95%	Nov	91.8%	■	92.2%	■	
% referred to the Adult Physiotherapy Service who are treated within 8 Weeks	95%	Nov	91.9%	◆	91.5%	◆	
% referred to the Parkinson Nursing Service who are treated within 8 Weeks	95%	Nov	100.0%	●	98.8%	●	
% referred to the Diabetic Nursing Service who are treated within 8 Weeks	95%	Nov	100.0%	●	97.8%	●	
Elective cancellations	Threshold	Month	Performance		YTD performance		6 month trend
Cancelled operations - 28 day breaches	0	Oct	3	◆	48	◆	

***STF Trajectory**

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

In November there were 8 patients who were waiting longer than 52 weeks for treatment.

Ongoing capacity issues within the complex spinal service are the primary cause for the 4 breaches at North Bristol Trust (1 in T&O, 3 in Neurosurgery).
There were 3 52 week breaches at GHNHSFT in Urology and 1 at Milton Keynes University Hospital in T&O.

There has been an increase in Gloucestershire patients waiting over 35 weeks at the end of November, with 384 compared with 362 in October. The effectiveness of this process is being reviewed with CCG support to ensure that all opportunities for patient transfer are maximised.

The CCG regularly receive updates on the progress of treatment for Gloucestershire patients at out of county providers. Commissioners are provided with assurance that all patients have been clinically reviewed and we regularly request patient TCI dates. Performance management is being undertaken in conjunction with the lead commissioner for planned care, through the access and performance meeting

For the Trusts where we are an associate commissioner, we receive the monthly performance position highlighting the issues and have an opportunity to challenge progress. Some of the key recovery actions taken include:

- A Risk of Harm report sent to GHFT Quality & Performance Committee
- GHNHSFT RTT Recovery plan has been drafted and sets out plans to recover performance by speciality. GHNHSFT are also investigating how to expedite recovery with CCG support
- Other capacity – Nuffield discussing levels and which specialities immediate discussions T&O, General Surgery and possibly Gynaecology
- Further communication to GPs to raise awareness of current pressures and performance at GHFT – waiting times of other providers to be shared
- Referral pathways being discussed with CPG leads.
- 52 week waiters - Ensure early warning flag system at 35 weeks is in place and robust.

G-care Website

The G-care website has been designed for use by clinicians working in primary care, specifically to support Gloucestershire based GP's in their work. The website

pulls together useful information from a range of sources and includes local care pathways, clinical guidance, referral forms, patient and care information, service information, as well as links to community resources such as social prescribing and voluntary sector groups. There have been 786 new users visit the site in December bringing the total number of unique visitors to the site to 1,199. The site was visited 3,082 times with 10,866 pages viewed.

https://g-care.glos.nhs.uk

December 2016		
Total Users	1,199	
New Users	186	
Site Views	3,082	
Page Views	10,866	
Top Pages Viewed	1. Chronic Obstructive Pulmonary Disease COPD 2. Irritable Bowel Syndrome (IBS) 3. Supported Self-Management 4. Antibiotic Use 5. Ambulatory Emergency Care (AEC)	
Top Referral Forms	1. Gloucestershire Community Drug and Alcohol Recovery Service 2. Primary Care Transfer (NEWS) Form 3. Suspected Urological Cancer 4. Gloucestershire Respiratory Service 5. Complex Leg Wound Service	
Content Updates	• Recurrent UTI's in Children - Pathway • MHRA Toolkit – Perinatal Mental Health • RCGP – Blood Cancers: GP E-learning Modules	

Top Site Searches	1. Antibiotic 2. Podiatry 3. IBS 4. Diabetes 5. DVT

2.4.2 Cancer waiting times

Delivery of cancer targets continues to be challenging in 2016/17.

2 Week Cancer waits

Performance against the 2-week wait target increased to 93.5% in November meeting the national target of 93%. There were 116 breaches of which the main area of concern was still within the Urology service at GHFT (23 breaches), Skin (24 breaches) and Upper Gastro intestinal (29 breaches). GHNHSFT have put in place actions to maintain performance which include:

- **2WW Appointment Booking Project**: CPG team have run an information campaign in Q3 with practices to ensure patients understand the importance of attending 2WW appointments. A new joint "task & finish" project to be launched this week to understand problems and implement short-term improvements.
- **Referral Pathways**: There has been extensive discussion about the shift that is evident from routine referrals to 2WW referrals. This was expected as a result of the new NICE guidelines, however as a system there is a need to have a full appreciation of any other factors and understand the current availability and waiting times for routine appointment too as part of this pathway work. A number of potential solutions were discussed, these will be investigated further.

62 day cancer waits

Performance against the 62-day wait target improved significantly from 73.6% in October to 79.8% in November, with 34 breaches of which 18 were in Urology and 8 in Haematological. The Trust performance is on track with the improvement trajectory agreed. Other actions for recovery include:

- The implementation of the new service model, one-stop MAD Clinics, has commenced in December. A tight focus on maintaining progress is required
- Urology Peer Review: An in-depth external visit recently undertaken, included very positive support for the improvement actions being enacted
- Timed Pathways: some good progress made on confirming all current

pathways. However we requested greater clarity on the status and reporting of the timed pathways

- Capacity review: some detailed discussion on ensuring key recruitment and equipment enhancement are remaining on track.
- Demand and Capacity mapping: with CCG supporting key specialities to determine any potential gap and map these against workforce and commissioning requirements.

104 day breaches

There were 17 over 104 day breaches reported at the end of November, whom have all been treated in December. The number of patients in this category is tracked weekly by the Trust, the CCG have requested weekly updates to be shared.

Urology remains the speciality of most concern with ongoing discussions between GHNHSFT and GCCG regarding recovery actions. The key actions in October have focused upon creating capacity at GHNHSFT:

- GHNHSFT have plans to expand the current multidisciplinary and diagnostic clinics which will shorten patient pathways. Business case in in development.

GP Care is operating a clinical assessment service in conjunction with GHNHSFT and GCCG. In the 13 months (November 15 to November 16) since the service was commissioned it has accepted 1474 referrals and has so far seen 1243 of those patients. On average, to date 73% of patients complete their pathway with GP Care, with 27% going on to GHFT for surgery.

GCCG have agreed a recovery trajectory with GHNHSFT with performance against the standard being achieved by January 2017. Additional CCG support has also been provided to GHNHSFT to support the recovery plan process to ensure that performance improves, with sustainable delivery during 2016/17. The CCG organised a tripartite meeting with GHNHSFT & NHSI to discuss the 62 day Cancer position in September.

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

There has been significant pressure on the 6-week diagnostic waiting time target, with performance challenged in particular in the Audiology service.

Performance in November at 1.0.1% has just failed to meet the target (STP target of 1%) with the majority of breaches due to Audiology (52 breaches out of 78).

Year to date performance is 1.8% against an YTD STP target of 1.4%. The underlying cause is a lack of audiologists which has caused a delay to some treatments.

The CCG is looking to source additional capacity to support this speciality. They are also looking at available capacity in Great Western Hospital which would be targeted at residents closer geographically to GWH. The CCG will continue to monitor the audiologist vacancy situation and if required look at an AQP contract for alternative provision.

2.5 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 2.5.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Mental health indicators	Threshold	Month	Performance		YTD		6 month trend
Dementia diagnosis rate	67%	Nov	68.2%	●	68.2%	●	
Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	95%	Nov	98.0%	●	98.0%	●	
IAPT Access rate: Access to psychological therapies for adults should be improved	6.25%	Nov	5.08%	◆	5.08%	◆	
The proportion of people who complete therapy who are moving towards recovery	50%	Nov	44.0%	■	47.0%	■	
IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	75%	Nov	33.0%	◆	33.0%	◆	
IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	95%	Nov	81.0%	◆	85.0%	◆	
CYPS Mental Health	Threshold	Month	Performance		YTD		
Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	98%	Nov	99.0%	●	99.0%	●	
95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	95%	Q2	98.0%	●	99.0%	●	
Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	80%	Q2	76.0%	◆	77.0%	◆	
Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	95%	Q2	93.0%	■	92.0%	■	

2.5.1 Dementia diagnosis rate (DDR)

Dementia diagnosis rate in November 2016 was 68.2% which has met the 67% target. The CCG has a robust plan in place to maintain the figure and has completed regular case finding audits.

Using Quality Improvement and Clinical Programme Approach methodologies, the Primary Care Dementia Pathway is being reviewed through extensive stakeholder engagement that includes those living with dementia. The review includes key national targets such as DDR and post diagnostic support, and has already identified a number of key issues such as secondary care responsibility for prescribing and monitoring dementia drugs leading to duplication and gaps in annual review. The focus of dementia in the local Sustainability and Transformation Plan will facilitate the shift to support primary care diagnosis of dementia.

Improving Access to Psychological Therapies (IAPT) -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 2G.

2Gether NHSFT 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 and a new care pathway has been introduced.

During the recent NHSE Intensive Support Team (IST) visit, it was identified that some of the Improving Access to Psychological Therapies (IAPT) activity should not be counted towards the IAPT Access and Recovery rates as it was carried out by nurses who were not NICE compliant. By removing this activity 2G have shown improvement in their IAPT recovery results and Year to date figures are slightly below the target at 47%. This has however had impacted on the Access to IAPT services figure which is 5.08% against a year to date target of 10%

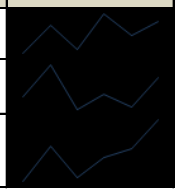
A member of the national IAPT Team is supporting 2G. They have also had an on-site visit from the NHSE Intensive Support team. 2G have created an improvement plan for access and recovery which has been shared with the CCG, which includes an internal productive review and the providing of an E-provision via an external company to improve access rates.

2.6 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 2.6.1. This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Significant improvement is required in order to achieve all performance targets on a sustainable basis. A performance notice was issued in December 2015 and the

CCG is closely monitoring the Arriva Transport Services Ltd (ATSL) remedial action plan and performance improvement trajectory. A further exception report was issued in May 2016 as ATSL failed to achieve the worst case performance trajectory level expected for PTS04 for the month of March and saw a downturn in performance from February 2016.

Patient transfer services	Threshold	Month	Performance		YTD performance		6 month trend
Arrival within 45 minutes before, to 15 minutes after, booked arrival time	95%	Nov	83.4%	◆	84.5%	◆	
Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey	85%	Nov	78.4%	◆	78.8%	◆	
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%	Nov	87.3%	●	84.8%	■	

2.6.1 PTS 04 - Arrival within 45 minutes before, to 15 minutes after, booked arrival time – Target 95%

Inbound on-time arrival is an area where performance remains challenging. A significant performance improvement in January 2016, following implementation of actions identified in the ATSL Remedial Action Plan, has not been sustained in subsequent months. November's report shows a decrease, with 83.4% of patients arriving within key performance indicators (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 November shows that 78.4% were achieved within the one hour compared to the target of 85%. This is an increase from October, but below that achieved in January. Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys.

Performance improvement in January 2016, following implementation of actions identified in the ATSL Remedial Action Plan, has not been sustained in subsequent months. An exception report will be issued against this KPI if there is further deterioration in performance below the agreed worst case performance trajectory in coming months.

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%

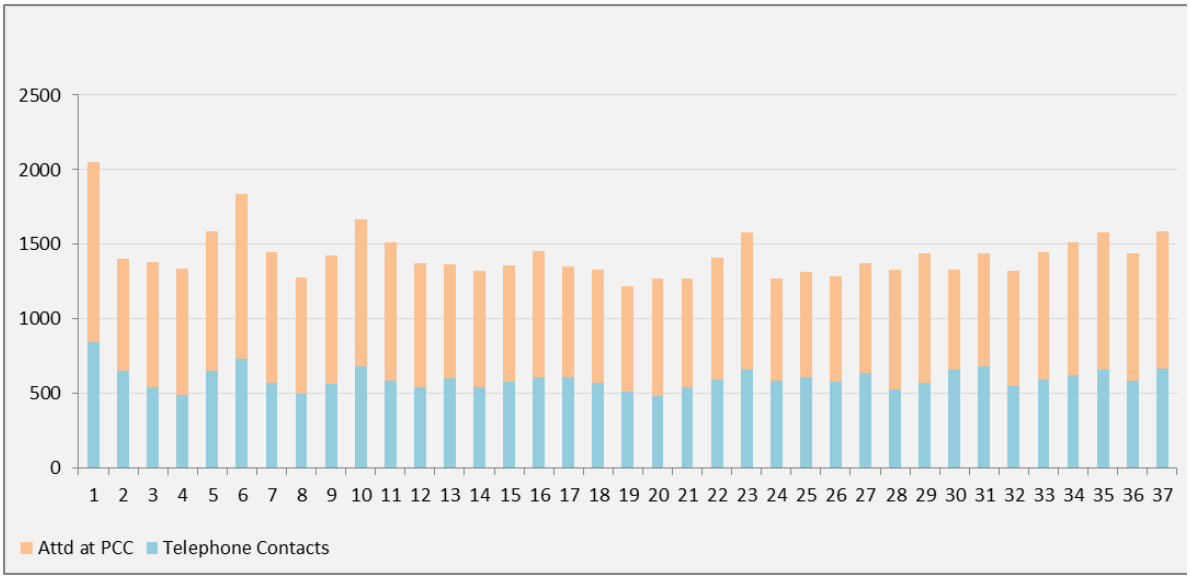
November 2016 saw a decrease in performance to 87.3% compared to a target of

85%. The high number of on the day bookings made by the Acute Trust for discharge and transfer, particularly those made at the end of the day, remain challenging for ATSL. In the 16/17 contract with GHFT a CQUIN around on the day transport bookings has been agreed. CQUIN payment is predicated on <50% of discharge/transfer bookings being made on the day. Actions to increase the number of bookings made in advance should support achievement of this target and improve patient experience. Actions outlined in the ATSL Remedial Action Plan will also support performance improvement.

2.7 Out Of Hours

The SWAST Out of Hours Service commenced on 1st April 2015. There have been 68,203 OOH contacts made in 16/17 with an average of 1,843 contacts per week.

The graph below shows the total number of weekly OOH contacts split by face to face and telephone; face to face contacts predominantly include Treatment Centre, Walk In, Home Visit and ED/MIU Referral contacts. The marked increase in weeks 22 and 52 co-incide with the late August bank holiday and Easter holiday respectively, with weeks 1 and 39 (in 15/16) also falling during bank holiday periods.



The average number of face to face contacts per week stands at 1,035, accounting for 56% of all contacts. The last six weeks (weeks 32 to 37) have seen significant rise in the number of face to face contacts, with the average for these six weeks being 1,112 per week. The previous six weeks averaged 966 per week. Levels of telephone contacts have been variable with 846 in week 36 rising to 973 in week 37.

The dashboard below provides performance data for a number of the key quality indicators;

National Quality Requirements		Nov-16	Year to Date Compliance
Requirement 10: (Walk in)	All immediately life threatening conditions to be passed to the ambulance service within 3 minutes following face to face clinical assessment in PCC	100%	100%
Requirement 10a: (Adult Walk in)	For urgent adult patients - % definitive face to face clinical assessments started within 20 minutes of arrival in PCC.	80.00%	73.12%
Requirement 10a: (Children Walk in)	Children, who are ill and have an urgent OOH need, will receive definitive clinical assessment within 15 minutes of arrival in PCC	100%	70.37%
Requirement 10b: (Walk in)	Definitive clinical assessment for less urgent cases presenting at PCC to start within 60 minutes	98.09%	96.16%

Local Quality Requirements		Nov-16	Year to Date Compliance
L12	All calls to the OOH clinical service must be answered within 60 seconds	82.24%	80.6%
L12	For calls prioritised as emergency: Timely calls backs within 1 hour of notification from the NHS 111 service where a call back is required	85.92%	85.35%
	For calls prioritised as urgent: Timely calls backs within 2 hours of notification from the NHS 111 service where a call back is required	85.81%	81.57%
	For calls prioritised as less urgent: Timely calls backs within 6 hours of notification from the NHS 111 service where a call back is required	92.45%	83.93%
L15	Qualified response to urgent paramedic requests for advice within 20 minutes of the request	73.25%	65.65%
L18	Transfers to Emergency Departments	4.01%	4.60%

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
Infection control							
Number of MRSA infections (Health Community)	0	Nov	0	-	6	-	
Number of MRSA infections (GHNHSFT)	0	Nov	0	-	1	-	
Number of C.diff infections (Health Community)	157	Nov	10	■	113	■	
Number of C.diff infections (GHNHSFT)	37	Nov	4	◆	23	●	
Mixed sex accommodation							
Mixed-sexed accommodation breaches	0	Nov	5	◆	145	◆	
Other quality indicators							
Number of Never Events	0	Nov	0	●	1	◆	

2.8.1 Number of MRSA infections (Health Community)

There was 7 MRSA cases reported year to date. 6 were pre 48hr (attributed to community care) and 1 post 48hr (attributed to acute hospital) A Post Infection Review (PIR) of each case was undertaken within 14 days as required by Public Health England.

2.8.2 Number of total C. difficile infections (Health Community)

The threshold for 2016/17 has remained the same with 157 for the CCG, and 37 for GHFT.

Year to date performance is 23 cases of C. diff reported at GHNHSFT and 113 in the wider health community.

Breaches are reviewed by GCCG quality team.

2.8.3 Number of Escherichia coli infection (Health Community)

There is no threshold set for 2016/17. Year to date is 204 cases of E.coli reported in the wider health community.

2.8.4 Season influenza uptakes rates

Uptake rates for week 52 (01.01.17) for all groups except for 64 and over and 6mths to 2 years are comparable to % uptake last year. Compared to National end of season ambitions most groups uptake % is 5% or more below the comparator %. NHSEngland continue to support practices to achieve National ambitions

2.8.5 Mixed Sex Accommodation breaches

During November, there were 5 breaches affecting 31 patients. Any breaches reported, are reviewed against the delivering same sex accommodation decision matrix agreed with GHNHSFT, NHSE and the CCG.

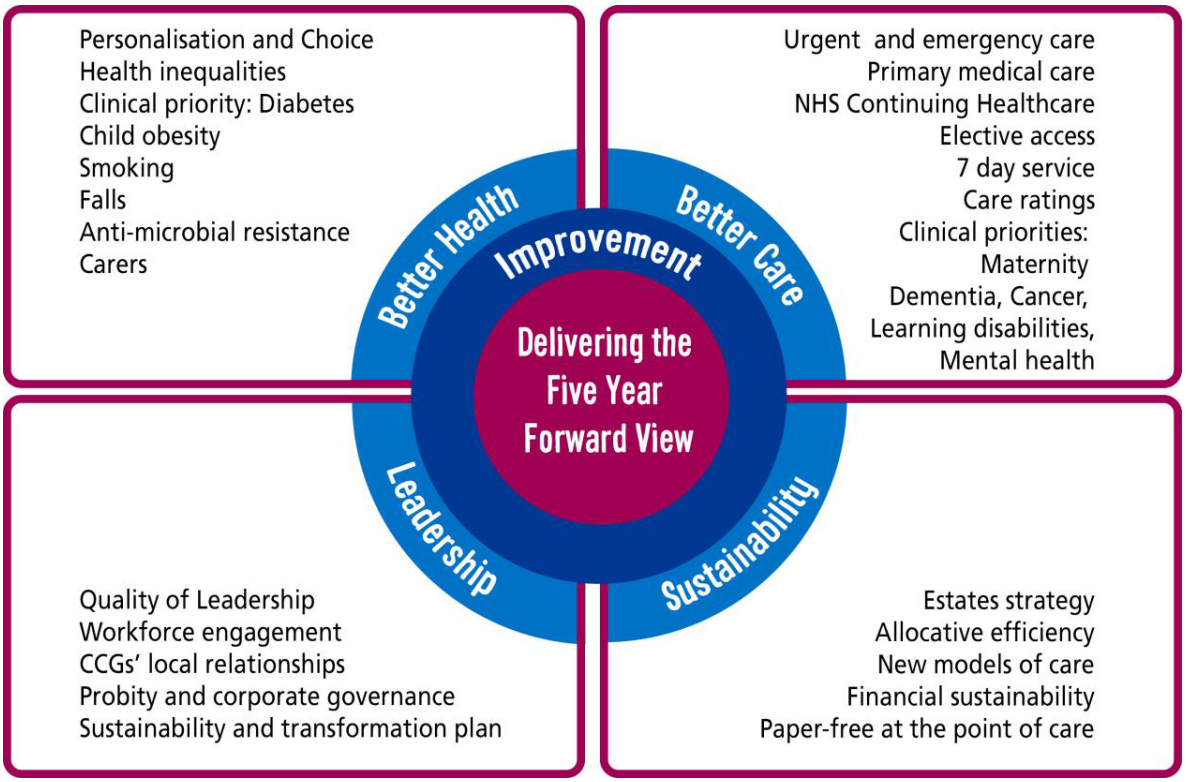
2.9 The New CCG Improvement and Assessment Framework

NHS England has introduced a new Improvement and Assessment Framework for CCGs from 2016/17 onwards, to replace both the existing CCG Assurance Framework and separate CCG performance dashboard.

The new CCG Improvement and Assessment Framework is designed to fit with the forthcoming Sustainability and Transformation Plans. It supplies metrics for adoption in those plans as markers of success.

Components: 4 domains; 6 clinical priorities. The 4 domains consist of 60 Key performance indicators, some of which are being developed in year.

- **Better Health:** this section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve;
- **Better Care:** this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas;
- **Sustainability:** this section looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends;
- **Leadership:** this domain assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity for example in managing conflicts of interest.



We have received the initial baseline results for 42 of the 60 KPIs in July and some have been updated in October.

Improvement & Assessment Framework Dashboard						
Theme	Top Performing	Performing Well	Needs Improvement	Greatest Need for Improvement	N/A	Data Not Yet Available
Better Health	5	6	2	0	1	0
Better Care	9	5	3	3	1	11
Sustainability	0	1	0	0	2	5
Well Led	1	0	0	0	3	2
Total:	15	12	5	3	7	18

Notes:

The rankings have been based on our position from all 209 CCGs on the MyNHS website and our ratings have been based on our ranking position as follow;

If ranked 1-52 - we have assumed we are 'Top performing'

If ranked 53-104 - we have assumed we are 'Performing well'

If ranked 105-156 - we have assumed we are 'Needs Improvement'

If ranked 157-209 - we have assumed are are 'Greatest need for Improvement'

Please note the rankings and ratings are not those given by NHS England and may change

6 Clinical Priority Areas

New ‘Ofsted style’ ratings (Top performing, Performing well, Needs Improvement and Greatest need for improvement), with assessments overseen by independent groups, will be assigned in the following 6 clinical priority areas:

- Mental health – chair, Paul Farmer, Chief Executive of MIND;
- Dementia – chair, Jeremy Hughes, Chief Executive of the Alzheimer's Society;
- Learning disabilities – chair, Rob Webster, Chief Executive of the NHS Confederation and Gavin Harding, Learning Disability Advisor, NHS England (acting as co-chairs);
- Cancer – chair, Sir Harpal Kumar, Chief Executive of Cancer Research UK;
- Diabetes – chair, Chris Askew, Chief Executive of Diabetes UK.
- Maternity – chair, Baroness Julia Cumberlege, Chair of National Maternity Review

Process

The first assessment for each of these six clinical priorities was published on the MyNHS website in September 2016 with baseline performance and informs whether NHS England intervention is needed.

The aim is to ensure that data will be available at least quarterly for nearly all of these metrics. NHS England’s regional teams will ensure that the framework is discussed with CCGs during the year, through a rolling programme of local conversations drawing on expertise and insight from the national programme teams.

The formal annual assessment against the 2016/17 framework will be published in summer 2017. Each CCG will receive an annual headline assessment in one of four categories. The assessment will be a judgement, reached by taking in to account the CCG’s performance in each of the indicator areas over the full year. To ensure that the framework is being applied consistently, regional and national moderation will take place. NHS England’s Commissioning Committee will oversee the process and sign off the ratings. The Committee will also track progress in-year. Ratings will be published.

The current assessment for the 6 areas is:

6 Clinical Priority Areas: October 2016	
Cancer	Needs Improvement
Dementia	Performing Well
Diabetes	Performing Well
Learning Disabilities	Needs Improvement
Maternity	Performing Well
Mental Health	Needs Improvement

2.9.1 **Cancer**

Cancer	Cancers diagnosed at early stage	People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral
Needs Improvement	54.4% of patients diagnosed at an early stage	79.8% of people treated within 62 days
	One-year survival from all cancers	Cancer patient experience
	71.3% one-year survival	8.7 is the average score given by patients asked to rate their care on a scale from 1 to 10 (10 being best)

The main reason we are currently rated as Needs Improvement in Cancer is due to the 62 day cancer target being in the bottom quartile nationally. Improvement in this one indicator out of the bottom quartile will see our rating improve to Performing well. We have a 62 day cancer recovery plan agreed with GHNHSFT and expect performance to recover by January 2017.

It should be noted that Gloucestershire CCG has been identified as one of the CCGs with the most improved position in country on one-year cancer survivorship, and that we can also report significant improvements in cancer patient experience over the last 3 years. Nationally 2020 objectives have been set for these key indicators and our cancer clinical programme is ensuring we have the appropriate work plans in place.

2.9.2 **Mental Health**

Mental Health	Improving Access to Psychological Therapies recovery rate	People with 1st episode of psychosis starting NICE-recommended treatment within 2 weeks of referral	Children and Young People's Mental Health Services - Transformation
Needs improvement	49% of people who finished treatment moving to recovery	85% of 20 people with first episode of psychosis starting treament with a NICE-recommended package of care treated within 2 weeks of referral	70% Percentage compliance with a self-assessed list of minimum service expectations for Children and Young People's Mental Health, weighted to reflect preparedness for transformation
	Crisis Care and Liaison Mental Health Services - Transformation	Out of area placements for acute mental health inpatient care - transformation	
	85% Percentage compliance with a self-assessed list of minimum service expectations for Crisis Care, weighted to reflect preparedness for transformation	25% Percentage compliance with a self-assessed list of minimum service expectations for Out of Area Placements, weighted to reflect preparedness for transformation	

Mental Health is a particular area of concern for the CCG with the IAPT recovery rate performing in the bottom quartile nationally. We have also received a Needs immediate attention for our self-assessment return on out of area placements for acute mental patients. Improvement in both these Key performance indicators will see our rating rise to Performing well.

The CCG and 2G have agreed a recovery plan for the improvement of the IAPT recovery and access rate and have been support by the NHS England intensive support team. Actions have included redesigning the IAPT pathway which was implemented in November 2016. The CCG is also in discussions with 2G around improving the reporting of out of area placements in order to meet the compliance requirements of the self-assessment return.

2.9.3 Learning Disabilities

Learning Disabilities	Reliance on specialist inpatient care for people with a learning disability and/or autism	Proportion of people with a learning disability on the GP register receiving an annual health check
Needs improvement	**36 per million registered population**	**48% of 3403 people on the GP register**

This indicates improvements are required in reducing our reliance on specialist inpatient care for people with a learning disability and/or autism in order to improve our rating to Performing well. The current identified numbers of patients in receipt of inpatient care is being challenged at a national level as there appears to be a discrepancy between the national Transforming Care Programme and specialist commissioning numbers.

Gloucestershire is well placed to improve our local resilience with regards to an increase in the range and type of community based provision. A new assessment and treatment unit, plus place of safety beds are coming on stream in the new year. These bed based services will augment our already successful learning disabilities intensive support service (LDISS).

Commissioners are working on a system wide improvement and promotion plan in order to increase the take up of annual health checks. Our current performance of 48% is slightly above the national average of 47%. It is hoped that the current plans will improve this further and improve our overall rating.

2.9.4 Diabetes

Diabetes	Diabetes patients that have achieved all the NICE-recommended treatment targets	People with diabetes diagnosed less than a year who attended a structured education course
Performing well	**40.8% In the top half of performers. 75.9% participation in the NDA.**	**4.7% 75.9% participation in the NDA.**

In order to move to Top performing we will need to improve the number of people with diabetes diagnosed less than a year who attended a structured education course, so that our performance is significantly above the national

average of 5.7% (approx. 4% improvement).

The most recent national diabetes audit (NDA) participation figures show that the participation rate in Gloucestershire has increased from 75.9% in 14/15 to 91% in 15/16. It has been recognised that the documentation of completed structured education is poor across England because it relies on practices in primary care coding completion of Structured Education. In Gloucestershire, the face to face courses are delivered by GCS in the community.
Practices are informed about patients who have attended the education courses but they do not prioritise coding patients as completing courses because;

- they don't recognise that this is what is being measured centrally
- they are not incentivised to do it by QOF and
- It is a low administrative priority.

It has been recognised nationally that both completion of Structured Education programmes and coding on completion needs to be improved.

The implementation of Mapmydiabetes across Gloucestershire should increase the number of people offered and attended structured education (although we still need to qualify how we can ensure this is coded appropriately on completion).
The Diabetes Treatment and Care transformation Programme has allocated £40m for 17/18 and 18/19 and is asking for bids from CCGs to improve the recording of structured education and increase the uptake of structured education. It is expected that CCGs will increase the documented attendance by 10% year on year until 2021

At their next meeting (December 1st) the Diabetes CPG will be deciding on details of their bid which ***could*** involve:

- Use of health trainers to provide some of the structured education programme (to increase provision and offer alternative times and venues)
- Use of administration staff to code attendance of SE programmes centrally or in practices
- Alternative methods of informing practices of patients who have attended education allowing for more efficient coding
- Use of the CES to incentivise appropriate coding
- Working with GHNHSFT to ensure patients with Type 1 diabetes receive SE and that this is documented in primary care (for NDA).

We will also need to maintain our performance for diabetes patients that have achieved all the NICE-recommended treatment targets at above 40.2%.

NDA data suggest that we achieve targets for adult patients above the age of 65 (Type 2 diabetes) but fall below expectations for all adult type 1 patients and adult patients with type 2 diabetes under the age of 65 year.
We also underperform with children under the age of 18 with type 1 diabetes.

The intention is to work with GHNHSFT to improve treatment targets for type 1 diabetes (and investigate whether the correct data is on primary care systems for NDA purposes). We will also consider how we improve treatment targets for adult type 2 patients under 65 years.

2.9.5 **Dementia**

Dementia	Estimated diagnosis rate for people with dementia	Dementia care planning and post-diagnostic support
Performing well	**66.7% of the estimated number of people with dementia have a recorded diagnosis**	**78.5% of patients with dementia whose care plan has been reviewed in the preceding 12 months**

Latest performance figures published in October for our dementia diagnosis rate at 67.7%. If we could also improve our Dementia care planning and post-diagnostic support result by 1% or more, then we would move into Top performing.

The Primary Care Clinical Audit Team (PCCAG) is working with practices on case finding patients with dementia on practice lists. The MiQUEST query identifies those who may have dementia but do not have a diagnosis, and support is offered by the Community Dementia Nurses to review those with the practice team to facilitate a primary care or secondary care diagnosis as appropriate. It is anticipated that the impact of the audit will in Q4 16/17.

The primary care dementia pathway is currently undergoing review, with potential service redesign to address a number of issues. For example,

- closer collaboration between the Community Dementia Nurses and Alzheimer's Society Dementia Advisers
- timely and appropriate use of information
- support for those with Vascular Dementia and Mild Cognitive Impairment

Improved annual dementia review is being addressed in GP Cluster Pilot, where CCG is working with 2gether NHSFT to review the current secondary care prescribing and review guidance for dementia drugs (ACIs) which has led to an inequitable process of annual review and reduced Community

Dementia Nurse capacity.

2.9.6 **Maternity**

Maternity	Neonatal mortality and stillbirths	Women's experience of maternity services
Performing well	6.2 stillbirths and neonatal deaths per 1000 births. A similar rate to most other	83.1 is the score out of 100 based on six survey questions. Among the CCGs with the
	Choices in maternity services	Maternal Smoking at Delivery
	70.1 is the score out of 100 based on six survey questions. Among the CCGs with the	8.8% of 1645 mothers smoked at delivery

We will need to improve either the Neonatal mortality & stillbirths or Maternal smoking at delivery performance so it is statistically significantly better than the national average figures (7.1% Stillbirths, 10.2% Smoking). If we are able to do this we should move into the Top performing rating.

Maternity services are performing well and the ambition is for services to become 'Top rating'. In order to achieve this the CCG in partnership with GHNHSFT and key partners will implement the action plan associated with the National Maternity Review 'Better Births' Report (2016) to ensure we continue to improve women's experience of maternity services and reduce stillbirths and neonatal mortality by :

- Developing and implementing different ways of engaging women and families in diverse communities in conjunction with Health watch and GHNHSFT through social media and other means.
- Work with women, families and stakeholders to improve women's experience of postnatal care
- Implement the action plan relating to Saving Babies Lives, aiming to reduce stillbirths via smoking cessation and monitoring movements and growth of babies.

- Develop community hubs and integrating better together services that support women and families in the early years including health visiting and children's services.

Improvement and Assessment Framework dataset October 2016

	Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
	Better Health						
▼	Maternal smoking at delivery	Q1 16/17	8.8%	10.2%		L	
◀▶	Percentage of children aged 10-11 classified as overweight or obese	2014-15	31.3%	33.2%		L	
▼	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults an	2014-15	40.8%	39.8%		H	
▲	People with diabetes diagnosed less than a year who attend a structured education course	2014-15	4.7%	5.7%		H	
◀▶	Injuries from falls in people aged 65 and over	Mar-16	1,926	2,014		L	
▲	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	Jul-16	73.1%	52.0%		H	
◀▶	Personal health budgets	Q1 16/17	18.4	11.3		H	
▼	Percentage of deaths which take place in hospital	Q4 15/16	40.5%	47.0%		<>	
▼	People with a long-term condition feeling supported to manage their condition(s)	2016	67.8%	64.3%		H	
▲	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q4 15/16	782	929		L	
▼	Inequality in emergency admissions for urgent care sensitive conditions	Q4 15/16	2,030	2,168		L	
▼	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Jul-16	1.0	1.1		<>	
▼	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Jul-16	10.0%	9.3%		<>	
▼	Quality of life of carers	2016	82.1%	80.0%		H	
	Better Care						
◀▶	Cancers diagnosed at early stage	2014	54.4%	50.7%		H	
▲	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q1 16/17	79.8%	82.2%		H	
▲	One-year survival from all cancers	2013	71.3%	70.2%		H	
◀▶	Cancer patient experience	2015	8.7			H	
▲	Improving Access to Psychological Therapies recovery rate	Jun-16	49.0%	48.9%		H	
▲	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Jul-16	85.0%	72.0%		H	
▼	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q1 16/17	36			L	
◀▶	Proportion of people with a learning disability on the GP register receiving an annual health check	2014-15	48.0%	47.0%		H	
◀▶	Neonatal mortality and stillbirths	2014-15	6.2	7.1		L	
◀▶	Women's experience of maternity services	2015	83.1			H	
◀▶	Choices in maternity services	2015	70.1%			H	
▲	Estimated diagnosis rate for people with dementia	Aug-16	66.7%	67.3%		H	
◀▶	Dementia care planning and post-diagnostic support	2014/15	78.5%	77.0%		H	
◀▶	Achievement of milestones in the delivery of an integrated urgent care service	August 2016	3			H	
▼	Emergency admissions for urgent care sensitive conditions	Q4 15/16	2,011	2,359		L	
▲	Percentage of patients admitted, transferred or discharged from A&E within 4 hours	Aug-16	93.6%	91.0%		H	
▲	Delayed transfers of care per 100,000 population	Aug-16	12.4	14.1		L	
▲	Population use of hospital beds following emergency admission	Q4 15/16	0.9	1.0		L	
▲	Management of long term conditions	Q4 15/16	679	795		L	
▼	Patient experience of GP services	H1 2016	89.4%	85.2%		H	
◀▶	Primary care workforce	H1 2016	1.1	1.0		H	
▲	Patients waiting 18 weeks or less from referral to hospital treatment	Aug-16	92.1%	91.0%		H	
▲	People eligible for standard NHS Continuing Healthcare	Q1 16/17	17.6	46.0		H	
	Sustainability						
◀▶	Financial plan	2016	Green			H	
◀▶	In-year financial performance	Q1 16/17	Green			H	
◀▶	Outcomes in areas with identified scope for improvement	Q1 16/17	CCG not incl	58.3%		H	
▲	Digital interactions between primary and secondary care	Q2 16/17	69.3%			H	
◀▶	Local strategic estates plan (SEP) in place	2016-17	Yes			H	
	Well Led						
◀▶	Staff engagement index	2015	3.7	3.8		H	
◀▶	Progress against workforce race equality standard	2015	0.1	0.2		L	
◀▶	Effectiveness of working relationships in the local system	2015-16	74.4			H	
◀▶	Quality of CCG leadership	Q1 16/17	Green			H	

3.1 Patient Experience

3.1.1 Patient Experience – Period up to 31st December 2016

PERSPECTIVE 2	Patient Experience	Green
Success criteria 1: *Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.*		Green
Key performance indicators		
Outcomes measures for patient safety have been developed based on the CCG Outcome framework and sign up for safety initiative.		Green
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.		Green
Success criteria 2: Reporting: *Improve reporting of patient experience including FFT (Marion Andrews-Evans)*		Green
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in patient and staff FFT		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average in patient and staff FFT score		Amber
All providers of NHS funded services commissioned by GCCG participating in National Patient Survey Programme (2015/16)		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average results in National Patient Survey Programme (2015/16)		Green
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.		Green
Key performance indicators		
CCG has a programme of case reviews across urgent care, which feed into System resilience / clinical programme groups as appropriate.		Green
Focus on emergency admissions and discharge.		Green
Success criteria 4: *National targets-PROMs*		Green
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in PROMs (2015/16)		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average PROMs results (2015/16)		Green
Success criteria 5: *All active Clinical Programme Groups are working with*		Green

patients to ensure experience is incorporated into the programme and outcomes	
Key performance indicators	
All CPGs have regular 'lay' input	Green
All CPGs receive and review patient experience data	Green
Work to ensure PE is incorporated within QIPP schemes	Green
***Success criteria 6:** Develop patient experience work within primary care through working with PPGs to help inform and influence commissioning across the whole spectrum*	Green
Key performance indicators	
PPGs are informing countywide priorities and Locality developments	Green
All GP practices in Gloucestershire have a PPG by 31 March 2015	Green

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.

In October, NHS Gloucestershire CCG won the Nursing Times Patient Safety Improvement Award, and was praised by the expert judging panel for its system-wide approach to sepsis which demonstrates the role that everyone can play in the safe and effective care of people across the community. They felt that Gloucestershire's work has both depth and breadth as well sustainable impact, and that it could be replicated across the NHS.

GCCG is a 'Beacon CCG' and was one of the first CCGs to commit to the 'Sign up to Safety' campaign. The campaign is now approaching its second birthday and is truly national, stretching across 360 organisations. 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.

To further highlight the Sign up to Safety (SU2S) campaign and engage CCG member practices, the quality team are working with G-care to include medical safety alerts, educational information and safety information. G-care is considered the most appropriate medium to share this information as it is established and is the go to place for member practices. The safety section is now available in draft form and hopes to go live before Christmas.

As part of our ongoing work with the West of England Academic Health

Science Network (AHSN), the CCG has identified an 'innovator' practice within to county to work with them on improving safety reporting and associated learning in Primary Care. The AHSN project is being developed across the whole of the West of England and aims to focus GPs and practice teams on the idea of increasing openness and transparency around patient safety, which will in turn improve the patient experience.

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 data included in this report has been taken from the NHSE FFT website. All FFT data (including current and historic acute and staff FFT data) can now be found at: https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

		Aug-16		Sep-16		Oct-16	
		Provider	Nat Ave	Provider	Nat Ave	Provider	Nat Ave
GHT Inpatients	Response Rate	18.9%	25.2%	11.70%	24.60%	18.60%	24.70%
	% Recommend	95.0%	95.0%	95%	96%	95%	95%
	% Not	1.0%	2.0%	1%	2%	1%	2%
GHT A&E	Response Rate	26.7%	13.7%	25.90%	13.00%	26.60%	12.80%
	% Recommend	88.0%	87.0%	85%	86%	85%	86%
	% Not	6.0%	7.0%	8%	8%	9%	8%
GCS	Response Rate						
	% Recommend	94.0%	96.0%	94%	95%	95%	95%
	% Not	3.0%	1.0%	3%	1%	3%	1%
2g	Response Rate						
	% Recommend	86.0%	88.0%	92%	87%	91%	88%
	% Not	4.0%	4.0%	2%	5%	3%	4%

The latest data reported was in August 2016 (above). This shows a continuing increase in response rates and % recommend for the GHNHSFT A&E and Inpatient FFT. GHNHSFT awarded the FFT data collection contract to a new provider in April 2016.

3.1.4 Success criteria 3: National targets-PROMs

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical

treatment using pre- and post-operative surveys.

The four procedures are:

- hip replacements
- knee replacements
- groin hernia
- varicose veins

PROMs have been collected by all providers of NHS-funded care since April 2009.

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

PROMs casemix-adjusted scores and outliers — 2015-16 Provisional
Publication date: May 12, 2016:
Gloucestershire provider 'not an outlier' for all procedures.
http://systems.hscic.gov.uk/maps/proms/20160512_1516/index.html

Success criteria 4: All active Clinical Programme Groups are working with patients to ensure experience is incorporated into the programme and outcomes

All CCG Clinical Programme Group activity is supported by lay involvement.

The Eye Care CPG was recently shortlisted for a prestigious national award. The Lay Champion was invited to the award ceremony in London.

Success criteria 5: Develop patient experience work within primary care through working with PPGs to help inform and influence commissioning across the whole spectrum

GCCG has established a Gloucestershire Patient Participation Group (PPG) Network.

The focus of the most recent event, held on 14 October 2016, was: reducing stigma in mental health, patient facing website and social prescribing and working with the community and voluntary sector. In response to requests from PPG members, two workshops have been arranged, facilitated by PPG members themselves, on the topics of 'Developing your PPG' and 'Using online forums'. It is intended that the product of these workshops will be developed in to local fact sheets.

Members of the CCG Engagement Team have recently been invited to attend a number of individual PPG meetings to discuss developments and to provide advice and guidance. Recent discussions have focussed on a possible merger between practices and a new capital development.

4.1 Partnerships

4.1.1 Partnerships – Period up to 31st December 2016

PERSPECTIVE 3	Partnerships	Green
Success criteria 1: *Building effective partnership working by putting in place a joint planning and governance framework to improve outcomes for the Gloucestershire population*		Green
Key performance indicators		
Developing a plan for Gloucestershire, via Gloucestershire Strategic Forum, to identify the most appropriate service roadmap for Gloucestershire to take forward the five year forward view		Green
GSF work plan – develop further and deliver with partners including GCC. GSF work plan now the STP work plan.		Green
Further develop and maintain system wide BCF forum encompassing all providers across health and social care, independent sector and voluntary sector and housing.		Green
Success criteria 2: *Work with the voluntary sector alliance to take forward the work with the voluntary and community sector in Gloucestershire.*		Green
Key performance indicators		
Roll out social prescribing and build on the existing evaluation to take forward learning		Green
Develop the “kitemark” for voluntary sector organisation		Green
Develop a cultural commissioning programme in conjunction with the New Economics Foundation, National Voluntary of Community Council’s and Arts Council England		Green
Build capacity in the voluntary sector (re work with VCS)		Green
Success criteria 3: *Effective urgent care pathway to enable more patients to stay in their own home*		Green
Key performance indicators		
Effective relationships across adult social and health care to enable: i) Reduce non-elective admissions which can be influenced by effective collaboration across the health and care system.		Green
ii) Reducing inappropriate admissions of older people (65+) in to residential care		Green
iii) Rehabilitation / reablement, increase in effectiveness of these services whilst ensuring that those offered service does not decrease		Green

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.	Green
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 (Green)

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 and of providing one to one support where this is needed. 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.

This scheme is now fully operational across the county with social prescribing hub coordinators accepting referrals from all 81 GP Practices in the county and from staff in the county's 21 Integrated community Teams (ICTs) and staff from community hospitals.

The external evaluation of social prescribing by the University of the West of England (UWE) has been received and was presented to Governing Body in November. There were particularly positive impacts on the well-being of people who had participated in the programme and also a significant reduction in GP time in terms of appointments, home visits and telephone calls. In conjunction with Gloucestershire County Council the CCG has tendered the service. New providers are expected to be operating from early June 2017.

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 in excess of 60 organisations have completed the questionnaire which seeks assurance in areas such as staff training and support, policies and procedures and insurance. A graphic for a kitemark for social prescribing is now in use. The VCS Alliance undertook a survey of the impact of social prescribing on organisations in the county and the findings are included in the UWE report.

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 the summer, Arts and Cultural organisations from the VCSE were invited 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. Examples of successful applicants include singing for respiratory disease, mindfulness based art approach for chronic pain in men and a multi-art programme for young people exploring themes of social media; bullying; self-harm & violence in relationships.

Clinical Programme Groups will be working alongside clinicians, lay members and the VCSE to co-develop appropriate and effective service models. This will provide the opportunity for commissioners and the public to ensure that the pilots are designed in a way that provides meaningful and measurable outcomes.

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

The national cultural commissioning programme formally finishes in April 2016. The CCG and partners (CREATE Gloucestershire, Gloucester City Council, Tewkesbury Borough Council and the Forest of Dean District Council) have been working alongside the New Economics Foundation (NEF) and the National Council for Voluntary Organisations (NCVO) to help disseminate the work which has been undertaken in Gloucestershire. This includes contributing to national reports and presenting at a number of conferences (including the All Party Parliamentary Group for Arts, Health

and Wellbeing)

The CCG recently re-advertised two grant projects focusing on how arts and culture opportunities may reduce barriers to engaging with weight loss programmes and how arts and culture could promote confidence and healthy lifestyles for people diagnosed with colorectal and prostate cancer. Bids received are currently being evaluated. Work is ongoing to co-develop and deliver the other 9 grant projects.

Build capacity in the voluntary sector (re work with VCS)

Gloucestershire Health and Wellbeing Board and Leadership Gloucestershire have ratified a policy outlining how they will work to enable local communities to become more active, stronger and more sustainable, and in turn improve the health and wellbeing of local people. The Health and Well Being Board aims to ensure that this activity is joined up and learning is shared from community to community across the county. Its Enabling Active Communities objectives are designed to build community appetite and capacity for neighbourhood-level working, through three separate strands:

- Using existing assets e.g. workforce, buildings and community hubs;
- Building knowledge and resilience within individuals and communities and ensuring effective provision of advice and information;
- Developing local solutions – working with communities to identify local needs and how these might be better met using new or existing partnerships.

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.

4.1.4 Reduction in non-elective admissions (general and acute)

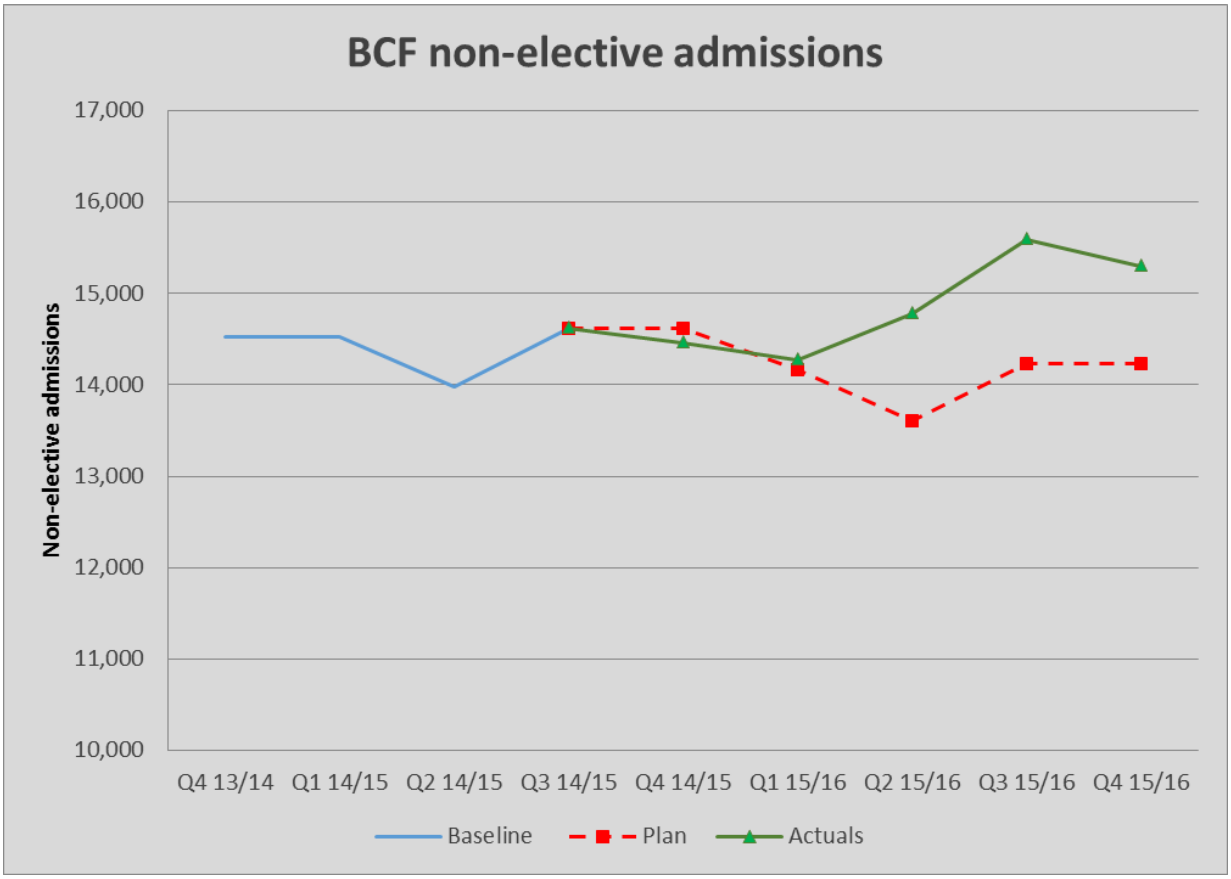
Avoidance of hospital admissions helps to ensure the most effective management of social care requirements. Minimising delayed transfers of care and avoidable admissions transforms the quality of care of individuals, enabling service users to receive the most appropriate care in the most appropriate location.

Within Gloucestershire we have seen 2.5% growth in non-elective admissions over the period January 2014 to December 2015. The 2.5% has been calculated using the

defined BCF metrics (based on providers monthly activity returns MAR).

The Gloucestershire BCF plans for reducing non-elective admissions are aligned with the Gloucestershire CCG and Gloucestershire Hospitals NHSFT plans for 2016/17.

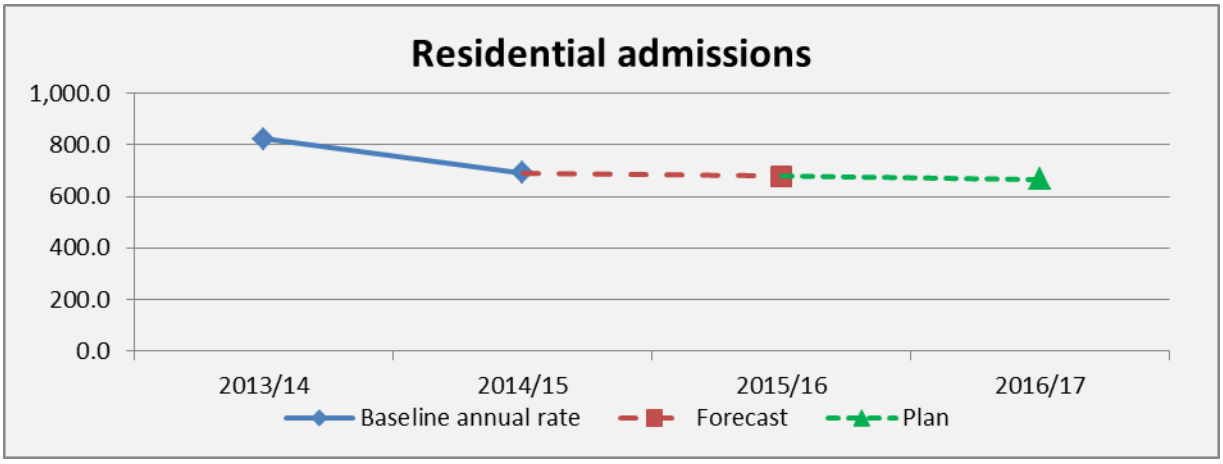
Gloucestershire CCG's plan is for a 1.6% reduction in non-elective admissions. Within this assumption growth is 2.5%, while revised contract baseline and admission avoidance schemes are estimated to make a 4% reduction.



Reducing inappropriate admissions of older people (65+) into residential care

This 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.

Gloucestershire plans to continue the trend in the reduction of service users entering residential and nursing care. The CCG forecast for 2015/16 was a 2% reduction on the 2014/15 baseline, which equates to a 17% reduction on the BCF baseline period.

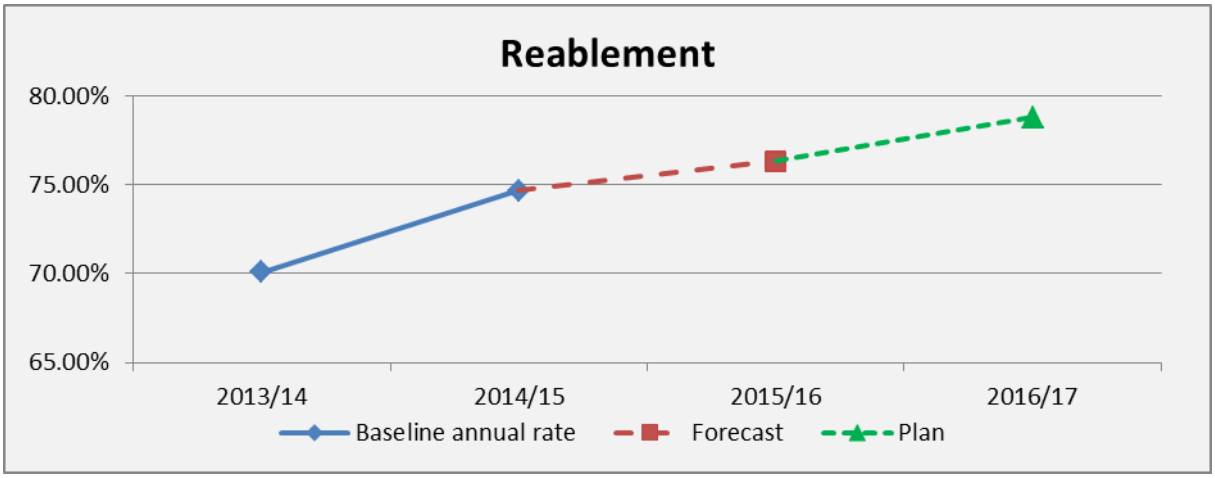


Increase in the number of people at home 91 days post discharge

This 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 proportion of people who were still at home 91 days after discharge increased by 4.6% during 2014/15, the plan is to improve to meet the south west average which represents a 4.1% increase by the end of 2016/17.

Focus and prioritisation continue in this area to ensure we have robust preventative and crisis management services in the community, in particular effective re-ablement services that support people post-discharge and help them to achieve their full potential recovery.



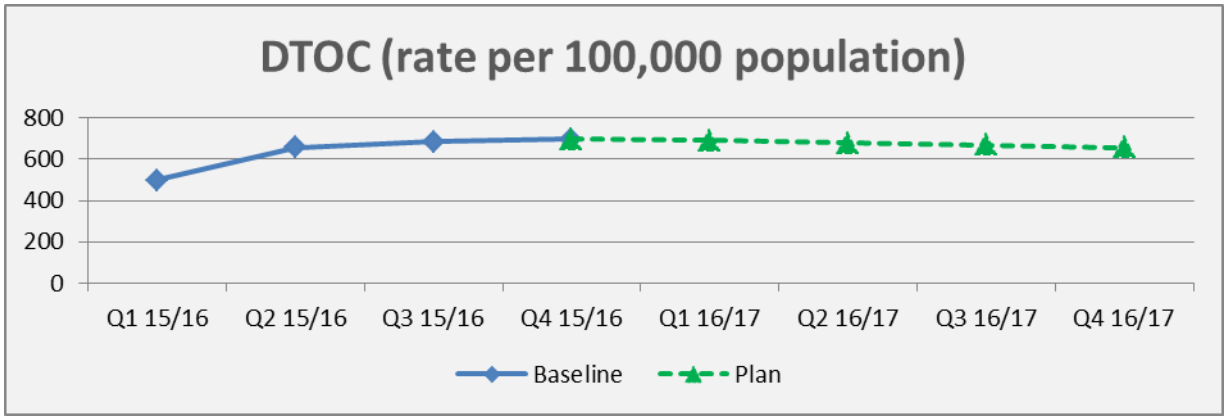
Reduction in Delayed Transfers of Care (DTOC)

This indicator is based on the ASCOF Delayed transfers of care from hospital per 100,000 population metric.

Gloucestershire performance on delayed transfers compares favourably to the England average. The next version is due for publication Autumn 2016 but was not yet published as at 15th November 2016.

Figures available on the NHS England website show the total number of Delayed transfers of care for Gloucestershire by quarter and this is provided below.

Period	Total DTOCs (Acute + Non-Acute)	Change	% Change
Q4 2015/16	3,564		
Q1 2016/17	4,062	+498	+14%
Q2 2016/17	5,886	+1,824	+45%



Across 2016/17 we have shown a 5% reduction from the Quarter 4 positon across the year as this is an area of focus for our system.

Improved Patient Experience

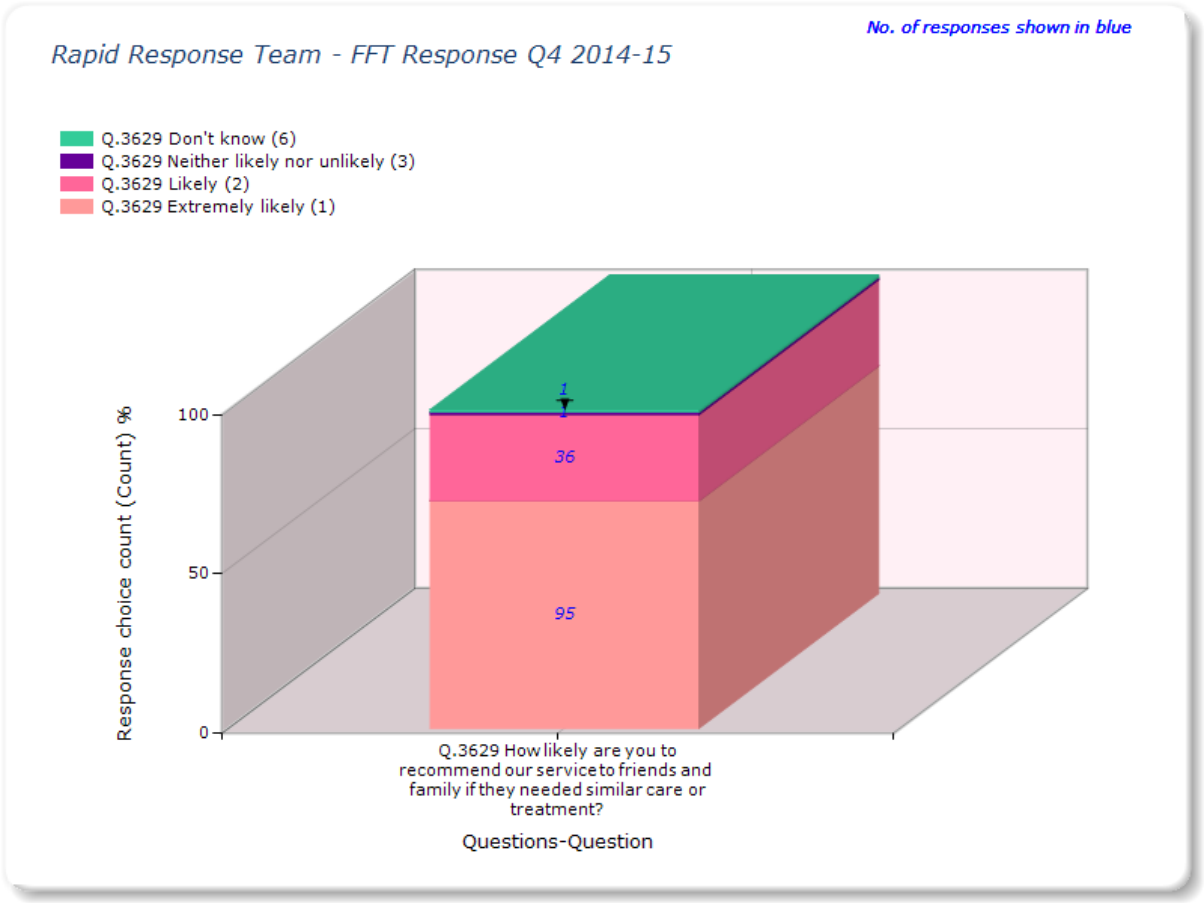
This is a locally set metric based on the Gloucestershire Care Services Integrated Community Teams Rapid Response Experience Comment Card.

The expectation is that this metric will assess the services ability to look at individual patient needs and improved health and social care outcomes.

A baseline was recorded during quarter 4 of 2014/15, with the following question asked of ICT rapid response clients, 'How likely are you to recommend our service to friends

and family if they needed similar care or treatment':

2014/15 baseline results: 131/133 clients (98.5%) provided a positive response (95 extremely likely and 36 likely)



The latest results collated at the end of December 2015 indicate that from the 1st of April 98.93% of respondents have provided a positive response.

The main question is supported by 6 further questions based on NHS voices:

1. I always knew who the main person in charge of my care was
2. I didn't need to keep repeating how I was feeling and explain what I needed to different people
3. I was involved in discussions and decisions about my care as much as I wanted to be
4. Information was given to me when I wanted it
5. The information given to me was appropriate to my condition and circumstances
6. I feel the people I met were kind to me

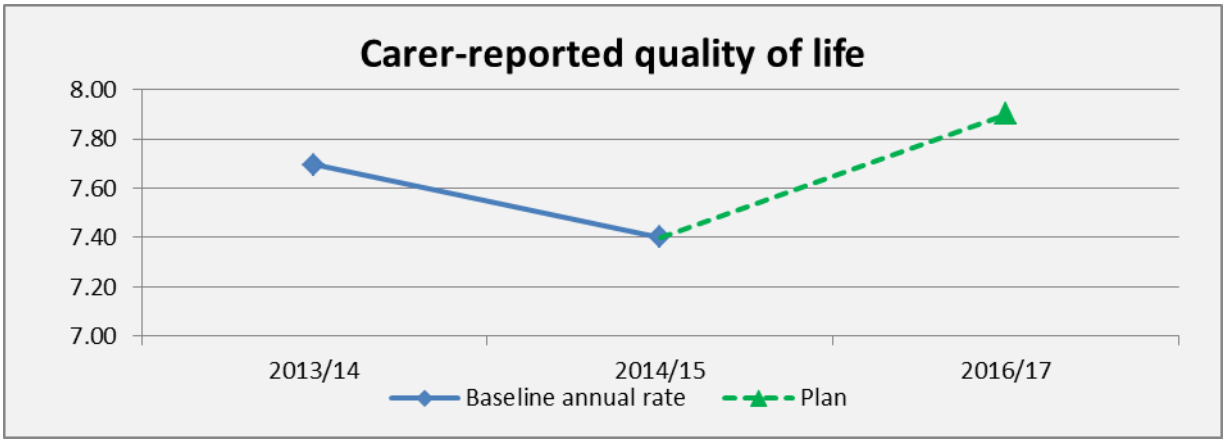
The plan for 2016/17 is to increase the response rate from 14.6% during 2015/16 to 15% in 2016/17; this is in line with the national guidance on the Friends and Family test.

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.

Results for the 2014/15 survey showed a 3.8% reduction in quality of life from the 2012/13 baseline. The plan for 2016/17 is to reach the England average by meeting the original BCF target of 7.9 (6.4% increase on 2014/15). This will be assessed when the Bi-annual survey results for 2016/17 are published due Autumn 2016.



Carers Gloucestershire hosts the Gloucestershire Carers Alliance whose mission is to provide a strong, independent, diverse and inclusive carer-led and carer-centred group influencing policy and services to improve outcomes for all carers. Plans are in place to further develop relationships with the Alliance/Carers Gloucestershire to provide a route through which providers and commissioners of services can engage and hear views and feedback from carers.

All of the 'carers' services' contracts include satisfaction surveys and are showing a strong positive response, with an increase in the number of carer's assessments undertaken and evidence of meeting the 6 week target from referral to assessment. In addition, each contract in turn will be subject to a carer peer group evaluation, which includes monitoring of contracts and interviews with carers.

5.1 Staff

Staff – Period to 31st December 2016

PERSPECTIVE 4	Staff	Green
Success criteria 1: *Attracting and retaining high quality staff aligned to the CCGs vision and values*		Green
Key performance indicators		
Turnover - % of employees leaving the organisation		0.98%
Number of current Vacancies in structure		4
Success criteria 2: *Personal development processes that are linked to the strategic plan*		**Green**
Key performance indicators		
All staff should have a PDP (90% target) and should have had an appraisal in the last 12 months		**Audit underway**
95% of staff who have completed their mandatory training by the end of March 2017		
Success criteria 3: *Staff are Happy and Motivated*		Green
Key performance indicators		
Staff sickness levels		3.0%
Staff Survey		**Completed**
Completion of updated OD plan		**Completed**

5.1.2 Attracting and retaining high quality staff aligned to the CCGs vision and values

Monthly turnover in December was 0.98%. The number of leavers since the 1st April is 25, giving a monthly average of 2.78 leavers per month.

As at the end of December 2016, there were 4 jobs 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. A full audit is underway to ensure all PDPs have been completed and recorded. Once records are updated, a review against strategic objectives will take place.

5.1.4 Staff are Happy and Motivated

Staff survey has taken place, and the results are being collated and will be reported on shortly.

Staff sickness levels for December are 2.43 %, and year to date is 3.0% meets the GCCG target.

6.1 Perspective 5. Finance and Efficiency

6.1.1 Finance and efficiency – Period to 31st December 2016

Summary:

Perspective 2	Finance & Efficiency	Amber

Success critieria: To ensure a financially viable commissioning organisation with an underlying recurrent surplus			Amber
	Threshold	Lower threshold	RAG
Underlying recurrent surplus (%age)	2%	1%	Amber
Surplus - year to date variance to planned performance (%age)	0.10%	0.50%	Green
Surplus - full year variance to planned performance (%age)	0.10%	0.50%	Green
Running costs year to date (variance to running costs allocation)	Within RCA		Green
Running costs forecast outturn (variance to running costs allocation)	Within RCA		Green
BPPC performance on non-NHS invoices by value (year to date)	95%	80%	Green
Cash drawdown in line with planned profiles (%age variance)	2%	5%	Green
Success critieria: QIPP Full year Forecast			**Amber**
	Threshold	Lower threshold	RAG
QIPP - full year forecast delivery to planned performance (%)	95%	75%	Amber

- The CCG is forecasting to deliver a surplus of £9.456m, which is in line with the plan. There are significant risks to the achievement of the financial plan.

- Known risks and pressures have been fully assessed and included within the CCG's position with mitigating actions where appropriate. There is slippage on QIPP schemes within the financial year.

- Financial risks are managed through a continuous review of budgets and proposed investments and the use of the CCG's contingency reserve. All budgets and discretionary CCG expenditure has been and continues to be reviewed.

- A revised urgent care reset plan has been developed by the community to address urgent care over performance which is forecast to impact on the

financial position, this assessed impact has been included in the financial forecast

- A revised prescribing plan has been developed and the part year impact included in the financial forecast

- The better payment practice code performance (for non-NHS invoices by volume) is in line with the targeted figure.

Key risks:

- Provider contracts over perform in excess of those levels provided within the year end forecast

- Further slippage on QIPP schemes (noting that the current RAG ratings are embedded within current financial forecasts)

- The urgent care reset plan does not have the forecast financial impact

- Prescribing costs are volatile and there is a risk that the current growth trend will change and the revised prescribing plan will not have the forecast impact.

The overall assessment for the finance and efficiency perspective is amber, more detail is provided in the following sections.

6.2 Resources

The CCG's resource limit (see Appendix 2) is £836.1m. This includes all primary care co-commissioning delegated budgets. There was an additional allocation for Quality Premium relating to 2015/16 totalling £511k.

6.3 Expenditure

The financial summary as at 31st December 2016 shows a year to date surplus of £7.092m; which is in line with the plan. Further detail is shown at Appendix 3. Key budget areas with either a significant financial risk or forecast outturn variance are highlighted below:

Key ↑ Indicates a favourable movement in the month ↓ Indicates an adverse movement in the month	**Trend**	**Forecast Over/ (Under) Spend £'000**
Gloucestershire Hospitals NHSFT		
The CCG and GHFT have agreed on an outturn settlement for 2016/17 of £305m, equal to the contractual value. This reduces the risk on achieving the surplus considerably.	→ ←	£0

Initiatives within the urgent care reset plan such as the GP in ED and rapid response at the front door, have been impacting since August and the run rate for emergency activity is now lower and expected to be maintained at this level.

The outpatient follow up project is now also impacting with reductions being seen in some specialties.

Excluded drugs is underspending, this includes the impact of the project on biosimilars and biologics.

The recurrent impact of the contract, including agreed coding changes, continues to be monitored and has been brought into the contract proposal for 2017/18.

Great Western Hospital NHST

There is over-performance in all areas of the contract:

- Elective surgery over performance due to general surgery and T&O.
- Non elective activity within geriatric medicine, T&O multi trauma and general medicine.
- Adult critical care

The CCG and Trust have reached an agreement on an outturn value for this contract at £9,063k and therefore any changes in activity will not impact financially in 2016/17.

Oxford University Hospital NHSFT

Performance has improved from last month however there remain overspends in all areas of the contract.

- Emergency activity
- Maternity
- Elective activity, within spinal surgery, colorectal surgery and T&O
- Day cases within gynaecology, respiratory medicine and clinical haematology
- Non elective activity within nephrology, T&O major hip, general surgery, gastroenterology, paediatrics and general medicine specialties.
- Drugs, predominantly Adalimumab, Vedolizumab and Idelalisib.

A formal letter is being raised regarding a shift in activity from non elective activity when the AAU opened and further clarification has been sought regarding coding of planned

care outpatients and the increased usage of Vedolizumab.

There are a number of long stay patients, including critical bed days, which have been included within the forecast.

University Hospital Bristol NHST

Small underspends are continuing in day case procedures for blood & marrow transplant, cardiology & gastroenterology. However, there are overspends in the following areas which offset this position:

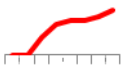
- Elective inpatient care within clinical haematology and cardiology
- Non elective care in cardiology, paediatric surgery.
- Non PbR in adult critical care and high cost drugs and devices.

£65

Winfield Hospital

There has been a substantial adverse movement in the forecast overspend. Overall the activity stands as follows:

- Elective activity is up by 186 spells in general surgery, T&O and spinal surgery
- Outpatient attendances are up by 2,045 in spinal, urology and T&O specialties.



£1,292

Some of this movement reflects transfers of patients to achieve the RTT waiting times and it is anticipated that these transfers will continue in order to help alleviate pressure in other providers.

North Bristol NHST

Activity levels have increased from a breakeven position to a significant overspend.

The key pressures are:

- Elective admissions in plastic surgery reconstruction,
- Non electives admissions in T&O and nephrology
- Non PbR costs relating to wheelchair maintenance.

Underspends are being experienced in

- Elective T&O and
- Non elective general medicine
- Non PbR in Adult Mental Health

£260

University Hospital Birmingham NHSFT

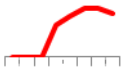
The forecast overspend on this contract has remained relatively static this month with overspends being reported in:

- Day cases in hepatobiliary/pancreatic procedures with immediate complications.

£127

- Drugs, primarily antifibrinolytic and haemostatic blood products.

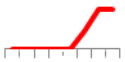
There are small underspends within pancreatic surgery that slightly mitigate the overspend elsewhere.



Non Contracted Activity

The forecast for Non Contracted Activity is based on the last three years activity trends, and this month's forecast is showing a marginal improvement from previous months. The pressure is mainly seen within the following provider organisations :

- Salisbury NHS FT from delayed discharge fees associated with spinal patients
- Abertawe Bro Morgannwg Uni LHB
- Royal Cornwall Hospital NHST
- Greater Glasgow & Clyde NHST

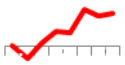


£570

Planned Care – Any Qualified Provider

The overspend is predominantly within the following contracts:

- **GP Care (Urology)** has increased its capacity from 43 patients to 220 per month and this is to continue to March 17. This is enable patients on the GHFT backlog waiting list to be seen in a more timely manner.

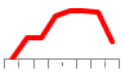


£304

- **Cobalt** – This reflects a decision by GHNHSFT to suspend access by GPs to the MRI service, which has resulted in this being undertaken at the Cobalt facility. This is anticipated to continue until the end of March.

Mental Health Non Contract Activity

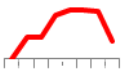
A substantial improvement has been experienced due to challenges being resolved with Avon & Wiltshire Mental Health Partnership Trust and it is anticipated spend going forward of £7k per month rather than the original £46k.



£259

Learning Difficulties

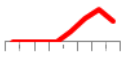
A significant improvement in the position this month predominantly due to transforming care patients where start dates have been moved into the next financial year



£40

Children and Mental Health Services

One to one nursing care has shown an Improvement from the previous month but this is not anticipated to be recurrent and continues to be the main pressure area, along with non-

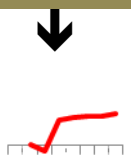


£151

contracted activity.

Continuing Healthcare

The main pressure areas are domestic care and funded nursing care which are marginally offset by underspends within physical disabilities and adult fully funded continuing health care positions.
A national review of Funded Nursing Care is anticipated for January 2017 and the outcome is awaited.



£2,886

Prescribing

When comparing October 2016 against October 2015, there has been a further decrease in growth of 5.66% for the month itself. This has the effect of decreasing the year to date growth in cost terms to -1.23% (from - 0.42%). The overall forecast underspend for primary care prescribing has reduced as a result primarily of the forecast savings relating to Category M Drugs.

Clinical pharmacists are now in post in a number of areas and the roll out of the Optimise Rx system is progressing, both these initiatives are starting to show an impact in expenditure within the relevant practices.

(£1,263)

Running costs

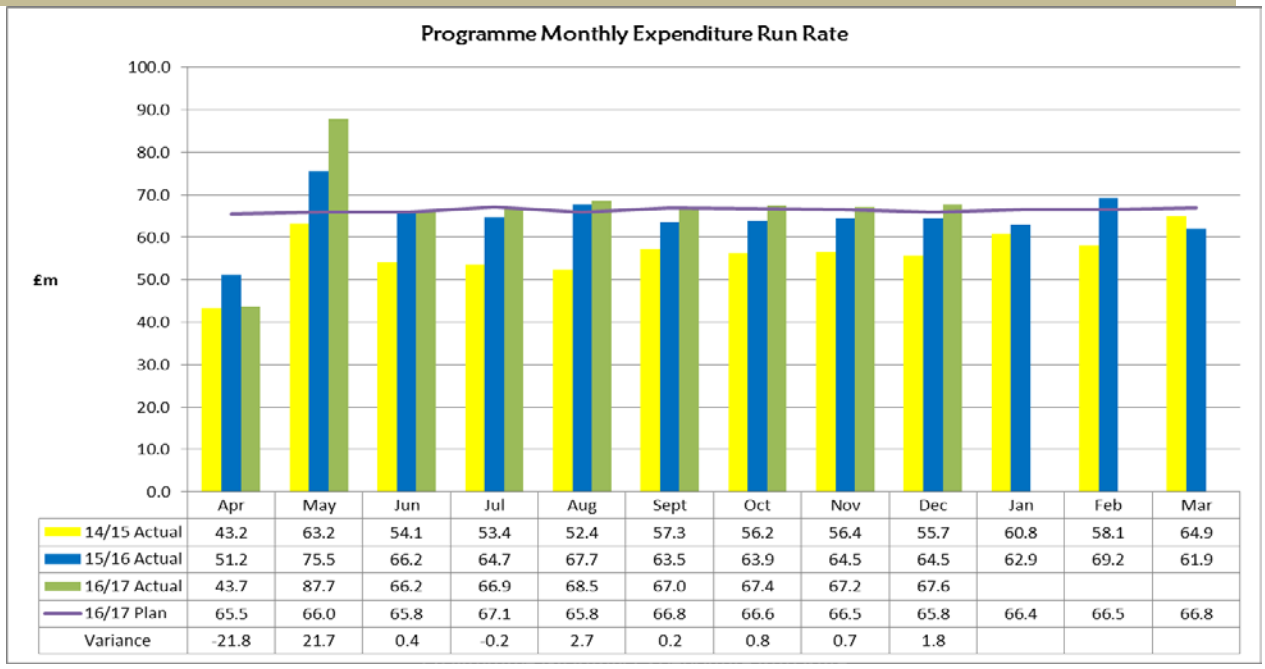
This area has improved slightly this month with a reported underspend predominantly due to slippage on recruiting to vacancies.

(£215)

6.4 **QIPP (Appendix 4)**

Based on the information available indications are that there is slippage against the plan of £3.23m. The urgent care reset schemes, including the GP in ED and rapid response at the front door, have been included within this position.

6.5 Run Rate



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
14/15 Actual	43.2	63.2	54.1	53.4	52.4	57.3	56.2	56.4	55.7	60.8	58.1	64.9
15/16 Actual	51.2	75.5	66.2	64.7	67.7	63.5	63.9	64.5	64.5	62.9	69.2	61.9
16/17 Actual	43.7	87.7	66.2	66.9	68.5	67.0	67.4	67.2	67.6			
16/17 Plan	65.5	66.0	65.8	67.1	65.8	66.8	66.6	66.5	65.8	66.4	66.5	66.8
Variance	-21.8	21.7	0.4	-0.2	2.7	0.2	0.8	0.7	1.8			

The graph above highlights the expenditure relating to programme budgets for this and the previous two financial years, compared to the resource available for programme excluding any reserves and the surplus. The in-month position in December shows that programme spend is above anticipated levels by £1.8m. Cumulatively the CCG is still above estimated spend for Programme by £6.2m. Additional QIPP schemes have been implemented and a review of discretionary spend is being undertaken to counteract this.

6.6 Cash (Appendix 5)

At the end of December, the CCG has drawn down 75.4% of the total cash limit which is only slightly higher than a straight line trajectory. This is due to the timing of payments made to Gloucestershire County Council for the Better Care Fund. The cash balance at the end of December was £6.69m.

6.7 Better Payment Practice Code (Appendix 6)

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 98.62% invoices paid by value and 97.49% by volume; both being on target.

6.8 Statement of Financial Position (Appendix 7)

The position shown includes the audited opening balances from the 15/16 Annual Accounts.

6.9 Financial Risk

Risks to the achievement of the financial forecast are:

- Contract Performance
  A large number of the CCG contracts are variable and there is an ongoing risk of over performance against the contracted value, both in planned and in urgent care. There are a number of challenges that have been raised with providers that have yet to be resolved. The agreement with GHFT has mitigated some of this financial risk.

- Prescribing
  The prescribing forecast is on plan, whilst growth rates have been decreasing this is a volatile budget and growth rates can change significantly in a month, other factors are national changes to category M drug prices and changes to NICE guidance.

- Funded Nursing Care
  On 13 July, a 40% increase to the FNC rate was announced by Department of Health, back dated to 1st April. The impact on the CCG is an unplanned pressure of approximately £3.2m which is included within the current position. The rates will be reviewed further in January 2017.

- 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 further slippage to the programmes. The forecast includes the impact of the urgent care reset and follow up programme, these schemes are heavily dependent on partner input, if these benefits are not realised then this will impact on the overall financial position.

- Estates
  New national arrangements have been undertaken this year to charge on a market rent basis which could leave the CCG with a significant pressure that nationally NHS England has agreed to fund non recurrently this year however we are currently awaiting formal confirmation that quantifies the level of support.

Appendices:

Ref	Description
1	GCCG Dashboard 2016/17
2	Resource Limit Position
3	Summary Financial Position
4	QIPP Programme
5	Cash
6	Better payment practice code
7	Statement of Financial position

Gloucestershire CCG 2016/17 Integrated Performance Scorecard

Appendix 1

Target	Principal Delivery Targets		2015-16 Outturn	Apr-16	May-16	Jun-16 / Q1	Jul-16	Aug-16	Sep-16 / Q2	Oct-16	Nov-16	Dec-16 / Q3	Jan-17	Feb-17	Mar-17 / Q4	Year / Quarter to date	Year End Forecast
Unscheduled Care																	
Accident & Emergency																	
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		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		GRH Attendances		6,926	7,621	7,355	7,638	7,232	7,136	7,471	7,090	6,965				65,434	65,434
		GRH Breaches		1,113	1,320	1,186	1,379	948	1,086	1,266	1,251	2,223				11,772	11,772
		GRH %	5	83.9%	82.7%	83.9%	81.9%	86.9%	84.8%	83.1%	82.4%	68.1%				82.0%	82.0%
		CGH Attendances		3,851	4,233	3,988	4,331	4,103	4,167	4,226	3,951	3,867				36,717	36,717
		CGH Breaches		463	172	282	297	111	164	367	223	607				2,686	2,686
		CGH %	0	88.0%	95.9%	92.9%	93.1%	97.3%	96.1%	91.3%	94.4%	84.3%				92.7%	92.7%
		GHNHSFT Attendances		10,777	11,854	11,343	11,969	11,335	11,303	11,697	11,041	10,832				102,151	102,151
		GHNHSFT Breaches		1,576	1,492	1,468	1,676	1,059	1,250	1,633	1,474	2,830				14,458	14,458
		GHNHSFT %	5	85.4%	87.4%	87.1%	86.0%	90.7%	88.9%	86.0%	86.6%	73.9%				85.8%	85.8%
		GCS - MIU Atts		5,771	6,774	6,473	7,377	6,882	6,396	6,070	5,422	5,575				56,740	56,740
		GCS - MIU Breaches		25	17	22	30	31	27	22	18	24				216	216
		GCS - MIU %	0	99.6%	99.7%	99.7%	99.6%	99.5%	99.6%	99.6%	99.7%	99.6%				99.6%	99.6%
		PC in ED Attendances		244	345	268	279	326	349	295	390	316				2,812	2,812
		PC in ED Breaches		0	0	0	0	0	0	0	0	0				0	0
		PC in ED %		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%
		Overall ED Attendances		16,792	18,973	18,084	19,625	18,543	18,048	18,062	16,853	16,723				161,703	161,703
		Overall ED Breaches		1,601	1,509	1,490	1,706	1,090	1,277	1,655	1,492	2,854				14,674	14,674
		Overall ED %		90.5%	92.0%	91.8%	91.3%	94.1%	92.9%	90.8%	91.1%	82.9%				90.9%	90.9%
E.B.S.5	**12 hour trolley waits** (no A&E attender should wait more than 12 hours from the decicision to admit to admission)	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		GRH		0	0	0	0	0	1	0	0					1	2
		CGH		0	0	0	0	0	0	0	0					0	0
		GHNHSFT total		0	0	0	0	0	0	0	0					1	1
		GCS - MIU		0	0	0	0	0	0	0	0					0	0
Ambulance																	
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%
		SWASFT %		72.7%												72.7%	72.7%
		Glos %		63.2%												63.2%	63.2%
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%
		SWASFT %		56.9%												56.9%	56.9%
		Glos %		54.9%												54.9%	54.9%
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%
		SWASFT %		86.1%												86.1%	86.1%
		Glos %		87.2%												87.2%	87.2%
	SWASFT Ambulance Response Programme (Trial) - **Red**	SWASFT Red Responses		1,636	3,937	3,689	4,009	3,631	3,563							20,465	20,465
		SWASFT Red Resp < 8 mins		1,092	2,718	2,577	2,644	2,510	2,488							14,029	14,029
		SWASFT Red %		66.7%	69.0%	69.9%	66.0%	69.1%	69.8%							68.6%	68.6%
		Red 50th Percentile (mins)		6.6	6.3	6.3	6.6	6.3	6.3							6.4	6.4
		Red 75th Percentile (mins)		9.2	9.0	8.8	9.6	8.9	8.9							9.1	9.1
		Red 95th Percentile (mins)		18.0	16.7	15.8	17.8	17.2	16.8							17.1	17.1
	SWASFT Ambulance Response Programme (Trial) - **Amber**	Total Amber Responses		19,350	53,454	50,855	54,357	52,236	50,878							281,130	281,130
		Amber Transport Responses		3,879	9,099	8,530	8,997	7,522	6,730							44,757	44,757
		Amber T - 50th percentile (mins)		22.2	23.0	22.8	24.8	21.5	22.3							22.8	22.8
		Amber T - 75th percentile (mins)		42.8	44.5	43.0	48.1	42.7	42.6							44.0	44.0
		Amber T - 95th percentile (mins)		109.5	110.3	103.7	119.3	104.3	103							108.4	108.4
		Amber Response Responses		12,178	35,954	33,794	36,115	24,184	22,689							164,914	164,914
		Amber R - 50th percentile (mins)		19.7	22.3	21.8	23.1	20.5	20.4							21.3	21.3
		Amber R - 75th percentile (mins)		36.5	41.5	40.6	43.3	38.2	37.5							39.6	39.6
		Amber R - 95th percentile (mins)		85.2	94.6	91.5	100.6	86.2	84.6							90.5	90.5
		Amber F2F Responses		3,293	8,401	8,531	9,245	20,530	21,459							71,459	71,459
		Amber F2F - 50th percentile (mins)		15.2	16.7	17.2	18.8	19.8	21							18.1	18.1
		Amber F2F - 75th percentile (mins)		29.1	31.7	32.3	36.7	36.3	37							33.8	33.8
		Amber F2F - 95th percentile (mins)		74.6	78.9	77.5	95.6	86.8	84							82.9	82.9
	SWASFT Ambulance Response Programme (Trial) - **Green**	Total Green Responses		4,715	12,682	12,229	13,112	12,713	11,740							67,191	67,191
		Green Face to Face Responses		670	1,593	1,424	1,410	1,064	852							7,013	7013
		Green F2F - 50th percentile (mins)		37.0	36.4	34.9	37.1	32.9	33.4							35.3	35.3
		Green F2F - 75th percentile (mins)		77.1	79.4	69.2	76.4	79.3	77.3							76.5	76.5
		Green F2F - 95th percentile (mins)		183.9	207.8	172.3	222.9	203.1	211.1							200.2	200.2
		Green Transport Responses		571	1,469	1,385	1,531	1,853	1,951							8,760	8,760
		Green T - 50th percentile (mins)		47.7	48.9	48.0	49.2	47.8	49.8							48.6	48.6
		Green T - 75th percentile (mins)		88.8	99.1	90.6	97.7	97.3	98.7							95.4	95.4

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Appendix 1

Target	Principal Delivery Targets		2015-16 Outturn	Apr-16	May-16	Jun-16 / Q1	Jul-16	Aug-16	Sep-16 / Q2	Oct-16	Nov-16	Dec-16 / Q3	Jan-17	Feb-17	Mar-17 / Q4	Year / Quarter to date	Year End Forecast
		Green T - 95th percentile (mins)		218.3	230.7	199.8	234.9	226.7	223.8							222.4	222.4
		Green Hear & Treat Responses		2,062	6,198	5,620	6,327	6,076	5,209							31,492	31,492
		Green H - 50th percentile (mins)		5.6	6.4	6.0	7.3	5.9	6.6							6.3	6.3
		Green H - 75th percentile (mins)		15.4	17.7	17.7	23.5	17.4	19.7							18.6	18.6
		Green H - 95th percentile (mins)		51.2	58.2	63.5	74.6	61.5	67.9							62.8	62.8
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
		Actual		153	173	141	191	122	149	177	122					1228	1228
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
		Actual		0	2	9	10	6	7	6	1					41	41
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
		Actual		190	227	217	266	263	238	256	375					2032	2,032
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
		Actual		19	14	16	19	16	18	16	40					158	158
Delayed Transfers of Care (DTOC)																	
Local	Number of Delayed Transfers of Care for acute patients	Acute target		14	14	14	14	14	14	14	14	14	14	14	14	14	14
		Acute actual	13.6	23	12	16	35	22	36	45	47	36				30	30
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	Acute only	0	0	0	0	0	0	0							0	0
Local	Number of Delayed Transfers of Care for non-acute patients	Non-acute target		10	10	10	10	10	10	10	10	10	10	10	10	10	10
		Non-acute actual		2	3	4	5	8	7	15	21	16					0.0
Harmoni 111																	
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%
		Actual	92.4%	85.6%	92.2%	93.5%	91.3%	95.8%	96.0%	98.2%	98.0%						
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%
		Actual	1.7%	3.3%	1.5%	1.2%	2.0%	0.6%	0.9%	0.3%	0.5%						
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%
		Actual	84%	81.7%	81.3%	80.7%	79.2%	80.9%	82.5%	80.9%	82.4%						
Local	% calls referred to ED	Target		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
		Actual	6.0%	6.4%	6.1%	6.3%	6.6%	6.5%	7.0%	7.0%	7.3%						
Local	Calls warm transferred	Target		26.0%	30.2%	33.3%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
		Actual	38.2%	26.9%	32.3%	34.1%	28.8%	46.3%	39.2%	44.9%	44.4%						
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
		Actual	-	00:10:46	00:11:19	00:09:29	00:08:47	00:12:46	00:06:40	00:05:08	00:06:07						
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
		Actual	-	00:05:12	00:06:31	00:05:20	00:05:03	00:09:06	00:06:01	00:08:09	00:06:33						
Planned Care																	
Acute Care Referral to Treatment																	
E.B.1	Percentage of admitted non adjusted pathways treated within 18 Weeks	Target		-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Actual		83.4%	82.9%	78.7%	80.0%	79.9%	78.7%	78.6%	78.7%					81.3%	81.3%
E.B.S.4	Number of completed admitted non adjusted pathways greater than 52 weeks	Target		-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Actual	-	3	5	6	5	6	7	10	8						
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%	95.0%
		Actual		91.4%	91.5%	91.4%	89.8%	89.3%	86.4%	85.5%	87.4%					91.0%	91.0%
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
		Actual	-	2	3	10	13	10	7	15	18						0
Local	Number of specialties where non-admitted standard was not delivered	Actual	-	14	14	14	14	17	15	14	14						
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%
		Actual		92.7%	92.7%	92.8%	92.0%	92.1%	91.5%	91.0%	88.3%					92.6%	92.6%
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
		Actual	-	10	12	9	13	8	10	11	8						
Local	Number of specialties where incomplete standard was not delivered	Actual	-	9	7	7	6	7	8	8	11						
Cancelled Operations																	
E.B.S.2	**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	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		Actual	-	20	7	8	4	4	2	3							
E.B.S.6	**Urgent operations cancelled for a second time** - number of urgent operations that are cancelled by the trust for non-clinical	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0

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Target	Principal Delivery Targets		2015-16 Outturn	Apr-16	May-16	Jun-16 / Q1	Jul-16	Aug-16	Sep-16 / Q2	Oct-16	Nov-16	Dec-16 / Q3	Jan-17	Feb-17	Mar-17 / Q4	Year / Quarter to date	Year End Forecast
E.B.3.0	reasons, which have already been previously cancelled once for non-clinical reasons	Actual	-	*currently not receiving data from GHFT*													
Diagnostics																	
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%
		Actual breaches		414	119	126	52	65	203	146	78					1,203	1,203
		Actual Perf		4.5%	1.3%	1.4%	0.6%	0.8%	2.5%	1.9%	1.0%					2.0%	2.0%
Cancer Waits																	
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%
		Actual breaches		353	226	151	165	244	190	184	116					1,629	1,629
		Actual Perf		78.0%	86.6%	90.6%	90.1%	85.8%	88.4%	89.1%	93.5%					86.3%	86.3%
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%
		Actual breaches		11	11	19	14	13	6	8	15					97	97
		Actual Perf		95.0%	94.7%	90.9%	91.5%	92.7%	96.3%	95.6%	92.1%					93.1%	93.1%
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%
		Actual breaches		4	1	3	2	1	3	6	14					34	34
		Actual Perf		98.4%	99.6%	98.9%	99.1%	99.6%	99.0%	97.7%	95.4%					99.0%	99.0%
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%
		Actual breaches		1	0	0	0	0	0	0	4					5	5
		Actual Perf		98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.8%					99.6%	99.6%
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%
		Actual breaches		1	0	0	0	0	0	0	0					1	1
		Actual Perf		98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					99.6%	99.6%
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%
		Actual breaches		0	0	1	0	0	2	0	0					3	3
		Actual Perf		100.0%	100.0%	98.1%	100.0%	100.0%	94.7%	100.0%	100.0%					99.5%	99.5%
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%
		Actual breaches		27	33	27	32	27	32	34	34					246	246
		Actual Perf		80.1%	76.1%	81.8%	74.8%	79.5%	78.1%	73.6%	79.8%					78.3%	78.3%
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%
		Actual breaches		2	3	1	0	3	0	3	0					12	12
		Actual Perf		91.7%	83.3%	95.0%	100.0%	90.9%	100.0%	85.7%	100.0%					92.6%	92.6%
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%
		Actual breaches		0	0	0	2	0	0	1	0					3	3
		Actual Perf		100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	90.0%	100.0%					88.2%	88.2%
Long Term conditions																	
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%
		Glos		84.6%	89.0%	83.8%	86.2%	96.2%	84.0%	85.7%							
E.A.S.1	Dementia diagnosis rate	Target		66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%
		Numerator		5,633	5,636	5,616	5,650	5,686	5,750	5,767	5,820						
		Denominator		8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530		
		Glos		66.0%	66.1%	65.8%	66.2%	66.7%	67.4%	67.6%						44.51%	
Community Care Referral to Treatment (GLOUCESTERSHIRE only)																	
Paediatric																	
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%
		Actual		95.9%	92.8%	99.5%	98.7%	97.1%	99.1%	99.3%	98.8%					97.7%	97.7%
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%
		Actual		97.2%	97.4%	96.9%	96.7%	100.0%	95.2%	96.2%	96.9%					97.1%	97.1%
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%
		Actual		97.6%	98.3%	99.1%	97.2%	98.2%	94.0%	92.3%	87.9%					95.6%	95.6%
Adult																	
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%
		Actual		84.8%	88.6%	94.1%	100.0%	97.1%	98.9%	98.1%	98.7%					95.0%	95.0%
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%
		Actual		99.2%	99.3%	97.6%	92.6%	95.0%	96.0%	97.0%	96.6%					96.7%	96.7%
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%
		Actual		90.8%	90.5%	89.9%	92.8%	94.9%	94.6%	92.4%	91.8%					92.2%	92.2%
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%
		Actual		93.6%	93.9%	92.7%	92.5%	90.3%	88.3%	88.6%	91.9%					91.5%	91.5%
Specialist Nurses																	
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%
		Actual		100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					98.8%	98.8%

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Target	Principal Delivery Targets		2015-16 Outturn	Apr-16	May-16	Jun-16 / Q1	Jul-16	Aug-16	Sep-16 / Q2	Oct-16	Nov-16	Dec-16 / Q3	Jan-17	Feb-17	Mar-17 / Q4	Year / Quarter to date	Year End Forecast
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%
		Actual		95.8%	95.0%	100.0%	95.9%	100.0%	96.0%	100.0%	100.0%					97.8%	97.8%
Mental Health and Learning Disabilities																	
Adults of Working Age																	
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				95.0%			95.0%			95.0%			95.0%	95.0%	95.0%
		Glos				98.2%			97.2%								0.0%
Improving Access to Psychological Therapies (IAPT)																	
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%	3.75%	3.8%
		Glos actual				2.1%			3.7%							2.1%	2.1%
E.A.S.2	The proportion of people who complete therapy who are moving towards recovery	Glos target				25.8%			33.5%			41.2%			50.0%	50.0%	50.0%
		Glos actual				53.0%			44.0%							53.0%	53.0%
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				75.1%			75.1%			75.1%			75.1%	75.1%	75.1%
		Glos actual	-			35.0%			31.0%							35.0%	35.0%
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				95.1%			95.1%			95.1%			95.1%	95.1%	95.1%
		Glos actual	-			90.0%			82.0%							90.0%	90.0%
Quality																	
Quality Indicators																	
E.B.S.1	Eliminate mixed-sexed accommodation breaches at all providers sites (patients)	CCG		60	0	26	19	17	0	0	24						
		GHFT		69	0	30	23	18	0	0	31						
		Care Services		0	0	0	0	0	0	0	0						
		2gether		0	0	0	0	0	0	0	0						
	Number of Never Events	GHT		0	0	0	1	0	0	1							
		Care Services		0	0	0	0	0	0	0							
		2gether		0	0	0	0										
		SWAST		-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Percentage of all adult inpatients who have had a VTE risk assessment	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%
		GHNHSFT		94.0%	92.5%	94.0%	93.2%	93.2%	93.9%	93.1%							
		GCS		95.4%	96.0%	91.5%	96.7%	97.9%	96.8%	97.2%	98.2%						
Cleanliness and HCAIs																	
Methicillin Resistant Staphylococcus Aureus (MRSA)																	
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
		Glos HC actual		3	1	0	1	1	0	0	0					6	6
	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		GHNHSFT actual		1	0	0	0	0	0	0	0					1	1
Clostridium Difficile (C.Diff)																	
E.A.S.5	Number of total C Diff infections (Health Community)	Glos HC target		15	12	12	16	16	8	12	10	9	16	16	15	142	157
		Glos HC actual		14	17	17	11	15	20	9	10					113	113
	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target		3	3	3	4	4	2	3	2	2	4	3	4	33	37
		GHNHSFT actual		5	3	1	4	1	4	1	4					23	23
Local Priorities																	
LP1	Reduction in COPD admission	Glos HC target															
		Glos HC actual	n/a														
LP2	Injuries due to falls per 100,000 population ages 65+	Glos HC target															
		GHNHSFT actual	2,236														
LP3		Glos HC target															
		GHNHSFT actual	n/a														

```
select          COUNTER

from       [Warehouse_14_15].[GHTActivity].[Episodes_Daily]

where      start_date_episode between '20140401' and '20150331'
and          age_on_admission >= 65
and          admission_method_hospital_provider_spell like '2%'
and          organisation_code_of_commissioner = '11m00'
and          organisation_code_of_provider = 'RTE00'
and          episode_number = '01'

and          (((primary_diagnosis_icd_1 like 'S%' or primary_diagnosis_icd_1 like 'T%')
and          SUBSTRING(primary_diagnosis_icd_1,2,2) between '00' and '98')

and          (((secondary_diagnosis_icd_2 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_2,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_3 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_3,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_4 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_4,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_5 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_5,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_6 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_6,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_7 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_7,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_8 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_8,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_9 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_9,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_10 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_10,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_11 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_11,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_12 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_12,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_13 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_13,2,2) between '00' and '19')
))

union all

select          COUNTER
```

```
select      COUNTER

from      [SUS].[final].[Full_APC_finished_final]

where     start_date_hospital_provider_spell_year = '2014/15'
and         age_on_admission >= 65
and         admission_method_hospital_provider_spell like '2%'
and         organisation_code_of_commissioner = '11M'
and         organisation_code_of_provider <> 'RTE'
and         episode_number = '1'

and         (((primary_diagnosis_icd_1 like 'S%' or primary_diagnosis_icd_1 like 'T%')
and         SUBSTRING(primary_diagnosis_icd_1,2,2) between '00' and '98')

and         (((secondary_diagnosis_icd_2 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_2,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_3 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_3,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_4 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_4,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_5 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_5,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_6 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_6,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_7 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_7,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_8 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_8,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_9 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_9,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_10 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_10,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_11 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_11,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_12 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_12,2,2) between '00' and '19')
```

Appendix 2

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position as at 31st December (Month 09)

AS AT Month 09 2016/17	2016/17 R £000	2016/17 NR £000	2016/17 TOTAL £000	Cash Limit £000
2016/17 baseline excl growth rolled forward	**707,886**		**707,886**	**707,886**
BCF	11,596		11,596	11,596
ETO	2,300		2,300	2,300
Future in Mind	1,100		1,100	1,100
Capital Grant	3,000		3,000	3,000
Market Rent	321		321	321
GPIT	1,622		1,622	1,622
Neurology	43		43	43
Court Liaison	(35)		(35)	(35)
Wheelchairs	462		462	462
Cross Border	135		135	135
Co Commissioning	75,113		75,113	75,113
Growth - Prog	15,421		15,421	15,421
Growth - Admin	28		28	28
Growth Co - commissioning	3,410		3,410	3,410
15/16 Surplus Bfwd		9,456	9,456	
Maximum Cash Adj				1,506
Eating Disorders		311	311	311
Choice +		1,350	1,350	1,350
General Practice Resilience Programme		132	132	132
GP Development Programme - reception and clerical training		55	55	55
SWAST Resillience		1,774	1,774	1,774
Vulnerable Practices pilot funding		95	95	95
Mental Health		130	130	130
Improvement Grants		166	166	166
Overseas Visitors Adjustment		(469)	(469)	(469)
Learning Disability Transformation funding to TCPs		10	10	10
Perinatal funding		224	224	224
Last month total	**822,402**	**13,234**	**835,636**	**827,686**
Adjustments in month				
Quality Premium		511	511	511
Adjustments actioned in month		**511**	**511**	**511**
TOTAL NATIONALLY REPORTED LIMIT	**822,402**	**13,745**	**836,147**	**828,197**

Appendix 3

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Summary Financial Position

Overall financial position as at 31st December 2016 (Month 09)

	Year to Date			Forecast Outturn		
	Budget	Actual	(Under)/Over spend	Annual Budget	Forecast Outturn	(Under)/Over spend
	£000	£000	£000	£000	£000	£000
Acute services						
Acute contracts -NHS (includes Ambulance services)	269,653	271,430	2	358,916	361,065	2,149
Acute contracts - Other providers	11,349	12,751	1	15,263	17,780	2,517
Acute - NCAs	4,514	4,956	0	6,070	6,640	570
Pass-through payments						
Sub-total Acute services	**285,517**	**289,137**	**3,620**	**380,249**	**385,484**	**5,236**
Mental Health Services						
MH contracts - NHS	58,792	59,058	266	78,389	78,908	519
MH contracts - Other providers	2,945	3,219	275	4,038	4,273	235
Sub-total MH services	**61,736**	**62,277**	**541**	**82,427**	**83,181**	**754**
Community Health Services						
CH Contracts - NHS	70,679	71,025	346	95,023	95,373	350
CH Contracts - Other providers	(8,581)	(8,587)	(6)	(11,405)	(11,487)	(82)
CH - Other						
Sub-total Community services	**62,098**	**62,438**	**340**	**83,619**	**83,887**	**268**
Continuing Care Services						
Continuing Care Services (All Care Groups)	14,067	15,236	1,169	19,085	20,548	1,463
Local Authority / Joint Services	1,854	1,164	(690)	2,472	1,549	(923)
Free Nursing Care	6,686	9,679	2,994	8,914	11,261	2,346
Sub-total Continuing Care services	**22,607**	**26,079**	**3,473**	**30,471**	**33,358**	**2,886**
Primary Care services						
Prescribing	71,736	70,439	(1,297)	95,971	94,198	(1,773)
Co-Commissioning and Enhanced services	63,051	62,695	(356)	84,150	83,805	(344)
Other	8,985	8,885	(100)	11,549	11,544	(5)
Sub-total Primary Care services	**143,772**	**142,019**	**(1,753)**	**191,670**	**189,548**	**(2,122)**
Other Programme services						
Other	20,659	20,214	(446)	27,838	27,321	(517)
Sub-total Other Programme services	**20,659**	**20,214**	**(446)**	**27,838**	**27,321**	**(517)**
Total - Commissioned services	**596,390**	**602,164**	**5,774**	**796,273**	**802,779**	**6,506**
Specific Commissioning Reserves (Inc headroom and Contingency)	7,390	1,895	(5,495)	16,855	10,565	(6,290)
Total - Programme Costs (excl Surplus)	**603,780**	**604,059**	**280**	**813,128**	**813,343**	**215**
Running Costs (incl reserves)	10,172	9,893	(280)	13,563	13,348	(215)
Total - Admin Costs (excl Surplus)	**10,172**	**9,893**	**(280)**	**13,563**	**13,348**	**(215)**
Surplus	7,092	0	(7,092)	9,456	0	(9,456)
Total Application of Funds	**621,044**	**613,952**	**(7,092)**	**836,147**	**826,691**	**(9,456)**

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Appendix 4

QIPP Programme 2016/17

Theme	Planned Gross Savings 2015/16 £'000	Forecast £'000	Variance £'000	Theme RAG	Savings RAG	Recurrent / Trend RAG
Urgent Care	6,136	5,001	(1,135)	A	A	A
Planned Care	6,435	4,234	(2,201)	A	A	A
Community	1,050	1,350	300	G	G	G
Prescribing	4,420	4,228	(192)	A	A	A
Transactional	0	0	0	A	A	A
Unidentified	0	0	0			
Grand Total	**18,042**	**14,813**	**(3,229)**			
Additional Schemes			0	**n/a**	**n/a**	**n/a**
Additional QIPP / Slippage / Contingent resources / Application of QIPP rule		3,229	3,229			
Grand Total	**18,042**	**18,042**	**0**			

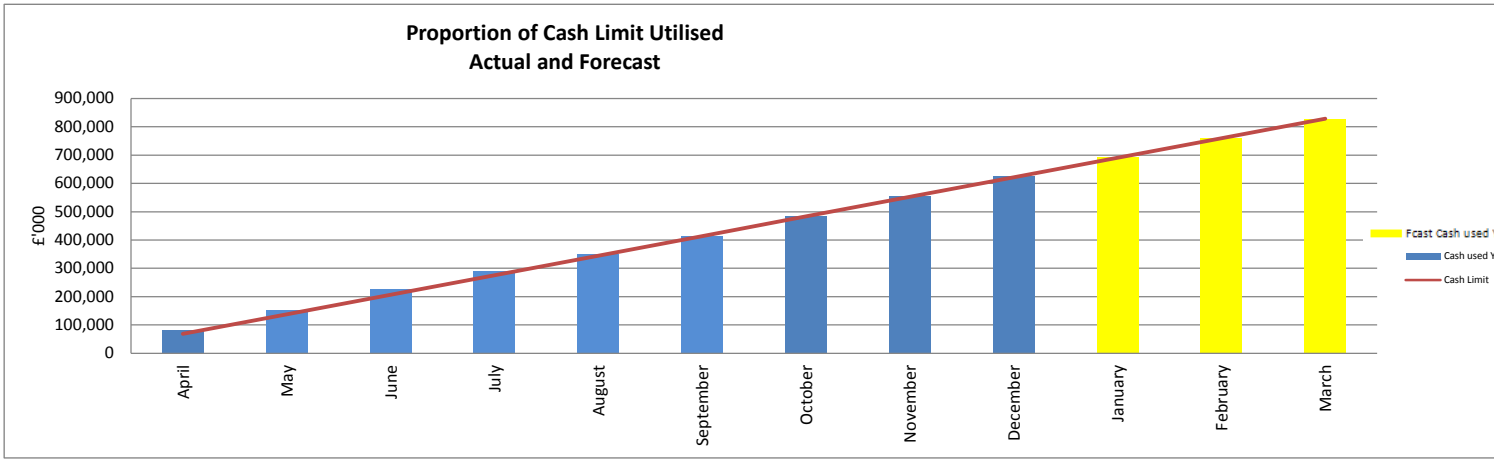
Appendix 6

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 31st December 2016 (Month 09)

		Actual/Forecast Charges in Month												
Month	Status	Drawn £000	Prescribing £000	Home Oxygen £000	Advance Drugs Payments £000	Co Commissioning	CHC inc Risk pool contribution	Capital Allocation	TOTAL MONTH £000	TOTAL YTD £000	CASH LIMIT 1/12ths £000	CASH AT MONTH END £000	% CASH LIMIT DRAWDOWN %	Bal/Cash Limit %
April	Act	75,000	6,742	87	(175)		462		82,116	82,116	69,016		9.92%	0.00%
May	Act	62,000	6,836	85	28				68,949	151,065	138,033	6,181	18.24%	0.75%
June	Act	67,000	7,261	84	(35)				74,310	225,375	207,049	14,793	27.21%	1.79%
July	Act	59,000	6,826	85	20				65,931	291,306	276,066	14,595	35.17%	1.76%
August	Act	52,000	7,078	86	123				59,287	350,593	345,082	6,291	42.33%	0.76%
September	Act	57,000	6,943	89	(137)				63,895	414,488	414,099	1,136	50.05%	0.14%
October	Act	64,000	6,827	86	25				70,938	485,426	483,115	2,313	58.61%	0.28%
November	Act	64,000	7,033	71	(133)				70,971	556,397	552,131	7,950	67.18%	0.96%
December	Act	61,000	6,878	72	87				68,037	624,434	621,148	6,690	75.40%	0.81%
January	F'cast	61,000	6,878	86					67,964	692,398	690,164		83.60%	0.00%
February	F'cast	60,936	6,878	86					67,900	760,298	759,181		91.80%	0.00%
March	F'cast	60,935	6,878	86					67,899	828,197	828,197		100.00%	0.00%



Overview of current position

At the end of Decmber £624m had been drawn down (75.4%) of the anticipated cash limit against 75.0% on a straight line basis.

Appendix 6

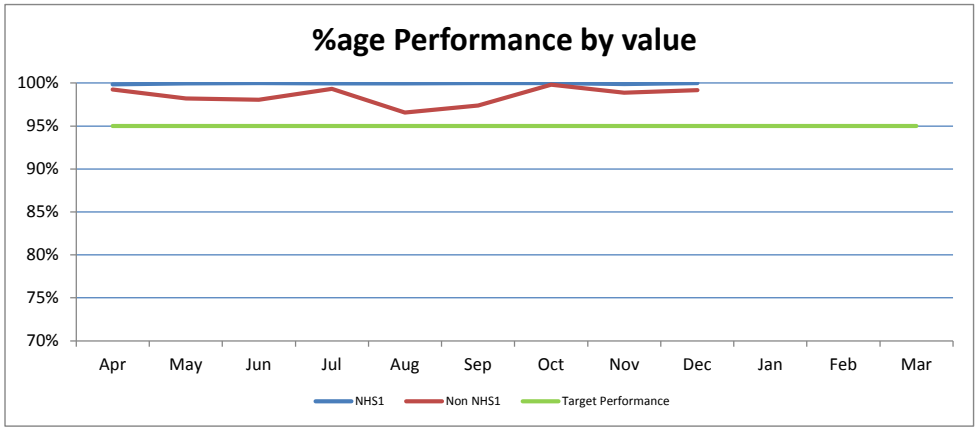
NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

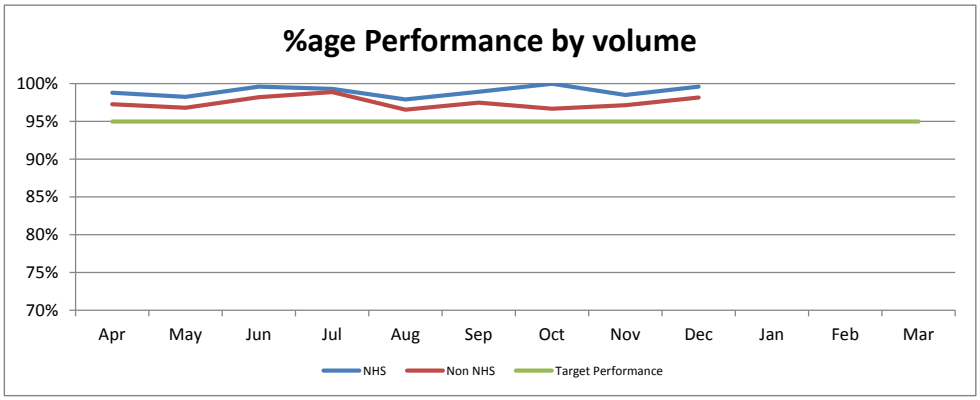
Performance against better payment practice code

As at 31st December 2016 (Month 09)

	In Month		Year to Date	
	NHS	Non NHS	NHS	Non NHS
By volume				
Total number of invoices	257	1,027	2,683	10,121
Number paid within target	256	1,008	2,657	9,867
Performance	**99.61%**	**98.15%**	**99.03%**	**97.49%**
By value				
Total value of invoices (£'M)	19.72	4.92	193.62	44.79
Value paid within target (£'M)	19.72	4.88	193.54	44.17
Performance	**100.00%**	**99.19%**	**99.96%**	**98.62%**

The target performance level is 95%





Appendix 7

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Statement of Financial Position

As at 31st December 2016 (Month 09)

	Opening Position as at 31 March 2016	Current Month end Position	Forecast Position as at 31 March 2017
		£000	£000
Non-current assets:			
Premises, Plant, Fixtures & Fittings	290	229	206
IM&T		0	0
Other		0	0
Long Term Receivables		0	0
Total non-current assets	**290**	**229**	**206**
Current assets:			
Inventories		0	0
Trade and other receivables	7,238	10,932	6,000
Cash and cash equivalents	23	6,690	1
Total current assets	**7,261**	**17,622**	**6,001**
Total assets	**7,551**	**17,851**	**6,207**
Current liabilities			
Payables	(43,221)	(43,699)	(40,000)
Provisions	(1,782)	(1,123)	(300)
Borrowings		0	0
Total current liabilities	**(45,003)**	**(44,822)**	**(40,300)**
Non-current assets plus/less net current assets/liabilities	**(37,453)**	**(26,971)**	**(34,093)**
Non-current liabilities			
Trade and other payables		0	0
Other Liabilities		0	0
Provisions		0	0
Borrowings		0	0
Total non-current liabilities		**0**	**0**
Total Assets Employed:	**(37,453)**	**(26,971)**	**(34,093)**
Financed by taxpayers' equity:			
General fund	(37,452)	(26,971)	(34,093)
Revaluation reserve			
Other reserves			
Total taxpayers' equity:	**(37,452)**	**(26,971)**	**(34,093)**

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 9

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Sustainability and Transformation Plan (STP): Update Paper**
Executive Summary	This paper provides an update on progress since the November 2016 STP Board Paper including details of the National Transformation Bids which are due to be submitted on 18th January for Diabetes, Mental Health, Cancer and Learning Disabilities. Recent activity in specific STP Programmes has also been captured and is attached at Appendix A. A further paper is attached providing an update on STP communication and engagement progress to date (Appendix B).
Key Issues	• Recent updates from key programmes • Communication & Engagement progress to date • National Transformation Bids
Risk Issues: **Original Risk** **Residual Risk**	The main risks currently inherent in the development of the STP are still present. This consists of the capacity and capability of programme and project teams to deliver and the challenge of developing a shared resources plan for Gloucestershire.
Financial Impact	The STP sets out a system wide resources plan for Gloucestershire until 2020.
Legal Issues (including NHS Constitution)	The STP includes a commitment to ensure compliance with NHS Constitution Standards and meet the requirements set out in the national planning frameworks.
Impact on Health Inequalities	The STP includes a clear commitment to focus on areas of health inequalities.

Impact on Equality and Diversity	The STP includes a commitment to ensure equality, value diversity and therefore, there will be a net positive impact as a result of developing and implementing the plan. An equality impact assessment will be completed for the STP.
Impact on Sustainable Development	The STP supports sustainable development.
Patient and Public Involvement	Patients and the public were involved in developing the STP through the work done on Joining Up Your Care. Patient and public representatives are engaged through various stakeholder events; an update on progress to date can be found in Annex B.
Recommendation	The Governing Body is asked to note: • Top Line Messages from Key Programme Areas • Communication & Engagement progress to date • National Transformation Bids submitted by Gloucestershire's footprint
Author	Beth Gibbons
Designation	STP Project Officer
Sponsoring Director (if not author)	Ellen Rule – STP Programme Director

Agenda Item 9

Governing Body

Thursday 26th January 2017

Sustainability and Transformation Plan Update

1 Introduction

1.1 Gloucestershire's footprint published its STP Plan and accompanying Short Guide on 11th November 2016 (these can be found online at www.gloucestershireSTP.net). Our STP has brought together the health and care leaders in Gloucestershire to drive the delivery of improved health and care based on the needs of our local population. Together we have identified the areas that we believe can be transformed by working together in a new way, driving genuine and sustainable transformation in patient experience and health outcomes over the longer-term.

1.2 Our STP framework does not replace existing local bodies, or change local accountabilities - it is a shared endeavor to work together and improve future care, and this plan does not seek to capture everything we do every day in our health community to improve care. What it describes are the areas where we have agreed that working together is in the best interests of our county, and where we believe the biggest step changes can be achieved.

2 Top Line Messages from Key Programme Areas

2.1 STP programmes and supporting work streams are all underway and moving into delivery. The contracting round has ensured strong alignment of STP assumptions and contract agreements.

2.2 A high level update of progress to date per programme can be found at Appendix A.

3 Communication and Engagement

3.1 A communication and engagement strategy and plan has been

developed to support the STP approach, to ensure comprehensive and planned engagement and communication with interested parties throughout the life time of the programme. The plan is owned by a working group, which has been set up to include all of the Communications and Engagement leads of the STP partners, who will continue to embed and develop the plan.

3.2 Materials have been developed and senior members have been supported to ensure key STP messages are consistent across the system. A communications media schedule to promote success stories has been produced and briefings have been issued around key programmes such as Diabetes, Prevention and Respiratory. Please see Appendix B for a detailed list published to date.

3.3 Engagement has taken place in the form of public drop-in sessions at over 16 locations across the county held on the Information Bus. Further planned engagement is scheduled at local leisure centres and shopping arcades to gather feedback as well as focused stakeholder engagement events.

The STP survey has been well received with 164 responses received so far (as of w/c 2nd January 2017).

The STP engagement period concludes on 24 February 2017 at which time an 'Outcome of Engagement Report' will be prepared to share with system partners.

4 Transformation Bids

4.1 NHS England created a transformation fund to enable footprints to deliver on key ambitions and have asked systems to apply for funding on specific interventions explicitly linked to local STP plans.

4.2 Gloucestershire are due to submit plans for the following interventions by the deadline of 18th January 2017:

- Improving Uptake of Structured Education (SE) for People with Diabetes
- New or Expanded Multi-Disciplinary Footcare Teams (MDFTs)
- Improving Access to Psychological Therapies (Integrated

IAPT)

- Reducing Reliance on Specialist Inpatient Care for People with Learning Disabilities

4.3 An eligible bid requires system-wide partners (STP Delivery Board) to have formally supported the bids with their own agreed organisational control totals in place. Local agreement and support has been confirmed at the STP Delivery Board on 5th January 2017.

4.4 Gloucestershire will be part of a combined set of bids for Cancer from a possibility of Early Diagnosis for People with Cancer, Cancer Recovery Package and/or Cancer Stratified Follow Up Pathways. Cancer bids however have to be submitted by the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance for projects to be implemented across a larger geographical area.

5 Recommendations

5.1 The Governing Body is asked to note:

- Top Line Messages from Key Programme Areas (Appendix A)
- Communication & Engagement progress to date (Appendix B)
- National Transformation Bids submitted by Gloucestershire's STP footprint

6 Appendices

6.1 Appendix A: Gloucestershire's STP Progress to Date

Appendix B: Communication & Engagement Update

Gloucestershire's STP
Progress to Date

January 2017 Governing Body - Appendix A

One Gloucestershire

Transforming Care, Transforming Communities

Recent Progress:

- Full STP and Short Guide published and available online www.gloucestershirestp.net
- Public Engagement Programme underway with steady flow of positive feedback being received to inform next steps
- Work streams all underway and moving into delivery, with strong alignment of STP assumptions to contract agreements
- Governance arrangements revised and agreed across organisations including a ‘virtual’ PMO proposal to support delivery

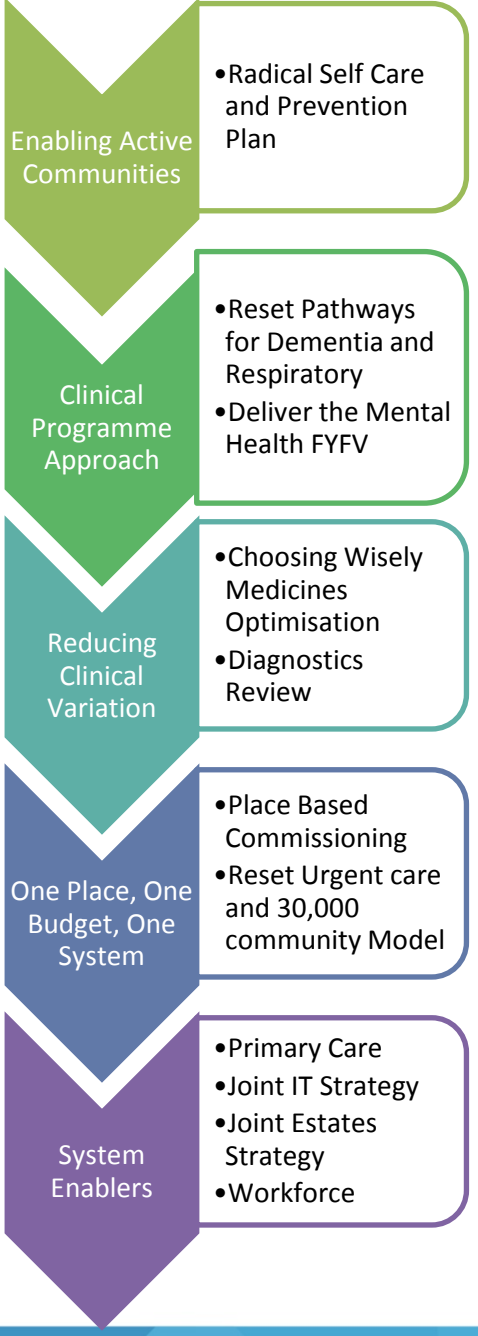
Top Line Messages

- We will invest in keeping people healthier for longer by enabling communities to support each other, and support self care and prevention
- We will reduce variation in prescribing and services, cut waste, and fund interventions that can deliver the greatest health benefit for our population
- We will review the patients' care journey, to ensure that care is delivered efficiently and effectively, and when appropriate, closer to home
- We will join up care around communities, creating 16 GP practice clusters delivering integrated care with community services to support physical and mental health needs

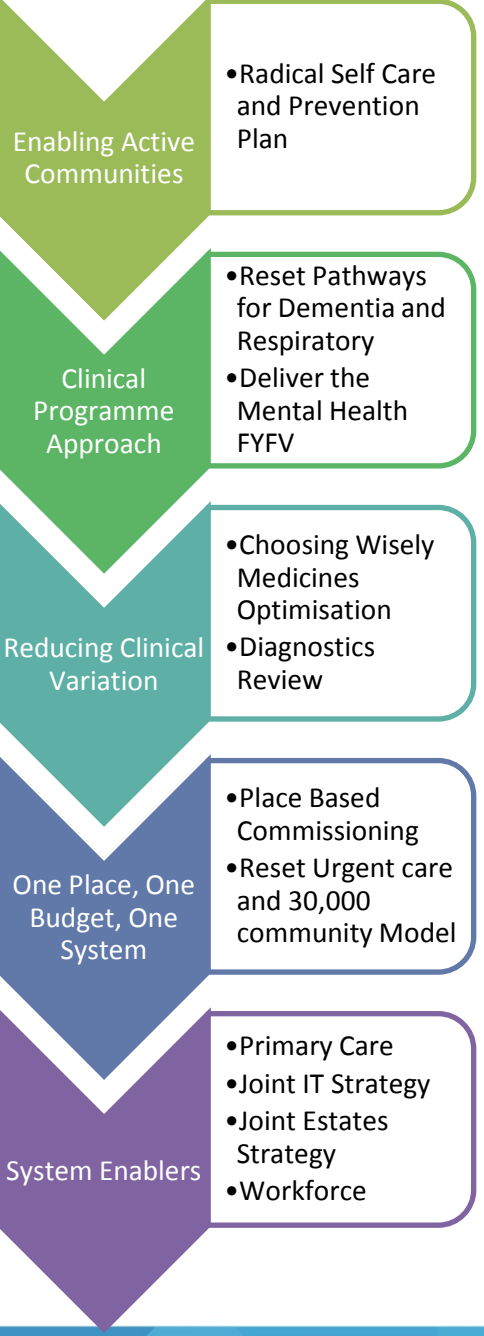
Top Line Messages

- We will have a clear joined up approach to urgent care provision, so that people will know when and where to access urgent care, when they need it
- We will introduce urgent care centres and streamline assessment services when we are clear this will improve quality and safety, and reduce waiting times for our population
- We will have a ‘one county’ approach to IT, Estates, and other system enablers
- We will introduce countywide leadership, training, education and learning opportunities to support the shift to new roles and responsibilities for staff

Enabling Active Communities:

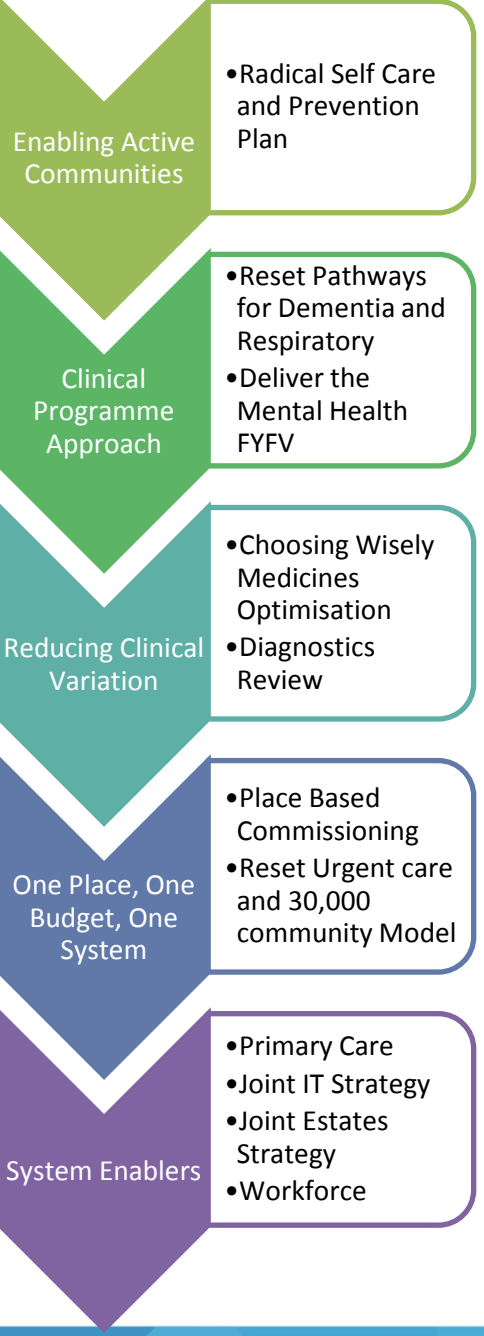


- Successful bid to National Diabetes Prevention Programme, Gloucestershire 1/13 areas in country for next phase of the rollout
- Implementation of the Patient Activation Measures continues across all three test & learn projects
- Expanded Social Prescribing & Community Agents Service to commence 2nd June 2017
- 35 businesses signed up to Workplace Wellbeing Charter, 16 more working towards accreditation
- Application submitted to NHSE for National VCSE Provider (NESTA) to support development of a model for personalised care and support planning
- Strong engagement with Districts to ensure joined up approach to delivery plan
- Innovative proposal to get 90,000 people active, develop in partnership with Active Glos and Sport England



Clinical Programme Approach:

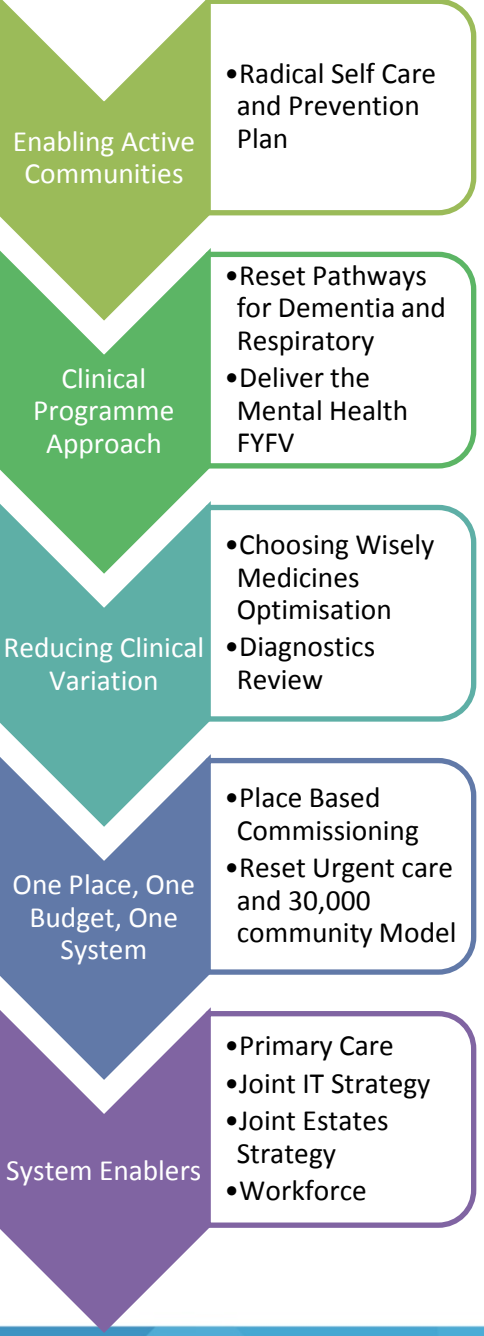
- Respiratory group approved final recommendations and outline pathway for COPD, and are implementing a winter review programme with primary care to ensure better care this winter for people living with COPD
- Cancer programme secured further investment to for the community based 'living with and beyond' service
- MSK new service model developed, and nearing agreement with all STP partners to enable implementation in 17/18
- Four priority work programmes identified within Dementia CPG
- Eye Health roll out continues with second eye and community minor eye conditions service now live
- Programme management arrangements now in place and performance reporting to be ready by January



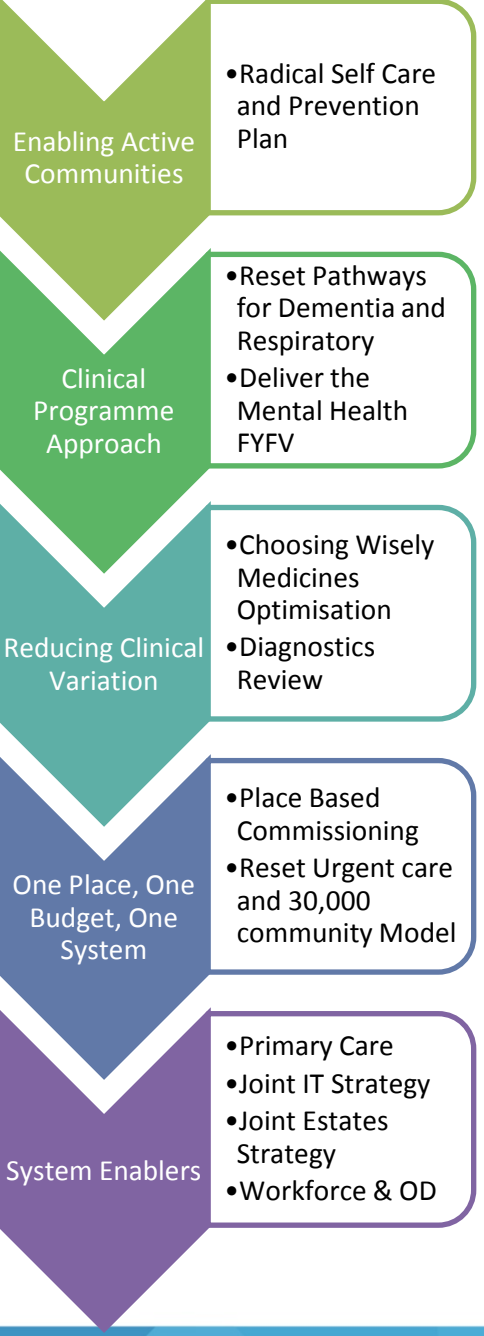
Reducing Clinical Variation:

- Strong support for continuing to develop the work stream of Primary Care Variation and implement preliminary recommendations
- Open follow-ups available in all specialities and roll-out of negotiated and telephone follow-ups in development
- Following initial meetings of the Pain Transformation Programme Meeting, the scope has been outlined and Dr Cathy Stannard, Pain Consultant is now in post to support delivery. First pain medicine protocol to be delivered in January with support of Cochrane Group
- Medicines Optimisation Dashboard developed
- Gluten Free & Sip Feed guidelines now published with new approach for managing through the joint formulary agreed with LMC
- Diagnostics review to be commissioned in New Year

One Place, One Budget, One System:



- Urgent Care new Model of Care - engagement programme now live, with first public engagement meeting and session with HOSC held w/b 12/12/16
- Urgent Care Breaking the cycle event held for 2 days w/b 12/12/16 with 2 days planned in January - early evidence is that it had a positive impact
- Place Based Model work is continuing, with 16 GP clusters agreed and starting to work constructively together across the county
- Frailty work in progress with service specification being drafted following Away Day to map clinical pathways
- Proposal being developed to deliver new enhanced approach to support people with mental health needs at cluster level
- General Practice Forward View Plan due to be submitted 23rd December



System Enablers:

Workforce and Organisational Development

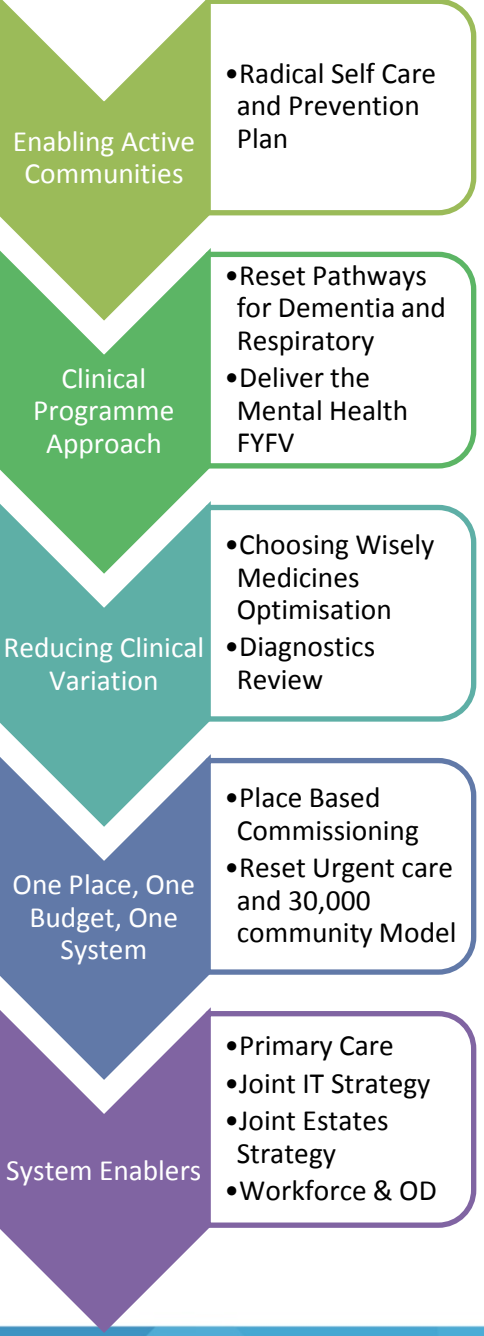
- Three thematic groups: Capacity, Capability & Culture Two HR Workshops scheduled 22nd & 28th February 2017
- Information Sharing Gateway proposal in development to allow workforce and other information to be shared across the STP under appropriate governance arrangements
- Initial Options Appraisal undertaken regarding adoption of a staff engagement framework/tool across the STP

Primary Care Strategy

- Patient version of the Strategy developed with support of Healthwatch Gloucestershire & their Reader's Panel
- Countywide Membership Event 24th January, implementation of Primary Care Strategy & General Practice Forward View

Joint Estates Strategy

- Strategic Asset and Delivery Plan in development
- £25k Programme Funding received and contract awarded



System Enablers:

Joint IT Strategy

- Local Digital Roadmap Review Meeting with NHSE on 11th November indicated additional funding may be available

Quality Academy

- First meeting held by Steering Group
- Successful QSIR Fundamentals Day 13/12/16

STP Programme Development and Governance Models

- Co-production and distribution of various support materials including a media schedule by Comms & Engagement Group
- Positive feedback to date following engagement events
- STP Strategic Networking Away Day scheduled 2/2/17
- Cross-organisational virtual PMO approach agreed
- Extensive work completed on STP Solutions to align these to contract agreements

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Appendix B

Governing Body - January 2017

Sustainability and Transformation Plan – Communications & Engagement Update

1 Introduction

1.1 A communication and engagement strategy and plan has been developed to support the STP approach, to ensure comprehensive and planned engagement and communication with interested parties throughout the life time of the programme. The plan is owned by a working group, which has been set up to include all of the communications and engagement leads of the STP partners, who will continue to embed and develop the plan.

2 Communications

2.1 Materials have been developed to ensure key STP messages are consistent across the system. Support has been provided to all senior members at partner organisations in the form of media and stakeholder briefings. A media schedule to promote stories related to the STP has been produced; media briefings issued to date have included:

- Better support for patients at risk of falling highlights greater focus on prevention
- Better support for patients with respiratory conditions
- Gloucestershire secures nearly £1.5M to improve mental health support for pregnant women and new mums
- Gloucestershire selected as Diabetes Prevention Programme site
- Helping people and communities to stay healthy
- Public invited to give their views on five year health and care plans
- Social prescribing supporting a growing number of people.
- University of Gloucestershire gets green light for nursing degree in 2017:

Full stories can be found at: http://www.gloucestershireccg.nhs.uk/gloucestershire-stp/gloucestershire-stp-news/

3 Engagement Events & Feedback

3.1 Members of the public gave their views on the STP at Public Drop Ins held on the Information Bus at eight locations across the county during November and December 2016.

3.2 During January and February 2017 the Information Bus is visiting a further eight county locations. Taking advantage of New Year Resolutions, members of the STP Communications and Engagement Team will also be raising awareness of the STP and seeking feedback from the public at local Leisure Centres, as well as at shopping arcades in Cheltenham and Gloucester.

3.3 Details of Public Drop Ins taking place January and February 2017 can be found at: http://www.gloucestershireccg.nhs.uk/gloucestershire-stp/gloucestershire-stp-drop-ins/

3.4 In addition, stakeholder engagement events have taken place focussing on STP priorities including Urgent Care, Place Based services and Enabling Active Communities. Targeted engagement with key stakeholders such as GP practice Patient Participation Groups is also scheduled to take place before the engagement period ends. Gloucestershire Hospital NHS Foundation Trust has hosted a well-attended STP engagement event for FT Members and has also hosted several staff engagement events, which have been shared on the Trust's intranet with all staff.

4 STP Survey Feedback

4.1 The online STP survey can be found at: https://www.snapsurveys.com/wh/s.asp?k=147627879240 and a freepost version of the survey can be found at the back of the STP Short Guide, copies of which have been distributed to a wide range of venues such as GP practices, Healthwatch Gloucestershire, libraries and district council offices. To date, there has been a good amount of completed surveys received (164 as at first week January 2017). Analysis of responses has not yet taken place.

5 Outcome of Engagement

5.1 The STP engagement period concludes on 24 February 2017 at which time an ‘Outcome of Engagement Report’ will be prepared and reported to STP system partners and Health and Care Overview and Scrutiny Committee.

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Agenda Item 10

Governing Body

Board Room, Sanger House

Meeting Date	**Thursday 26th January 2017**
Title	**Operational Plan 2017/18-2018/19**
Executive Summary	The Operational Plan 2017/18-2018/19 builds on the Operational Plan 2016/17 and provides an overview of our CCG commitments for years 1 & 2 of our system wide Sustainability and Transformation Plan (STP). The final draft was submitted to NHS England on 23rd December 2016, following the draft submission to NHS England on 24th November 2016.
Key Issues	The Operational Plan describes transformation of services that is required to meet GCCGs strategic and operational aims. Our approach to ensuring system resilience, particularly when there are high demands placed on the whole health system. Consistency and alignment between STP submission and the activities of the activities of the CCG. How the CCG will meet all the requirements of NHS England, including addressing the 9 'must-dos.'
Risk Issues: **Original Risk** **Residual Risk**	Described in the Operational Plan (Annex 5)
Financial Impact	The Operational Plan ambitions align to those submitted in the STP. Therefore successful delivery of the Operational Plan will ensure the achievement of financial targets in 2017/18-2018/19.

Legal Issues (including NHS Constitution)	Successful delivery of the Operational Plan will maximise system performance including those cited in the NHS Constitution.
Impact on Health Inequalities	Operational Plan includes measures to reduce Health Inequalities.
Impact on Equality and Diversity	Operational Plan includes considerations to support policies on Equality and Diversity.
Impact on Sustainable Development	Operational Plan includes considerations to ensure sustainable development.
Patient and Public Involvement	Approach to public and patient involvement is described in the Operational Plan (Annex 6).
Recommendation	The GCCG Board is asked to: • Formally note the submission of the Operational Plan 2017/18-2018/19 to NHS England on 23rd December 2016. • Note amendments to draft (24th November submission) prior to submission o Demand Section – 2.4.1 o Annex 9 STP Solutions Overview o Amendments to language within content highlighted by board members • Note the General Practice Forward View Key Lines of Enquiry (KLOE) submitted to NHS England due 23rd December 2016.
Author	Sadie Trout
Designation	Head of Planning
Sponsoring Director (if not author)	Ellen Rule, Director of Transformation and Service Redesign

Agenda Item 10

Governing Body

Thursday 26th January 2017

Operational Plan 2017/18-2018/19

1. Introduction

1.1 The GCCG Operational Plan sets out the ambitions of Gloucestershire Clinical Commissioning Group (GCCG) in what will be a pivotal two years for the 'One Gloucestershire' Health and Care system. We have been working over the last year to develop a shared vision for improvement, which we have published as our Gloucestershire Sustainability and Transformation Plan (STP). Our Gloucestershire Operational Plan provides an overview of our CCG commitments for years 1 and 2 of our system wide STP. In line with national planning requirements our operational planning and contracting processes have changed to support the development of our STP and reaffirms our commitment to delivering the Five Year Forward View via system wide improvements and new ways of working.

Our Operational Plan sets out the delivery priorities for 2017/18 and 2018/19 for the CCG, with clear alignment to system wide delivery of the Gloucestershire STP and takes into consideration progress made in 2016/17. The document outlines our financial context over the next two years, describing the challenging environment we face and an overview of the system wide solutions we have developed as part of our STP to address it.

2. Submissions

2.1 In line with National Planning Guidance GCCG has submitted the 2017/18-2018/19 Operational Plan to NHS England; a draft version on 24th November and a final version on 23rd December 2016.

Both versions were shared with Governing Body members ahead of submission dates to ensure support and Board level sign off and subsequent amendments made. This included an additional

appendix to provide an overview of the system wide STP solutions and improvements to the narrative provided in the Demand Section.

National Planning Guidance also requested the inclusion of the local approach to the requirements set out in the GP Five Year Forward View. In response GCCG completed a KLOE document (included), to support the detail provided in the Operational Plan and described in the Gloucestershire Primary Care Strategy.

Feedback from NHS England, as part of the CCG assurance process is anticipated in January 2017.

3. Recommendation(s)

3.1 The GCCG Board is asked to:

- Formally note the submission of the Operational Plan 2017/18-2018/19 to NHS England on 23rd December 2016.

- Note amendments to draft (24th November submission) prior to submission
  - Demand Section – 2.4.1
  - Annex 9 STP Solutions Overview.
  - Amendments to language within content highlighted by board members

- Note the General Practice Forward View KLOE submitted to NHS England due 23rd December 2016.

4. Documents Included:

Document 1: Gloucestershire Clinical Commissioning Group – Operational Plan 2017/18-2018/19

Document 2: Gloucestershire GPFYFV KLOE Document

Gloucestershire Clinical Commissioning Group

Operational Plan

2017/18 – 2018/19

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1. Introduction from the Chair and Accountable Officer

This Operational plan sets out the ambitions of Gloucestershire Clinical Commissioning Group (GCCG) in what will be a pivotal two years for the 'One Gloucestershire' Health and Care system. We have been working over the last year to develop a shared vision for improvement, which we have published as our Gloucestershire Sustainability and Transformation Plan. Our challenge now is to turn our vision into delivery of real and tangible improvements in health and care for people in Gloucestershire.

The financial and operational delivery context for our system remains challenging, but we believe Gloucestershire can achieve a sustainable position. To do so will require strong partnerships and a robust approach to system transformation. We will need people in Gloucestershire to take the lead in being responsible for living well, and will support them where needed through delivery of our self-care and prevention plan.

We have a strong track record of delivery of new ways of working, and we will need to learn from our experiences in previous years and build on our successes. Here are some of the achievements from 2016/17 that have helped to frame this plan for 2017/18 and beyond.

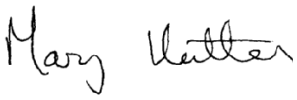
Key achievements for 2016/17:

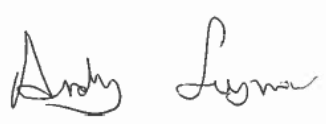
- Promoted healthy lifestyles by commissioning our local County Sports Partnership to support and train primary schools to take up the 'Daily Mile' initiative. We have continued to roll out Facts4Life across the county with 76 schools now having received training (target 96). The initiative is currently being independently evaluated by the University of the West of England.
- Developed and agreed a Primary Care Strategy (including Primary Care Infrastructure Plan, and Primary Care Workforce Plan) and through the new models of care work 16 emergent GP clusters have been established, covering the county in circa 30,000 population models.
- Delivered a continuing transformation programme through the Clinical Programme approach, reshaping end to end pathways of care with a focus in the last year on rolling out a new Chest Pain Pathway (Trop T) , an integrated Chronic Obstructive Pulmonary Disease pathway, a new service model for MSK and falls, continued to roll out new pathways for follow up cancer care and commissioned a new countywide community eye service.
- Supported planned care delivery and our objectives of ensuring right care, right place, right time by establishing the G-Care platform for disseminating pathway information supporting integrated care pathway development. New pathways have published in a number of key specialty areas including Ophthalmology, MSK, ENT and Urology.
- Delivered the Mental Health Crisis Action Plan and implemented a new model of Crisis Care with shared goals agreed across commissioners and providers. This has included the extension of the Crisis Café opening hours from October 2016 and the introduction of a new 'Crisis House'.
- Taken steps to address a health inequality for Black and Minority Ethnic (BME) people living with dementia by investing in a new BME Community Hub (based on the existing county wide Community Hub model), this has been established most

successfully at the Friendship Café and has been establishing networks with other BME and support groups in sheltered housing units.

- Developed stronger joint working with Gloucestershire Fire and Rescue Service (GFRS) including rollout of a Telecare Responder Service, providing Safe and Well visits and the development of Community Support Multidisciplinary Teams which has been nationally recognised and forms part of GFRS's 'Beyond Blue Lights' strategy.
- Ensured the provision of high quality and safe services by ensuring all system partners took part in Sign Up to Safety campaign. GCCG was proud to be awarded a Nursing Times Award for Patient Safety Improvement for our work to raise awareness of sepsis and support frontline clinical decision making. As part of this initiative a number of tools to support clinical decision making were developed, including the National Early Warning Score (NEWS) which is being adopted.

To ensure successful delivery of our plan we will stay true to the principles set out in our 'Joining Up Your Care' strategy which was shaped by local people. Our health and care community is committed to working together to transform our health and care delivery system to ensure it is fit for purpose for the future. We look forward to working with you to deliver our part of ensuring a better future for people in Gloucestershire.





Mary Hutton
Accountable Officer

Andy Seymour
Clinical Chair

2. The System Challenge

The Gloucestershire Operational Plan provides an overview of our CCG commitments for years 1 and 2 of our system wide Sustainability and Transformation Plan (STP). Our operational planning and contracting processes have changed to support the development of our STP and reaffirms our commitment to delivering the Five Year Forward View via system wide improvements and new ways of working. The development of our STP provides an opportunity to take a holistic and collaborative approach to providing an improved and more sustainable health and care system in Gloucestershire.

2.1 The Gloucestershire Context

The Five Year Forward View outlines three critical gaps (Health and Wellbeing Gap, Care and Quality Gap and Finance and Efficiency Gap) facing the NHS, that need to be tackled across the health system by driving improvements in health and care provision, restoring and maintaining financial balance and delivering core standards. In Gloucestershire our system is facing a number of challenges:

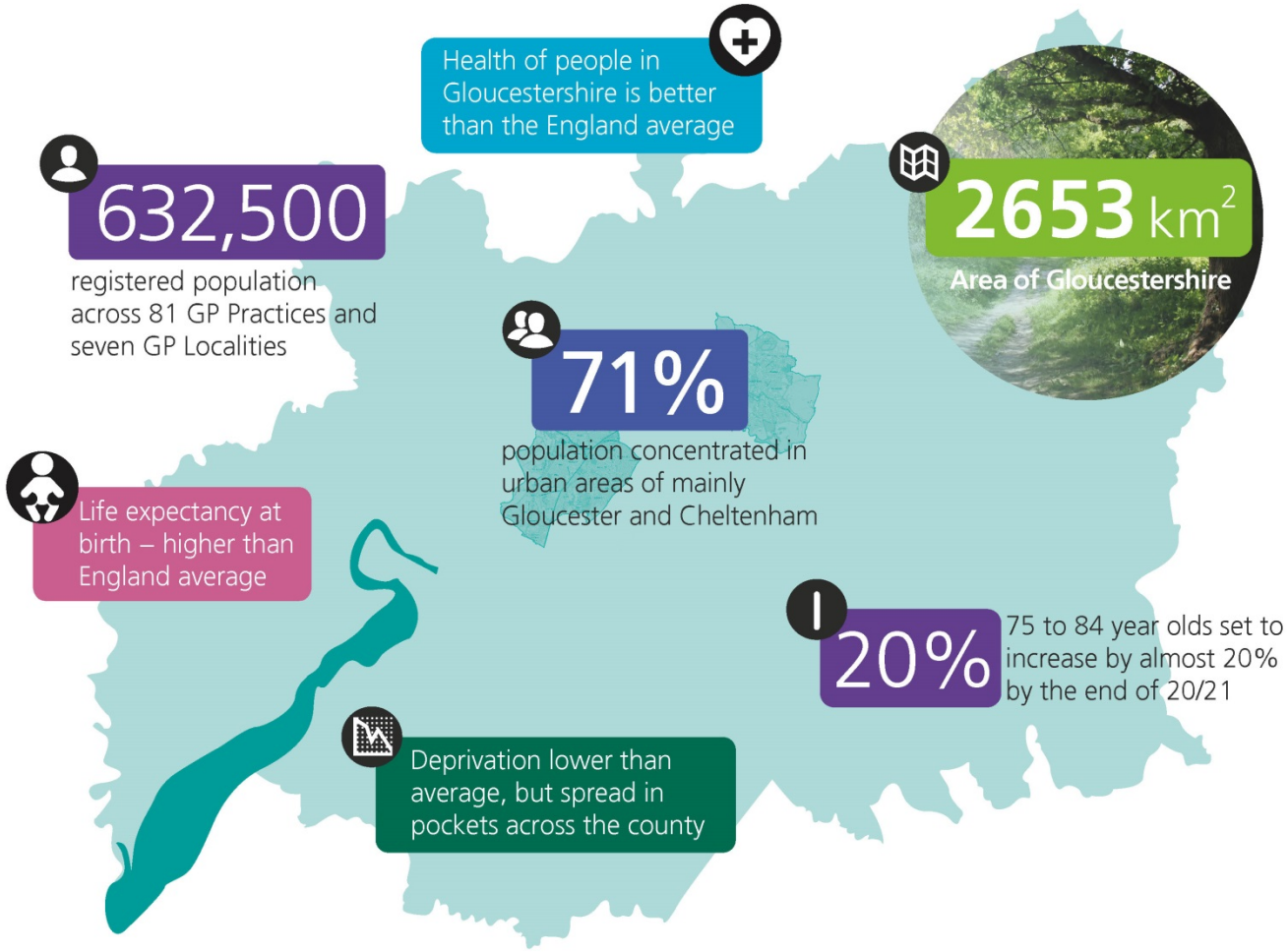
- A growing population with more complex needs – it is estimated 47,500 people over the age of 65 are living with long term conditions, which is projected to rise to 77,000 by 2030.
- Increasing demand for services and rising public expectations, coupled with low levels of personal responsibility in some areas over personal health and care and lack of ownership over personal health planning.
- Innovation in new medical technology and medicines, which has the potential to improve lives for many people but needs funding for implementation.
- Considerable pressure on NHS and social care finances. The health and care community is facing a gap of circa £226m over the next four years unless we make radical changes to the way we deliver services.
- Strengthening Mental Health Care and Support.
- Significant pressures on our NHS and Social Care workforce capacity, with the potential for gaps to arise in key roles unless action is taken to develop new roles and ways of working.

Our long term ambition is to have a Gloucestershire population, which is:

- Healthy and Well – taking personal responsibility for their health and care, reaping the personal benefits that this can bring. A consequence will be less dependence on health and social care services for support.
- Living in healthy, active communities and benefitting from strong networks of community services and support.
- Able to access consistently high quality, safe care when needed in the right place, at the right time,

2.2 Gloucestershire Facts and Figures

Diagram 1: Gloucestershire Facts and Figures



2.3 Our Vision

Our Vision: "To improve health and wellbeing, we believe that by all working better together – in a more joined up way – and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people"

Our shared vision was developed through extensive public consultation and set out in the strategy 'Joining Up You Care' in 2014. We believe that the NHS and social care in Gloucestershire is in good shape to move forward, but that there remain significant opportunities for a new conversation with the public and for organisations to work together to ensure a sustainable future for health and social care in the county.

In October 2014 Simon Stevens published a compelling vision and strategy for the NHS, the Five Year Forward View. The vision describes the opportunities and challenges facing the NHS for the future, expressed as three key 'gaps' and urges local health and care communities not to rely on 'short term expedients to preserve services and standards' at a time which calls for true leadership and transformational change. In Gloucestershire health and social care organisations have made a commitment to work together to deliver system level change in four ways:

- **Enabling Active Communities** – building a new sense of personal responsibility and promoting independence for health, supporting community capacity and making it easier for voluntary and community agencies to work in partnership with us. Using this approach we will deliver a **radical Self-Care and Prevention Plan** to close the **Health and Well-being Gap.**

- **One Place, One Budget, One System –** by taking a place based approach to commissioning and providing services we will deliver best value for every Gloucestershire pound. Our first priority will be to **redesign our Urgent Care system** and **develop a 30,000 place based care model** through this principle. This will ensure we close the **Finance and Efficiency Gap,** and move us towards delivery of a **new care model** for our county.

- **Clinical Programme Approach –** systematically **redesigning pathways of care**, building on our success with **Cancer, Eye Health and Musculoskeletal** redesign, challenging the system to remove barriers to pathway delivery. In year one, we will focus on delivery of new pathways for **Respiratory Disorders and Dementia** and progress the Mental Health Task Force recommendations to help us close the **Care and Quality Gap.**

- **Reducing Clinical Variation –** elevating key issues of clinical variation to the system level to have a new joined up conversation with the public around some of the harder priority decisions we need to make. Our first priority will be to deliver a '**Choosing Wisely for Gloucestershire' Medicines Optimisation** and undertake **a Diagnostics Service Review**, This programme will turn the dial for our system to close the **Care and Quality Gap.**

2.4 Financial Challenge – Sustainable Finances

The health community is facing increasing demands including demographic pressure, rising public expectation and technological change which all contribute to the financial challenge to fund and deliver health and care across our system. The financial cost of the demands on the system exceed the funding available.

The overall gap for the health community for the period 2017/18 to 2020/21 is forecast to be circa £226m. This gap includes the main Gloucestershire providers, specialist commissioning, social care as well the CCG. The CCG component of the gap is estimated to be c£72m with £31m falling into the first two years.

The table below shows the allocations for the three funding streams for Gloucestershire CCG for 2016/17 and the two years covered in the financial plan, 2017/18 and 2018/19 along with the growth received in each of the financial years. Gloucestershire CCG, under the national funding formulas for both programme and primary care allocations, is deemed to be at its target funding level, therefore the growth received in both years for programme and primary care is the minimum growth uplift.

Table 1: Programme Allocations

Allocation	2016/17 £'000	2017/18 £'000	2018/19 £'000
Programme Allocation *(pays for the purchasing of acute, mental health, community health care services plus primary care drugs expenditure)*	730,181	744,807	759,606
Total change in allocation from previous year	21,603	14,626	14,799
Delegated Primary Care Allocation *(pays for GP services excluding drugs and some local services)*	78,523	79,968	81,511
Total change in allocation from previous year	1,721	1,445	1,543
Running Costs *(pays for the CCG's administration costs)*	13,563	13,558	13,553
Total change in allocation from previous year	-29	-5	-5
Total Allocation	**822,267**	**838,333**	**854,670**
Total change in allocation from previous year	23,295	16,066	16,337

The aim of the CCG's financial plan is to ensure financial balance and stability through the effective management of available resources and financial risks to ensure statutory duties are met each year. Planning assumptions include the following:

- Population growth of 0.7%.
- The recurrent impact of over performance in 2016/17 is £17.5m including the increase in funded nursing care.
- The impact of new drugs and technologies.

- The additional requirements outlined in the NHS Mandate.
- A planned surplus of £9.156m (TBC) in 2017/18 and £8.856m (TBC) in 2018/19. The CCG has in previous year's delivered a surplus greater than the required 1%, from 2017/18 plans include the phased draw down over a four year period of the surplus above 1%.
- A contingency reserve of at least 0.5%.
- A 1% non-recurrent reserve. 0.5% of this reserve will be utilised to fund non recurrent expenditure, non recurrent items of expenditure, pump prime change and cover double running costs incurred as a result of change programmes, 0.5% will be held to operate as a risk pool across the Gloucestershire STP Footprint.
- Increases in prices for both acute and non-acute services in line with the national tariff.
- The impact of the change to the tariff base in moving to HRG4.1, this is assumed to be cost neutral at this point in time, however, work is ongoing to assess this risk.
- The impact of changes to funding between specialist commissioning and CCGs, this is assumed to be cost neutral, however, the changes are currently being worked through and any financial impact will be included in the final budget for the CCG.
- The change in commissioning responsibility of morbid obesity from specialist commissioning to the CCG.
- The impact of changes to cross border commissioning; these are currently being worked through and will be included in the CCG budget.
- Growth in mental health services.

Savings within the community for 2017/18 and 2018/19 are estimated to be a minimum of £47m in each of the two years. These figures include provider cost improvement programmes, specialist commissioning savings and social care savings. For the CCG, in order to meet these planning assumptions, savings of at least £15m (TBC) in 2017/18 and £16m (TBC) in 2018/19 are required, this represents just over 2% of the CCG's allocation.

The development of the savings programme has been as a part of the STP process with partners within Gloucestershire. The table below shows the programme areas identified to achieve these savings.

Table 2: Expected Programme Savings

	2017/18 £'000	2018/19 £'000
Enabling Active Communities	0	2,500
Clinical Programme Approach	3,939	4,205
One System, One Place, One Budget	4,731	3,423
Clinical Variation – Medicines management	5,416	5,416
Other	750	750
Total	**14,836**	**16,294**

The delivery of individual QIPP schemes during the year will be reported to and monitored by the relevant STP Programme Boards as well as to the CCG Governing Body.

2.4.1 Managing Demand

The need to manage a year-on-year increase in demand on services and ensure that services are provided in the most appropriate settings is central to the CCG's plans within both the STP and this Operational Plan. The approach taken is based on evidence from a number of sources including the use of benchmarking data and evidence of what has worked well in other areas, allied to needs assessment at a locality level. The conflation of different evident sources has resulted in the implementation of a package of initiatives, managed by STP Programmes, that the CCG expect will deliver the planned management of demand as described in the Solutions Analysis (see Annex 9).

Our overall approach is, firstly, to help people to stay well to reduce their need to access health and care services. Secondly, where care is required, we aim to provide services in the most appropriate settings with an emphasis on providing high quality, safe care close to home. Finally, where we identify instances where access to services is inefficient or unnecessary (either through referrals or by patients presenting directly) the CCG will look to make best use of available resources whilst ensuring patients receive the care they require.

The key themes within our demand management approach are as follows:

- Reducing morbidity through the promotion of healthy lifestyles (as described in the Prevention and Self-Care Plan) and support for self-management (see Section4 for further detail). Clearly, the best way to manage demand is to invest in prevention so that people can live healthy, active lives. Building on this approach the CCG is then looking to support patients to manage their own health by providing the necessary information and peer support.
- Managing elective demand by supporting GPs to refer appropriately into secondary care. For example, G-care is a website which has been developed locally to collate a range of useful local and national information including care pathways, clinical guidance, referral forms, clinical commissioning policies and patient information. Another initiative involves monitoring practice variation (as part of the primary care offer) and supporting localities to review, interpret and encourage a consistent approach to referrals to secondary care.
- Managing demand for urgent care through improved signposting, integrated community teams, 'front door' initiatives and the development of new place based approaches and integrated urgent care service models (see section 5.1). The aims are to remove any confusion regarding how to access appropriate urgent care services, to intervene early in a community setting to prevent patients from requiring an emergency admission or A & E attendance, to provide effective triage at A & E (e.g. to redirect patients to more appropriate primary care or mental health services) and to develop new ways of working to improve integration between different providers.
- Identifying and reducing low value interventions and clinical variation. The CCG's focus includes reviewing variations in the number of outpatient follow-ups across a range of specialities compared to best practice, facilitating early access to diagnostics to support early intervention, commissioning a wider review of diagnostics, and medicines optimisation (see section 7.1). Evidence suggests that

greater consistency, based on best practice, will reduce demand, maximise the quality of care and patient experience, and improve health outcomes.

- Managing demand for GP services by signposting patients to accessible, equivalent alternatives. For example, the CCG promotes Pharmacy First for patients that need advice regarding minor, common ailments but don't need to see a GP and may benefit from specialist pharmacist advice. In addition, the CCG has introduced social prescribing (with most referrals from GPs) to signpost patients to a wide range of health and services which will more effectively provide the support they need.
- Joint decision-making between clinicians and patients about the best treatment approach not only ensures that the right care is provided to meet the needs and wishes of the patient but has also been shown to reduce variability and demand for services. The rollout of Personal Health Budgets and Integrated Personal Commissioning are examples of greater joint decision-making and control for patients.

Further detail about the approaches described above can be found in the referenced sections of this document.

3. Our Delivery Priorities

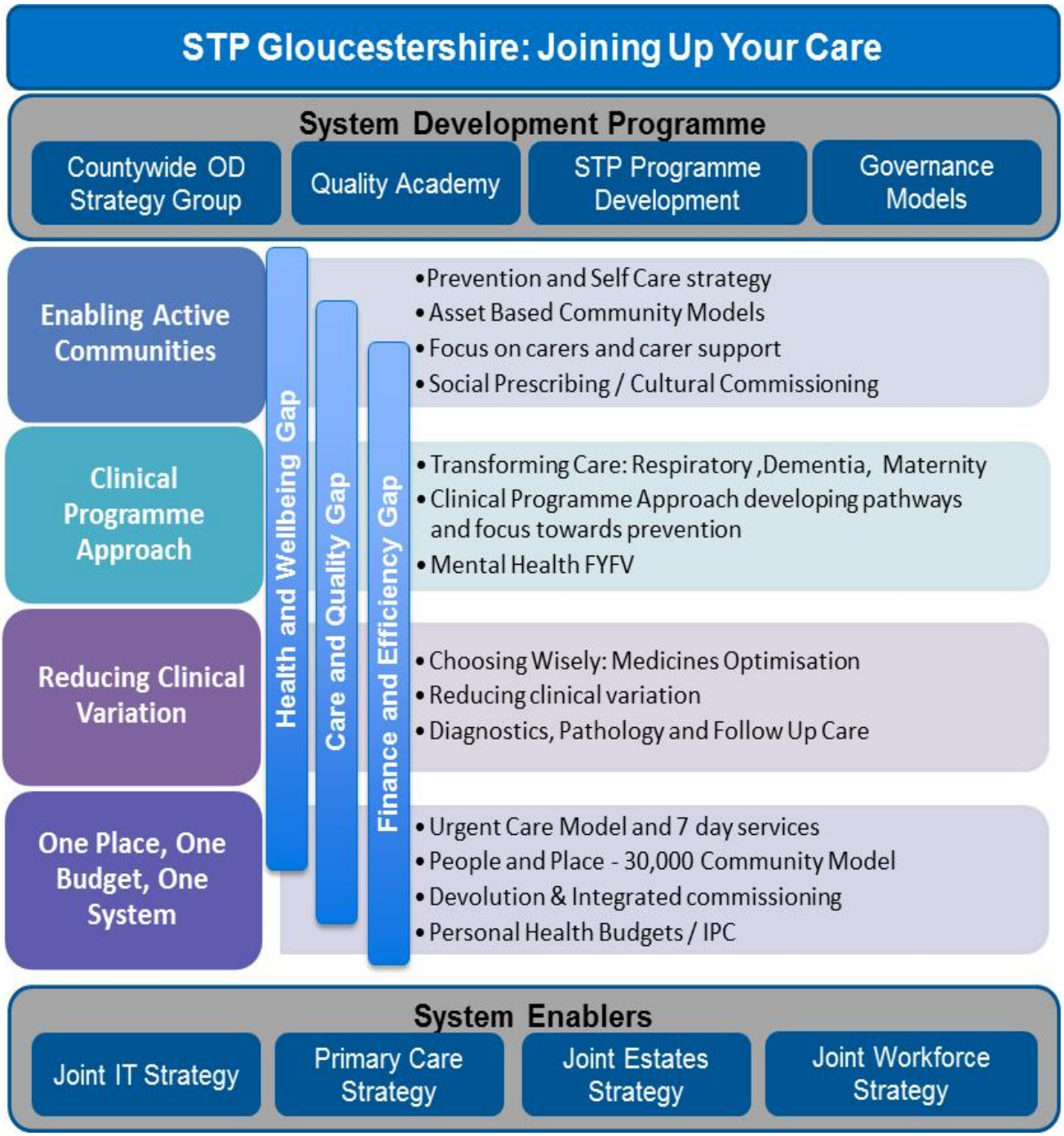
Our operational Plan sets out the delivery priorities for 2017/18 and 2018/19 for the CCG in support of our wider STP, building on our 5 year strategy Joining Up Your Care. Our Operational Plan takes into consideration the progress we have made in 2016/17.

Our 2017/18-2018/19 CCG Operational Plan sets out the following objectives:

Enabling Active Communities	Work with system partners to deliver the **Enabling Active Communities** Strategy, and improve health and well-being for people in Gloucestershire, further building on the work we have developed through the prevention and self-care agenda. We will ensure there is a focus on prevention and self-care through all our key programmes of work.
One Place, One Budget, One System	Work through the principle of **One Place, One Budget, One System** to develop a place based approach to service delivery, using this to develop our system response to the New Models of Care agenda, prioritising the redesign of our urgent care system and delivery of ongoing integration of our health and care system facilitated by the work on Gloucestershire Devolution.
Clinical Programmes Approach	The CCG will work with system partners through the **Clinical Programmes Approach** for people in Gloucestershire, particularly looking to create more joined up pathways moving from models of episodic based care to pro-active care and case management, particularly for those with long term conditions.
Reducing Clinical Variation	Work with our system partners to ensure **Reducing Clinical Variation** is a key focus across the development, redesign and delivery of our services, aiming to improve the quality, safety, consistency and efficiency of services by reviewing, amending and redesigning, as appropriate.
Parity of Esteem for Mental Health and Learning Disabilities	The CCG will ensure a continued focus on achieving **Parity for Mental Health and Learning Disabilities** for our population, and delivering the Mental Health Five Year Forward View.
System Development	Work with health and social care partners on our shared **System Development** Programme, to deliver a system wide Sustainability and Transformation Plan for Gloucestershire
Primary Care and Locality Development	The CCG will focus on **Primary Care and Locality Development** to ensure the future sustainability of this critical part of our system and lead the Primary Care Strategy on behalf of the STP system.
System Sustainability.	Have a continuous focus on **System Sustainability**, ensuring constitution compliant, high quality and cost effective services, reducing avoidable variations in outcomes, aligning delivery incentives and use ways of working such as case reviews to bring a clinical and evidence based focus to service redesign and improvement.

This document therefore sets out the high level intentions of Gloucestershire CCG in support of our strategic aims, for the financial years 2017/18-2018/19. The financial context creates a challenging environment, and our commitment is to ensure the money is used effectively across the health and care system to support joined up care, underpinned by ensuring the right care is provided in the right place, at the right time, by the right person at the right price.

Diagram 2: STP Plan on a Page



4. Enabling Active Communities

Our Enabling Active Communities programme aims to build a new sense of personal responsibility and improved independence for health, supporting community capacity and ensuring we make it easier for voluntary and community agencies to work in partnership with us. The programme aims to deliver a radical Self-Care and Prevention Plan in order to take a systematic approach to prevention, recognising its significant role in reducing our overall health burden. The programme provides a clear framework and plan for whole system change that enables patients and communities to take a lead in their health and care and aims to create the conditions for communities and individuals to thrive, to remove barriers and for our services to meet the needs and harness the assets of our communities.

Our approach to prevention will help us to focus on how we remove the barriers to reducing health inequalities and develop plans in relation to social inclusion and social reablement programmes. For example, we will address how individuals with mental health needs can access and be supported to engage with health screening programmes. We will also look to ensure they are supported into employment opportunities and have access to appropriate accommodation in order to minimise the impact these factors may have on their ill health. Developing and implementing these programmes of work will contribute to improving 'Parity of Esteem' for patients with mental health needs.

The Enabling Active Communities Programme is a key priority in addressing the health and wellbeing gap, with £1.9m of funding secured to support our key initiatives outlined in the Prevention and Self-Care Plan. The programme saw significant progress in 2016/17, commencing with work to promote healthy lifestyles and ensuring self-care and prevention is a key focus across our clinical programmes:

2016/17 ACHIEVEMENTS

CULTURAL COMMISSIONING PROGRAMME

- **12 'test and learn' projects in 16/17**
- **Evaluation by University of Gloucestershire underway**
- **National report published by New Economics Foundation showcasing work in Gloucestershire**

HEALTHY LIFESTYLES

- **Commissioning of Health@work to roll out the Workplace Wellbeing Charter across 40 organisations across the county**
- **Working with Active Gloucestershire to increase physical activity levels of older adults**

HEALTHY LIFESTYLES

- **Successful tender alongside GCC of new Healthy Lifestyle Pathway**
- **Commissioning of a local County Sport Partnership to support schools to take up 'daily mile' initiative**
- **National Diabetes Prevention Programme implementation anticipated April 2017**

Social prescribing is central to our enabling active communities approach and is now available across Gloucestershire. Our next stage of development will be to develop a stepped care social prescribing model offering non-standard interventions for people living with a range of long term physical and mental health conditions. With a focus on prevention and self-management, an arts on prescription model within an enhanced social prescribing

framework offers delivery impact and social value through system partnership, including public health and social care.

The CCG, and our partners CREATE Gloucestershire, Gloucester City Council, Tewkesbury Borough Council and Forest of Dean District Council were successful in an application to become one of two pilot partners in the national Cultural Commissioning Programme (CCP). The pilot was extended until December 2016, following the CCG's expansion of the level of investment in the prevention agenda 2016/17 to encompass a broader remit to commission a range of prevention and health and well-being interventions from the Voluntary, Community Social Enterprise (VCSE) sector. As part of this commitment £150,000 was allocated to commission a grant programme consisting of 12 test and learn pilot projects across 8 long term health conditions, to be delivered by a total of 7 local VCSE arts and culture organisations. Each project was developed and overseen through a co-production process involving patients, clinicians, artists and commissioners, and projects have covered a range of physical and mental health conditions across the life course. Examples include:

- Engagement with Black & Minority Ethnic (BME) community to raise awareness of dementia through comedy and animation, and leading to an event attended by 120 people from a range of BME communities.
- Development of a dance project for young people with Type 1 diabetes, leading to the production of a rap and street dance film to be shared with other young people to promote self-management.
- A self-sustaining patient led arts group for men of working age with chronic pain to support medication optimisation, improve confidence and reduce social isolation.
- Singing for people with Chronic Obstructive Pulmonary Disease (COPD) to improve breath control, confidence and reduce social isolation.
- Music therapy as part of personalised care planning to reduce challenging behaviours associated with placement breakdown for people living with advanced dementia.

The CCG over the next two years will continue to explore opportunities to develop place based arts and culture based approaches, supporting key priorities in the Self-Care and Prevention Plan and care pathways in transformation, particularly for groups not currently accessing services e.g. men; BME communities; people with learning disabilities.

Over the next two years, the CCG working with our key partners will:

- Be part of the National Diabetes Prevention Programme supporting 2000 patients per year in Gloucestershire.
- Implement the NHS Staff and Well-being and Preventing Ill Health by Risky Behaviours CQUINs across our main providers.
- Roll out Atrial Fibrillation Diagnosis Treatment Programme with Allied Health Science Network to 81 practices.
- Expand the Workplace Wellbeing Charter and double the number of workplaces accredited from an expected 40 in August 2017 to 80 by August 2018.
- Review the case for developing a whole community approach to increase physical activity levels through the 'Gloucestershire Moves' initiative.

- Review the case for developing a comprehensive and seamless obesity weight management pathway, to include a Tier 3 Specialist Weight Management Service for children and a review of the service specification for Tier 3 Specialised Weight Management Service for adults and Tier 4 Bariatric.
- Deliver a new Art on Prescription service, via Social Prescribing, to support both mental and physical health.
- Undertake a procurement of a new Social Prescribing and Community Agents Service with expected implementation in June 2016.
- Develop a grant based programme to support community capacity, across health and social care, including a more strategic approach to investing across the voluntary and community sector.
- Implement the Patient Activation Measure across the health system. This will initially focus on three test and learn projects including: frailty, Winter Pressure Local Enhanced Service for COPD and the MacMillan Next Steps Programme.
- Consider developing a system wide health coaching approach, ensuring all 16 clusters have a dedicated lead trainer to adopt a 'train the trainer' method.
- Design and implement an Integrated Self-Management and Peer Support Programme by December 2017.
- Support Public Health with the implementation and mobilisation of a new Healthy Lifestyles Service.

5. One Place, One Budget, One System

The One Place, One Budget, One System programme will take a place based commissioning approach to our resources, with our first priority being the redesign of our Urgent Care system and delivering our 30,000 community model. This will reset the way we deliver urgent and community care to ensure efficient and effective services.

5.1 Urgent and Emergency Care

In order to make our vision for urgent and emergency care a reality and provide safe and sustainable services going forward, we need to consider how to make best use of individual and community based resources, primary health care, health and social services and acute and community based hospital services.

The national long term vision is to create an Urgent and Emergency Care System that delivers the right care, first time for the majority of patients through an integrated model, which is easy to navigate and understand. This will be supported by developing a range of responses that health and care services provide to people who require, or perceive the need for same day advice, assessment and treatment.

We are committed to improving our urgent care performance and achieving the 4 hour A&E waiting time standard as a system. Achieving this requires significant reduction in levels of emergency admissions, attendances at our Emergency Departments and delays in discharge from hospital. Decreasing demand and improving flow necessitates significant system redesign which will require our emergency services to connect to our wider healthcare system. Our system has come together to develop a new emerging Urgent Care model of care which will:

- Provide better support for people to self-care.
- Help people with urgent care needs to get the right advice in the right place, first time.
- Provide highly responsive urgent care services outside of hospital so people no longer choose to attend Emergency Departments.
- Ensure that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.
- Connect urgent and emergency care services so the output of the overall system becomes more than the sum of its parts.

Urgent Care Pathways

We will deliver our 30,000 model and community pilots through which we will pilot new approaches to reducing emergency admissions to hospital.

Integrated Urgent Care and the Clinical Hub

We will develop a 'Clinical Hub' offering patients who require it access to a wide range of clinicians; both experienced generalists and specialists and including, Primary Care, Community clinicians and mental health expertise. It will also offer advice to health professionals in the community, such as paramedics and primary care, so that no decision needs to be taken in isolation. The clinicians in the hub will be supported by the availability of clinical records such as 'Special Notes', Summary Care Record (SCR) as well as locally available systems. In time, increasing IT system interoperability will support cross-referral and the direct booking of appointments into other services.

Urgent Care Centres

We plan to develop an urgent primary care service in key locations throughout Gloucestershire so that patients access these services at somewhere that's convenient to where they live. These Urgent Care Centres in key locations could also be the clinical hub that could link patients to other services. As well as a primary care service they will have other highly trained staff who can further assess what care patients need, provide diagnostics and treat a wide range of conditions. Our vision is that everyone should be able to access this level of expert care close to where they live, every day of the week.

The Emerging Model

Our community care redesign will ensure responsive community-based care is delivered through a transformative system approach to health and social care. The intention is to enable people in Gloucestershire to be more self-supporting and less dependent on health and social care services, living in health communities, benefitting from strong networks of community support and being able to access high quality care when needed in the right place, at the right time. New locality led "Models of Care" pilots will be carried out to "test and learn" from their implementation and outcomes to help inform and develop the future model of care for Gloucestershire.

7 Day Services to Support Urgent Care

Our vision for Urgent Care will deliver the right care for patients, when they need it. We plan that it will deliver 7 day services across the county by 2021. In order to make this vision a reality and provide safe and sustainable services going forward, we need to consider how to make best use our resources, facilities and beds in hospitals and the community. We want to improve arrangements for patients to access timely and senior clinical decision making about their treatment and ensure specialist support is accessed as soon as possible.

Over the next two years the CCG working with our key partners will:

- Complete a clinical evidence based proposal to reshape urgent and emergency care pathways within Gloucestershire across hospital and community based services for engagement with our local community by autumn 2017. This will start to inform our thinking on a whole county capacity model to make the best use of our resources available and support the delivery of 7 day services.
- Develop a model for beds utilisation across our county to ensure best use of resources by winter 2017.

- Establish a clear Memorandum of Understanding by summer 2017 to enable shadow pooling of budgets in a one system approach for urgent and responsive care.
- Contribute to the delivery of the 30,000 model and community pilots through which we will pilot a number of local clinics to reduce admissions and provide an expanded Community Intravenous Therapy Service by winter 2017.
- In line with our self-care and prevention plan and in conjunction with Public Health, help people take care of their own health, supported by making advice and treatment available within a network of local community pharmacies and through publicly accessible information by summer 2017.
- Continue to promote online resources such as, ASAP online to help people identify their symptoms, obtain self-care advice, find the nearest relevant services, information on when to use them and check opening hours. This will be supported by the development of an urgent care digital platform by winter 2017 that will ensure 24/7 access to reliable and robust directory of services for both public and health and social care staff.
- Ensure patients have access to even better information about local services, including, by winter 2017, access to the same detailed local 'Directory of Service' used by health professionals.
- Consider the development of a responsive Mental Health Crisis Service for young people and adults.
- Provide a consistent approach to the use of the National Early Warning Score across the urgent care system, which would support improved clinical outcomes of care commencing from summer 2017.
- Develop plans to consider innovative deployment of link paramedic practitioners and additional mental health staff to practices and make sure pharmaceutical advisors cover a single cluster. Pharmaceutical advisor posts to be filled by April 2017.
- To continue to develop a system-wide approach for 7 day services with the main focus on achieving the 4 specified clinical standards (consultant assessment, access to diagnostics, consultant-directed interventions and consultant on-going review). Monitoring of this is via 6 monthly prospective case reviews.

We are looking to our providers to:

- Work with us on developing the new models of urgent care.
- Commit to pooling Urgent Care resources in shadow form to take place-based commissioning approaches and agree County Bed Model.
- Pilot new approaches to urgent care delivery.
- Continue to develop new approaches to responding to urgent and emergency care demand.

5.2 New Models of Care

Our community care redesign will ensure responsive community based care is delivered through a transformative system approach to health and social care. The intention is to

enable people in Gloucestershire to be more self- supporting and less dependent on health and social care services (see Enabling Active Communities Section 3), living in healthy communities, benefitting from strong networks of community support and being able to access high quality care when needed in the right place, at the right time.

Developing 'networks' of 30,000 patients will require primary care, acute, community and local authority colleagues to all work alongside each other playing a pivotal role in ensuring we can provide place-cased care for our patients in an integrated way. This is likely to involve:

- An extended team of GPs, nurses, allied health professionals and specialists offering easy access to a wide range of health and care closer to people's homes.
- Provision centred around GP practices and primary care hubs.
- Support for populations based on a natural community.
- Promotion of self-care and prevention.
- The potential for a range of current health providers working together under a contractual (e.g. alliance) arrangement to improve health outcomes of the population.

New locality led 'Models of Care' Pilots have started to be carried out during 2016/17 to 'test and learn' from their implementation and outcomes to help inform and develop the future model of care for Gloucestershire. These pilots are already testing one system working across organisational boundaries, with staff accountability to each other as well as to their own organisations, giving an opportunity for greater integration of health and social care services to support delivery of co-ordinated care. The pilots provide an opportunity for clinicians to design and implement models of care based upon the needs of the local population to provide the best outcomes for local people. We are open to the possibility that this could lead to the potential for organisational change in our system, but strongly believe the model of care must lead any such change and demonstrate that patient care would benefit as an outcome.

Over the next two years, the CCG working with our key partners will:

- Work with a number of pilot localities, our providers and VCSE organisations and other key stakeholders to develop operational structures, governance and legal frameworks, delivery models and outcome and evaluation measures.
- Support localities in developing their place-based provider models with appropriate patient engagement, managerial, informatics and finance support.
- Provide information and intelligence, inclusive of Public Health needs assessments, to inform a place based approach that reduces health inequalities and improves patient health outcomes for the place based populations.
- Further develop our Social Prescribing offer and integrate Cultural Commissioning pilots by the end of 2017 (see section 4).
- Link paramedic practitioners and additional mental health staff to practices and make sure pharmaceutical advisors cover a single cluster.
- Work with practices to support them through merger or federation conversations as required.

5.3 Integration - Community Services

The Gloucestershire health and social care community has made strong progress on integration, both at system-wide design and service provision levels. An example of our shared commitment to creating system wide approaches to solving issues can be seen with our joint work to develop an innovative, integrated commissioning model across health and social care. GCCG and Gloucestershire County Council (GCC) have a number of arrangements in place, principally through joint commissioning agreements, to manage and drive change across a number of complex systems based on strategies such as Joining Up Your Care and the Children and Young People's Plan.

The commissioning process is resource intensive and there are benefits in doing this jointly. In many instances, the needs of patients and service users are indivisible across agency boundaries. We know that transformation will not happen overnight, but by further integrating our commissioning functions together GCC and CCG aim to encourage providers to work together and create more seamless services. In recent months we have been working to implement Integrated Commissioning Hubs. These hubs are places where staff from GCC and GCCG come together, and are co-located, to work collaboratively on projects, programmes and policy related to specific areas of the business and manage the whole commissioning cycle. In order to achieve this we have:

- Established clear leadership for integrated commissioning by the creation of a Joint Director of Integration post.
- Extended 'dual nationality' to officers in the integrated commissioning hubs who will report to joint commissioners.

The benefits include:

- Improved outcomes and experience for local people.
- Alignment of intentions and spend between GCC and the CCG.
- Facilitating the development of new market opportunities in the County.
- Improvements in core services.
- Reduced duplication of effort and spend.
- Increased focus on quality standards.
- The alignment and improvement of business processes for commissioning.

Person Centred Care

GCCG, GCC, and a number of local voluntary and community sector organisations form part of the only regional demonstrator site for Integrated Personal Commissioning (IPC) in England. This looks beyond the implementations of Personal Health Budgets (PHBs) to truly implement IPC, working across key programmes within our STP. PHBs have been implemented in Gloucestershire on a small scale since April 2014 and there are currently 30 adults eligible for Continuing Health Care and 2 patients with learning disabilities with a personal health budget in place. Gloucestershire has developed and embedded a PHB process and pathway that is also fit for purpose for a larger scale roll-out of PHBs for people

with long term conditions. We continue to work with key stakeholders and members of the Integrated Personal Care Steering Group to identify and offer PHBs to people who fall in these high need groups that may benefit from a personal health budget being in place. This is supported by training and mentoring for Personal Assistants of budget holders and use of quality methodologies to evaluate impact, both in terms of outcome delivery and financial assessment.

The IPC work programme has multiple interdependencies with other workstreams across health and social care and the steering group will ensure that work is not duplicated or carried out in an isolated manner. The key workstreams include:

- Training and Recruitment of Personal Assistants (PAs) for PHB holders.
- Exploring new payment options such as pre-payed cards.
- New cohorts of patients with PHBs or improved access to personalised care planning.
- Develop robust governance, finance, and contracts processes.
- Working collaboratively with NHS England to improve Wheelchair Services.

Over the next 2 years we will:

- Continue as a part of the South West consortium as a regional demonstrator for IPC, expanding our role beyond PHBs to work with NHS England to develop IPCs further.
- Continue to develop the IPC work programme including developing robust governance, finance and contracting processes, training and recruitment of personal assistants and budget holders, exploring new payment options and developing plans for new patient cohorts with personal budgets or improving access to personalised care planning.

End of Life Care

Our Gloucestershire End of Life Strategy was approved in September 2016 by the Health and Wellbeing Board. This strategy provides a whole system approach to planning and delivering end of life care and adopts the priorities in the Department of Health Ambitions Framework. This includes:

- Supporting people to be cared for and die in their place of choice.
- Maximising the use of Advance Care Planning to ensure joined up provision across the care system.
- Training and education of front line staff to have confidence when discussing end of life care with patients and families.
- Remodelling of the Hospice @ Home service and the work and engagement with the hospices.
- Support the use of ‘Advance Care Plan’ (ACP) to aid information sharing and care planning between providers around individual patients by establishing a ‘locally commissioned service’ for End of Life care.

Over the next two years, the CCG in partnership with GCC will:

Further develop our priority workstreams that deliver the outcomes outlined within the Gloucestershire EoL Strategy, reporting via the End of Life Strategy Board. This will include:

- Development of a quality dashboard that commissioners will use to measure quality of care and patient outcomes across all providers with respect of end of life care.
- Developing a co-produced service model for end of life care, across all stakeholder including the public.
- Developing our workforce via a programme of education and training to support staff to discuss, plan and deliver end of life care.
- Embedding the End of Life Needs Assessment
- Implementing an Electronic Palliative Care Co-ordination system (EPaCC's), as per national requirement by 2020
- Developing a single point of clinical access for 24/7 access to specialist palliative care.

Continuing Health Care

NHS Continuing Healthcare is a package of care which is arranged and funded solely by the NHS for individuals aged over 18 years, outside of hospital that have ongoing complex or intense or unpredictable healthcare needs. Complex patients account for 2% of the Gloucestershire population and are responsible for 15.3% (circa £35m) of the total CCG spend. Managing and improving performance continue to be a key driver in commissioning of Continuing Healthcare services in Gloucestershire in order to meet the increasing demand upon our resources.

Over the next two years, the CCG working with our key partners will:

- Benchmarking ourselves against our comparable peers and ensuring we receive value for money.
- Develop a range of key performance indicators that monitor the impact upon our organisation, such as the number of people going into a long term placement and client and resident satisfaction.
- Implementing clear pathways for patients in secondary care to ensure we have systems in place to make sure everyone understands how to access provision.
- Ensure that integrated health and social care multi-disciplinary teams (MDTs) are embedded to quickly respond to requests for a home or care home assessment on discharge and ensure that an appropriate package of care is in place.

Other community based initiatives

Over the next two years, the CCG will:

- Review the postural management aspect of the rehabilitation pathway to create a 'one stop' for management of postural needs.
- Ensure rehabilitation pathways enable evidence based decision making on provision of high cost specialist equipment, efficient access and repatriation of equipment for reuse.
- Develop a countywide stroke pathway, including a business case for the provision of community stroke beds, utilising existing community bed capacity.
- Further develop the approach to providing a complex leg wound service for Gloucestershire.

- Review the case for a pilot scheme to test the need for a county-wide specialist continence assessment service for ambulant patients.

6. Clinical Programme Approach

In collaboration with our system partners, we have continued to develop our Clinical Programme Approach (CPA) in Gloucestershire, ensuring the successful delivery of a number of key transformation programmes creating more joined up pathways and focusing on pro-active care from prevention through to end of life. The CPA is central to the way we work in Gloucestershire to improve the outcomes for our population using a pathway based approach that focuses on prevention, diagnosing earlier and treating and managing conditions from their early stages, achieved through the application of structured programme disciplines informed by improvement science. The development of our CPA provides a strong foundation, which will be further strengthened by a new system leadership model in order to deliver truly integrated pathways.

2016/17 ACHIEVEMENTS

CARDIOLOGY

- **Action Plan developed based on outcomes from pathway walkthrough and workshop for Cardiology.**
- **Chest Pain Pathway (Trop T) initial test completed and roll out commenced Oct 2016.**
- **Countywide roll out of Brain Natruretic Peptide Testing.**

RESPIRATORY

- **COPD pathway review completed to inform development of an integrated approach for COPD pathway redesign**

CANCER

- **Successful delivery of Early Diagnosis programme, including an extensive GP education programme**

MSK

- **Implementation of MSK new service model – Phase 1 complete.**
- **Implementation of Falls Strategy underway**

DIABETES

- **Clinical Programme Approach for Diabetes initiated for both Type 1 and Type 2 Diabetes.**

EYE HEALTH

- **Commissioning of new Community Eye Service**

The following sections outline our priorities within the priority clinical programmes over the next two years:

6.1 Respiratory

The Respiratory Clinical Programme Group (CPG) was relaunched in May 2016 with a focus on system wide transformation and has rapidly begun to progress pathway redesign in priority areas i.e. Chronic Obstructive Pulmonary Disease (COPD). In 2016/17 significant progress has been made in reviewing the COPD pathway to inform development of an

integrated approach for COPD pathway redesign. The winter review scheme for respiratory patients has been offered across primary care to provide additional support in winter months.

Over the next two years, the CCG will:

- Embed a holistic approach to prevention and self-management across Respiratory pathways, including the use of a Patient Activation Measures (PAM), smoking cessation, flu vaccinations, self-management planning, education and training.
- Implement priority pathways for COPD, Bronchiectasis, Sleep Apnoea including ventilation services, and Asthma.
- Develop and implement integrated community service model for delivery of the COPD pathway.
- Implementation of a discharge care bundle across acute and community settings.
- Support more people who have respiratory disease to live well at home.

6.2 Musculoskeletal

The Musculoskeletal (MSK) CPG has a well embedded programme that continues to focus on pathway redesign and improvement of key services, working with our existing providers to deliver equity and quality services across the system. This has included implementation of changes in delivering Orthopaedic follow-ups, embedding changes in the role and provision of GP with a Specialist Interest (GPwSI) services and working with the voluntary sector to strengthen their role in providing support to patients. Implementation of priorities identified within the Falls Strategy will continue to be a key focus and we will continue to develop System Wide Outcome Measures for MSK services, working with Oxford University.

Over the next two years, the CCG working with our key partners will:

- Ensure patients are supported at the earliest opportunity with education and advice that supports self-management and prevention.
- Develop a multi-organisational “Integrated MSK Model”.
- Develop and implement redesigned pathways for Hip, Knee, Shoulder and Lower Spine.
- Develop a proposal for virtual fracture clinics in Orthopaedics.
- Develop a model for a MSK Advanced Practitioner Service/Orthopaedics single point of access (at locality level – linked to place based approach).
- Embed MSK Advanced Practitioner Physiotherapists in Primary Care.
- Embed cross-organisational multidisciplinary team compliance.
- Ensure adherence to implemented pathways across the system.
- Implement preferred options regarding Orthotics as per outcomes of an options appraisal.
- Develop a Countywide integrated approach to falls prevention by ensuring early identification and interventions for people at high-risk of falls.

6.3 Eye Health

Our Eye Health programme continues to deliver pathway redesign with a condition specific focus that has seen good progress in making service delivery improvements in priority areas such as Cataracts and Minor Eye Conditions. A new community eye service was commissioned in 2016/17 and work will continue to monitor the impact that the new service has had across the system. The CCG will continue to support the provision of School Vision Screening and will work collaboratively with GHNHSFT and the Primary Eye Care Company to ensure refreshed and embedded protocols are ready for go live in January 2017.

Over the next two years, the CCG working with our key partners will:

- Implement an agreed pathway for Glaucoma, making use of community services to deliver care close to home.
- Implement recommendations to reduce health inequalities.
- Review the outcome of the new NICE guidelines for Wet Macular Degeneration and implement any service improvements required.

6.4 Circulatory

The Circulatory CPG has a well-developed programme plan that was built on the completion of a pathway walk-through, stakeholder workshops and further provider engagement to ensure Cardiology services can respond to the increasing demands upon them. The programme has successfully undertaken an initial Low Risk Chest Pain Troponin testing pilot, aiming to reduce urgent admissions for low risk chest pain by 30%. Pathway developments in key areas across Cardiology and Stroke requiring improvement continue to be a key focus, such as length of stay, ward access and access to CT for acute stroke care.

Over the next two years, the CCG working with our key partners will:

- Focus on prevention, embedding the Familial Hypercholesteraemia (FH) service to develop this risk factor identification and to reduce the overall risk for cardiovascular disease for patients and their families.
- Improve access and use of diagnostic testing including echocardiography and the introduction of Brain Natruretic Peptide (BNP) testing for early diagnosis and management of heart failure.
- Undertake a quality improvement review of heart failure services for the county.
- Develop and implement a proposal regarding Electrocardiogram (ECG) diagnostics in primary and community care with the aim of upskilling and reviewing equipment.
- Implement a remote follow up service for cardiac device follow up, implantable cardiac Defibrillators, Cardiac Resynchronisation Therapy Devices and implantable loop recorders.
- Develop a Stroke Rehabilitation business case.

- Continue to increase the service profile for stroke thus providing improvement and sustainability in stroke/transient ischaemic attack performance (e.g. Therapy, Thrombolysis, TIA).
- Review Best Practice Tariffs for Stroke, Heart failure, Arrhythmia and Chest Pain to ensure effective service development opportunities are recognised and aligned with CCG improvement plans.

6.5 Diabetes

The Diabetes programme has engaged with stakeholders from across the system in the planning and design of Type 1 and Type 2 Diabetes patient pathways. This work has been critical in developing an approach to highlighting the recommendations for improvements that need to be made to the patient pathway. In Gloucestershire we have initiated implementation of 'Mapmydiabetes' as part of the West of England Academic Health Science Network Diabetes Digital Coach test bed which enables patients in Gloucester City and the Forest of Dean to access online, NICE approved, diabetes structured education and self-management resources.

Over the next two years, the CCG working with our key partners will:

- Ensure information about Type 1 (adults and paediatrics), Type 2 diabetes and diabetic footcare pathways are available on G-Care for primary care clinicians.
- Review the implementation of a diabetic foot care pathway in order to reduce amputations (subject to business case approval).
- Review the continued implementation of Mapmydiabetes (from Forest of Dean and Gloucester City to all localities).
- Reduce practice variation for diabetes care. This will include a review of the current Diabetes Community Enhanced Service in the context of the pathway, with consideration given to the place based model.
- Review prescribing practice in diabetes and introduce a recommended treatment plan for Type 2 diabetes.
- Introduce top tips for "caring for patients with diabetes" – this will be used in care homes, domiciliary staff, carers, relatives etc. This will provide a footprint for other clinical areas e.g. caring for someone with respiratory disease, eye problems, at risk of falls etc.
- Review the provision of structured education for diabetics within Gloucestershire with a view to increasing the documented uptake of face to face education (Type 1 and Type 2) and ensure the appropriate skill mix is used to provide the face to face sessions.

6.6 Cancer

In Gloucestershire we have an extensive programme that is delivering an improvement in health outcomes to the people affected by cancer in line with the national strategy 'Achieving World-Class Cancer Outcomes: A Cancer Strategy for England 2015-16'. We continue to build our partnerships within the county and beyond and in October became members of the Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance.

Over the next two years, the CCG working with our key partners will:

- Run a local public awareness campaign targeting health inequalities/key health needs to support cancer prevention and early diagnosis.
- Maintain a GP Education Programme, evaluating the first 3-years of the programme, collate learning from a large-scale Significant Event Audit and share best practice from the Primary Care Living With and Beyond Cancer Case Study Programme.
- Complete full roll out of NG12 NICE Guidelines on referral for suspected cancer and associated changes to diagnostic and patient pathways.
- Support and agree a model for integrated demand planning and management to respond to the rising trend for 2 week wait referrals, and ensure cancer staging is reported for over 70% of cancers.
- Redesign of county's referral and diagnosis pathways in preparation for the NHS England/Independent Cancer Taskforce goal requiring "patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP".
- Maintain partnership working with GHNHSFT to support delivery of the cancer waiting time standards by collaborating on a range of projects, including the redesign and implementation of streamlined colorectal diagnostic pathways.
- Scope the development of cancer prehabilitation to support patients being fitter and more resilient and improve health outcomes (to link to cross cutting themes).
- Embed and sustain the provision of the Recovery Package including Risk Stratified Pathways with appropriate remote surveillance plans at GHNHSFT, for all breast, colorectal and prostate cancer patients. Cancer recovery package incorporates holistic needs assessment, care planning, treatment summaries and referral/co-delivery of patient education for supported self-management. This will include considered roll out to other cancer sites during 2017/18.
- Develop a new local approach for the provision of Cancer Care Reviews in primary care, building on the Practice Nurse Education Plan.
- Evaluate and prepare forward commissioning proposals for Macmillan Next Steps Cancer Rehabilitation.

6.7 Dementia

Through new ways of working we will develop our pathway for dementia as a test bed for integrated pathways across the system. This will include working closely with our partners in Gloucestershire to provide a more person centred approach for people with dementia and a holistic view of their physical and mental health.

Over the next two years, the CCG working with our key partners will:

- Continue to maintain the current dementia diagnosis rate of 67.4% and comply with national targets for 2017/18.
- Ensure delivery of national dementia ambitions around improved diagnostic support, workforce development and care standards. This includes care home standards, supporting carers and developing community capacity to support those living with dementia.

- Embed learning from ongoing review of primary care dementia pathways and stakeholder events to inform service change to address areas in need of improvement i.e. Vascular Dementia.
- Address inequalities in access to dementia services for Black & Minority Ethnic (BME) and Young Onset Dementia groups.
- Develop the Connect Befriending and Peer Support to include people with stroke, dementia and other long term conditions.

6.8 Children and Maternity

The Children's Clinical Programme Group and Maternity working groups have continued to make significant progress in 2016/17 including steps in delivering the commitments set out in Gloucestershire's Future in Mind Plan (see Mental Health section 8.1), progressing the response to the gaps identified in perinatal mental health care and improvements in paediatric continence and autism pathways. Work is ongoing to review the support available to children who are frequently admitted to hospital and the CPG has taken steps to tackle reducing emergency admission rates for common conditions such as gastroenteritis in children under one year old and lower respiratory tract infections for children under five.

Improving the experience of our maternity services (monitored via the NHS Assurance Framework) and the findings of the National Maternity Services Review: Better Births (2016) continue to be key drivers in our approach to improving maternity services in Gloucestershire. We are in a good position locally with our maternity services, for example in Gloucestershire there is a full choice offer of home birth, delivery suite, midwife led freestanding birth units and a birth unit within Gloucestershire Royal Women's Centre. We have also implemented the revised pathway for unscheduled care for maternity services including an innovative approach to providing advice to women with urgent care needs in conjunction with the South Western Ambulance Service Foundation Trust. Our benchmarking position against Better Births has highlighted postnatal care, including maternal mental health as a key area of focus for improvement locally.

Over the next two years, the CCG working with our key partners will:

- Continue to implement the action plan associated with the Better Births Report (2016) to include:
  - Continue to develop and implement different ways of engaging women and families including in diverse communities in conjunction with Health watch and GHNHSFT through social media and other means.
  - Work with women, families and stakeholders to improve postnatal care.
  - Develop community hubs and integrating better together services that support women and families in the early years including health visiting and children's services.
  - Implement the action plan relating to Saving Babies Lives, aiming to reduce stillbirths via smoking cessation, monitoring movements and growth of babies.

  - Work with public health and the new Healthy Lifestyles service to embed pathways of support for women to improve their health and wellbeing.

- Consider the development of an integrated specialist perinatal health service comprising specialist maternity, infant and adult mental health knowledge and support to ensure that women and families with complex mental health needs consistently receive robust specialist assessment, multiagency planning and support. This will include a skilled workforce that is trained to be able to support women, an increased range of community support options and the development of an anti-stigma campaign.
- Begin implementation of the paediatric continence action plan ensuring that children's continence issues are detected as early as possible, with children being supported in the community to ensure the best experience and outcomes.
- Continue to improve transition for young people with long term conditions to ensure that the Ready, Steady, Go Programme is fully embedded.
- Improve health support and capacity and implement service changes to support health assessments and planning for children in care and those being adopted (including those who may be refugees or unaccompanied asylum seekers) and in responding to the change that follow implementation of the Regional Adoption Agency arrangements.

6.9 Frailty

The CCG will support a Frailty CPG to widen the scope of the South Cotswolds Frailty Pilot that has been established in 2016.

Over the next two years, the CCG working with our key partners will:

- Develop the frailty model with both the South Cotswolds and Gloucester localities and evaluate to inform learning and potential roll out across Gloucestershire

6.10 Planned Care Delivery

Our Planned Care Programme is a cross cutting theme across all of our clinical programmes and ensures that whilst delivering improvement for patients throughout their healthcare journey we maximise quality and ensure best value for money. The programme focuses on the wider journey of our patients from self-care and self-management through to exiting care, avoiding unnecessary entry into the health care system and supporting patients to return to normal life. Our key focus remains ensuring appropriate and timely access to services, ensuring care is provided as close to home as is possible and affordable and ensuring that care is provided by the right professional.

2016/17 ACHIEVEMENTS

REDESIGNING CARE PATHWAYS

- **Ensuring all care provided is evidenced based and compliant with NICE and local policies and procedures.**
- **Development of IFR policies and application process across Primary and Secondary Care.**
- **Community Urology Service commissioned.**

G-CARE

- **Implementation of the G-Care platform which disseminates pathway information to clinicians and support improved pathway compliance and reduced clinical variation.**

In line with constitutional standards at section 11.1, ensuring delivery of our key planned care performance standards is fundamental to our planned care programme. We continue to embed robust contract and performance management, with cross-organisational working practices in place to ensure providers are both supported to deliver and held to account where necessary. Alongside the focus across the breadth of the indicators we will ensure a focus on improving our performance against the following:

- Diagnostic performance at both a local and national level has been monitored throughout 2016/17 to ensure appropriate action is taken with our providers to ensure a high quality diagnostic service. This has included increasing capacity within the system, reviewing access to services on a geographical basis and improving GP education to ensure patients have timely access to care, closer to their home.
- Work with the Cancer CPG has reviewed the current gaps in diagnostic services that need to be filled to support the implementation of NG12 NICE Guidelines and working with providers to ensure provision is available at the earliest opportunity. In implementing these direct access diagnostics we are helping to ensure we avoid variations in clinical outcomes.
- A review of the IT infrastructure that supports radiology services, especially in a multi-provider landscape is also underway, working closely with the South, Central and West Commissioning Support Unit (SCWCSU) to determine options moving forwards.

The following planned care improvement projects will be prioritised:

Dermatology

- Building on the work started in 2016/17 to embed the use of Dermatoscopes across primary care clusters.
- Review and implement opportunities for change within outpatient provision.

ENT

- Implement pathways for ear wax removal and tinnitus.

Neurological

- Implement a Pain Management Programme considering the provision of pain management services across the county, including the redesign of the pain pathway, GP and patient education and support and a focus on analgesic prescribing practice. This will include the development of an action plan for high cost, individual complex patients who have addiction to prescription pain medication.
- The programme will also evaluate further opportunities within non-elective pathways.

Renal

- Completion of a renal services review and implementation of agreed recommendations.

Cross cutting themes

- Design and implement a patient facing website that supports patients to self-care and self-manage;
- Develop and embed an education strategy across all CPGs.

Over the next two years for planned care, the CCG working with our key partners will:

- Continue to increase the number of electronic referrals made in Gloucestershire in line with NHS England's ambition to achieve 100% utilisation of the e-RS by 2018 (currently 73% October 2016), by placing a stronger focus on supporting practices to improve their utilisation.
- Further develop and implement care pathways with Clinical Programme Groups and continue to improve compliance, by ensuring further publication of pathways on G-Care focusing on high volume/high spend conditions.
- In addition to the CPGs, ensure that care pathways are in place for all common conditions within Urology, Gastroenterology, Gynaecology, ENT and Neurology to ensure patients receive the right advice, care and treatment at the right time.
- Implement initiatives that acknowledge the recommendations outlined within the NHS England Demand Management Good Practice Guide. Including further development of Advice and Guidance (to include telephone advice and guidance), embedding choice (via the implementation of the Clinical Decision Support Tool), offering alternatives to outpatient appointments, direct access diagnostics and management and monitoring of outpatient follow-up appointments.
- Continue to define our approach to out-patient follow-ups in order to progress achievement of upper quartile peer group new to follow up ratios. This includes continued implementation of the existing follow up programme including:
    - Increasing the role of patients in follow up decision making to help reduce low value activity.
    - Increased use of follow up protocols/criteria to reduce clinical variation.
    - Use of alternative approaches to follow up – telephone/virtual.
    - Challenging clinical outliers.
    - Decommissioning low value follow up activity (such as post hernia follow up).
- Commission diagnostic services that meet the national performance targets for access and the local targets for reporting as well as ensuring care is available closer to home and in the appropriate setting; avoiding unnecessary entry into the secondary care system.
- Complete an evaluation of the Community Urology Service pilot to understand service provision and explore the potential options for delivering the service moving forward.
- Develop business cases for the expansion of the GHFT Multidisciplinary Assessment and Diagnostic (MAD) service to cover all new urology appointments and implementation of Urolift as an alternative to Transurethral Resection of the Prostrate (TURP) for patients with benign prostatic hyperplasia.
- Work with the GHNHSFT Home Enteral Feeds Team to develop our local position on blended diets to minimise risk and demands upon the service.
- Take an active role in ensuring ongoing system resilience for planned and urgent care.
- Focus on delivering the CCG outcomes framework.

We are looking to our providers to:

- Actively engage and commit with the Clinical Programme Approach and the associated delivery programmes, including commitment of senior clinical and managerial time in support of this work and leadership and delivery of key component projects as agreed.
- To commit to work collaboratively on specific service reviews and consequent identified service improvements, whilst recognising that this will be subject to agreement of revised service specifications on a case by case basis.
- Work as part of the system to reduce clinical variation across all aspects of patient care.
- Take an active role in devising referral criteria to assist with improving referral quality and reducing demand.
- Engage in developing our speciality community provision, supporting 'Care Closer to Home'.
- Work to develop policies for Interventions Not Normally Funded, (INNF) i.e. are treatments which are considered of low clinical priority.
- Continue to work to ensure the NHS constitutional targets are achieved and sustainable.

6.10 Specialised Commissioning

NHS England has had responsibility for specialised commissioning since April 2013, bringing in new and standardised national service specifications. In the South West a Specialised Commissioning Oversight Group (SCOG) was established in 2015 to establish governance of co-commissioned services and set the local priorities for co-commissioning. Now during 2016 with the formation of STPs more detailed proposals are under consideration to develop the governance and budgeting arrangements to support a flexible approach to varying footprints of collaboration; these could reflect service specific pathways either sub-regionally or at a STP /multi-STP level. We support making this work in practice and ensuring an integrated approach across commissioning boundaries with the patient at the centre.

In terms of service development, during 2016/17 a number of regional specialised commissioning programmes have progressed including: significant service improvement on complex spinal surgery, developing new models of care for mental health services, service development for Children's and Adolescents' Mental Health and progressing the Transforming Care Programme. Gloucestershire CCG will maintain its ongoing involvement in these development areas.

During 2016/17 there have been challenges in completing the proposed devolution of commissioning responsibility from NHS England to CCG for morbid obesity surgery and renal dialysis. Both areas present opportunities for joined up pathway service development within Gloucestershire and the CCG has begun engaging with providers. We will therefore continue to liaise with NHS England on agreeing next steps for either commissioning transfer or joint service redesign during 2017/18.

7. Reducing Clinical Variation

The need to manage clinical variation has been recognised and will be addressed through a dedicated Reducing Clinical Variation Board operating at the system level and seeking public consultation as required for difficult priority decisions. Benchmarking analysis indicates that there are significant opportunities available with respect to improving the quality, safety, consistency and efficiency of services by reviewing, amending and redesigning, as appropriate, a range of services.

The focus of the programme will be on a 'Choosing Wisely for Gloucestershire' and Medicines Optimisation Approach, a review of diagnostics, variations in follow-up appointments, a Pain Pathways Programme and practice variation in primary care.

Over the next 2 years, the CCG working with our key partners will:

- Continue to develop the Outpatient Follow Up project to achieve upper quartile benchmark position, including developing standard follow up protocols, developing innovative ways of delivering follow up care, validating follow up pending lists, consultant variation and supporting CPGs in considering pathway redesign.
- Commission an independent review of diagnostics provision in Gloucestershire.
- Develop and implement an innovative pain pathway across the system, including a focus on medicines optimisation and the development of an education programme to support both patients, the public and health care professionals.
- Develop a clear action plan to manage a very small number of specifically complex individual cases of addiction to prescription pain medications currently in our community and using the learning to inform the long term approach to a service model for Gloucestershire.
- Continue to support the work already in place with localities that focuses on determining drivers of practice variation and how to reduce it. This will include building on the tested approaches i.e. Primary Care Offer, GP portal and GP led review group.
- Continue to focus on the role of practice variation as our new models of care move to a 'place based' approach including using data at a population or cluster level.

7.1 Medicines Optimisation

Medicines optimisation forms a key part of our STP in Gloucestershire. We know that medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. The programme addresses the need to ensure that we receive the best possible quality outcomes for the level of resource we invest in them e.g. ensuring that the medicines are taken correctly, avoiding taking unnecessary medications, reducing wastage and improving medicine safety.

In Gloucestershire our Medicines Optimisation programme adopts the principles set out in the Choosing Wisely approach. This promotes the conversation between clinicians and their patients to choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm and truly necessary. We have run successful

waste medication reduction programmes across Gloucestershire over the years and have established relationships with our key providers, including embedded joint formularies and gain share arrangements that support a system wide approach to medicines management.

The primary care Prescribing Improvement Plan continues to be refreshed and offered to practices on an annual basis. In 2016/17 all practices in Gloucestershire signed up to the initiative, which provides targeted support to practices to achieve a number of things e.g. reduce prescribing of inappropriate, high cost, high volume medications, and also to look at quality based topics such as polypharmacy and medications in older people. This has been supported by attendance of CCG medicines management leads at primary care locality meetings and the introduction of an Independent GP Peer Support role, to provide a critical friend to practice prescribing behaviours.

Over the next two years, the CCG working with our key partners will:

- Develop a new and innovative medicines optimisation approach for patients living with pain, considering the role of pharmaceutical interventions, the pathway of care and new ways to provide alternative and holistic support.
- Continue to strengthen the number of Clinical Pharmacists working with our local GP practices.
- Development and implementation of the 'Do Not Prescribe' List.
- Continue to work with secondary care to ensure that drugs are initiated and continue to be prescribed in the most appropriate setting i.e. acute/secondary or primary care. This includes the repatriation of appropriate drugs from primary to secondary care to ensure the best value for money across the health care system.
- Embed a new dietetics role to support the change in provision of Gluten Free food and Sip feeds, to ensure appropriate support to patients via primary care.
- Introduce a Repeat Prescription Ordering Service for Gloucestershire patients to support the reduction of waste medication.
- Continue to work with community pharmacy to ensure continued engagement with commissioned services e.g. Minor Ailment Scheme, Urgent Repeat Medication Service, Not Dispensed Scheme and Urgent Care Medication List.
- Work with Gloucestershire Hospitals NHS Foundation Trust to improve the use of biosimilar medications, homecare and enhance the use of low molecular weight heparins.
- Work with 2gether NHS Foundation Trust to improve the use of Circadin Melatonin and develop medication guidelines for mental health medicines.
- Continue to pilot the ONPOS Dressing Ordering supply in practice to understand the benefits and potential arrangements for countywide roll out.
- Continue to support the role of Pharmcare in providing care homes with Clinical Pharmacists to provide medication reviews.

8. Parity of Esteem for Mental Health & Learning Disabilities

8.1 Mental Health

Gloucestershire CCG will continue to fully implement the Mental Health Five Year Forward View for all ages, focusing on providing parity for mental health for our population. We will continue to focus on the services available across the system, from prevention through to crisis care, whilst considering the impact of health inequalities in accessing support and intervention.

Health inequalities will remain central to our planning and delivery of mental health services and we aim to address how individuals with mental health needs can access health prevention screening, planning and interventions, available to the general public. This will be supported by ensuring mental health services and patients co design a programme of interventions that facilitate access for those patients that need individual motivation, help and support. In line with the national planning framework and our STP, our key priorities for the next two years are:

- Continue to take steps to Improve Access to Psychological Therapies (IAPT), to ensure we meet the requirements of the IAPT national targets for access, recovery and waiting times to treatment. We will continue to review the capacity available within the system and ensure the service model is responsive to the increasing demand.
- Continue to work towards the delivery of the 'early intervention in Psychosis' standard including expanding the age range covered by the service.
- Make further improvements to the Eating Disorder Pathway including addressing the resource implications of providing physical health checks and ongoing observation in primary care.
- Work with partners in Public Health to develop strategies and interventions to achieve the ambition of reducing suicide by 10%.
- Build on the work undertaken to implement the extended hours Psychiatric Liaison service available in Gloucestershire, to ensure that it meets the Core 24 standard.
- Continue to work with 2gether NHS Foundation Trust, NHS England and social care to reduce out of area placements, by understanding the factors that are requiring people to be treated out of area and develop joint pathways to repatriate when clinically appropriate.

Over the next two years, the CCG working with our key partners will:

- Review the Mental Health Intermediate Care Team in terms of allocation of resource to see how this can further support the delivery of the IAPT service.
- Work with 2gther NHS Foundation Trust to extend the Medically Unexplained Symptoms pilot to a broader range of practices.

- Use the learning from the 2016/17 Personality Disorders CQUIN with 2gether NHS Foundation Trust to make improvements to the existing pathway and develop a specification for a Personality Disorders Service.
- Review the Complex Psychological Interventions Action Plan to identify further opportunities to enhance delivery across both specialist and generic mental health teams.
- Ensure delivery of the Crisis Care Action Plan to enable delivery of shared goals of the Mental Health Crisis Concordat within Gloucestershire; specifically delivering a new model of care for the crisis service.
- Develop a business case to expand the Individual Placement and Support Vocational Services so that it can see more people with serious mental illness and expand into early intervention and prevention in IAPT.
- Fully implement the Mental Health Acute Response Service across Gloucestershire to cover people under 16 years of age and ensure delivery of agreed standards and KPIs.
- Continue the implementation of the Mental Health Liaison Team.
- Explore the outcomes and future commissioning arrangements of Crisis House, commissioned by 2gther NHS Foundation Trust and Swindon/Gloucestershire Mind.
- Develop the Crisis Care Workforce Strategy, developed by leads at GCC through the Crisis Care Concordat.
- Continue to support the Crisis Café pilot, to consider the benefits, outcomes and future commissioning arrangements.
- Commission a specialist community perinatal mental health service.
- Review the Adult ADHD aspect of the Recovery Service Specification and agree the process by which individuals can access a review.
- Assess the impact of the remodelling of Approved Mental Health Professionals provision including the integrated operating model of social work.
- Review the method of transporting patients detained under the Mental Health Act in order to improve the method of transport utilised.
- Implement an all age Autism strategy to work towards delivery of waiting time standards for adults with Autistic Spectrum Conditions.

8.1.1 Children's Mental Health Services

In 2016/17 work continued to deliver Gloucestershire's Future in Mind, 5 year transformation plan for children and young people's mental health. The plan has a whole system approach to improving outcomes, identifying two main priorities to provide earlier intervention and a range of different ways of accessing advice, guidance and help in a timely way; and to develop much more joined up models of care across health, education, social care and other agencies for very vulnerable young people who have experienced trauma, abuse and neglect (including how we address the needs of young people who are on the journey to developing personality disorders and long term enduring mental health difficulties). Over the

next two years we will continue to work towards delivering the commitments set out in the transformation plan.

Over the next two years, the CCG working with our key partners will:

- Roll out mandatory mental health training for staff in schools and in other universal 'non mental health specialist' services. Ensuring mental health is 'everybody's business' and as such the workforce who are not 'specialists' in this area should nevertheless have a consistent level of knowledge and competence in mental health.
- Develop our early intervention approaches, by evaluating face to face and online counselling provision and plan to implement what works for young people.
- Roll out across the county the learning from our schools and mental health pilot to help inform how school mental health services need to be remodelled and address capacity issues to ensure children are identified earlier and get the support they need.
- Review children's mental health pathways to test how they can be joined up to provide a streamlined pathway.
- Address the gap in local provision for mental health support for children with long term conditions, including the review of children who have recurrent admissions to hospital and the small number of children and young people who have complex but medically unexplained symptoms.
- As part of the Integrated Personalised Commissioning Programme we will be piloting individual budgets and approaches to support the mental health of children in care. This will include developing models of effective working with vulnerable children and young people and working with our key partners in GCC to think about how we could utilise the resources of both social care and mental health workers to provide the best support we can to families where children have experienced, abuse, neglect and chaotic parenting.
- Develop an intensive interventions service in conjunction with Gloucestershire County Council to meet the needs of young people with a psychological and/or social care crisis, including alternatives to CAMHS inpatient care and places of safety.
- Continue to implement the perinatal mental health strategy.
- Work collaboratively with NHSE Health & Justice team and other partners (eg council, Office of Police & Crime Commissioner) to ensure improved pathways of support in a number of areas including for children who have suffered sexual abuse / assault (including child sexual exploitation), and/or for those young people at risk of coming into contact with the criminal justice system.
- Develop a school age autism pathway for children and young people to improve the journey for families and make the best use of the resources across the county.

8.2 Learning Disabilities

The delivery of our transforming care plan continues to be a main driver for change in learning disability services in Gloucestershire. Following events at Winterbourne View, we have continued to ensure that appropriate care for those with complex and challenging needs is being delivered in our local community, ensuring out of county placements are minimised and opportunities developed to ensure that assessment and treatment beds are used for only the highest needs and for the shortest possible time.

2016/17 ACHIEVEMENTS

WESTRIDGE DECOMMISSIONING

- **Decommissioning of Westridge Inpatient facility in consolidation of inpatient beds at Hollybrook Inpatient Facility run by 2Gether NHS Foundation Trust.**

ANNUAL HEALTH CHECKS

- **Successful Health Action Day where GP workshops aimed to address the under delivery of Annual Health Checks for people with Learning Disabilities.**

Over the next two years, the CCG will:

- Continue to provide countywide leadership of the transforming care plan, ensuring national targets are fully met. This will include the introduction of a new model to ensue all LD deaths are appropriately reviewed, arranging placements for patients currently in inpatient facilities (currently 16 patients) and enhancing the Experts by Experience quality checking to include people in inpatient units that are not currently covered.
- Ensure that 75% of LD patients undergo an Annual Health Check.
- Increase capacity for people within mainstream health services in order to reduce the degree of funding necessary for specialist LD services. This will support the decommissioning of duplicate health care being delivered in specialist services.
- Embed the Integrated High Needs Team that amalgamates the health and social care aspects into a single point of delivery. This will ensure appropriate linkages with Learning Disability Intensive Support Service and ensure that the model is sufficiently robust to ensure patient safety and progression.
- Continue to address the overall issue of health inequalities for people with a learning disability by engaging in wide ranging clinical engagement across the areas where the needs of people with a learning disability may need to be articulated and supported.

9. System Development Programme

9.1 STP Programme Development

We continue to work with our system partners on our shared System Development Programme, which will furthermore be shaped and embedded to support the delivery of our STP. The Gloucestershire Strategic Forum (GSF) continues to be the key driver in shaping our approach to local system leadership and a series of workshops have continued to be held to develop our response to STP requirements such as refining our vision, identifying opportunities to innovate and developing the Roadmap to Delivery; which have also been supported by a Gloucestershire Finance Summit. These workshops have had the commitment of Chief Executive/Accountable Officers, Chairs from across the health system, Council Leaders and Directors of County Council and culminated in the development of our key priorities to transform our local system that underpin our STP in Gloucestershire.

A Memorandum of Understanding (MOU) has been agreed by all organisations to support the delivery of STP across the system. The MOU sets out the way we have agreed to work, confirming the approach of sharing risk, information sharing and governance and clinical governance to support integrated working.

As STP Partners we are working together to deliver a range of system enablers. Of particular note is the development of a shared Quality Academy supported by the West of England Academic Health Science Network and the national NHS Quality Service Improvement & Redesign (QSIR) College to ensure application of the latest thinking, application in practices and education materials. We plan to commence system wide learning programmes from autumn 2016 and expect that participants of our Quality Academy will be able to access a range of support including coaching, access to on-line resources (e.g. local case studies) and action learning sets. We will develop and include a new approach to building improvement capability in primary care to ensure we support primary care to make the transition needed to work as a central part of our New Models of Care.

Over the next two years, the CCG working with our key partners will:

- Develop and launch a collaborative system wide academy with a curriculum designed to meet the needs of system-wide transformation and quality improvement.
- Schedule programmes to meet the needs of teams responsible for the delivery of STP strategic priorities.
- Train approximately 200 key service improvers by 2017, with a further 200 trained year on year.
- Build on our case reviews to inform improvements in pathways and discharge.

9.2 Governance Arrangements

Our system has agreed a collaborative leadership approach for our STP, with system leaders taking ownership of key STP work programmes on behalf of partners across Gloucestershire.

Diagram 3: STP Governance Structure

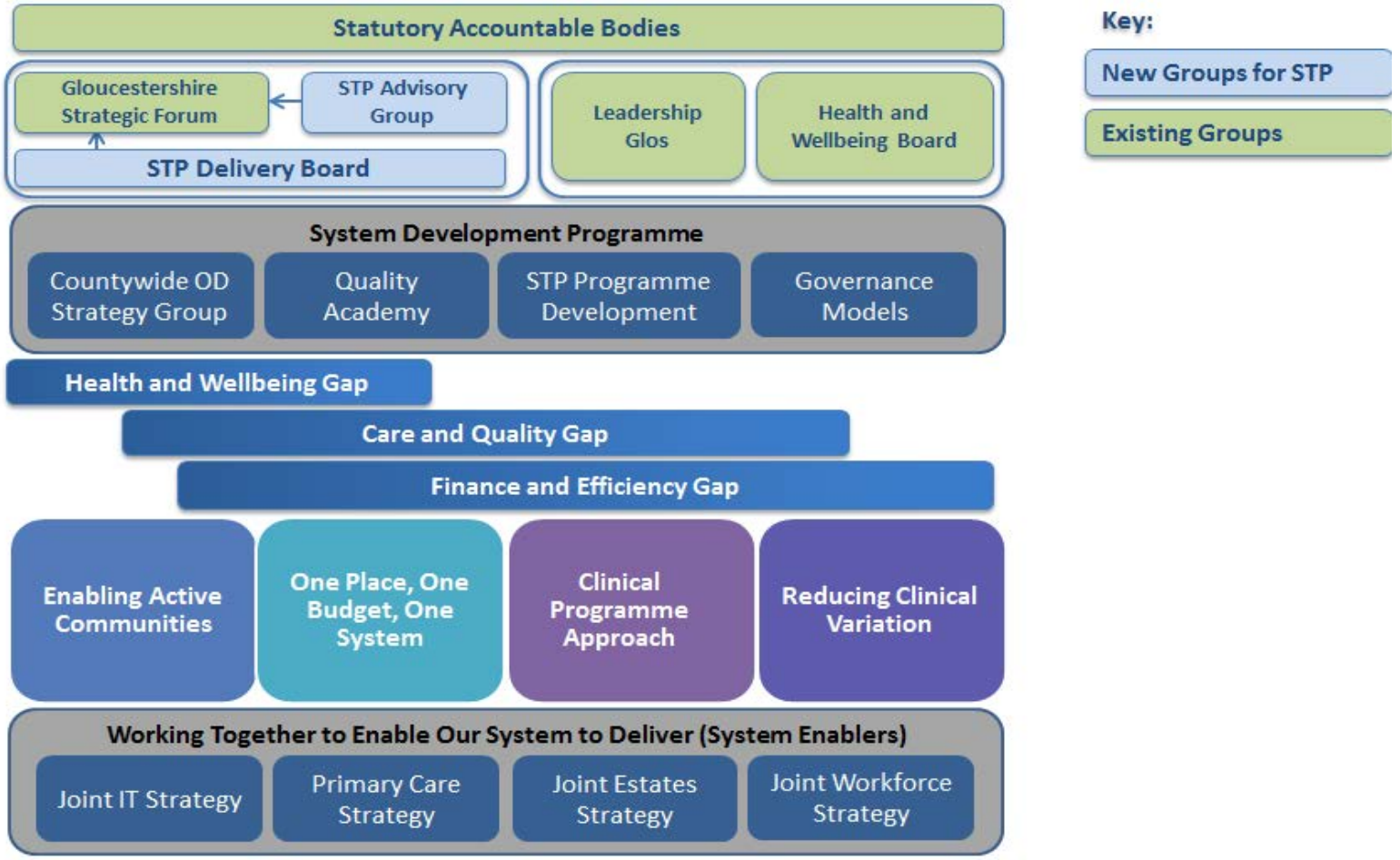
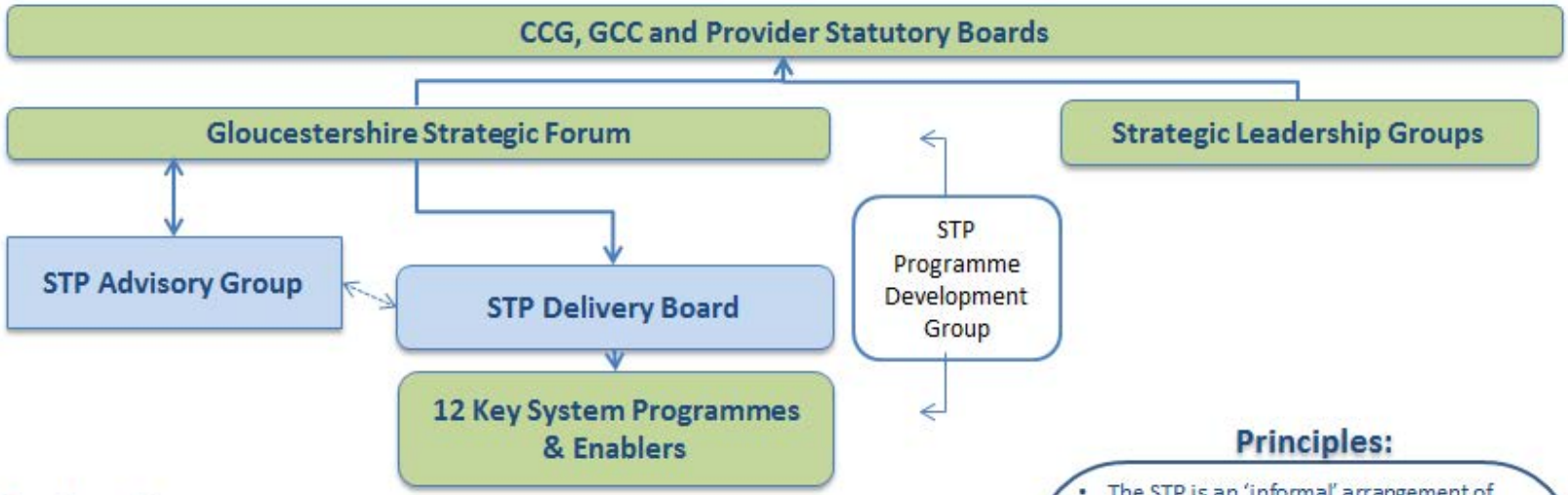


Diagram 4: STP Governance Principles



Membership:

Gloucestershire Strategic Forum	Chairs and Executive health and local authority commissioner and provider representation to enable decision making ,Independent Chair
STP Delivery Board	Representation from Provider & County Council CEO's, DASS, DPH, NHSE,PC, Independent Chair
STP Advisory Group	Delivery Board Members, Chairs and Council Leaders County and District Councils, NHSE, NHSI ,AHSN, Voluntary Sector, Healthwatch Gloucestershire to ensure wide partner engagement in STP programme
Key Programmes	Appropriate representation from system partners in each programme with agreed leadership supported by an MOU to achieve transformational change at scale. Terms of Reference established to support collaborative working.
STP Programme Office	Representation from all STP partner PMO's to ensure a standardised approach is adopted to provide assurance, information and support delivery of change across all programmes.

Principles:

- The STP is an 'informal' arrangement of organisations working together to deliver sustainable transformation. It does not have statutory status and cannot replace the existing statutory accountabilities of organisations
- Joint working arrangements and approach to decision making is set out in the MOU and reflected through terms of reference of working groups
- The Governance approach for the STP will be managed through the STP Programme Development Group, and supported by the STP programme office
- The Governance approach for the STP will make use of existing groups where possible, minimising the burden of additional meetings
- Lay representation will be included throughout the governance structure
- The Governance structure will be reviewed 6 monthly, and any recommended changes would be subject to same approval process

10. Primary Care and Locality Development

10.1 Primary Care Strategy

Our vision for Primary Care in Gloucestershire is for a safe, sustainable and high quality primary care service, provided in modern premises that are fit for the future. Our ambition is to support patients to stay well for longer, connect people to sources of community support and ensure people receive joined-up out of hospital care. To achieve this vision requires a resilient primary care service at the core of local communities, playing a leading role not only in the provision and co-ordination of high quality medical care and treatment, but also in supporting improved health and well-being.

The challenges being experienced by general practice in Gloucestershire mirrors those that have been described nationally, such as increased demand, a growing population with more complex needs, workforce pressures and constrained funding growth. Despite these pressures, there continues to be overall high levels of patient satisfaction with the quality of primary care in Gloucestershire. There is also resolve and common purpose amongst primary care professionals in Gloucestershire to explore new ways of working to protect and enhance the primary care service for current and future generations of patients, carers and healthcare professionals.

GCCG has already made significant strategic progress in 2016/17. For example developing our Primary Care Strategy inclusive of detailed plans for workforce and estates, developing 16 clusters across our seven localities to commence working closer together in circa 30,000 patient population groups, trialling new working arrangements across providers in these clusters to “work without walls” in delivering the best outcomes for patients.

Work to date has developed our thinking about the future organisation of primary care, with GP surgeries in Gloucestershire proposing to form 16 GP ‘clusters’ from 2017/18. These clusters will enable practices to work together to share skills, expertise and in some cases back office functions, providing a stronger and more robust primary care service for Gloucestershire. In addition the CCG has funded 7 GP clinical leaders, one for each locality to champion integrated ways of working and to act as conduits between Practices and the New Models of Care Board (NMOC).

In Gloucestershire we have already made good progress in improving access within primary care, however work is required to drive improvement on out of hospital care offered to our patients. For example, working with the CCG, Gloucestershire Doctors (GDoc) were successful in a bid for the second wave of the GP Access Fund, which has seen the implementation of Choice+, providing additional appointments both in and out of hours. This has delivered:

- In excess of 5,000 additional appointments per month across primary care, with at least one dedicated site in each locality.
- Appointments being offered during weekends and during the evening, providing flexibility for patients.

- Doctor time freed up from urgent appointments has been re-invested into longer appointments for those patients that require them, such as those with long term conditions.

Information Management and Technology (IM&T) continues to be a key enabling focus of the delivery of the Primary Care Strategy. There are many elements to this, including the internal GP clinical systems, interaction between different practices and their systems, interaction with patients and providers and contemporaneous access to information across the health care system. We recognise that not all patients have access to the internet and via our Gloucestershire IM&T Strategy will ensure they are not 'digitally excluded.'

GCCG has recognised the importance of primary care estate in line with the ambitions of our Primary Care Strategy. In response we have developed a five-year prioritised Primary Care Infrastructure Plan, which sets out the where investment is anticipated to be made in either new or extended buildings, subject to business case approval and available funding. This supports the intention to deliver primary care at scale and ensure sustainable general practice infrastructure to provide more out of hospital care. As a CCG, we have also been proactive in implementing the General Practice Forward View and going beyond the mandated requirements. For example, we have:

- Invested in seven GP Provider Leads to take forward the leadership of the clusters within their localities; supporting their development in those leadership roles and being the members representing Primary Care at the New Models of Care Board.
- Implemented the mandatory requirement of a non-recurrent £1.50/head/year investment in primary care for 2017/18 and 2018/19 early, by offering investment at £1.89/year in 2016/17 (pro-rata) and then recurrently thereafter. We have invited bids from our clusters that will support their resilience and sustainability and provide transformative care delivery. Ideas have ranged from clinical pharmacists and mental health therapists working in primary care, to repeat prescribing hubs.
- Offered all practices to nominate themselves, or within their clusters, for the General Practice Resilience Programme, as well as supporting those practices most at risk through the vulnerable practice programme. We have undertaken practice visits to support both these programmes too and supported those who required it most urgently with additional resource.
- As part of Delegated Responsibility for Primary Care Commissioning, supported our member practices in the recruitment, retention and return of the GP workforce; Practice Nurse Education and Training; and supporting new skill mixes. Priority schemes have been identified and are aligned to the GP workforce 10 point plan, the General Practice Forward View and the Gloucestershire Primary Care Strategy. Additionally we have invested in a multi-media campaign to support member practices to recruit General Practitioners, entitled Gloucestershire General Practice.
- Have been approved to set up a Community Education Provider Network (CEPN or Training Hub) and we are working closely with various local stakeholders as well as the West of England Academic Health Science Network to develop the CEPN to support education and training requirements in Gloucestershire.

- Taken steps to develop IM&T in primary care such as resourcing a pilot of email consultations, supporting a practice in our South Cotswold locality to set up a dermatology photo service for patients and embedding electronic prescribing to enable patients to collect their prescriptions directly from their pharmacy between 5 minutes and 2 hours after their GP consultation.

Over the next two years, the CCG working with our key partners will:

- Work with our clusters and practices to implement the recurrent transformation schemes described above that provide the sustainability and resilience they need to provide the strong primary care foundation our system needs.
- Expand the trials started under the auspices of the New Models of Care Board, for working across providers to deliver place-based care in circa 30,000 population-based list sizes, integrating services with primary care at the centre in 'virtual' multi-speciality community provider (MCP) arrangements.
- Implement the Primary Care Workforce Plan. Ensuring continued development of the existing primary care workforce, such as GPs and Practice Nurses, but also the development of succession planning, planning for recruitment of more staff and the new roles required to deliver new, innovative approaches to patient care.
- Continue to deliver our commitment to provide patients with extended evening and weekend access to primary medical care in Gloucestershire that is integrated across providers, by providing patients, practices, localities and our local providers to design the long-term models of care. This will include the implementation of the 'Ten High Impact Actions.'
- Develop and deliver a programme of clinical leadership training for existing General Practice leaders and develop the skills that are needed for future General Practice Leadership.
- The CCG Community Enhanced Services will continue to be reviewed on an annual basis to ensure that they are meeting current guidelines and are in line with CCG priorities. One of the priorities being developed for 2017/18 is frailty.
- Development of integrated primary and community led/ based urgent care. On the basis that service models are agreed, we will begin implementation of key locality proposals. This will include agreed services (such as out of hours, Choice+-, 'walk-in' patients at Gloucester Health Access Centre, minor injuries, minor illness and clinical navigation) being housed in a small number of locations across the County and combine this with a programme of operational integration that moves from colocation to full collaboration between services to improve the patient experience and to help to deliver more resilient and flexible service provision.
- Undertake a procurement exercise to secure the delivery of primary medical services for the registered list at Eastgate House and Matson Lane (approx. 5,500 patients).
- Begin to implement the IM&T commitments outlined in the GPFYFV and our Local Digital Roadmap through offering a number of initiatives that will improve clinical effectiveness, decision making and health and wellbeing i.e. use of remote monitoring, access to patient digital health records and further development of 'the Portal' for primary care.

- Review the implementation of the Primary Care Infrastructure Plan – The CCG will consider a number of prioritised business cases for the development of new surgeries. During 2017 to 2018 this is expected to include a new large scale Primary Care Centre in Cheltenham Town Centre for five existing practices, a three practice development in the centre of Stroud, development for Minchinhampton, a new surgery proposal for Cirencester and a replacement surgery for City Centre Gloucester. During 2018/ 2019 it is anticipated proposals will come forward for Tetbury, a further proposal for Cirencester, a joint surgery development for Brockworth and Hucclecote, one for the West of Stonehouse and proposal for the Forest of Dean (aligned with the Forest of Dean community services review).

  Additionally the CCG will work with surgeries progressing committed schemes to ensure prompt delivery during the period 2017/2019. The following developments are expected to be completed (in some instances, subject to planning consent):

  - The opening of:
    - A new surgery in Churchdown.
    - A new surgery in North West Bishop Cleeve.
  - The extension and refurbishment of:
    - Stoke Road Surgery.
    - Glevum Surgery in Gloucester.
  - The completion of:
    - A new surgery in Kingsway, Gloucester.
    - A new surgery in Stow in the Wold.

11. System Sustainability

11.1 Constitutional Standards

The CCG expects all providers to deliver to constitution standards and will commission improvements against key measures as set out in the national planning guidance produced by NHS England. In 2017/18 this will include a particular focus upon achieving parity for mental health. The national planning framework sets out the expectation that commissioners and providers will set out realistic and aligned assumptions about the expected activity levels for elective and emergency care, including diagnostics, that will be required to meet demand and deliver waiting times standards. Diagnostic capacity has been assessed with the GHNHSFT Chief of Service and Divisional Manager with commissioning leads for the delivery of constitutional targets.

The activity plan and the contract will require providers to deliver the constitutional targets. The planning model we have presented and agreed with our main provider accounts for population and referral growth, linear trends have been reviewed and activity assumptions agreed. Alternative provision through a mixed market model, support both choice and capacity for delivery of RTT standards. Furthermore the focus on alternative providers is being assessed for delivery of specialities such as Audiology, Orthopaedics, Ophthalmology, General surgery, ENT and Urology capacity which will positively impact the Gloucestershire population in areas where this has been a challenge in 2016/17.

For A&E waits a system-wide 4 hour recovery plan is in place and is monitored by the A&E Delivery Board. The focus is to achieve a sustainable delivery and key areas of work include strengthening admission avoidance schemes, internal support for the management of flow (this is supported by the implementation of the SAFER CQUIN) and addressing workforce issues.

The CCG has noted that SWASFT is participating in the Ambulance Response Programme Code Set Trial (ARP) which has seen a change to the way in which ambulance response times are measured. The trial has been running since April 2016 and the expectation is that it will extend the trial to all Ambulance trusts in Quarter 4 of 2016/17. We will continue to monitor the results of the trial and assess any changes to the national ambulance key performance indicators.

11.2 High Quality and Safe Services

Our strategy ‘Our Journey for Quality’ remains a core focus for Gloucestershire CCG over the next two years. The strategy is supported by adherence and delivery of national priorities such as the ‘Sign Up to Safety Campaign and Compassion in Practice (6Cs) to ensure that we plan, develop and commission high quality services. There are a number of key national policy drivers for delivering quality and patient experience and our strategy, processes and procedures are based on not only delivering national standards but where possible innovating to exceed them.

In Gloucestershire, we are a beacon site for the national 'Sign Up to Safety' patient safety campaign, which aims to strengthen patient safety in the NHS and make it the safest health care system in the world. In October 2016 we were awarded a Nursing Times Award for Patient Safety Improvement for our work to raise awareness of sepsis and support frontline clinical decision making. As part of this initiative a number of tools to support clinical decision making were developed, key to which is the National Early Warning Score (NEWS) that is being adopted across our local health system to help prioritise the urgency assigned to a patients care.

Building on the success of the Compassion in Practice (6Cs), "Leading Change, Adding Value" is the next stage in the professions framework aligned with the Five Year Forward View. The strategy seeks to develop new ways of working that are person - focused and that will provide seamless care across the boundary that is traditionally separated health and social care. The strategy will remain central to the way we commission and assure high quality care across our providers and services. The new strategy highlights the need to focus on unwarranted variation that cannot be justified by reasons of geography, demography and infrastructure.

Gloucestershire CCG takes responsibility for Quality Assurance by holding providers to account for delivery of contractual obligations and quality standards. We also take responsibility for working closely with providers to ensure service delivery continually improves and they have in place processes to drive this continual improvement including the adoption and sharing of innovation. As a membership organisation we also take seriously our responsibility to work with and help member GP practices and wider primary care to quality assure current standards. We work closely with NHS England and want to continually improve the range and quality of services we offer.

Our governance structure ensures that quality is embedded across the local health care system, supported by the development of our Quality Assurance Framework, which monitors and challenges quality in the organisations we commission services from. This is monitored by the Clinical Quality Review Group (CQRG), ensuring that quality sits at the heart of everything the CCG does. Our governance arrangements ensure transparency across the system through quality representation at the Primary Care Commissioning Committee, which routinely reviews the CQC inspections of practices, monitors and offers support to enable improvement. We ensure the Governing Body is cited on how commissioned services and CCG member practices are delivering safe and effective services via a number of early warning systems developed by the CCG. These ensure we are aware of quality and safety concerns within the organisations we contract services from. Significant risks are presented to the Governing Body through our risk register.

Over the next two years, the CCG working with our key partners will:

- Develop an assurance framework that demonstrates providers are working together to deliver safeguarding services for all vulnerable groups (reference NHS Quality Assurance Safeguarding Framework.

- Engage and work collaboratively across the system to further the Sign Up to Safety Plan, including the developing the patient safety area on G-Care to highlight the CCG safety pledges and demonstrates actions to be taken.
- Continue to learn from Serious Incidents and the National Mortality Review.
- Further the development of systematic reporting and monitoring of quality indicators across the local health system, including the annual countywide quality conference.
- Work with GP's as delegated co commissioners to routinely deliver high quality clinically and cost effective healthcare to Gloucestershire residents. Quality assurance will be through the Primary Care Commissioning Committee and established quality assurance processes.
- Ensure a continued focus on monitoring and assurance of the NICE NG 15 (Antimicrobial Stewardship 2015 Guideline) and consider the national PHE antimicrobial resistance (AMR) work plan.
- Embed a strategy for the promotion of Equality and Valuing Diversity and raise the profile across the CCG.
- Continue to embed the Equality Impact Assessment and Quality and Sustainability Impact Assessment process across the organisation, ensuring it is a core tool of the CCG PMO toolkit.
- Work together with the Gloucestershire Research and Development Consortium to promote and encourage R&D within primary care.
- Continue to lead the Primary Care Clinical Quality Review Group utilising the Primary Care Quality Assurance Framework to contribute to ongoing analysis of patient experience and feedback.
- Oversee the implementation of new arrangements for the commissioning of health care for patients living in England but registered with a Welsh GP practice, by effectively manage local engagement and communication regarding the new commissioning arrangements for this cohort of patients.

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. The additional action plans from CQC visits will continue to be scrutinised by the CCG through the established quality review process. The service providers will be required to present their plans

11.2.1 CQUIN

As in previous years it is expected that NHS England will publish their CQUIN 2017/19 guidance shortly. This year the draft guidance for consultation was available in October to which the CCG provided a comprehensive response. To date, the final National guidance has not been made available in any form, as of the date of this plan being shared with NHS England.

Key areas of change for the period 17/18 and 18/19 are as follows and applies to all providers:

- 1.5% will be assigned to deliver against mandated national CQUIN indicators.

- The indicator set has been streamlined; for acute and community the national indicator areas cover 6 areas for mental health, 5 for ambulance and 111 services have 2.
- Given the importance of the policy areas, there will be no flexibility to agree local CQUIN variations.
- Indicators are anticipated to be over the two year contract period.
- The remaining 1% will be assigned to support providers locally.
- 0.5% will be subject to provider engagement and commitment to the STP process.
- 0.5% will be subject to a risk reserve, which is subject to the system is delivering its control total.

11.2.2 National mandatory CQUINs

Every year a number of national CQUINs are set out for delivery by applicable providers using the national standard contract. It is not yet known what these confirmed CQUINs will be given the consultation period. But it is clear that less local deviation is anticipated. The National Indicator set can be found here: https://www.england.nhs.uk/wp-content/uploads/2015/12/ann-a-cquin.pdf

11.3 Financial Approach

There is an obligation to patients to ensure that services are delivered with the greatest possible effectiveness and efficiency. There is agreement across the system that there is a joint responsibility for effective management of resources within Gloucestershire. We are committed to building the right incentives into the system to support the changes required.

Over the next two years, the CCG working with our key partners will:

- Ensure a structured approach to commissioning is fully embedded within the CCG, working with our providers to ensure that the STP programme is fully reflected within contracts, that we work to consistent planning assumptions with provider organisations.
- Ensure that we have a shared understanding of the implications of pathway redesigns with providers which move activity into new settings and that we work jointly to manage this process ensuring that risk is not unfairly shifted across the care system.
- Ensure we deliver services within our means.
- Ensure that the CCG operates good financial management processes throughout.
- We will use the national tools available including Right Care to benchmark with the aim of maximising the value gained. We expect to work with our providers and with primary care to reduce unnecessary activity within the principles of providing the lowest level of intervention required to manage the patient's condition effectively.
- In addressing the challenges in the Gloucestershire health economy, the CCG uses both the resources developed nationally e.g. the Atlas of Variation in Healthcare and

the Commissioning for Value insight packs and local resources e.g. bespoke pathway benchmarking to identify and triangulate opportunities to deliver optimal healthcare for the residents of Gloucestershire. Right Care provides the platform for the CCG to identify variation in terms of healthcare spend and outcomes to outline the opportunities in the Gloucestershire healthcare system to meet current and future challenges.

- We will not commission services that are deemed by evidence to not be cost or clinically effective.
- Work with all key partners to agree the framework we will use to measure and monitor all aspects of service delivery and effectiveness.

11.4 Activity

The following principles will be applied to our activity assumptions during 2017/18-2018-19, in line with our Operational Plan Finance and Activity submission to NHS England:

General Activity:

- Be in line with STP plan (reflecting year 1 & 2 areas of focus).
- Incorporate STP solutions.
- Allow sustainable performance against national performance standards (including performance recovery).
- Be affordable.
- Take into account known capacity constraints.
- Reflect the totality of our commissioning position (i.e. reflect position across all key providers).
- Be signed off by all key system partners as part of the STP process.

Elective (All Providers):

- Review of long and short term referral trends.
- Outcome of GHFT demand & capacity modelling (phase 1: Orthopaedics, Urology, Gynaecology and Dermatology).
- Testing of sustainable RTT, diagnostic and cancer targets and impact of non-recurrent activity.
- Review of pending lists on activity planning.
- Impact of national campaigns i.e. cancer.

11.5 Procurement Intentions

The table below outlines procurement processes that GCCG anticipates that it will undertake in 2017/ 2018. It should be noted this list is indicative and is not intended to be exhaustive or binding.

- Provision of Commissioning Support Services (Lead Provider Framework).
- Clinical Decision Support Tool.
- Orthotist Services and Provision of Orthosis.
- Direct Access Computerised Tomography Services (AQP).
- Direct Access Magnetic Resonance Imaging Services (AQP).
- Direct Access Non-Obstetric Ultrasound Services (AQP).
- Direct Access Endoscopy Services (AQP).
- Direct Access Community Vasectomy Services (AQP).
- Provision of Primary Care Out of Hours Services (including NHS111 and Clinical Hub).
- Hospice at Home Domiciliary Services.
- Repeat Prescribing Services (Medicines Management).
- Primary Care Medical Services – Eastgate House and Matson Lane Surgery.

11.6 Patient Experience and Engagement

As set out in the GCCG Experience and Engagement Strategy 'Our open Culture': 'We want to hear the 'quiet voices' and be 'commissioners on the ground'. The CCG will continue to develop its approach to patient engagement and experience; ensuring voices are heard by commissioners and are central to the strategic development of all of our programmes of work. Our Strategy is supported by a resources page on the CCG website, which is regularly updated. In particular we will ensure that our approach responds to new guidance issued by NHS England with regards to engagement with our local communities about service changes associated with our Sustainability and Transformation Plan (STP).

'Our Open Culture' Framework promotes 'Equality' and working in 'Partnership' and the desire to enable 'Anyone and Everyone' to have a voice. To achieve this we will provide 'Information and good Communication', focus on 'Experience' feedback and undertake good 'Engagement and Consultation'. The Strategy's aim is to ensure that the CCG: achieves the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual's experience of care is a driver for quality and service improvement.

This will be achieved through facilitating the collection, analysis and reporting of feedback and views received from patients, carers, stakeholders, the wider public and staff. These views will then inform and influence GCCG commissioning priorities. A dynamic and robust system is in place to ensure intelligence obtained from individuals' experiences of local NHS services, alongside other quality data on safety and clinical effectiveness, and engagement

and consultation activities, is collected and reported. This intelligence will be used to monitor the quality and clinical effectiveness, from a patient or public perspective, of current commissioned services and thus inform future commissioning decisions, service redesign and reconfiguration proposals.

As leaders of the local health economy, we have ensured that the heart of our shared system vision is the person – around which care will be designed, developed and delivered. This is embedded by ensuring lay representation within our Clinical Programme Approach and within our key programmes of work. Lay representation is embedded in two ways: through our contracted 'Lay Champions', whose role is to ensure that patient experience data is fully taken into account and is informing CCG discussions, and via Healthwatch Gloucestershire, whose representation brings a patient perspective to CPG discussions and working groups.

We will continue our focus on supporting engagement within Primary Care, supporting both practices to work as effectively as possible with their Patient Participation Groups (PPG) and vice versa supporting PPGs to work with their practices. We will continue to promote the Friends and Family Test in Primary Care (and in all other NHS services) and will continue to monitor the results of this and feedback received through the national GP Patient Survey.

The CCG is particularly keen to hear the opinion of the staff working in the health service and we will both consider the staff survey results, as well as staff engagement exercises to form a view of the quality of our local health services.

Our programme of planned engagement for 2017/18 focusses largely on engagement to support the STP process and any subsequent formal consultation required, where service change might be considered to be a 'significant' variation'.

Over the next two years, the CCG working with our key partners will:

- 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.
- Support the amplification of patients' voices within primary care, though our Patient Participation Group Network.

11.7 Joint IT Strategy

We have a shared approach to developing a Digital Road Map and have developed a Local Digital Roadmap Footprint (Gloucestershire) aligned to our STP boundary. We will digitally enable people to support their care, support staff in the adoption of new technologies, utilise data to support commissioning and work towards becoming a paper free NHS by 2020.

As a system we have a shared records implementation plan: Joining up Your Information (JUYI). This will enable those involved in the delivery of urgent care services to be able to see all records held about a patient in the County in 2017/18. The ability to share information

across professionals and organisations is fundamental to supporting the effective delivery of our new models of care. It will improve the quality of clinical decision making and support the development of electronic care plans. We are committed to using technology to support more efficient working e.g. through roll out of Electronic Prescribing and E-rostering.

We also see the use of technology as pivotal to supporting our self-care agenda and we are working with the ASHN test bed to evaluate the use of apps in our clinical pathways. We have established a Joint IT Strategy Group to take this work forward and the LDR roadmap/strategy has been developed.

Over the next two years, the CCG working with our key partners will:

- Have introduced a public facing directory of services to support people to understand local pathways and support opportunities in their communities.
- Delivered Joining Up Your Information (JUYI).
- Created a pool of decision support tools for use at the point of delivery/care.
- Continue to work towards become a paper free NHS.
- Enable clinicians across the county to see relevant information about patients at any point of contact.

11.8 Joint Estates Strategy

Partners within Gloucestershire, including the County and District Councils, Police, Fire Service, Ambulance Service, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Care Services and 2Gether Trust are working together on the 'One Gloucestershire Estates' initiative. This group has mapped information on all assets held by all organisations. The next year will see further work to:

- Identify the opportunities within each area as part of the One Gloucestershire Estates Programme through area based review; this may include the potential to develop multi-disciplinary hubs.
- A review of how estates are managed and shared procurement opportunities, eg utilities.
- Review the opportunities from investing, including technology, in new working environments to enable smarter working across the sector and how technology could help to enable this including impacting on the estate requirements.

The CCG has approved a Primary Care Infrastructure Plan for the period 2016/ 2021 setting out key priorities for investment in GP surgeries to deliver new models of care. The STP now provides the catalyst, in conjunction with the wider strategic plan, for taking this strategy forward to meet the following ambitions:

- Enhance the patients' experience.
- Provide staff excellent facilities to work in.
- Use the existing estate more effectively.
- Reduce running and holding costs.

- Reconfigure the estate to better meet population needs.
- Share property (particularly with social care and the wider public sector).
- Dispose of surplus estate to generate capital receipts for reinvestment.
- Ensure effective future investment.

Over the next two years, the CCG working with our key partners will:

- Identify and implement quick wins within the existing estate.
- Identified new development(s) with identified benefits and return on investment providing value for money.
- Develop clear service delivery strategies linked to estate provision
- Strategy to dispose of all surplus assets.
- Work towards place based service delivery achieved with strategic partners.
- Start to embed clear flexible working arrangements in place supported by optimised space and IT provision.

11.9 Joint Workforce & Organisational Development Strategy

As part of our Joint OD and Workforce Programme we are working with partners across our footprint to understand our current workforce, address key gaps and support the development of the workforce we need to deliver 7 day working commitments and our new models of care. Our 3 priorities are:

- Developing a sustainable primary care workforce.
- Developing a sustainable nursing and Allied Health Professions (AHPs) workforce.
- Ensuring that our workforce has the skills to work effectively within new models of care and to work collaboratively to close the three Five Year Forward View gaps.

We are actively supporting the development of new roles to help us to bridge our workforce gaps, to widen access to the healthcare professions and respond to national directions. Our expectation is that whilst workforce numbers will broadly stay level, the skill mix within our staff profile will change to match new healthcare models and current availability gaps in key professions. We are pursuing innovative developments including proposals to develop a concept of having a University Technical College, wider provision for registered nurse education in the county and working with our Local Economic Partnership to develop a collective approach with local schools and colleges. We are committed to developing a single Gloucestershire branding for health and care recruitment so that we can attract people to live and work within our diverse county. We are working to understand opportunities for greater productivity and efficiency within our workforce by reducing agency spend and introducing supportive technology. Our key challenge is to further develop our future workforce projections and to anticipate the roles and skill-mix we need in the future and to support our financial gap. We are working closely with the new care models programme and the pilots within our STP to understand how we need to adapt our current projections to meet these needs.

Over the next two years, the CCG working with our key partners will:

- Develop a single Gloucestershire branding to support our health and care recruitment in the county.
- Refine and develop our workforce projections for 2020.
- Support the development of nurse associates as part of the Rapid Follower Wave.
- Support 400 staff with CPD masterclasses that will help achieve our STP goals.

Annex 1: Planning Timetable

Key dates in 16-17 Planning Round

Key: **Key Decision Point**

DATE	EVENT
September	
9th	STP Assurance meeting
16th	STP Finance re-submission
20th	• Publication of NHS planning guidance for 17/18 and 18/19 • GCS Board Meeting
22nd	• Planning Guidance published • Technical Guidance issued • Commissioner Finance Template published • Draft NHS Standard Contract and national CQUIN scheme guidance published • Draft National Tariff Prices published
23rd	Internal Contract Planning Session
27th	Annual General Meeting
29th	2G Board Meeting
30th	• Providers submit contract intentions to GCCG • First draft CCG internal budget plans 17/18 • Provider control totals and STF allocations published • Counting & coding notification received • Counting & coding sent to key providers • Letter to providers re Operational Plan/Financial Context • GHFT Board Meeting
October	
3rd	CQUIN workshop (internal GCCG & GCC)
18th	GCS Board Meeting
21st	• Commissioner allocations published • NHS Standard Contract consultation closes • STP whole re-submission (by organisation)
24th	Confirm finance split by organisation as per STP submission for baseline
31st	• Updated draft CCG internal budget plan • National Tariff Section 118 consultation issued • Final CCG and specialised services CQUIN scheme guidance issued
November	
1st	• Provider finance, workforce and activity templates issued with related Technical Guidance (providers only) • Submission of summary level 2017/18 to 2018/19 operational finance plans (noon)
4th	• Commissioners to issue initial contract offers that form a reasonable basis for negotiations to providers • Final NHS Standard Contract published • *Provider finance, workforce and activity templates issued with related Technical Guidance (providers only)*

	• *Awaiting confirmation from NHSE re dates – submission of UNIFY activity & QP*
w/c 7th	17/18 – 18/19 local prices received
11th	Providers to respond to initial commissioner contract offer
17th	CCG Development Session to review Operational Plan
24th	Submission of full draft 2017/18 to 2018/19 operational plans (noon) CCG Governing Body – to note Operational Plan Submission
21st/22nd	Weekly contract tracker to be submitted (weekly up to 31st Jan)
30th	Updated draft CCG internal budget plan
December	
5th	• Local decisions to enter mediation to be made – if contract sign deadline is at risk • Contract Mediation (5th – 23rd)
6th	National Tariff section 118 consultation closes
w/c 12th	National Tariff Section 118 consultation results announced
15th	Extraordinary Priorities Committee - to sign off Operational Plan
16th	Contracts finalised for signature (final draft) incl. Finance & Solutions
20th	Publication of National Tariff
22nd	CCG Priorities Committee
23rd	• Final Operational Plan submitted • National deadline for signing of contracts

2017	
January 2017	
7th	Possible mediation
9th	Submission of joint arbitration paperwork where contracts not signed
Within two working days of panel date	Arbitration outcome notified to GGCs/providers
31st	Contract and schedule revisions reflecting arbitration findings completed and signed

Annex 2: Finance and Business Rules

Service Changes

- Gloucestershire STP programme groups will be developed, including clinical programme groups, to the point where they are working with full visibility of resources in 2017/18 to enable prioritisation of resources across programmes and will use this work to further develop and implement STP priorities for 2017/18 and beyond. 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 and within commissioned pathways we will look for cost effectiveness (eg ensuring that a procedure is carried out in the most appropriate setting), minimising the number of steps and driving greater efficiency across the system;
- As part of pathway development, the CCG and providers will work to develop tariffs and currencies that enable a move to contracting methods that better incentivise the desired outcomes and that share risk appropriately across the system. Any changes will also include a pace of change for significant changes.
- Where review of non-tariff activity indicates a required change in the overall level of investment in the service under consideration the CCG will work with providers to agree a reasonable 'pace of change' arrangement that is commensurate to the scale of the change in investment / disinvestment required;
- We will consider whether any pilot(s) delivery of care in different ways will require us to develop any new and innovative approaches to contracting.
- The CCG will not support investment business case proposals outside of the CCG and STP prioritisation process.
- Providers should not initiate in-year service developments unless formally agreed by the CCG.
- Business cases for specialist services must go through the National NHS England process, the CCG will not pick up costs incurred by a provider as a result of a business case proposal for a specialist service that has been rejected by NHS England's specialist commissioning teams;

Costing of Services

- Where new services are being developed that do not fall within the scope of PbR, then the process to develop a local tariff will be through discussion and agreement with the provider, using national costing principles, and in line with the process described within the 2017/18 and 2018/19 National Tariff Payment System guidance;
- The CCG will look to understand actual costs of delivery and reasonable overheads where new service models are developed, and will not agree to an automatic default to consultant responsible tariff when activity is delivered by different healthcare professionals in a multi-disciplinary team;

Application of National Tariff, Inflation & Efficiency

- The CCG will assume application of national inflation and efficiency requirements to all services, , across all healthcare providers. This includes non PbR services, where uplifts are not already determined within contracts
- The PbR business rules will be applied to all contracts
- The CCG will adopt any PbR mandatory tariff items including Best Practice and any new PbR terms which link the tariff to delivered outcomes; where providers claim for a best practice or outcome based tariff, they will need to demonstrate that requirements are being delivered to receive payment;
- CQUIN is not payable on certain areas such as excluded drug and devices spend in the 2017/18 and 2018/19 financial years.
- CQUIN for 2017/18 and 2018/19 is set at level of 2.5 per cent value for all healthcare services commissioned through the NHS Standard Contract. This will be further broken down as
    - 1.5 per cent will be linked to delivery of nationally identified indicators
    - 0.5 per cent subject to full provider engagement and commitment to the STP process
    - 0.5 per cent to be held within the STP risk reserve
- The CCG anticipates that all national changes (e.g. Identification Rule changes for specialist activity, the introduction of HRG 4.1 and changes to cross border responsibilities) will be incorporated within final contracts.

Commissioning Principles

- The CCG will ensure commitment to a risk share approach aligned to the priorities of the county's Sustainability and Transformation Plan (STP) (which may include a risk sharing approach to the delivery of whole system savings). This should be underpinned by an open, transparent approach to the development of opportunities for change;
- The CGG will model demography in line with the assumptions set out in calculating the CCG's national allocations, adjusted for any new demographic information as required. The CCG will use this information combined with profiles of current demand, performance and benchmarking assess likely levels of future service demands for the local population
- The CCG will only contract with Providers that abide by the CCG's policies and protocols. These include, but are not limited to, local clinical policies and access criteria (including treatments of limited clinical effectiveness, prior approval thresholds and pathways as determined by the CCG). Providers should work to ensure that they have robust internal processes to ensure that they can avoid undertaking work that will not be reimbursed. Providers will ensure activity can be audited for IFR and criteria based access. If information is not shared deductions will be made proportional to activity carried out where these policies apply. The CCG will not pay for procedures that fall outside clinical policies unless there is evidence of prior approval or that criteria based access procedures have been followed;

- New NICE guidance should be implemented according to the Gloucestershire protocol.
- Activity Recording
- Where activity is being recorded by providers it is the CCG's expectation that this activity will be recorded in line with the definitions applied by the NHS Data Dictionary. Where this is not the case the CCG will not pay for this activity and will seek to fund applying the correct tariff
- The CCG will not pay for an admission price when the provider chooses to 'admit to assess'. Examples include stays in Paediatric Assessment Unit of less than 4 hours, for which usual A&E tariff will apply, and patients being assessed on ACUA and subsequently discharged by the Older Peoples Assessment and Liaison Service (OPAL) or Integrated Discharge Team (IDT);
- All coding and counting proposals are expected to overall cost neutral and follow the contractual process unless otherwise formally agreed. Any proposed changes will need to be in line with the NHS Data Dictionary;

Excluded Drugs & Devices

- A number of rules will relate to payment for Excluded Drugs & devices, including:
    - Validating clinical usage decisions at source to address unwarranted variation in prescribing practice;
    - Improving transparency in prices paid to better target shared areas on procurement opportunity; Working with other commissioners and providers, the CCG will secure the benefits of more widespread use of best value prices for drugs and devices, alongside increased transparency of billing;
    - Updated risk and reward sharing protocols to provide practical approaches to covering the resources needed where providers and commissioners aim, in addition to usual therapeutic switching, to dedicate additional resources to 'go the extra mile' together on more significant projects;
    - Budgets for excluded drugs and devices will be set annually based on the provider's assessment of need through horizon scanning, subject to a 'confirm and challenge' meeting with the provider, with review of any outliers in rates of growth by the national specialised pharmacy lead. New excluded drugs and devices will not be funded in-year unless approved by NICE or previously identified and planned for within the planning round;
    - Excluded drugs and device costs charged to the CCG will be reflective of actual product costs to hospitals and will be subject to audit to demonstrate this. Providers will charge the commissioner all drugs subject to discounts, rebates or other such Patient Access Schemes at net cost. These costs are also excluded from the tariff efficiency deflator arrangements;

There will also be a move to ensure contracted drugs/devices are recorded at a patient level, where not available this should be by exception;

Annex 3: Operational Plan Programme Delivery 2016/17

NHS Gloucestershire CCG Operational Plan – Assessment of 2016/17 Programme Delivery

The 2016/17 Operational Plan set out our commitments to be delivered against our strategy, Joining Up Your Care, which sets out our ambitions we aim to achieve across the Gloucestershire health community on behalf of our local population. The plan identified the approach and key programmes that will deliver change across our system and improve health for the people of Gloucestershire. This paper provides an overview of the delivery against our 2016/17 operational plan commitments across our programmes.

Enabling Active Communities	
Commitment	**Achievement**
• Deliver Diabetes Self-Management Programme • Commit additional resources to invest in voluntary sector • Simplify online information for patients • Enhance knowledge and skills of workforce • Social prescribing at locality level • Standardise personalised care planning • Redesign Obesity pathway • Link to publish health commissioned services	• Expression of interest submitted to join Wave 2 of the National Diabetes Prevention Programme • 12 test and learn projects undertaken as part of cultural commissioning programme, pilot showcased by NEF • Commissioned: o Health@work to roll out Workplace Wellbeing Charter o Local County Sport Partnership for daily mile initiative o Review continued Facts4Life o Tendered for new integrated healthy Lifestyle Pathway o Active Gloucestershire to increase activity levels of older adults • G-Care online-platform developed • Social prescribing in place across 81 practices, approx. 1500 patients referred each year • A key partner within the AHSN collaboration leading on the NHSE Digital Test Bed (Map My Diabetes & Ki Performance)
Primary Care and Locality Development	
Commitment	**Achievement**
• Develop and agree the Primary Care Strategy • Develop the role of localities in leading delivery of Placed Based Plans	• Primary Care Strategy developed and approved • 16 clusters established covering county in circa 30,000 population models • Community provision of an urgent care hub • GP Resilience Plan developed • Work started with G-Doc to provide Choice Plus appointments
Clinical Programme Approach	
Commitment	**Achievement**
• Delivery of transformation through Clinical Programme Approach • Ensure robust pathways compliance	• Implementation of pathway redesign underway for various CPG's • Ongoing work to ensure all care provided is evidenced based and compliant with NICE,

	supported by development of G-Care
Urgent Care	
• Support providers to continue to develop and implement plans for 7 day services • Work with Urgent Emergency Care Network to progress Integrated Clinical Hub • Continue work to reduce demand on Emergency Ambulance Services (999). • Information sharing arrangements between providers to encourage coordinated and continued patient care. • Develop further the use of our community hospitals.	• Ongoing work alongside NHSE to deliver the 4 key 7 day service standard by undertaking benchmarking • All key providers agreed and signed to allow safe and appropriate transfer of patient info. • The Urgent Care Strategy Group established to provide an overview of pathway redesign • A dispatch and disposition, utilisation and ambulance response programme of work has been undertaken.
Planned Care	
• Support the Clinical Programme Approach in providing operational and programme support to delivery of key clinical programme groups • Deliver the Planned Care work programme • Take an active role in ensuring ongoing system resilience for planned care.	• Joint working between acute and newly commissioned community urology services • Refractory IBS Service and GP Direct Access Faecal Calprotectin Testing launched in February 2016 • Fully established G-Care platform established • Programme of work to review all IFR policies completed • Developed follow up programme to address demand and capacity issues within the system • Development of Elective Demand Management Scheme • Review of Home Enteral Feeds Service
Parity for Mental Health & Learning Disabilities	
Commitment	**Achievement**
Mental Health	
• Deliver the Crisis Action Plan and specifically implement a new model of Crisis Care • Ensure delivery of Liaison Psychiatry Action Plan • Review Service Specifications for: o Adult ADHD o Perinatal Mental Health Recovery • Improve the transition from children to adult services both within and between providers.	• Crisis Action Plan in place • Extension of Crisis Café opening hours from October 2016, funded as a 1 year pilot. • Psychiatric Liaison service is now available 24hours a day, 7 days per week. • Mental Health Recovery service specification reviewed to include Adult ADHD. • A Quality Improvement Initiative has been embedded via a CQUIN across all 3 providers
Dementia	
• Strengthen 2gether NHSFT post diagnostic support services • Invest in the development of a BME Community Hub, based on the existing county wide Community Hubs • Participate in county wide dementia awareness programme in partnership with local media	• Completed a review of the primary care dementia pathway • The BME hub has been established best at the Friendship Café • The Intergenerational Dementia Project has: o Enabled Newent School pupils to provide dementia awareness training o Ran a competition for school children to produce a dementia awareness advert
Learning Disabilities	
• Establish a Priority Placement Committee • Ensure care for those with complex needs is being delivered in local community	• Priority Placement Committee established • The closure of Westridge and the consolidation of inpatient beds in Hollybrook.

	• The Learning Disability Support Service is now fully operational • Transforming Care Programme initiated • Successful Health Action Day • A patient led , expert by experience programme has been fully instituted to cover funded cases by the CCG
Integration	
Commitment	**Achievement**
• Continue to deliver and refine the ICT model. • Use Better Care Fund to support greater integration • Implement a 'Discharge to Assess' service • Simplify the reablement pathway • Develop stronger joint working with Gloucestershire Fire & Rescue Service (GFRS)	• The Rapid Response model continues • The Better Care Fund for Gloucestershire was fully approved for 2016/17. • Discharge to Assess model developed and embedded during 2016/17. • The reablement pathway was reviewed and the process simplified for acute hospital referrals. • A countywide responder service with GFRS is in place.
Person Centred Care	
Commitment	**Achievement**
• Pilot Personal Health Budgets in partnership with social care • Be an active participant in the South West Integrated Personal Commissioning Pilot. • Continue to ensure that patient voice is a strong influence	• A PHB process and pathway has been developed and embedded within Gloucestershire. • The CCG forms part of the only regional demonstrator site for Integrated Personal Commissioning (IPC) in England
System Sustainability	
Commitment	**Achievement**
• Develop aligned delivery incentives • Ensure constitutional compliant services • Ensure the provision of high quality & safe services • Reduce avoidable variation in outcomes	• CCG has an agreed CQUIN schedule across all of its main provider contracts in 2016/17. • For 2016/17 NHS England have introduced a new Improvement and Assessment Framework for CCGs. The baseline results for Gloucestershire CCG were published in September 2016 (by exception): • Cancer – 62 day cancer – Needs improvement • Dementia – Diagnosis rate – Performing well • Mental Health – IAPT recovery rate – Needs improvement • Learning Disabilities – Specialist inpatient care – Needs improvement • All providers and GCCG took part in Sign Up to Safety campaign • Quality representation embedded as part of Primary Care Commissioning Committee. • Continuing use of Dr Fosters • Fully adopted Right Care Approach

Annex 4: GCCG Outcomes Framework Ambitions

As part of the new Clinical Commissioning Group Improvement and Assessment Framework (CCGIAF) for 2016/17, an initial baseline rating for six clinical priority areas were published. The ratings have been derived from the indicators in the new framework looking at CCGs' current baseline performance using the most recent data available as at the end of July 2016. The baseline rating provides a starting point for future assessments from 2017/18 onwards.

The rankings have been based on our position from all 209 CCGs on the MyNHS website and our ratings have been based on our ranking position as follow;
If ranked 1-52 - we have assumed we are 'Top performing'
If ranked 53-104 - we have assumed we are 'Performing well'
If ranked 105-156 - we have assumed we are 'Needs Improvement'
If ranked 157-209 - we have assumed are 'Greatest need for Improvement'

Improvement & Assessment Framework Dashboard

	Top Performing	Performing Well	Needs Improvement	Greatest Need for Improvement	N/A	Data Not Yet Available
Better Health	5	6	2	0	1	0
Better Care	8	5	3	3	2	11
Sustainability	0	1	0	0	2	5
Well Led	1	0	0	0	3	2
Total:	**15**	**12**	**5**	**3**	**7**	**18**

NHS Gloucestershire CCG					
Clinical Priority Area	**Overall Rating**	**Indicator Ratings**			
Cancer	Needs Improvement	**54.5%**	**77.6%**	**71.3%**	**89.2%**
		New of cases of cancer diagnosed stage 1 & 2 as a proportion of all new cases of cancer diagnosed	Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral	Of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis	Of responses, which were positive to the question 'Overall, how would you rate, your care?'
Dementia	Performing Well	**67.1%**		**78.5%**	
		Estimated diagnosis rate for people with dementia		Of patients diagnosed with dementia whose care plan has been received a face-to face review in the preceding 12 months	
Diabetes	Performing Well	**40.8%**		**4.7%**	**75.9%**
		Of diabetes patients have achieved all of the NICE-recommended treatment targets		Of people with diabetes diagnosed for less than a year who attended a structured education course	Of GP practices that participated in the National Diabetes Audit

Annex 5: Performance

- **A5.1 Green**

The following targets have been assessed '**Green**' and therefore having minimal risk of delivery against the national targets for 2017/18 & 2018/19.

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.A.S.1: Estimated Diagnosis Rate 65+	66.7%	66.7%	66.7%
E.B.7: Cancer 2 week waits (breast symptoms)	93.4%	93.0%	93.0%
E.B.8: Cancer Waiting Times – 31 day 1st treatment	97.6%	96.0%	96.0%
E.B.9: 31-day standard for subsequent cancer treatments - surgery	96.9%	94.0%	94.0%
E.B.10: 31-day standard for subsequent cancer treatments – anti cancer drug regimens	99.5%	98.0%	98.0%

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.A.S.1: Estimated Diagnosis Rate 65+	66.7%	66.7%	66.7%
E.B.7: Cancer 2 week waits (breast symptoms)	93.4%	93.0%	93.0%
E.B.8: Cancer Waiting Times – 31 day 1st treatment	97.6%	96.0%	96.0%
E.B.9: 31-day standard for subsequent cancer	96.9%	94.0%	94.0%

treatments - surgery			
E.B.10: 31-day standard for subsequent cancer treatments – anti cancer drug regimens	99.5%	98.0%	98.0%

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.D.14: Extended access (evening & weekends) at GP services	100%	100%	100%
E.H.4: Psychosis treated with a NICE approved care package within 2 weeks of referral	60.7%	58.3%	58.3%
E.H.10: Proportion of CYP with eating disorders that wait < 4 weeks from ref to start of NICE-approved treatment	46.7%	52.6%	52.6%
E.H.11: Proportion of CYP with eating disorders that wait 1 week or less to start NICE-approved treatment	100%	100%	100%

- **A5.2 Amber**

The following targets have been assessed '**Amber**' as delivery of the target has been challenging during 2016/17. Recovery plans are in place and the providers have given their assurance that targets will be achieved by the end of 2016/17 at the latest.

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.A.S.2: IAPT Recovery Rate	49.3%	50.0%	50.0%
E.H.1: 6 week or less from referral to entering a course of	51.2%	75.0%	75.0%

IAPT treatment			
E.H.2: 18 weeks or less from referral to entering a course of IAPT treatment	88.6%	95.0%	95.0%

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.B.3: Incomplete RTT pathways	92.0%	92.0%	92.0%
E.B.4: Diagnostic test waiting times	1.7%	1.0%	1.0%
E.B.12: All cancer 62 day urgent referral to 1st treatment wait	81.8%	85.0%	85.0%

- **A5.3 Red**

The following targets have been assessed '**Red**' as delivery of the target has been challenging during 2016/17. Recovery plans are in place but there is still concern regarding the target for 2016/17 and into future years.

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.B.5: A&E waiting times	88.4%	86.6% against 95.0%	86.7% against 95.0%

The CCG has missed the 4 hr national target of 95% since August 2015 and this has also been reflected at a national level with 9 out of 10 A&E departments failing to meet the standard. There is a system wide 4 hour recovery plan and a summit has resulted in enhanced emphasis on delivery. Other factors in the system impacting on delivery of the target are A&E attendance demand +6.6%, Emergency Admissions +3.1% and an increase in DTOCs.

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.A.3: IAPT Roll out - No of people who receive psychological therapies	9.5%	15.0% against 16.8%	15.0% against 19.0%

The following remedial actions have been implemented for IAPT roll out delivery:

- CCG and 2G have agreed a recovery plan
- Redesigning the IAPT pathway which was implemented in November 2016
- Recovery trajectories agreed.
- Clearance of backlog of long waiting patients during Q3 2016
- Achievement of targets from April 2017 for both 6 week and 18 week

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.B.6: Cancer 2 week waits	89.1%	TBC against 93.0%	TBC against 93.0%

Performance against the 2 week standard has been challenging and main areas of concern include Urology and Lower Gastro Intestinal. There has also been impact of patient choice which has affected performance. Key actions to address this include:

- Support to GHFT regarding patient choice impact
- Targeted clinician to clinician support to ensure pathway compliance
- Implementation of NICE guidelines NG12
- Development of Urology one stop clinic

A5.6 For Review

The following constitution target has been assessed **'for review'.**

Description	2016/17 Projected FOT	2017/18 Target	2018/19 Target
E.H.9: Improve access rate for CYPMH	TBD	TBD	TBD

There have been issues identifying the total number of individual children and young people aged 0-18 with a diagnostic mental health condition, as the last research conducted nationally took place in 2004. Issues with this indicator are acknowledged by NHS England who are undertaking a review.

Annex 6: Risk Assessment

The following table identifies the key risks to delivering our 2017/18-18/19 Operational Plan within the context of delivering our Sustainability and Transformation Plan in Gloucestershire.

Risk	LxC (inc. RAG)	Mitigating Actions
System Risks		
Capacity and capability to deliver – unable to meet considerable resource requirements to deliver STP.	3x3	Complete review of capacity aligned to key programmes and ensure this is reviewed by the STP Delivery Board, discussion on commitment of resources with CEOs.
Reaching a common goal – language and definitions are inconsistent across organisations.	3x3	Common vision established in STP Plan and supported by Operational Plan. All STP programme documents shared through briefings and Gloucestershire STP webpage.
Changes in national priorities – although unlikely to move away from FYFV principles, organisations may not be flexible in their application.	3x3	Programme Office to keep watching brief on national policy and advise STP Delivery Board if changes are required.
Lack of external stakeholder support for change	3x3	Programme Development Group to manage duties under Health & Social Care Act to ensure smooth passage.
Identified quick wins and pilots do not inform longer terms roadmap.	3x3	Short term operational delivery must remain a key focus of the system whilst looking to longer term development.
Key workforce gaps are not addressed in key roles across our system.	3x4	Ensure system wide understanding of workforce issues to agreed shared priorities. Workforce plan developed by Workforce and OD Strategy Group.
GCCG Risks		
Level of transformational savings not realised, impacting ability to deliver recurrent savings	3x4	Established Programme Management Office processes are in place. Savings plans aligned to the agreed work programmes, building on developments already progressing in 16/17. Accountability and of the STP savings programme to be included in contracts. Allocation of specific workforce resource to enable comprehensive delivery.
Risk to the quality, resilience and sustainability of primary care due to GP practices running at maximum capacity	3x4	Ongoing monitoring and supporting practice visits embedded. Investment to support unplanned admissions DES to practices, new ways of working pilots and funding identified to support Primary Care initiatives. Localities working together on new ways of working.
Risk to financial performance if prescribing costs are in excess of the agreed budget.	3x4	Programme plan in place, which are monitored through the fortnightly Medicines Optimisation Programme Group regularly reporting to GCCG Core Team meetings. Benchmarking exercise to understand medicines opportunity completed and will be adopted by the Reducing Clinical Variation Board to focus on delivery across the system. Primary Care Prescribing Improvement Plan and a number of

		prescribing support initiatives implemented i.e. Clinical Support Pharmacists, Dietician Support.
Failure to deliver financial targets	3x4	Work ongoing with the local health and social care system to ensure transparency and understanding of system financial position and solutions to address the financial gap. GCCG ensures an ongoing process to ensure financial commitments are affordable and CCG is achieving a recurrent balance (at least quarterly.)
Failure to comply with the NHS Constitution Standards.	3x4	Work with providers to produce a detailed capacity plan in response to CCG demand planning that sets out the level of capacity the provider expects to need to deliver a constitution compliant performance in all areas, and to highlight where there are risks to delivery of core standards.
Public, patients or stakeholders challenge plans.	2x4	Communication and Engagement Plan developed, building on JUYC exercise, to ensure countywide engagement regarding our plans for new ways of working and new models of care from autumn 2016 to early spring 2017 and with regards to more detailed proposals for service change commencing in summer 2017.
Lack of staff engagement and staff development could limit the achievement of objectives	2x4	Staff included within STP Communication and Engagement Plan. Organisational Development Plan for GCCG in place and will be refreshed to meet the needs of the organisation in line with the STP Workforce and OD Strategy.

Annex 7: STP Communication & Engagement

Our 2016/17-18/19 Operational Plan aligns to the commitments outlined within our One Gloucestershire Sustainability and Transformation Plan and therefore will be supported by the STP communications and engagement approach which will be delivered in a two phases.

In developing our two phase communications and engagement approach we have drawn upon published national guidance, as well as our local experience of what works well in Gloucestershire. Phase One will support countywide engagement regarding our plans for new ways of working and new models of care. This will build upon our earlier *Joining Up Your Care engagement*, when over 2000 local people were involved in shaping our current thinking. Phase One will run through autumn 2016 to early spring 2017.

Phase Two, will support our legal duty to consult with the public regarding more detailed proposals for service change. Phase Two will commence during summer 2017.

For Phase One, we have identified key stakeholders and plan to target our communications and engagement activities in ways to maximise their interest and involvement. We have prepared key messages that are easy to understand for both individuals, staff and partners who are frequently engaged with health and care services, as well as for the wider general population, for whom health and care is not something they think about very often. Our engagement approach in Phase One will include both qualitative and quantitative methods such as independently facilitated deliberative events, public drop-ins and staff feedback events, Information Bus visits, and online surveys.

Our aim is to ensure we achieve comprehensive engagement, co-production, consultation and communication with local people throughout the life time of the STP. We want everyone who has a view to be able to have their say and know that their voice will be heard and feel confident that the impact of their contribution will be recognised and acknowledged.

Our Sustainability and Transformation Plan (STP) Communication and Engagement Strategy and Plan states that during Phase 1 ‘Engagement’ we will:

- **Establish a calendar of existing events**
- **Establish a calendar of additional events/engagement sessions**

On publication of the STP in November we will contact 1200+ contacts on our Stakeholder database. This communication will include details of the STP document and STP Short Guide (including questionnaire). The communication will invite stakeholders to let us know if they would like us to meet them to discuss our STP.

- **Organise public debates**

We will use the STP engagement period to obtain expressions of interest to become a member of a Public Panel. This Panel will meet on a regular basis to debate and act as a public ‘sounding board’ for STP matters.

Annex 8: National 9 'Must Dos'

2017/18 and 2018/19 'Must Dos'
1. STPs
• Implement agreed STP milestones, so that you are on track for full achievement by 2020/21. • Achieve agreed trajectories against the STP core metrics set for 2017-19.
2. Finance
• Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19. • Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. • Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self-care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes. • Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.
3. Primary Care
• Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes. • Ensure local investment meets or exceeds minimum required levels. • Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems. • By no later than March 2019, extend and improve access in line with requirements for new national funding. • Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part
4. Urgent and Emergency Care
• Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan. • By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. • Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls. • Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department. • Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.
5. Referral to treatment times and elective care
• Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). • Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018. • Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups. • Implement the national maternity services review, Better Births, through local maternity systems.

6. Cancer

- Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.
- Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.
- Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
- Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.
- Ensure all elements of the Recovery Package are commissioned, including ensuring that:
  - all patients have a holistic needs assessment and care plan at the point of diagnosis;
  - a treatment summary is sent to the patient's GP at the end of treatment; and
  - a cancer care review is completed by the GP within six months of a cancer diagnosis.

7. Mental Health

- Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:
  - Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;
  - More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;
  - Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral;
  - Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
  - Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
  - Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.

8. People with learning disabilities

- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
- Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.
- Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.

9. Improving quality in organisations

- All organisations should implement plans to improve quality of care, particularly for organisations in special measures.
- Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.
- Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.

Annex 9: STP Solutions – Phasing 2017/18 to 2020/21

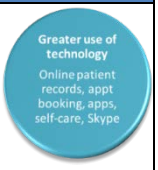
Solution	Total Savings (£m)	2017/18 Year 1* (£m)	2018/19 Year 2* (£m)	2019/20 Year 3 (£m)	2020/21 Years 4 (£m)
Enabling Active Communities - Prevention & Self-Care	17.0	0.0	2.5	7.5	7.0
Clinical Programme Approach - Dementia Programme	2.0	0.5	0.5	0.5	0.5
Clinical Programme Approach - Pathway Allocative Efficiency	18.0	3.4	3.7	5.4	5.5
Reducing Clinical Variation - Diagnostics Programme	0.8	0.2	0.2	0.2	0.2
Reducing Clinical Variation - Medicines Optimisation	20.0	5.0	5.0	5.0	5.0
Reducing Clinical Variation - Changes in settings of care	0.8	0.2	0.2	0.2	0.2
One Place, One Budget, One System - Proactive LTC Management	10.5	4.7	3.4	1.2	1.2
Other - Other Savings Programmes	3.0	0.8	0.7	0.0	1.5
Local Authority - Social Care Programme	36.0	9.0	9.0	9.0	9.0
Specialist Commissioning	20.2	5.9	4.2	4.7	5.4
Provider Efficiencies (CIPs)	70.6	17.6	17.7	17.6	17.7
Total	**198.9**	**47.3**	**47.1**	**51.3**	**53.2**

**17/18 -18/19 Operational Plan applies to Year 1 & 2 only*

NHS Gloucestershire CCG: Delivering the GPFV – Transformation Plan

Area of plan	Description
Vision A clear narrative on the vision for and delivery of sustainable general practice that reflects the ambition set out in the General Practice Forward View	**Background and Vision** NHS Gloucestershire Clinical Commissioning Group (GCCG), in conjunction with its member practices and partners, has developed an ambitious 5-year strategy for the future of Primary Care in Gloucestershire as part of our 'One Gloucestershire' Sustainability and Transformation Plan, reflecting the national ambitions of the General Practice Forward View, alongside those generated by our member practices. This Strategy was formally agreed by our CCG Governing Body in September 2016 with the following vision: **Our Gloucestershire Primary Care Vision** So patients in Gloucestershire can **stay well for longer** and receive **joined-up out of hospital care** wherever possible, we need to have a **sustainable, safe and high quality** primary care service, provided in **modern premises** that are fit for the future. To do this, we will: • **Attract and retain the best staff** through promoting Gloucestershire as a great place to live and work, and offering excellent training opportunities; • Ensure **good access** to primary care **7 days a week**; • Create a **better work-life balance** for primary care staff; • **Maximise the use of technology**; • **Reduce bureaucracy**; • Support practices to explore how they can work closer together to provide a **greater range of services** for larger numbers of patients The six components of our Strategy are set out below:

Area of plan	Description
	1. Access This section of our Strategy sets out our commitment to provide patients with improved access to primary care, including extended evening and weekend access that is joined up, easy to navigate and provided locally. Our approach will be informed by evaluation of our local GP Access Fund 'Choice Plus' pilot that has been in place across our localities and other local services and we will work with practices, patients and providers to design our long-term models of care in the context of the access requirements set out within the General Practice Forward View (GPFV). We will also further develop our approach to Social Prescribing. These initiatives, in all our localities, are helping practices to manage demand and support people with broader, non-medical needs to improve their well-being and access sources of community and social support. Finally, we will also utilise the funding provided for care navigation and handling clinical correspondence joined-up with the wider GPFV workstreams, particularly sustainability and transformation of primary care. **2. Primary Care at Scale** There is an increasing trend towards delivery of 'Primary Care at Scale', with the traditional small GP partnership model often recognised as being too small to respond to the demographic and financial challenges facing the NHS. This should result in a number of benefits including access to a wider range of local services for patients within the local community, increased staff resilience, improved staff satisfaction, work life balance and learning opportunities, and improved financial sustainability. **3. Integration** Through our localities, we will support GP practices to work as part of an integrated (joined-up) team of multi-disciplinary professionals (including community, voluntary and hospital services) for the benefit of a defined population of approximately 30,000 patients. This is likely to involve an extended team of GPs, nurses, allied health professionals and specialists offering easy access to a wide range of health and care close to people's homes. Our Strategy also sets out plans for developing a joined up, seven-day urgent care system, with centres and services to meet the needs of local communities. **4. Greater use of technology**

Area of plan	Description
	Through implementation of our IM&T Strategy and local 'digital roadmap', we will work to provide secure access to patient records for clinicians and care workers, where and when they are needed and provide access for patients and their carers to their digital health records.  We will also empower patients and their carers to take greater responsibility for their health through increased use of technology-based support tools and other on-line resources, including information on local services and support. We will also look to extend the role of technology to support direct patient care, including on-line video consultations and e-consultation, accelerated by the national funding from 2017/18. **5. Estates** Our Strategy describes how we will implement our five year Primary Care Infrastructure Plan. The Plan sets out where investment is anticipated to be made in either new or extended buildings to enhance the practice team and patient environment and to support modern healthcare. The Plan is informed by evidence of future population growth and need as well as considering current provision, condition of buildings and existing schemes in various stages of development. In some cases, it may be beneficial for practices to look at shared premises to meet the needs of their local populations, but not in every case – it is very much dependent on a range of local circumstances. Buildings will need to be developed in a flexible way to take into account future demand, new technology, and the bringing together of other community, care or leisure services. **6. Developing the workforce** This component is critical to the sustainability of primary care in Gloucestershire. Our Strategy describes our approach to recruitment, retention and return of the GP workforce, the education and training of the practice nurse workforce and development of the 'skill mix' in primary care, including new roles to support current professionals in providing care, such as clinical pharmacists. We have already made significant early progress across these components and in implementing the GPFV, details of which can be found in the sections below.
Investment in primary care	GCCG has already demonstrated a clear investment in general practice. Our CCG was in the first wave to take delegated commissioning arrangements for

Area of plan	Description
The investment plan (revenue and capital) in primary care to deliver all aspects of the General Practice Forward View, locally.	Primary Care, with the direct intention of increasing the resourcing of general practice and to commission across pathways so we can shift activity from secondary to primary care. For example, we have already invested £1m recurrently to support the Unplanned Admissions DES and invested in a 'Primary Care Offer' for all our practices that has improved the quality of general practice provision with investment of c.£3 per patient (c.£2m). We have also invested in the leadership development of seven new GP Provider Leads to represent their localities with regards to the GPFV and who are all members of our newly established New Models of Care Board, which reports to the STP Delivery Board. They are each funded at 3 sessions per month recurrently, demonstrating the early additional investment we are making in local delivery of the GPFV and the voice of Primary Care in the future of our Gloucestershire STP and organisational structure. Furthermore, the GPFV sets out that CCGs must invest £1.50/head in 17/18 and 18/19 non-recurrently to fund transformation. GCCG is committed, in addition to proposals on delegated budgets, to invest at least £3 per head (over £1.9m) into practices across 2017/18 and 2018/19 as part of a transformational support package. To ensure this is transformative we have asked practices to coalesce in units of c.30,000 registered populations, in accordance with our Primary Care Strategy, to develop transformative ideas that support the sustainability of both primary care and the wider system. The Primary Care allocation has increased by 1.8% in 2017/18 from the previous year and is as highlighted in the table below. The allocation is forecast to increase by a further 1.9% in 2018/19; both increases being predicated on an annual population growth of 0.7%. It should be noted that this level of growth is below the all England average.

Area of plan	Description

Description	2016/17 Forecast £000	2017/18 Plan £000
Contract payments - GMS	46,747	47,709
Contract payments - PMS	3,356	3,511
Contract payments - APMS	1,380	1,478
Enhanced Services	4,216	4,183
Other GP Services	2,175	1,468
Premises	8,147	8,960
Dispensing/Prescribing	3,125	3,191
QOF	8,199	8,268
	77,345	**78,768**
Contingency	393	400
Headroom	785	800
Allocation	**78,523**	**79,968**
		1.84%

- Premises expenditure in the plan assumes that the CCG will need to fund commitments resulting from completed projects involving capital expenditure and covers those schemes which were brought on-line part-way through 2016/17 and the impact of new schemes in the new financial year.

- Capital funding proposals (responses yet to be received) have been submitted to NHSE for the following projects relating to the next two financial years. If successful, the proposals relating to premises developments will offset some of the revenue costs set out in the Primary Care infrastructure Plan included in this document. Although there are some countywide schemes to ensure specific compliance across practices (e.g. N3, DDRB etc) the remaining projects highlight specific issues which will address both demographic changes and the potential movement of some activity from hospital and community settings:

Scheme	**2017/18 £000**	**2018/19 £000**
GP Practice IT network/hardware refresh	2,500	1,000
GP practice minor improvement grants	342	250
Beeches Green (Stroud)		3,989
Gloucester City Health Centre	1,687	
Romney House (Tetbury)		2,017
Minchinhampton Surgery		1,966
Cheltenham Town Centre		7,464
Cinderford Health Centre		2,296
TOTAL	**4,529**	**18,982**

- GP IT investment (non-capital) will remain static within the CCG for the

<table>
<tr><th>Area of plan</th><th>Description</th></tr>
<tr><td></td><td>next two financial years at £1,622k; this being consistent with the national position. However, the CCG will invest additional resources within the county's "Joining Up Your Information" project which is an integral element of the Local Digital Roadmap and involves all health and social care providers across the county (including all practices).</td></tr>
<tr><td>Support and grow the primary care workforce

A baseline assessment of workload, demand and supply side numbers.

A plan to:
- develop initiatives to attract and retain GPs and other practice staff

- develop expanded multi-disciplinary primary care teams</td><td>In order to better understand the workforce and recruitment needs of our practices, GCCG undertook a survey of its member practices in 2015/16 and will be repeating this survey during Q4 2016/17. Practices are asked to confirm whether they have any GP vacancies, the number of partner and salaried vacant sessions and whether they are aware of any planned or anticipated GP retirements. We had 77 practices respond to our short workforce survey with the following responses:

<table>
<tr><td>Does your practice have any GP vacancies?</td><td>31 practices</td><td>40% of all responses</td></tr>
<tr><td>Partner vacant sessions*</td><td>146</td><td>42 due to long term sickness</td></tr>
<tr><td>Salaried vacant sessions</td><td>49</td><td></td></tr>
<tr><td>Any planned GP retirements?</td><td>44 practices</td><td>57% of all responses</td></tr>
<tr><td>Total known retirements</td><td>57</td><td></td></tr>
</table>

*Not all practices confirmed number of sessions, therefore 8 sessions assumed where unstated

In addition to this survey that demonstrated the level of current and future vacancies that we need to respond to, we also have used the Health Education England survey data to provide a baseline assessment of our workforce numbers, which was then utilised within our STP forecasting. Our baseline therefore at 2015/16 is:

• GPs: 341 WTE
• GP support staff: 939 WTE
• Commissioner Administration Staff: 218 WTE

Forecasts within the STP show the growth of these figures in accordance with baselining against national trend alongside our local plans for recruitment of clinical pharmacists (at the time of writing this was assumed on basis of GCCG employment but three employment models have since emerged across our clusters), health visitors for the elderly, mental health workers in primary care, recruitment drive for GPs (both to fill vacancies and also for growth) as follows by end of 2020/21:

• GPs: 381 WTE
• GP support staff: 984 WTE
• Commissioner Administration Staff: 254</td></tr>
</table>

Area of plan	Description
	Our approach to supporting the workforce of our 81 member practices has been focused around the recruitment, retention and return of the general practice workforce, following the NHS England, Health Education England (HEE), the General Practitioners Committee (GPC) and the Royal College of General Practitioners (RCGP) produced GP workforce 10 point plan. The work programme has been developed with our GP-led Primary Care Workforce and Education Workstream Group. Going forwards our plans for developing the general practice workforce will also be supported by our newly-established Gloucestershire Community Education Provider Network (CEPN or training hub) and the workforce development needs identified by our clusters of general practices. **Recruit:** Countywide Recruitment Events GCCG, alongside the other main Gloucestershire Health and Social Care providers, held a recruitment event to support promotion of the health and social care job opportunities in the county in November 2016. General Practice shared their clinical and non-clinical vacancies and this showed the breadth of opportunities available to those looking to move to Gloucestershire. Whilst too early to evaluate the effect on recruitment the event was a good opportunity for all providers to work together and we plan to hold another in the future to support Gloucestershire providers including General Practice. Be a GP in Gloucestershire: Promoting local Primary Care campaign To support significant recruitment costs, GCCG has provided significant investment to support member practices to recruit general practitioners, by producing a multi-media campaign (print, online, social media) and provision of campaign branded recruitment advertisements and campaign materials for practices with the British Medical Journal (BMJ) during 2016/17. The aim of this project is to produce a campaign to support the short term recruitment pressures on our member practices as well as the longer term requirement for a primary care workforce that works in a more collaborative and sustainable way. The campaign promotes Gloucestershire as a place to be a general practitioner, but also highlights the benefits of the county's healthcare system alongside benefit to residents such as recreational, sporting and cultural activities[1]. **Retain:** Newly Qualified GP Scheme The workforce group identified a need to support GPs that have trained in Gloucestershire to practice in the county once qualified. Currently it is likely a proportion will either return to practice nearer to home (e.g. Bristol) whilst some of those who will practice in Gloucestershire will choose to do so as a locum, at

[1] https://jobs.bmj.com/minisites/beagpinglos/

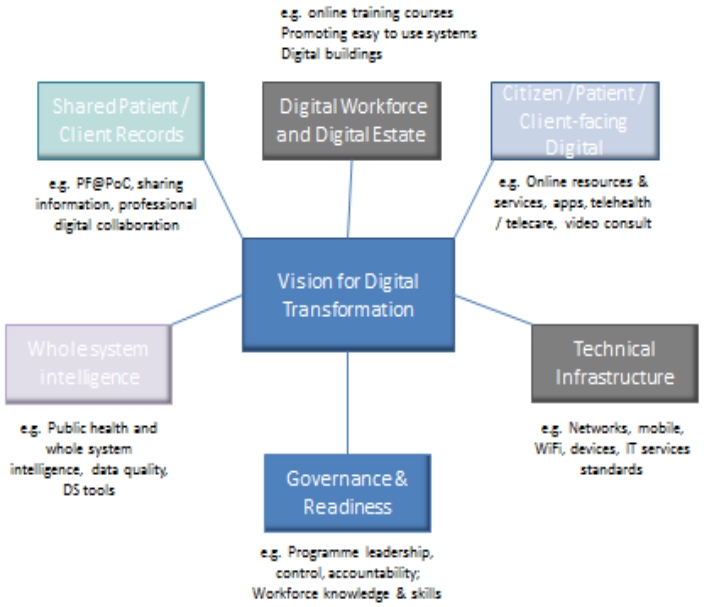
Area of plan	Description
	least to begin with. It is known from engagement with ST3s that there is some demand for an offer that bridges the gap between a salaried or partnership position and the flexible but sometimes less supported locum option. Working with current ST3s and other stakeholders we are developing the offer to support this retention scheme which will most likely include: • Flexible rotations of between 4 and 12 months per practice, with a minimum commitment to work in two different practices over the term to be defined with the individual. • CCG facilitation between newly qualified GPs and general practices based on reasonable requirements such as geographical location, with employment by the individual practices. • Allocated funding per Newly Qualified GP to cover postgraduate study or medical indemnity for Out Of Hours work. • Mentorship and support expectation of practices for the newly qualified GP alongside additional CCG-arranged development and networking opportunities. We believe the benefits for the GPs on the scheme would be to begin their careers with the benefits and stability of working in a practice for an extended period of time but without a full partnership commitment, trying a small number of different practices, mentor support, and the opportunity to continue to study and develop new skills for use in general practice or be supported with MDU costs. The mentor support in particular may be attractive as newly qualified GPs may find they miss the support mechanisms they had as a trainee. GCCG has engaged with the Gloucestershire ST3s and have found that there is a good level of interest in the proposed scheme. The trainees present felt the scheme would provide the flexibility and stability they are looking for, and would bridge the gap between the opportunity to work as a locum and working as a salaried GP. <u>GP Retainer Scheme</u> GCCG continues to work closely with stakeholders to promote the Gloucestershire GP retainer scheme, for example via the LMC newsletter, to raise the profile of relaunching this opportunity in county. This advertising has led to a number of enquiries from GPs who have expressed an interest in becoming retainers due to their personal circumstances. The workforce group will continue to support GPs to join the retainer scheme as appropriate in order to enable them to continue to practice. <u>Portfolio career offer for those considering leaving general practice</u> Following the results of our 2015 general practice survey, the workforce group began discussing methods to encourage GPs considering leaving general practice or retiring early to work in a different way in order to retain their skills

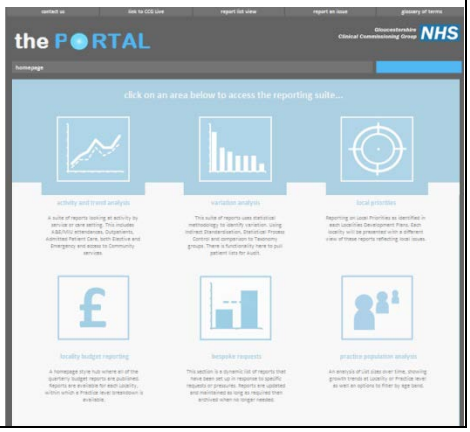
Area of plan	Description
	and experience within primary care in Gloucestershire. GCCG held an engagement event in 2016 to assess the requirements of the GPs that expressed an interest in the scheme. We continue to work closely with identified individuals looking for support to continue to practice, albeit in a different way, in order to retain their expertise in the Gloucestershire workforce. National developments to the GP Retainer Scheme to include GPs looking to retire but maintain a small number of clinical sessions has further enabled us to support this group. <u>Setting up a Community Education Provider Network</u> GCCG, of behalf of all practices in Gloucestershire, submitted an expression of interest in obtaining support to set up a Community Education Provider Network (CEPN) to improve provision of education and training for all roles in primary and community care. Following submission of a formal bid GCCG was successfully approved to set up the CEPN. HEE SW has a contract with the West of England Academic Health Science Network (AHSN) to host and deliver the CEPNs, and as such Gloucestershire is benefitting from the cross-regional experience of the AHSN. The funding available for the CEPN is at this stage is only short term, with a view to developing a sustainable structure following the pilot period. The Gloucestershire CEPN was set up in 2016 and includes various stakeholders with an interest in supporting and developing the workforce. During 2017 onwards, this will focus on addressing the education and development needs of the whole general practice workforce. The CEPN is aligned to our local plans to join-up services, bring care closer to home and support our member practices by promoting working in primary care and community-based roles. GCCG sees value in the CEPN supporting our 81 member practices to work in a more collaborative way, for example in practices providing training for groups of primary care professionals. The CEPN will support our pre-existing structures and plans to empower our primary care colleagues to play a role in developing provision of local services for their patients, in this case in the short, medium and long term sustainability of the primary care workforce. Identified early priorities of the CEPN include; • Developing the educational development of colleagues across general practice roles. • Piloting the integration of Mental Health practitioners into primary care, bridging the gap between primary and secondary mental health services, improving access for patients and supporting the sustainability of general practice. <u>Practice Nurse Education and Training</u>

Area of plan	Description
	This group, with practice nurse representation from all seven localities, is held bi-monthly. The purpose of the group is to provide informed, expert advice and strategic direction to support the development of nurses in General Practice and facilitate the implementation and development of an educational/career framework for nurses in General Practice. A number of schemes have already been agreed following the work of this group, notably; • Practice Nurse Facilitators across all seven localities • Advanced Nurse Practitioners – Funding for course and backfill in each locality agreed February 2016 to complete by 2021. • Consistent approach to mandatory training for Practice Nurses. • Practice Nurse Development Forums. • Health Care Assistant Development Forums. • Practice Nurse Education and training needs analysis and increasing the number of practice nurses with LTC courses. • Practice nurse placements. <u>New skill mixes in Primary Care</u> The CCG has been supportive of working with its constituent practices and stakeholders to develop new roles and skill mixes in primary care. One such example is support of prescribing clinical pharmacists in general practice to alleviate some of the pressures on GP time, both as part of supporting practices in the national scheme (we had five successful bids in Wave 1) and developing their ideas for the transformation funding we are making available (which is, for example, resulting in c.15 additional WTE clinical pharmacists). We will continue to work with our CEPN, HEE and the West of England Academic Health Science Network to further support new skill mixes and benefit from national best practice.
Improve access to general practice in and out of hours A baseline assessment covering local variation in access, in-hours and out of hours plus an assessment of current extended hours practices A plan to	The Gloucestershire GP practices are open from 8am to 6.30pm and 85% are currently providing extended hours through the Extended Hours DES. A number of practices are working at a cluster level to review integrated primary and community urgent care to provide better links and reducing duplication between providers across in hours and out of hours. GCCG is a General Practice Access Fund (GPAF) Wave 2 pilot; offering “Choice Plus” appointments across weekdays, evenings and weekends, which is available to patients registered at all our practices across the seven localities. This pilot is averaging over 30 minutes per 1000 patients as per the national core requirements and has been extended to March 2017 with the objective of developing a plan towards 45 minutes per 1000 patients by March 2017. There is also a focus on ensuring the appointments are provided based on population need and demand and to increase utilisation of the appointments offered. GCCG will continue to commission extended access through 2017 – 2020 in line with

Area of plan	Description
implement enhanced primary care in evenings and weekends – with a clear trajectory for delivery by 2020 A description of how the plan for access to general practice is linked into the wider integrated urgent care system including 111.	national guidance. A full options appraisal is being developed to support the consideration of the seven day model to be commissioned post March 2017. The options appraisal will include a baseline assessment of the current extended hours in practices and Choice Plus. It will also include: • How the service fits with system wide plans (STP), the GPFV and the local work on the integrated primary and community based/led urgent care services. • Maximising appointment utilisation against population need and geographical locations. • The cluster workforce model, potential skill mix and training. • GP cluster based services as opposed to locality focussed county wide provision. • Appropriate performance measures and outcomes. We have good provision of dentists, optometrist and community pharmacists across Gloucestershire and access to urgent provision is widely shared. We will work with NHS England, as the commissioners of these contractor groups, to bring wider primary care into the delivery of our strategy to support enhanced access arrangements and as part of placed-based working. Choice Plus appointments can already be accessed by Out of Hours at weekends to support surges in demand. For bank holiday periods in and out of hours, opening hours and capacity is reviewed and shared with all providers. In conjunction with the recommissioning of OOH and 111, GCCG is undertaking a review of primary and community urgent care which is considering how these services fit together to ensure patients are seen by the right professional at the right time to reduce duplication and better manage urgent, same day, demand within an integrated urgent care system for Gloucestershire.
Transform the way technology is deployed and infrastructure utilised A map of current estates and technology initiatives. A plan to deliver	Our Primary Care Strategy reflects the importance of estates and technology to the successful future of primary care as two distinct components of the Strategy. **<u>Technology</u>** The Gloucestershire IM&T plan on a page sets out how we will ensure delivery against the National Information Board (NIB) "Personalised Health and Care 2020" framework to action and how we will transform health and care services through data and technology:

Area of plan	Description
the requirements set out in the GP IT Operating Model 2016/18 A clear primary care estates and infrastructure strategy linked to the wider strategy for integrated out of hospital care. Confirmation that primary care requirements have been included in Local Digital Roadmaps	• Enable me to make the right health and care choices; • Transforming general practice; • Out of hospital care and integration with social care; • Acute and hospital services; • Paper-free healthcare and system transactions; • Data for outcomes and research. GCCG commission and oversee the delivery of high quality core and mandated GP IT services. In addition, as part of the Sustainability and Transformation Plan (STP), steps are taking place to deliver a fully interoperable health and care system by 2020 that is paper free at the point of care. Enhanced and transformational primary care IT services will complement core and mandated GP IT services and will align with and support the delivery of CCG strategic objectives, service improvement initiatives, Local Digital Roadmap (LDR) and the STP. In the implementation of our LDR and as part of our IM&T Strategy, we will improve clinical effectiveness, decision making and the health and wellbeing of the population through: o Moving towards a fully interoperable health and care system, connecting primary care with each other and all other providers. o 'Paper-free' at the point of care and available to all providers 7 days a week, with mobile working solutions for clinicians to access securely. o Access for patients (and their carers) to their digital health records. o Extending our online offering to patients, taking learning from our development of our innovative "ASAP" app to bring more services to fingertips. o Utilising remote monitoring technology, building on the Telehealth, Telecare and health alerting systems already in place. The Universal capability plan within the LDR outlines plans to provide access to, share and electronically transfer information for patients and providers, this includes the implementation of all national digital systems such as the Summary Care Record additional information, Patient Online, GP2GP, e-referrals and electronic prescriptions. It is recognised locally and nationally that the kinds of transformative change required to meet the challenges outlined in the STP and LDR cannot be achieved without the use and extensive deployment of digital technology. This includes delivering primary care at scale, securing seven day services, supporting new care models and transforming care in line with key clinical priorities along with the promotion of self-care.

Area of plan	Description
	 One Place, One Budget, One System (STP) – Place based services will require several different digital enablers for example: the ability to share primary care data and to write back into the record, mobile working, e-consultations, decision support tools. The CCG has bid for funds from the Estates and Technology Transformation Fund (ETTF) for the redesign of primary care IT to ensure that these services are provided as close to home as possible, support seven day working and helping patients to take more responsibility for actively managing their own health. The proposal has three core objectives: • Clustering of GP practices to support urgent, on the day appointments and extended hour's appointments. • Greater patient self-care- sources of information and apps to manage and record data relating to long term conditions. Improving patient access to their electronic health record both in primary care and other secondary and community care providers. • Improved capacity and efficiency in primary care. The proposal requires not only new ways of working (clustering/remote triage) but also flexible, intuitive and adaptive technology to provide new methods of interacting with primary care: apps, web-based authoritative and evidence-based service information, e-consultation requests and access to extended hours via a variety of interfaces, e.g. direct appointment request (either directly to practice or via a digital HUB), telephone triage or email directly to the GP via completion of a symptom based questionnaire. A second ETTF bid has also been submitted to deliver a common Wi-Fi platform for mobility, interoperability and in conjunction with other projects such as Server Upgrade/Single GP AD Domain which will facilitate integrated team working. The project has five core objectives: • Improving access to information from any location by implementing Wi-Fi in practices – for both staff and the public

Area of plan	Description
	• Migrating and upgrading the 81 practices onto a windows server 2012 single active directory domain server while replacing any redundant server hardware. • Giving clinicians the mobile tools that they need to be able to work out of any location e.g. tablets, laptops, VPN. • To ensure clinicians can access the clinical system in care homes and hospices. **Joining Up Your Information** The Joining Up Your Information (JUYI) project will help securely share important patient healthcare information across primary, community and secondary care, as well as mental health and social care teams on a read-only basis. This will include: • Medication and any changes to it made by a clinician • Medical conditions • Operations/treatment received • Contact details for next-of-kin and others involved in care • Tests that GPs or hospital clinicians have requested or carried out • Appointments (past and planned) and recent visits to out-of-hours GPs and minor injury and illness units • Documents, such as care plans and letters about treatment (for example "discharge summaries" following a hospital stay). Patient, carer and voluntary sector representatives have been involved in the project from the start, providing valuable insight into the best way to communicate JUYI to local residents. The project piloted sharing primary care information in a small number of practices and community teams in 2015/16 ahead of a wider rollout. A procurement process has been undertaken for the first phase of implementation. The intention is that a future phase of JUYI will enable patients to access their shared records. More information can be found at: http://www.gloucestershireccg.nhs.uk/joiningupyourinformation/index.php. **GP Portal** GCCG has invested in a talented Primary Care and Localities Information Team to improve information flow and provide GP practices with easily accessible activity information that enables them to examine and audit areas of variation which are material and unwarranted. In April 2016, 'the Portal' was launched, providing activity, trend and variation analysis that can be 

Area of plan	Description
	aggregated and disaggregated as required, with access for practices to their own patient data. This is being continually developed, with recent releases including interactive budgetary spend analysis and reporting available by practice, locality, or by the new emerging cluster groups, in addition to taxonomy group (similar practice groupings) views. This tool is therefore supporting clusters to identify the priorities for their practices and patients at a place-based level. **Estates** Recognising the importance of our Primary Care estate to our ambitions, we have a specific workstream covering the following core areas: 1. Ensuring the delivery of the committed premises developments to practical completion. 2. Progressing the priorities identified in the Primary Care Infrastructure Plan (PCIP), including proactively working to kick start development opportunities and supporting business case development. 3. Ensuring local practices take full advantage of national funding initiatives such as the Estates and Technology Transformation Fund (ETTF). 4. Working with other key delivery partners particularly NHS Propco where joint responsibility for business case development exists. 5. Managing local improvement grant processes. 6. Ensuring the CCG operates within Premises Directions and uses these regulations appropriately. 7. Ensuring delivery of the committed premises developments to practical completion. 8. Ensure good patient and public involvement takes place within this field of work. These will ensure we are well set to deliver the ambitions of the GPFV. Most importantly, we have a clear five-year prioritised Primary Care Infrastructure Plan (PCIP – approved in March 2016) that forms an integral part of our overall Primary Care Strategy. The PCIP sets out where investment is anticipated to be made in either new or extended buildings, subject to business case approval and available funding. The Plan reflects our strategic intent to deliver primary care at scale, where there is an opportunity to do so. Primary care infrastructure Plan 2(

Area of plan	Description
	Progress and future plans are set out against each of the core areas below: **1. Ensuring the delivery of the committed premises developments to practical completion** o The CCG has an agreed Primary Care Infrastructure Plan that supports model of care requirements, meets demographic need, supports / delivers NHS constitution and other relevant standards and the Plan is reviewed annually. o Plan approved March 2016 by the PCCC and Governing Body. Progress & review reported to the PCCC 3 times per year. **2. Progressing the priorities identified in the Primary Care Infrastructure Plan (PCIP), including proactively working to kick start development opportunities and supporting business case development** o Working with all 12 identified priorities on business case development. o Objective to deliver three completed business cases by the Spring of 2017 (Cheltenham Town Centre's 5 practice development; Beeches Green 3 practice development and Minchinhampton). o 2017/2018 business cases expected as follows: Gloucester City Health Centre; Romney House, Tetbury; Phoenix Surgery, Cirencester; Avenue & St Peters Surgery, Cirencester. o 2018/2019 business cases expected as follows: Brockworth & Hucclecote joint development; Regent Street Surgery; Cinderford Health Centre (as part of the Forest of Dean Community Services Review); Coleford Health Centre (also as part of the Forest of Dean Community Services Review); North West Cheltenham (the Elms) new surgery provision for new centre of population. **3. Ensuring local practices take full advantage of national funding initiatives such as the Estates and Technology Transformation Fund (ETTF)** o Developed local process for support to all practices seeking applications. o Worked closely with core priorities. o Invested £30k in professional to support applications. o Four successful applications (Cheltenham Town Centre, Culverhay surgery, Lydney and Springbank [these last two being managed as improvement grants]). o Close liaison with NHS England during process and will remain involved as oversight as NHS England manage the process direct with successful practices (albeit Lydney and Springbank surgeries being managed by CCG as now improvement grants.

Area of plan	Description
	4. Working with other key delivery partners particularly NHS Propco where joint responsibility for business case development exists o Additional support commissioned with business case input funded by CCG for Beeches Green proposal. **5. Managing local improvement grant processes** o 2016/2017 improvement grant priorities agreed for 2016/ 2017. Unable to progress because expected NHS England expected now unavailable. Seeking internal funding within the CCG. o 2017/2018 improvement grant process to be developed. **6. Ensuring the CCG operates within premises Directions and uses the regulations appropriately** o Clear governance structure in place. o Consistent processes. o Rent review processes enacted. o Fees policy. o Effective use of district valuations. **7. Ensuring the delivery of the committed premises developments to practical completion** o New Churchdown Surgery (additional financial support from CCG, practical support with land purchase and planning). o New Kingsway Surgery, Gloucester (additional financial support with extra £200k for fees.) o Glevum surgery refurbishment and extension, Gloucester (additional CCG support with revenue costs and enabling works). o Tewkesbury Primary Care Centre . o Stow Surgery (additional financial support from CCG with fees and practical support). o Longlevens Surgery extension (support from CCG on rent reimbursement). o Stoke Road Surgery refurbishment and extension (additional practical CCG support to speed up delivery of requirements). o Sevenposts Surgery new surgery (practical CCG support to confirm financial envelope and negotiation of shared benefits).

Area of plan	Description
	8. Ensure good patient and public involvement takes place within this field of work o Formal arrangements set out in the CCG's PCIP on Practice requirements for patient and public involvement in new proposals. Fully aligned with NHS England policy. o PCIP fully discussed at CCG sponsored PPG Countywide network event. Premises proposals continue to be discussed at these events. o Locality proposals frequently discussed at various local stakeholder forums (e.g. Gloucester City Locality Stakeholder Forums, which includes representatives from City's PPG groups, voluntary sector representation, Healthwatch, Gloucester City Council and Tewkesbury Borough Council). o CCG teams provide practical support to patient and public events relating to premises developments.
Better manage workload and redesign how care is provided A plan to improve the capacity in general practice through redesign (e.g. LEAN / Releasing Time to Care) and collaboration (such as shared clinical services and back-office functions)	When consulting our members on the future of primary care in the development of our Primary Care Strategy, reducing workload was a common request. In order to tackle this we have developed several approaches, leveraging the strength of the GPFV: • With the support of our GP Provider Leads, Locality Chairs and the Local Medical Committee (LMC), we have submitted a 'Releasing Time for Care' bid for our 81 practices to hold a CCG-wide (and therefore STP-wide) event in 2017. Our intention is to work with NHS England to develop a Releasing Time for Care programme that focuses on the specific high impact actions that are important to our practices, that improves capacity and collaboration and delivers against our Primary Care Strategy; • We are also holding an event in January 2017 for all practices to attend with at least 1 GP and their Practice Manager, focusing on the "Ten High Impact Actions"; • Through the transformation funding we have enabled our emerging clusters of practices to work together to employ shared additional clinical and back-office staff. For example, through this process alone we are anticipating an additional c.15 clinical pharmacists working in general practice. One cluster is also re-organising how repeat prescriptions are ordered, with a shared back-office function. Others are looking at utilising paramedics in a home-visiting service, while some are bringing mental health workers into primary care in the inner-city areas where this will significantly support the workload of GPs and support patients better with their needs; • Building on the successful GPAF pilot whereby, working with our 'at scale' GP Federation Gloucestershire Doctors (GDoc), we implemented: o 'Choice Plus' for urgent on the day appointments; o Social prescribing rollout to all seven localities and 81 practices;

Area of plan	Description
	o E-consultations; o Remote consultations. • Enforcing the new NHS Standard Contract with our local acute trust that reduces workload on our practices, such as preventing the hospital from re-referring patients back to their GP following an outpatient non-attendance. • Rolling out 'Pharmacy First' minor-ailment scheme, so that patients can be supported by their local community pharmacist in the first instance. We are also now planning other initiatives, such as working with the LMC to have a co-ordinated response from Primary Care to the Acute Trust to ensure that inappropriate work is not being transferred to primary care, along with intrinsically designing the impact assessment early on of our projects and programmes on primary care – whether intended or otherwise – to ensure that the sustainability of primary care is at the forefront of the mind for our organisation when considering pathway changes.
Organisational Form A description of the current organisational form of general practice within the CCG The ambition for primary care at scale underpinned by a delivery plan	Our Primary Care Strategy is a key system enabler within our One Gloucestershire STP Governance Structure. We have 81 practices in Gloucestershire, which has reduced slightly over the last couple of years with one practice closure and a small number of mergers. Up until the summer of 2016, these practices have worked within a locality commissioning infrastructure of seven localities, aligned with our GCCG constitution: • Cheltenham • Forest of Dean • Gloucester City • North Cotswold • South Cotswold • Stroud & Berkeley Vale • Tewkesbury, Newent & Staunton While that structure still exists, as mentioned in the previous section, we have supported the development of 'grass-root' initiated clusters over the last six months to start the delivery of our ambition of 'primary care at scale' set out within our Primary Care Strategy. The 16 clusters that have now formed are as follows:

Area of plan	Description

Locality	Collaborations
Cheltenham (three clusters, c.50,000 patients each)	**St Pauls** - Corinthian, Portland, Royal Well, St.Catherine's, St.George's **Central** - Berkeley Place, Crescent Bakery, Overton Park, Royal Crescent, Springbank, Underwood, Yorkleigh **Peripheral** - Leckhampton, Sixways, Seven Posts, Stoke Rd, Winchcombe
Forest of Dean (c.60,000)	All eleven practices in one cluster: Blakeney, Brunston, Coleford, Dockham, Drybrook, Forest Health Care, Lydney, Mitcheldean, Newnham, Severnbank, Yorkley
Gloucester City (five clusters, c.18,000-41,000)	• Rosebank and Hadwen • Bartongate, Gloucester City Health Centre, Partners in Health, Kingsholm • Brockworth, Hucclecote, Gloucester Health Access Centre • Cheltenham Road, Churchdown, College Yard, Longlevens • Barnwood, London, Heathville, Saintbridge
North Cotswolds (c.29,000)	All five practices in one cluster: Chipping Campden, Cotswold Medical, Mann Cottage, Stow, White House
South Cotswolds (c.58,000)	All eight practices in one cluster: Avenue, Hilary, Lechlade, Park, Phoenix, Rendcomb, Romney, St Peters
Stroud and Berkeley Vale (four clusters, c.18,000-39,000)	**Cluster 1:** Acorn, Cam & Uley, Chipping, Culverhay, Marybrook, Walnut Tree **Cluster 2:** Beeches Green, Locking Hill, Rowcroft, Stroud Valleys **Cluster 3:** Frampton, High Street, Regent Street, Stonehouse **Cluster 4:** Frithwood, Michinhampton, Painswick, Prices Mill
Tewkesbury, Newent and Staunton (c.43,000)	All four practices in one cluster: Church Street, Mythe, Newent, Staunton & Corse

We are now supporting clusters with the next stages of their development. We are funding GP Provider Leads, as described earlier, to lead these conversations locally and are also supporting their development as leaders on 'primary care at scale' through visits to Vanguard sites, such as Modality in Birmingham and the MCP being commissioned in Dudley.

Therefore, we are supporting the development of these c.30,000 cluster provider models with appropriate managerial, informatics and finance support, along with focusing the resources available through the GPFV on this 'at scale' approach, i.e. care navigation and clinical correspondence training, transformation funding, resilience funding, online consultations and so on, is all being wrapped around the clusters developing their approach. The General Practice Resilience Programme is a good example of how we have developed a process with our RCGP GP Ambassador and the LMC that has encouraged practices to work together in their clusters for the purposes of building longer-term resilience and maintaining an open process for clusters to self-nominate for the coming years, thereby providing an equitable solution for the whole county. This process is supported by our CCG Locality Development and Primary Care Directorate, with nominated leads for each cluster to provide additional support.

Furthermore, we have also developed a Memorandum of Understanding with our providers that enables us to commence 'working without walls' across the previous organisational boundaries. We have termed this the 'place-based' approach and are trialling this with the Stroud & Berkeley Vale cluster and the Gloucester City cluster, reporting to the New Models of Care Board described earlier. We intend to then rollout this programme in 2017/18 across all clusters. As described within the MCP Care Model Framework, we see this as the start of the journey towards MCP(s), with primary care at scale working then forwards to an alliance model of a 'virtual MCP' in readiness for future opportunities.

<table>
<tr><th>Area of plan</th><th>Description</th></tr>
<tr><td>Engagement

A description of how the CCG is engaging local primary care professionals and the local population and patients in the development and delivery of the Transformation Plan.</td><td>In the development of our Primary Care Strategy, the overall plan that sits within the Gloucestershire STP and describes our implementation of the intentions and ambitions of the GPFV, we commenced with a countywide general practice event with over 100 attendees from across our practices. This set the priorities that were important for them within the context of the original Five Year Forward View and commenced the early discussions of how they could consider working together to bring about transformation in future.

Through the development of the Strategy, we held two almost month long engagement exercises; the first the early draft agreed by our Primary Care Commissioning Committee; the second an updated version inclusive of all feedback from the first round of engagement. Both rounds of engagement included our GP practices, our Gloucestershire Patient Participation Group Network, County, District and Parish Councils, Gloucestershire Hospitals, Gloucestershire Care Services, 2gether Trust, South West Ambulance Service, the West of England Academic Health Science Network, VCS Alliance, Healthwatch Gloucestershire, Gloucestershire Police and Crime Commissioner and the Local Medical Committee.

Furthermore, the Sustainability and Transformation Plan will be supported by the STP communications and engagement approach which will be delivered in a two phases. In developing our two phase communications and engagement approach we have drawn upon published national guidance, as well as our local experience of what works well in Gloucestershire. Phase One will support countywide engagement regarding our plans for new ways of working and new models of care. This will build upon our earlier Joining Up Your Care engagement, when over 2000 local people were involved in shaping our current thinking. Phase One will run through autumn 2016 to early spring 2017. Phase Two will support our legal duty to consult with the public regarding more detailed proposals for service change, which will commence during summer 2017.</td></tr>
<tr><td>Risks and Mitigation
A description of the key risks and mitigations.</td><td>
<table>
<tr><th>Risks</th><th>Mitigation</th></tr>
<tr><td>Practices will not grasp the importance of acting now to work with their cluster colleagues in delivering transformation and primary care at scale, thereby risking their future sustainability and furthermore the resilience of neighbouring practices</td><td>• Established the 7 GP Provider Leads to lead this locally
• Hosting an event in January 2017 for all practices countywide
• Applying countywide for a local ‘Releasing Time for Care’ programme
• Investing resource in the cluster development of their ‘at scale’ models</td></tr>
<tr><td>The resource available within the CCG is insufficient to support the cluster’s emerging ambitions of how they want to deliver the GPFV</td><td>GCCG are utilising existing resource through re-prioritisation and re-alignment of work programmes in order to release sufficient capacity. For example, we are currently reviewing our locality commissioning infrastructure for 2017/18 to align this with the</td></tr>
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<tr><th>Area of plan</th><th>Description</th></tr>
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<tr><td></td><td>clusters, thereby reducing duplication of functions and investment by both CCG staff and GPs.

Clusters have also recognised their need for specialist support and have bid for General Practice Resilience Programme Funding, which we are supporting as a delegated CCG.</td></tr>
<tr><td>Key agreed estates developments are not supported by the local people, patients and key stakeholders, which hinder implementation.</td><td>Key strategic priorities were supported by the development and implementation of an engagement framework and communications strategy.</td></tr>
<tr><td>There is insufficient financial resource to fund the development of necessary premises requirements, which means that practices are unable to provide the right level of service to patients leading to less effective care</td><td>• Financial framework developed
• Use of ETTF to offset some costs
• Development of larger Centres, wherever possible to maximise estate efficiency
• Prioritising and scheduling of developments</td></tr>
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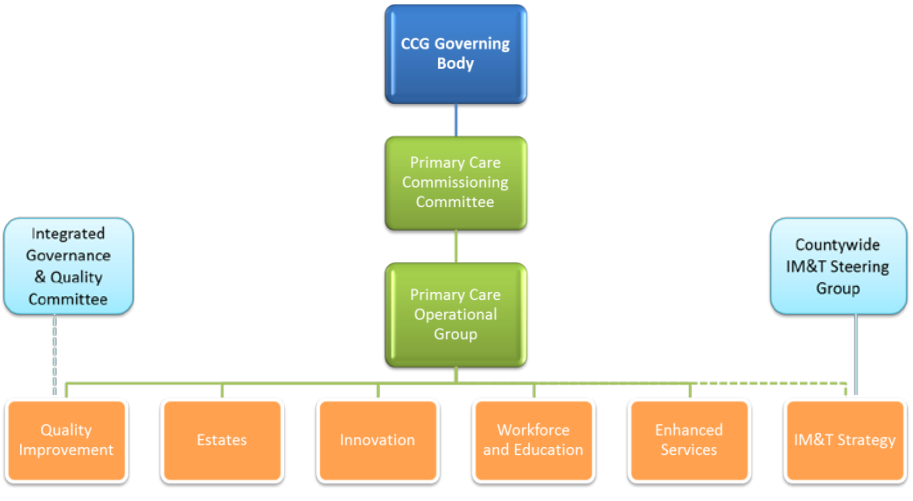
</td></tr>
<tr><td>Governance
A description of the governance arrangements to provide the CCG with assurance that the plan is being delivered fully and on time.</td><td>As described throughout this document, our Primary Care Strategy is the plan which describes our ambitions and intentions for Primary Care in Gloucestershire.

The CCG is committed to establishing effective governance procedures to ensure that it discharges its duties effectively and with due regard to mandatory regulations and voluntary guidance. This also applies to the risk of real, or perceived, conflicts of interest.

The Primary Care governance structure below demonstrates how we achieve this. It is in accordance with the Delegated Agreement between NHS England and GCCG dated 26 March 2015. The structure minimises the risk of conflicts of interest occurring while maintaining important clinical input to the design and delivery of our primary care commissioning responsibilities.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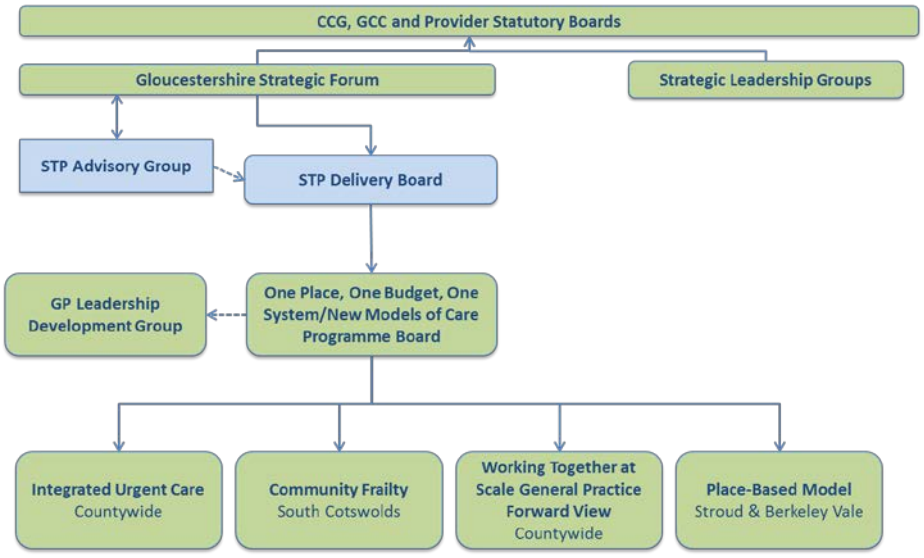
Area of plan	Description
	Primary Care Commissioning Committee The purpose of the Primary Care Commissioning Committee (PCCC), as a committee of the GCCG Governing Body, is to manage the delivery of those elements of the primary care healthcare services delegated by NHS England to the GCCG. The Committee have delegated responsibility for primary medical care decisions relating to: • The award, design and monitoring of GMS, PMS and APMS contracts; • Locally defined and designed enhanced services; • Local incentive schemes; • Procurement of new practice provision; • Discretionary payments (e.g. returner/retainer schemes); • Practice mergers; • Contractual action such as issuing branch/remedial notices and removing a contract. The Committee – which meets in public and is made up of CCG Executives, lay representatives, and representatives from Healthwatch/the Health and Wellbeing Board/NHS England – also report on, and make recommendations to, the Governing Body on the following: • Primary Care Strategy; • Premises improvement grants and capital developments. **Primary Care Operational Group** The Primary Care Operational Group (PCOG) has been established to implement and monitor the progress of the operational functions that delegated commissioning responsibilities provide, while making recommendations to the PCCC where decisions are required. In addition, the Group also has responsibility, on behalf of the PCCC, for oversight and delivery of the following groups: o Primary Care Clinical Quality Review Group (direct report); o Primary Care Estates workstream (direct report); o Primary Care Innovation Group (direct report); o Primary Care Workforce & Education Planning workstream (direct report); o Enhanced Services (direct report); o Primary Care IM&T Steering Group (reports to Countywide IM&T Steering Group).

Area of plan	Description
	Governance of the Primary Care Strategy **Approving the Primary Care Strategy** In accordance with the above, the approval process for the Strategy was via our CCG Governing Body, with progress reported through the Primary Care Commissioning Committee, which is held to account for delivery by the Governing Body. Operational delivery of the Commitments set out against the six components will be managed by the Primary Care Operational Group. **Oversight of GCCGs Sustainability and Transformation Plan and New Models of Care** Overseeing delivery of GCCG's Sustainability and Transformation Plan, of which the Primary Care Strategy is an enabler, is the Gloucestershire Strategic Forum along with a separate STP Delivery Board for oversight of implementation. The Primary Care Strategy delivery is therefore reported to the STP Delivery Board. As a key element of our Sustainability and Transformation Plan is the design and delivery of new models of care, a 'New Models of Care Programme Board' has been established to drive and oversee these models across our County. This New Models of Care Programme Board, reporting to the STP Delivery Board, has Executive membership from across our Providers, with Primary Care represented by our GP Provider Leads as described earlier. The GPFV delivery is therefore reported to the New Models of Care Board too.  In this governance structure, we therefore have statutory accountability for delivery through our CCG Primary Care Commissioning Committee, while we also recognise the importance to the whole system through reporting to the STP governance framework.

NHS
Gloucestershire
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Agenda Item 11

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Update on timetable for procurement of Social Prescribing**
Executive Summary	At the Governing Body meeting in November 2016 members received a full update on Gloucestershire CCG's social prescribing programme together with detail of the proposed procurement process. Members made a decision to fund the scheme for a period of seven years with a potential to extend to seven years. Members will recall that this is a joint procurement with Gloucestershire County Council which forms a key component of our Enabling Active Communities joint action plan. Permission to proceed jointly was approved by Gloucestershire County Council's Cabinet on the 16th November 2016. In addition to committing funding on 24th November, Governing Body members requested that an extraordinary Governing Body meeting should be held to ratify the award decision, which was scheduled to take place on 31st January. However, due to a problem with quoracy on that day, this was not possible. This paper provides an update on the revised procurement timetable and seeks delegated authority to ratify the award decision between 6th and 7th February 2017.
Key Issues	Delegated authority to ratify the award decision is required to allow sufficient time to mobilise the contracts for the new service to commence on 2nd June 2017.

Risk Issues: **Original Risk** **Residual Risk**	There is still a risk that the procurement will not be attractive to the market. This risk has been mitigated by the establishment of a Joint Procurement Team, by a Market Engagement event held on 11th October 2016 and by the ability of bidders to bid for up to two specified LOTs (LOTs 7, 8 and 9).
Financial Impact	None pertinent to the revised timetable.
Legal Issues (including NHS Constitution)	The procurement will be led by the CCG and conducted under the European Union 'Open' procedure.
Impact on Health Inequalities	Yes. Equality Impact Assessment has been completed.
Impact on Equality and Diversity	None. Equality and Diversity Impact assessment has been completed.
Impact on Sustainable Development	None.
Patient and Public Involvement	Yes. Patient feedback formed an integral part of the external evaluation. Patient and public involvement was undertaken as part of the development of the original business case.
Recommendation	The Governing Body is requested to grant delegated authority to ratify the award decision to the Accountable Officer the Lay Member Governance Lead and the Chief Finance Officer of GCCG.
Authors	Helen Edwards/David Porter/Jules Ford
Designation	Associate Director of Primary Care and Locality Development/Head of Procurement
Sponsoring Director (if not author)	Ellen Rule Director of Transformation and Service Redesign

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Governing Body

Thursday 26th January 2017

Social Prescribing

1. Introduction

1.1 At the Governing Body meeting in November 2016 members received a full update on Gloucestershire CCG's social prescribing programme together with detail of the proposed procurement process. Members made a decision to fund the scheme for a period of five years with a potential to extend to seven years.

1.2 Members will recall that this is a joint procurement with Gloucestershire County Council which forms a key component of our Enabling Active Communities joint action plan. Permission to proceed jointly was approved by Gloucestershire County Council's Cabinet on the 16th November 2016.

1.3 In addition to committing funding on 24th November, Governing Body members requested that an extraordinary Governing Body meeting should be held to ratify the award decision, which was scheduled to take place on 31st January. However, due to a problem with quoracy on that day, this was not possible. In addition the tender process has moved backwards by a week.

1.4 This paper provides an update on the revised procurement timetable and seeks delegated authority to ratify the award decision between 6th and 7th February 2017.

2. Procurement

2.1 A project team responsible for over-seeing the procurement process has been established with representatives from both GCCG and GCC. As GCCG will contribute the majority of the annually agreed funding, GCCG's procurement staff will lead the procurement process but will work collaboratively with GCC commercial staff.

2.2 Due to the number and nature of some of the clarification questions and a

number of requests from different potential bidders, the procurement project team took the decision to amend the deadline for bidder submissions. This moved back by one week to the 23rd January. A revised time table is therefore included below.

2.3 Revised procurement timetable

Stage:	Date(s):	Notes:
GCC Cabinet Meeting	16 November 2016	▪ Approval to commit funding
CCG Governing Body	24 November 2016	▪ Approval to commit funding
Publish Contract Opportunity Advertisements: ▪ Official Journal of the European Union (Light Touch Regime) ▪ Contracts Finder (GCCG) ▪ Pro-Contract (GCC)	25 November 2016	▪ EU Open Procedure ▪ Advertisement period 35 days minimum (or 30 days for electronic receipt of tenders). Assuming use of Pro-Contract e-tendering system. ▪ Include Provider Assessment Questionnaire (PAQ) in ITT ▪ Invitation to Tender document available from day of publication
Advertisements closing date	6 January 2017	
Deadline for receipt of ITT offer submissions	23 January 2017	▪ Electronic receipt by GCC

ITT evaluation process (to include): ▪ Clarification requests (where required) ▪ Bidder presentations (where required / to be determined) ▪ Scoring moderation meeting	23 January 2017 to 2 February 2017 inclusive	
Prepare / submit contract award recommendation paper	3 February	▪ Submit to Accountable Officer for approval via delegated authority
Decision to award made	6 and 7 February	
Inform preferred bidder(s) and unsuccessful bidder(s)	8 February 2017	
Observe mandatory standstill period	8 February 2017 to 18 February 2017	▪ Minimum of 10 calendar days
Formal contract award	From 18 February 2017	▪ Advise successful bidder(s) ▪ Populate NHS standard contract schedules ▪ Agree bidder debriefs where required

Contract mobilisation / implementation	From 19 February 2017	▪ TUPE transfers (where applicable)
Publish contract award notice	Within 30 days of contract award	▪ Contracts Finder / OJEU / ProContract
Contract commencement	2 June 2017	

3. Contract Award Recommendation Process

3.1 A contract award recommendation paper will be drafted on 3rd February in-line with the indicative procurement timetable. Governing Body approval to award is required and delegated authority is sought to ratify the award decision between 6th and 7th February 2017.

4. Recommendations

4.1 The Governing Body is requested to grant delegated authority to ratify the award decision to the Accountable Officer, Lay Member Governance Lead and the Chief Finance Officer of GCCG.

Agenda Item 12

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Assurance Framework 2016/17**
Executive Summary	The attached Assurance Framework for 2016/17 provides details of the assurances that will be provided to the Governing Body regarding the achievement of the CCG's objectives. 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.
Key Issues	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.
Risk Issues: **Original Risk** **Residual Risk**	The absence of a fit for purpose Assurance Framework could result in gaps in control or assurances not being identified and addressed. 8 (2x4) 4 (1x4)
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None

MINDFUL EMPLOYER

Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note this paper and the attached Assurance Framework.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Governing Body

Thursday 26th January 2017

Assurance Framework 2016/17

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; and
- 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 principal 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 5 Year Plan for 2014/19.

2.2 The document outlines the principal high-level risks, control systems and assurances 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.

MINDFUL EMPLOYER

2.3 Progress regarding the achievement of each objective is monitored separately through the performance management process.

2.4 This version of the Assurance Framework was considered at the December 2016 meeting of the Integrated Governance and Quality Committee (IGQC). Further updates of the document will be provided to future meetings of both the IGQC and the Governing Body.

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					Controls		Assurances		Actions / Status
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**
Objective 1: Develop strong, high quality, clinically effective and innovative services.									
L2	Risk to the quality, resilience and sustainability of Primary Care due to GP practices running at maximum capacity and certain practices not being financially viable. Increasing examples in 2016/17 of practices becoming unsustainable, with this likely to continue through 2016. Furthermore - NHS Property Services are notifying practices occupying health centres of significant increases in facility costs in 2016/17.	Ian Goodall Helen Edwards Andrew Hughes Stephen Rudd Jenny Bowker	12 (3x4)	12 (3x4)	Practice visits by Executive Team and CCG Lead GPs; Senior Locality Manager attendance at Locality Executive meetings; Implementation of Countywide Practice Manager Representative Group; Exercising Delegated Commissioning Responsibilities; close working with member practices.		Primary Care Commissioning Committee, Primary Care Operational Group, Risk and Issues log.		Ongoing monitoring, appointments made within Senior Management of Primary Care team, Investment to support unplanned admissions DES to practices, new ways of working pilots, funding identified to support Primary Care initiatives. Localities working together on new ways of working. (March 2017)
T12	Insufficient clinical capacity and leadership across the system to deliver changes required within the CPG.	Kelly Matthews/ Kathryn Hall	12 (3x4)	12 (3x4)	Clinical programme approach, locality structure and meetings. Terms of reference for CPG, Use of CPG Board.		Performance reports to Governing Body		Implementation of the Clinical Programme Development Plan 2016/17. Monitor clinician participation with Clinical Programme Groups. Clinical Programme Board to be established for 2016/17.
T13	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.	Simon Bilous, Helen Ford, Kathryn Hall	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		NHS England in process of procuring extra bed capacity nationally. But some cases are still not being found appropriate provision in a timely way which can have an impact on local systems with inappropriate admissions to GRH or Wotton Lawn. Opportunities for co-commissioning with NHS England are being explored. Local work ongoing includes changing the service arrangements for crisis support and psychiatric liaison including extending the age range to include u18s and u16s respectively as part of overall Children's Mental Health Transformation Plan; and developing additional options for care and support of young people in need of accommodating in a crisis (Safe Places / Place of Safety) - jointly with the council and other partners.

Risk					Controls		Assurances		Actions / Status
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**
T14	Ensuring there is sufficient project management resource and skills to deliver the transformation programme/QIPP across all organisations.	Kelly Matthews/Kathryn Hall	12 (3x4)	12 (3x4)	Project Resource identified, documented and agreed across all CPGs. Clinical Programme Approach understood. Provider Representatives appointed to CPGs along with TOR. STP agreed across health community. Clinical Programme Board developed for governance and assurance.		Performance reports to Governing Body		1. PID, detailing Project workstreams, leads and deliverables, to be developed and agreed by relevant CPG, including providers, for each project. 2. Project Board and Project Team Terms of reference agreed by relevant CPG, CCG and providers. 3. Resource Plan in place and monitored for Clinical Programme Team and relevant CPG provider representatives as appropriate.
Objective 2: Work with patients, carers and the public to inform decision making.									
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.									
C3	Increased risk of CCG receiving legal challenge as a result of competitive tendering following the introduction of the EU Remedies Act, the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 1 April 2013 and the Public Procurement (The Public Contracts Regulations 2015).	David Porter	12 (3x4)	12 (3x4)	Ensure that EU procurement process is followed for all procurement exercises (above and below) the EU threshold in accordance with DoH, Cabinet Office and Government Procurement Service Guidelines.		Project reports to Core Executive Team and Governing Body		Continual adherence to European Union Public Contracts Regulations 2015 and the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
C5	(Discharge) Risk that system partners will be unable to effectively deliver a timely and coordinated approach to patient flow and discharge ensuring a reduction of patients who remain in the acute trust when medically stable and with a LOS greater than 14 days.	Maria Metherall	16 (4x4)	12 (3x4)	A&EDB, Urgent Care Programme Board, Urgent Care Strategy Group		Performance Reports and dashboards, critical milestones reviewed, regular programme stocktake.		Continual monitoring and review via the A&EDB 4-hour Improvement Plan and consolidated with focus on admission avoidance and system-wide flow. Monitoring and review to be undertaken through the UC Programme Board and A&E Delivery Board throughout 2016/17.
C6	(Acute Care) Non-delivery of the Constitution standard for maximum wait of 4 hours within the Emergency Department.	Maria Metherall	12 (3x4)	12 (3x4)	A&EDB, Urgent Care Programme Board, Urgent Care Strategy Group		Performance Reports to Governing Body, weekly situation report, project status updates.		Continual monitoring and review via the A&EDB 4-hour Improvement Plan and consolidated with focus on admission avoidance and system-wide flow. Monitoring and review to be undertaken through the UC Programme Board and A&E Delivery Board throughout 2016/17.
C8 (inc C28)	(Signposting & Admission Avoidance) Risk of failure to reduce demand and prevent unnecessary acute attendances and emergency admissions.	Maria Metherall	12 (3x4)	12 (3x4)	A&EDB, Urgent Care Programme Board, Urgent Care Strategy Group		Performance Reports to Governing Body, weekly situation report, project status updates.		Monitoring via the A&EDB High Impact Four Hour Improvement Plan and Four Hour Recovery Plan. Remedial action plan in place and agreed with provider. Monitoring and review through Contract Management Board arrangements. Continuous assurance around training and recruitment plan for workforce in place. Work with GCS to increase SPCA focus on admission avoidance and assurance that all GPs are using the service.
T10 (inc F12)	Delayed implementation of QIPP Projects and/or failure of projects to deliver anticipated benefits could result in under-delivery on planned care QIPP savings target. Transformation projects may not deliver the expected outcomes.	Ian Goodall	12 (3x4)	12 (3x4)	Robust project management planning and reporting to the PMO.		Performance reports to Governing Body.		All projects to have clear baseline monitoring with agreed KPIs. Monthly project monitoring with focus on schemes at risk of non-delivery, with agreement on remedial action. Planned care QIPP manager recruit to Trust. Monthly QIPP Review meetings for Planned Care and Urgent Care.

Risk					Controls		Assurances		Actions / Status
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**
C15	Failure to comply with the NHS Constitution 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 to Governing Body	Number of targets not being met, insufficient capacity in planned care.	Insufficient planned care capacity to meet demand could result in increasing waiting lists and inability to meet waiting time targets, impacting on the quality of local health services. The IST will begin working with Urology at GHFT in relation to their capacity and demand modelling. A number of targets regularly not being met, including 62 day cancer target, 6 week wait for diagnostics, and a small number of 52 week wait breaches have been reported. Change fortnightly calls to weekly from October to monitor plans and trajectories. Monthly access and performance meeting arranged to discuss progress. Attendance at Trust internal cancer performance meeting. Recovery action plans in place in a number of areas. Monthly communications being sent to GPs regarding waiting times across providers to encourage informed choice. Waiting times have been included on G-Care as part of the referral process. Some patient transfers underway for long waiters, although this is primarily in General Surgery and Urology. Increase in Urology community outpatient services. (August 2016)
C34	Impact on discharges due to delays sourcing independent sector domiciliary care.		12 (3x4)	12 (3x4)	GCC CPAC / Brokerage for LA funded service users		Performance Reports to Governing Body		Maintain regular monitoring of performance/progress at quality groups. Daily updates for the System Call. Demand and capacity being mapped to try and understand underlying issues and monitored as part of the implementation of dom care new contracting arrangements. Extension to Hospital Rapid Discharge service supporting the new 'Hospital to Home' to run concurrently.
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). The delivery of 2016/17 financial performance targets are dependent upon QIPP performance in the last six months of the financial year. Work on Sustainability and Transformation plan within the Health Community is being refined with a final submission due in October leading to two year contracts.
					Robust contract management including activity monitoring and validation (particularly at GHFT), additional monitoring of volatile budget lines such as prescribing & CHC		Monthly performance dashboard for larger contracts with robust out of county contract monitoring reflected within performance reports. Monthly prescribing & CHC information including		Monthly performance meeting which reviews all contracts (including out of county) together with Contract Boards and Finance & Information Groups for larger contracts.
					Internal audit of financial procedures undertaken on an annual basis		Internal audit reports and recommendations to be reported to Audit Committee.		Procedures have been reviewed.
F17 (inc F19)	The CCG will be using the lead provider framework for the procurement of commissioning support services. This process may mean a different provider is chosen. This could mean disruption to services during the period of procurement and transition.	Cath Leech	12 (3x4)	12 (3x4)	Regular contract monitoring meetings.		Governing Body reports		The CCG will access support from NHSE in undertaking the process. If the contract is awarded to an alternative provider then a group will be set up to manage the contract transition
F18	Lack of alignment of IM & T strategy with partner and provider organisations.	Cath Leech	12 (3x4)	12 (3x4)	ICT Programme Group		Governing Body reports		Each project will be costed and prioritised by the CCG to determine whether to take forward.

Risk					Controls		Assurances		Actions / Status
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**
C35	Risk of break in Primary Care OOH service provision if alternative provider is not contracted from 1 June 2017	Gill Bridgland	12 (3x4)	12 (3x4)	Procurement Project Board, Core Team and Governing Body.		Monthly reports to Core Team and Governing Body		Options paper to Part II of GCCG Governing Body meeting on 28.07.16. Legal Advice has been sought. Project Board has been set up to oversee the fast track procurement to secure a 10 month contract. Advert will be placed for 10 month contract on 3 October 16.
C36	Risk of failure to meet A&E Delivery Priorities to support safe and effective services through winter.	Maria Metherall	12 (3x4)	12 (3x4)	A&E Delivery Board		Performance Reports to Governing Body		. Baseline assessment tool completed and presented to September A&E Delivery Board. Director level responsibility agreed with key delivery dates. A number of actions were contained within existing work programmes. Directors are responsible for updates on progress at A&E Delivery Board given the importance of delivery. . Winter plan produced from all system partners including updated system Escalation Framework. Winter Workshops arranged fro operational managers/leads. . Demand & Capacity modelling underway - due to be presented to October A&E Delivery Board. . October A&E Delivery Board to consider current schemes and their effectiveness in order to support winter. . Workforce remains the largest risk to delivery.
Objective 4: Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.									
F20	Shared Record Project - It will not be possible to get data from SystmOne practices in the short-term. This requires having EDSM (intra-SystmOne sharing) switched on which makes the entire patient record available to all other SystmOne users (i.e. national) which may put patients off and is a different model to that agreed for JUYI. The only current way to share with the JUYI solution would be via the MIG.	Cath Leech	12 (3x4)	12 (3x4)			Governing Body reports		Escalation to HSCIC. Meet with TPP (supplier for SystmOne). Seek alternative method of sharing TPP data. Regular calls with other shared care record programmes (Birmingham/Surrey/Nottingham/Leeds). Review options.
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.									
Q17	Higher than expected mortality in GHT patients experiencing fractured neck of femur.	Kay Haughton	12 (3x4)	12 (3x4)	Ongoing monitoring of data. CCG presence on #NOF working group. Monitoring of GHT Action Plan		Governing Body performance reports		Audit and action plan produced. Item remains on CQRG agenda and is actively discussed. CCG representation from MSK CPG attends GHT #NOF Group and also the #NOF Action Plan is monitored via the CCG CQRG
Objective 6: Develop strong leadership as commissioners at all levels of the organisation, including localities.									
F23	The proposed allocation change relating to the new tariff for 2017/18 may not be cost neutral for Gloucestershire.	Steve Lowson/Sarah Hammond	12 (3x4)	12 (3x4)	Due diligence being carried out through running information through the latest grouper.		Performance reports to Governing Body		Information behind the allocation change requested from NHSE Comparison of grouper results between CCG & GHFT being undertaken

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Agenda Item 13

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**An Open Culture: Engagement - Equality - Experience** **Annual Report: 2016**
Executive Summary	This report highlights the work NHS Gloucestershire CCG has undertaken towards meeting its general Public Sector Equality Duty, through engagement with patients, carers, staff and communities. The Public Sector Equality Duty came into force in April 2011. It requires the CCG, 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.
Key Issues	This report will be available via the CCG website. It covers: • "An Open Culture": an introduction to our strategies; • Legal requirements relating to engagement, experience and equality; • A profile of the population of Gloucestershire;

	• Innovative practice that demonstrates our commitment to engagement and equality (web links to case studies will be presented on the day); • Equality information regarding our workforce.
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	None
Legal Issues (including NHS Constitution)	The CCG is required to publish an annual report , by 31 January 2017, under the specific equality duty of the Equality Act 2010.
Impact on Health Inequalities	This report highlights the CCG's approach to work in partnership to reduce health inequalities in the county.
Impact on Equality and Diversity	This report highlights the CCG's approach to ensuring that equality issues inform the commissioning of health services for the people of Gloucestershire.
Impact on Sustainable Development	None
Patient and Public Involvement	None
Recommendation	Paper for information and approval
Authors	Becky Parish and Caroline Smith
Designation	Associate Director, Patient Engagement & Experience; Senior Manager, Engagement & Inclusion
Sponsoring Director (if not author)	Marion Andrews-Evans, Executive Nurse and Quality Lead

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Agenda Item 13

Governing Body

Thursday 26th January 2017

Promoting equality in commissioning: meeting the Public Sector Equality Duty (PSED)

1. Introduction

1.1 NHS Gloucestershire Clinical Commissioning Group (CCG) is publishing this report as required under the specific equality duty of the Equality Act 2010. This year, we have again chosen to combine our progress report on equalities work with examples of innovative practice in engaging and involving our local patients, carers, staff and communities.

1.2 The Public Sector Equality Duty came into force in April 2011. It requires the CCG, 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 [1]and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

1.3. This report covers:

- "An Open Culture": an introduction to our strategies
- Legal requirements relating to engagement, experience and equality
- A profile of the population of Gloucestershire
- Innovative practice that demonstrates our commitment to engagement and equality (web links to case studies)
- Equality information regarding our workforce

[1] There are 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.

2. Recommendation(s)

2.1 This paper is for information and approval.

3. Appendices

- Appendix 1: Gloucestershire Health Profile 2016

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An Open Culture

Engagement – Equality – Experience

Annual Report 2016

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An Open Culture: Engagement – Equality - Experience

Annual Report 2016

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Appendix 1: Gloucestershire Health Profile 2016

Foreword

On behalf of our Governing Body colleagues I am delighted to present NHS Gloucestershire Clinical Commissioning Group's (GCCG) annual Engagement, Equality and Experience Report, 2016: *Our Open Culture*.

This report sets out progress against our equality objectives, first published in 2013, and highlights the future direction of our work to promote equality and reduce health inequalities. It also gives some examples of how GCCG ensure that the healthcare experiences and views of the people of Gloucestershire inform our commissioning priorities, service design and delivery.

The report is published on-line and contains web-links to a range of resources which support or promote the CCG's engagement, equality and experience activities. Case studies and "Real life stories" are used to illustrate examples of engagement activity from the last twelve months.

During 2016, we have continued to develop an open culture which aims to:

- support our staff to understand the importance of engaging our diverse communities in the planning and delivery of local services;
- ensure equity of access to local health services for all our residents,
- support personalisation of care, diversity and fairness ; and
- provide a working environment where are staff can thrive and feel valued.

I would also like to take this opportunity to thank Valerie Webb, until recently the Chair, Equality and Health Inequalities Working Party and my co-sponsor of last year's report. Sadly Valerie has moved on from the CCG, but I am hopeful that the CCG will be able to announce a replacement lead for this important area of work soon. I would like to also welcome a new Lay Member, Joanna Davies, who joins me in taking a particular interest on the Governing Body in matters associated with public and patient engagement.

Going forward into 2017, we aim to strengthen our partnership working in relation to equality and engagement, to support the development and delivery of our Sustainability and Transformation Plan: *One Gloucestershire*.

We will work with our provider organisations to understand the requirements of new equality reporting, develop closer links with our "communities of interest" and ensure that the NHS in Gloucestershire is an employer of choice.

Alan Elkin
Chair, Primary Care Commissioning Committee
and Lay Member for Public and Patient
Engagement/Involvement, GCCG Governing Body

1. Introduction

1.1. *NHS Gloucestershire Clinical Commissioning Group* (CCG) is publishing this report as required under the specific equality duty of the Equality Act 2010. We have again chosen to combine our progress report on equalities work with examples of innovative practice in engaging and involving our local patients, carers, staff and communities.

1.2. The Public Sector Equality Duty[1] came into force in April 2011. It requires the CCG, 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.

1.3 Reducing health inequalities is 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.

1.3. This report covers:

- "An Open Culture": an introduction to our strategies;
- Legal requirements relating to engagement, experience and equality;
- A profile of the population of Gloucestershire;
- Innovative practice that demonstrates our commitment to engagement and equality (web links to case studies);
- Equality information regarding our workforce.

[1] Source: http://www.equalityhumanrights.com/private-and-public-sector-guidance/public-sector-providers/public-sector-equality-duty

2. Promoting equality and valuing diversity: 'An Open Culture'

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. 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.

2.2. The full Strategy and action plan can be found on the CCG website at: http://www.gloucestershireccg.nhs.uk/about-us/equality-diversity/

3. A Strategy for Engagement and Experience (incorporating Primary Medical Care from 1/4/2015) 'Our Open Culture'

3.1. We want to ensure that 'quiet voices' are heard and that we are recognised as 'commissioners on the ground'. The Strategy for Engagement and Experience, approved by GCCG in September 2014, describes how using a simple Framework, underpinned by three enabling principles and three methods of delivery, we achieve this.

3.2. ‘Our Open Culture’ Framework promotes ‘Equality’ and working in ‘Partnership’ and the desire to enable ‘Anyone and Everyone’ to have a voice. To achieve this we provide ‘Information and good Communication’, focus on ‘Experience’ feedback and undertake good ‘Engagement and Consultation’.

3.3. The Strategy’s aim is to ensure that the CCG: *achieves the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual’s experience of care is a driver for quality and service improvement*.

3.4. The Strategy is available on the CCG website at: http://www.gloucestershireccg.nhs.uk/feedback/gccg-engagement-and-experience-strategy/

4. Legal Requirements

4.1. **Equality:** Our 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. Further information on current legislation can be found at: http://www.gloucestershireccg.nhs.uk/about-us/equality-diversity/relevant-legislation/

4.2. **Engagement and Experience:** There are several ‘must dos’ in the field of engagement, equality and experience. These are set out in national legislation and guidance. The key requirements and mechanisms we must work with are described within three key pieces of legislation: Health and Social Care Act 2012, The Equality Act 2010 and The NHS Constitution 2010. Details of these requirements, which ensure the CCG meets these legal responsibilities, can be found on the GCCG website: http://www.gloucestershireccg.nhs.uk/feedback/gccg-engagement-and-experience-strategy/relevant-legislation/

5. Profile of Gloucestershire

5.1 We use a range of data and information when we develop policies, set strategies, design, review and deliver our services. We believe that it is important to understand the composition of our local population by protected characteristics so that we can:

- engage effectively with different communities to understand their varying health and self-care support needs;
- commission services to meet their health and self-care needs in an appropriate manner;
- assess the likely impact of our decisions on a diverse range of communities; and
- work with these communities to minimise any adverse impact and maximise any positive impact.

5.2 *Understanding Gloucestershire - A Joint Strategic Needs Assessment 2015,* aims to provide a common understanding of the County and its communities for use by decision makers and commissioners of services. It looks at need in the community and how we expect it to change in the future. The JNSA, together with a wealth of information about our county can be found at: http://www.gloucestershire.gov.uk/inform/ Public Health England also provides an annual Health Profile for each county. A copy of the profile for 2016 is included in Appendix 1.

5.3 An overview of our county population, by each of the protected characteristics[2] is given below. Further detail can also be found on the Inform Gloucestershire website: http://www.gloucestershire.gov.uk/inform/index.cfm?articleid=110774

[2] There are nine protected characteristics, as set out in the Equality Act 2010. Further information is available at: http://www.legislation.gov.uk/ukpga/2010/15/contents

5.4 **Current Population: Age**

In 2014 the resident population of Gloucestershire was estimated to be 611,332 people, of this:

- 22.6% are aged 0-19
- 57.1% are aged 20-64
- 20.3% are aged 65 and over

Gloucestershire has a lower proportion of 0-19 year olds and 20-64 year olds when compared to the national average. In contrast the proportion of people aged 65+ exceeds the national average. Projections suggest this trend will continue, with the number of people aged 65+ projected to increase by 85,000 or 72.2% between 2012 and 2037.

There is considerable variation at district level:

- At 24.9% Gloucester has the highest representation of children and young people and exceeds the county and national average.
- At 59.7% Cheltenham has the highest proportion of people aged 20-64, exceeding the county and national average.
- Cotswold, the Forest of Dean, Stroud and Tewkesbury all have an over-representation of people aged 65+ when compared to the county and national average. At 24.3% Cotswold has the largest proportion of people aged 65 and over.

5.5 **Current Population: Disability**

According to the 2011 Census 16.7% of Gloucestershire residents reported having a long term limiting health problem; this was below the national average.

Forest of Dean had the highest proportion of residents reporting a long term limiting health problem at 19.6% of the total population, and was the only district that exceeded the national average. Cheltenham had the lowest proportion of residents reporting a long term limiting health problem.

Given the ageing population the number of people with a limiting long term health problem is likely to increase in the future.

- Dementia is one of the major causes of disability in older people. Estimates suggest there are 9,042 people aged 65+ living with dementia in Gloucestershire.
- Learning disability is one of the most common forms of disability in the UK. Estimates suggest there are 11,434 people aged 18+ living with a learning disability in Gloucestershire.
- Sensory impairment: In 2012/13 approximately 1.0% of the 18+ population reported blindness or severe visual impairments. During the same period 4.0% of the adult population reported deafness or severe hearing impairments.

5.6 **Current Population: Gender**

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%. This situation is also reflected at district, regional and national level.

As age increases gender differences become more noticeable, with females outnumbering males by an increasing margin. In Gloucestershire 53.1% of people aged 65-84 are female, while males account for 46.9%. For people aged 85+ the difference is even more marked with females accounting for 65.9% of the total population.

5.7 **Current Population: Gender Reassignment**

There are no official estimates of gender reassignment at either national or local level. However, in a study funded by the Home Office, the Gender Identity Research and Education Society estimate that between 0.6% and 1% of the UK's adult population are experiencing some degree of gender variance. For Gloucestershire, this equates to between 2,900 and 4,900 adults.

5.8 **Current population: Marriage and Civil Partnership**

Among residents of Gloucestershire:

- 30.5% are single and have never married, or registered a same-sex civil partnership
- 50.2% are married
- 0.3% are in a registered same-sex civil partnership
- 2.3% are separated but still legally married or still legally in a same sex civil partnership
- 9.5% are divorced or formerly in a same sex civil partnership which is now legally dissolved
- 7.2% are widowed or a surviving partner from a same sex civil partnership

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.

5.9 **Current Population: Pregnancy and Maternity**

There were 6,631 live births in Gloucestershire in 2014. The largest number of live births was among the 30-34 year old age group, continuing the trend of later motherhood.

5.10 **Current Population: Race**

Gloucestershire is characterised by a comparatively small Black and Minority Ethnic population:

- The 2011 census showed Black and Minority Ethnic groups account for 4.6 % of the population; this was much lower than the England average of 14.6%.
- Gloucestershire's 0-19 year old population is more diverse than other age groups; 7.6% of 0-19 year olds are from BME groups.
- The population of Gloucestershire is however, becoming increasingly diverse. The Black and Minority Ethnic population has increased by 70% since 2001. The number of people classed as "White Other" which

includes migrants from Europe, increased by 105.9% during the same period.

5.11 **Current Population: Religion**

According to the 2011 Census, 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.

Gloucestershire has a higher proportion of people who are Christian, have no religion or have not stated a religion than the national average. In contrast it has a lower proportion of people who follow a religion other than Christianity, which reflects the ethnic composition of the county.

5.12 **Current Population: Sexual Orientation**

There is no definitive data on sexual orientation at a local or national level. A number of studies have attempted to provide estimates for the proportion of people who may identify as lesbian, gay or bisexual, generating a range of different results.

A recent estimate from the ONS Integrated Household Survey suggests that nationally Lesbian, Gay and Bisexuals represent 1.5% of people aged 16 and over. If this figure applied to Gloucestershire, it would mean there were around 8,000 Lesbian, Gay and Bisexuals in the county.

6. Innovative Engagement

6.1 The CCG is committed to effective engagement with our local communities to help us ensure that we provide equity of access and fair treatment, continuing to improve the quality of our services and achieve better health outcomes for everyone.

6.2 We have developed case studies to illustrate examples of activity undertaken in the last twelve months, which demonstrate how patient experience and engagement inform our commissioning priorities and

decisions. It is our intention to continue to gather and publish such case studies, as well as Real Life Stories. These can be found at http://www.gloucestershireccg.nhs.uk/feedback/

6.3 **Examples of innovative local practice**

We have collated examples of our engagement activity under the following headings:

- **Information and Communication**
- **Patient Experience**
- **Engagement and Consultation**
- **Primary care**

Examples of our engagement activity are accessible via the hyperlinks above on the web-based version of this document.

6.4 **Staff engagement**

Our Equality Objectives and Action Plan (April 2015 – March 2018) aims to raise staff awareness of how they can engage with disadvantaged and vulnerable groups, to ensure their feedback informs decision-making.

A series of "lunch & learn" sessions are being arranged to support this: the first of these was held in October 2016 and focussed on the transgender community. A guest speaker from Gloscats, a local organisation providing social support for the transgendered in Gloucestershire, led the well-attended session.

7. Workforce Equality

7.1 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.

7.2 **Workforce data**

As a relatively new organisation we do not yet have any significant equality and diversity trend information available regarding our workforce. However, we will collect this information year on year to enable us assess our progress, investigate any disparities in outcomes for our different employee groups, and identify where we may need to act.

More detailed information about our work force and recruitment activity from 1 January 2016 to 31 December 2016 is available in our on-line equality information http://www.gloucestershireccg.nhs.uk/about-us/equality-diversity/reports An overview of this information is presented below (source: Electronic Staff Records as at 31 December 2016):

- The CCG had a total of 277 employees as at 31December 2016.
- 57% of our staff work full time, while 43% work part time.
- 75% of our workforce are female.
- 3% of our workforce describe themselves as having a disability; 17% of our staff have not declared whether or not they have a disability.
- 9% of our workforce declared that they are from ethnic minority groups; 8% of our staff have not specified their ethnicity.
- 69% of our workforce is aged under 50.
- 60% per cent of our workforce declared a religion or belief.
- 82% of our workforce declared they are heterosexual; 1% per cent of our workforce declared that they are lesbian, gay or bisexual; 16% did not specify their sexual orientation.

- No staff have identified themselves as transgender.
- We do not monitor our staff on their marital or a civil partnership status, but may consider doing so in the future.

7.2 We have collated benchmarking data about our workforce to comply with the Workforce Race Equality Standard (WRES). This can be found on our website at http://www.gloucestershireccg.nhs.uk/about-us/equality-diversity/reports

7.3 Our latest staff survey, conducted in February 2016, aimed to help us monitor equality issues, identify areas for action and evaluate the initiatives such as Time to Change and other support mechanisms available to our staff. It will also help us to fill some of the gaps in data that are required as part of WRES reporting.

Public Health England

Protecting and improving the nation's health

Gloucestershire

County

This profile was published on 6 September 2016

Health Profile 2016

Health in summary
The health of people in Gloucestershire is varied compared with the England average. Gloucestershire is one of the 20% least deprived counties/unitary authorities in England, however about 14% (14,300) of children live in low income families. Life expectancy for both men and women is higher than the England average.

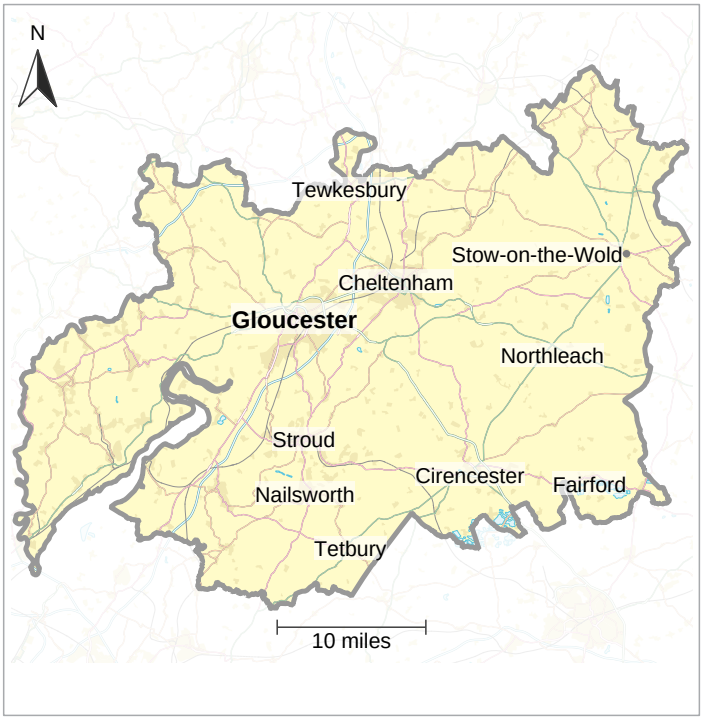
Health inequalities
Life expectancy is 8.3 years lower for men and 5.8 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

Child health
In Year 6, 17.2% (999) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 44.2*, worse than the average for England. This represents 54 stays per year. Levels of teenage pregnancy, GCSE attainment and breastfeeding initiation are better than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 669*, worse than the average for England. This represents 4,098 stays per year. The rate of self-harm hospital stays is 255.5*, worse than the average for England. This represents 1,534 stays per year. The rate of smoking related deaths is 235*, better than the average for England. This represents 877 deaths per year. Estimated levels of adult smoking and physical activity are better than the England average. Rates of hip fractures, sexually transmitted infections and TB are better than average. Rates of violent crime, long term unemployment, early deaths from cardiovascular diseases and early deaths from cancer are better than average.

Local priorities
The priorities for Gloucestershire are reducing obesity, reducing the harm caused by alcohol, improving mental health, improving health and wellbeing into older age, and tackling health inequalities. For more information see http://www.gloucestershire.gov.uk/publichealth

* rate per 100,000 population



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Population: 611,000

Mid-2014 population estimate. Source: Office for National Statistics.

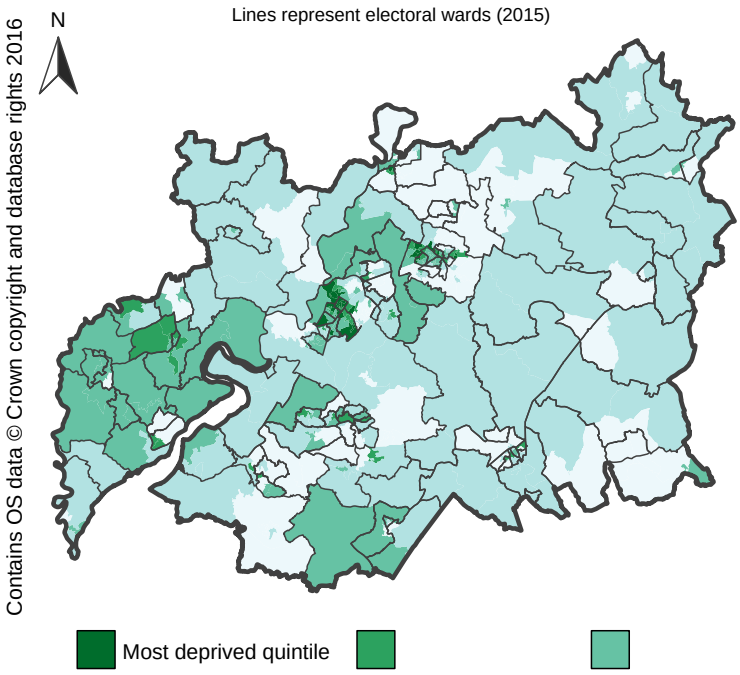
This profile gives a picture of people's health in Gloucestershire. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

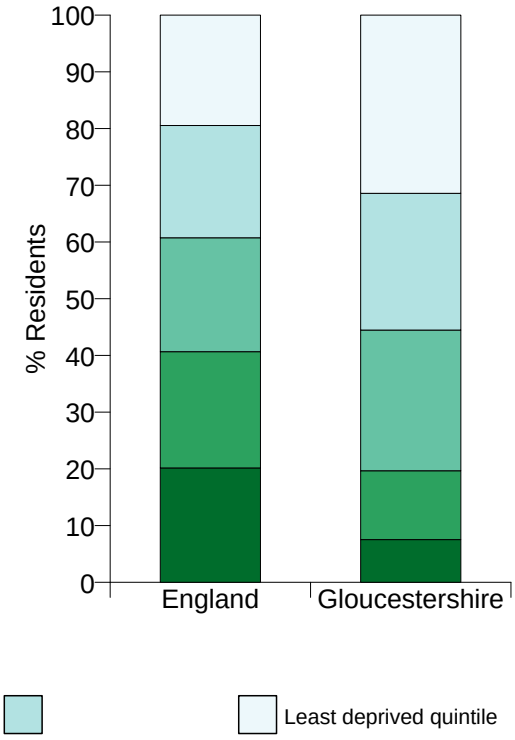
Follow @PHE_uk on Twitter

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.

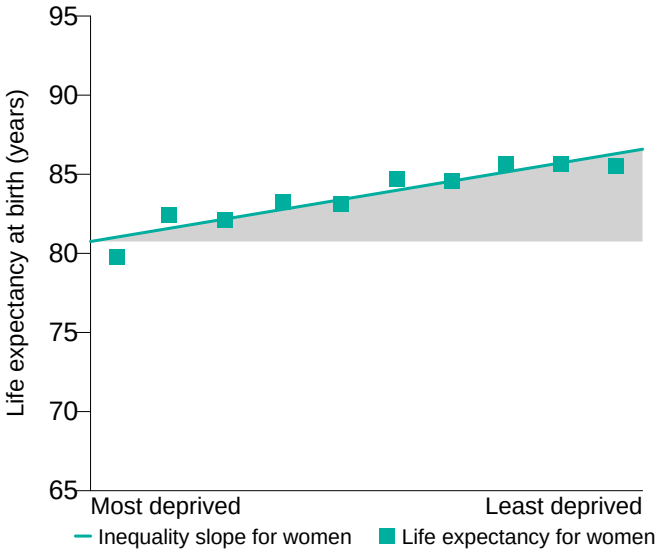


Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2012-2014. Each chart is divided into deciles (tenths) by deprivation (IMD2010), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 8.3 years

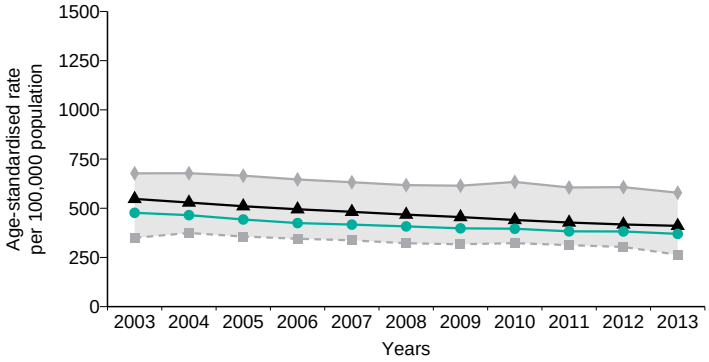
Life expectancy gap for women: 5.8 years



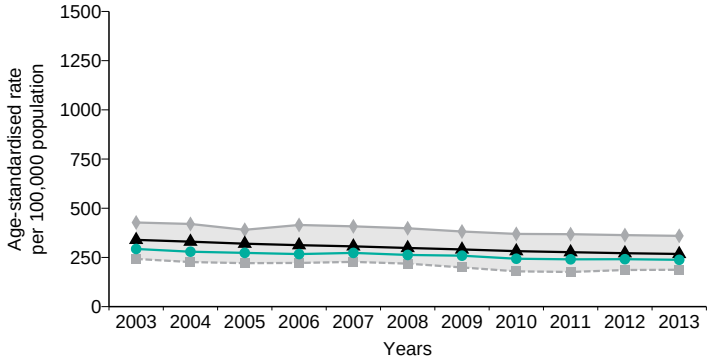
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile (IMD2010) in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

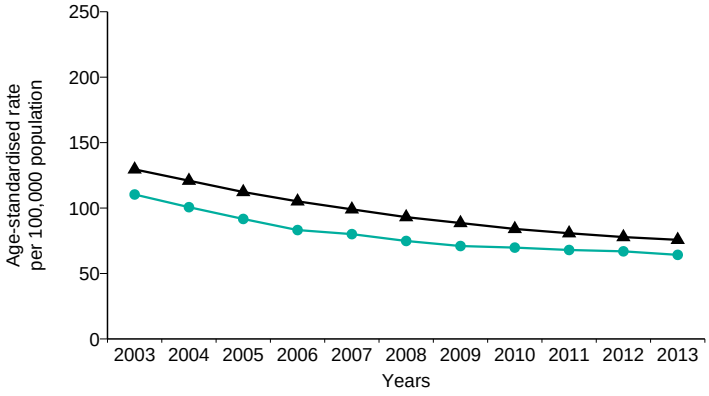
Early deaths from all causes: MEN



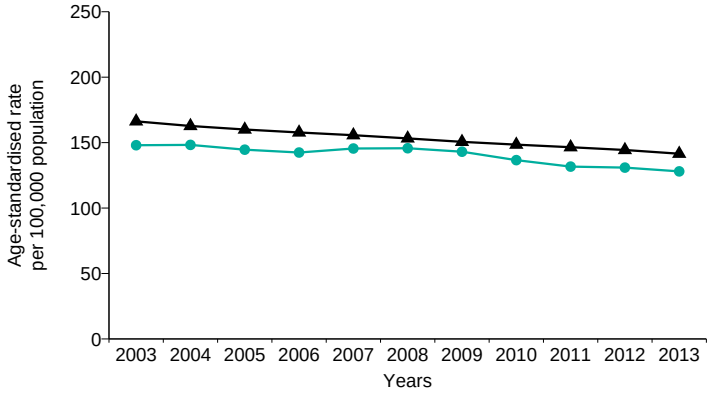
Early deaths from all causes: WOMEN

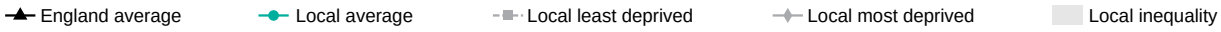


Early deaths from heart disease and stroke



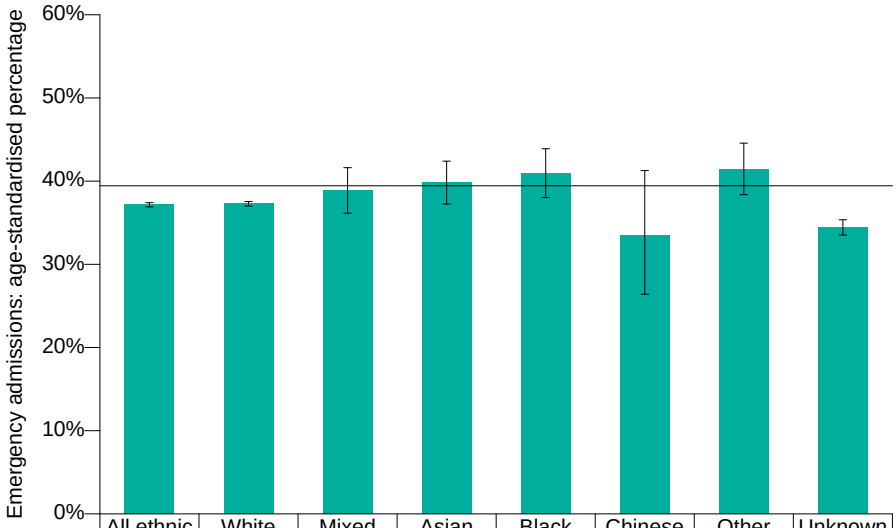
Early deaths from cancer





Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2014/15



This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

Gloucestershire

95% confidence interval

England average (all ethnic groups)

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
52,303	46,864	520	557	444	49	397	3,472	Local number of emergency admissions
37.2	37.3	38.8	39.8	40.9	33.4	41.4	34.4	Local value %
39.4	39.9	38.8	44.0	43.1	35.9	44.9	30.9	England value %

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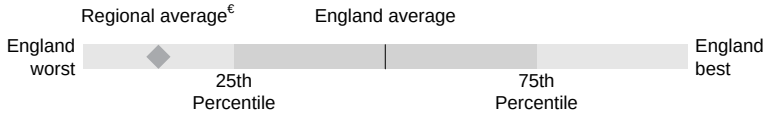
Health summary for Gloucestershire

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local No total count	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation score (IMD 2015) #	2015	n/a	15.0	21.8	42.0		5.7
	2	Children in low income families (under 16s)	2013	14,345	13.5	18.6	34.4		6.1
	3	Statutory homelessness†	2014/15	x[3]	x[3]	0.9			
	4	GCSEs achieved†	2014/15	3,799	60.3	57.3	42.0		71.4
	5	Violent crime (violence offences)	2014/15	5,101	8.4	13.5	31.7		5.2
	6	Long term unemployment	2015	937	2.5	4.6	15.7		0.7
Children's and young people's health	7	Smoking status at time of delivery	2014/15	726	11.2	11.4	27.2		2.1
	8	Breastfeeding initiation	2014/15	4,975	77.1	74.3	47.2		92.9
	9	Obese children (Year 6)	2014/15	999	17.2	19.1	27.8		10.5
	10	Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	163	44.2	36.6	92.9		10.9
	11	Under 18 conceptions	2014	183	17.0	22.8	42.4		8.4
Adults' health and lifestyle	12	Smoking prevalence in adults†	2015	n/a	14.6	16.9	26.8		9.5
	13	Percentage of physically active adults	2015	n/a	61.5	57.0	44.8		69.8
	14	Excess weight in adults	2012 - 14	n/a	65.0	64.6	74.8		46.0
Disease and poor health	15	Cancer diagnosed at early stage #	2014	1,356	54.4	50.7	36.3		59.7
	16	Hospital stays for self-harm	2014/15	1,534	255.5	191.4	629.9		58.9
	17	Hospital stays for alcohol-related harm	2014/15	4,098	669	641	1223		379
	18	Recorded diabetes	2014/15	31,547	6.1	6.4	8.9		3.7
	19	Incidence of TB	2012 - 14	103	5.7	13.5	100.0		1.6
	20	New sexually transmitted infections (STI)	2015	1,787	463	815	3263		287
	21	Hip fractures in people aged 65 and over	2014/15	685	517	571	743		379
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2012 - 14	n/a	80.1	79.5	74.7		83.3
	23	Life expectancy at birth (Female)	2012 - 14	n/a	83.7	83.2	79.8		86.7
	24	Infant mortality†	2012 - 14	70	3.5	4.0	7.2		1.6
	25	Killed and seriously injured on roads	2012 - 14	692	38.1	39.3	76.3		15.5
	26	Suicide rate†	2012 - 14	196	12.2	10.0	17.6		5.1
	27	Deaths from drug misuse #	2012 - 14	47	2.7	3.4			
	28	Smoking related deaths	2012 - 14	2,631	234.5	274.8	458.1		184.9
	29	Under 75 mortality rate: cardiovascular	2012 - 14	1,057	64.2	75.7	135.0		48.0
	30	Under 75 mortality rate: cancer	2012 - 14	2,125	128.0	141.5	195.6		105.8
	31	Excess winter deaths	Aug 2011 - Jul 2014	875	16.0	15.6	25.6		3.9

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 12 Current smokers, Annual Population Survey (APS) 13 % adults achieving at least 150 mins physical activity per week 14 % adults classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population 21 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged <1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10+) 27 Directly age standardised rate per 100,000 population 28 Directly age standardised rate per 100,000 population aged 35 and over 29 Directly age standardised rate per 100,000 population aged under 75 30 Directly age standardised rate per 100,000 population aged under 75 31 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
# New indicator for Health Profiles 2016. x[3] Value missing in source data

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

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NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 14

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**West of England Academic Health Science Network (WEAHSN) Board Report**
Executive Summary	The attached document is the thirteenth quarterly report produced by the West of England Academic Health Science Network.
Key Issues	The following key issues are referred to in the report: • Highlights from quarter 2; • Future of AHSNs; and • The Stakeholder Survey.
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	None
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note this report which is provided for information.
Author	Deborah Evans
Designation	WEAHSN Managing Director
Sponsoring Director (if not author)	Mary Hutton Accountable Officer

Appendix 1

Report from West of England Academic Health Science Network Board, 7 December 2016

1. Purpose

This is the thirteenth 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 for information.

2. Highlights of our work in Quarter 2 2016/17

The Parliamentary launch of "MINDset" was on Monday 5th December. This is a quality improvement website for people involved with providing or commissioning services for people with mental health problems. MINDset is the product of a partnership led by West of England AHSN which includes NHS Improvement and a number of other partners including the South of England mental health patient safety collaborative which we also host. Visit the website at www.mindsetqi.net. We have also produced a MINDset QI handbook.

Suzette Woodward, Director of Sign Up to Safety was guest speaker at our second Primary Care Patient Safety Collaborative meeting - with 13 GP practices drawn from across the West of England. We are planning to recruit a second cohort of practices for 2017/18. Contact Kevin.hunter@weahsn.net for details.

The Royal College of Physicians launched the acute hospital mortality review programme on 22nd November. West of England and Yorkshire and Humber are the only two areas where acute Trusts are working together to understand and act on the themes arising from mortality reviews. We are the only group who is involving primary care and public contributors. Three of our Trusts have had their trainers trained and the second training day will be in April 2017.

We are supporting the 5 Community Education Provider Networks in the West of England to develop and test new models of primary care workforce. Each CEPN now has proposals it want to test and these are part of the STP workforce planning. We will also support sharing and learning across the South West.

We are stimulating early stage innovation in primary care through our latest Small Business Research Initiative call. "GP of the Future" was designed by local GPs and asks companies to respond with the innovations under three themes: demand management; earlier triage and self-care and diagnostics. Over 250 companies have applied.

We are on track to recruit the first 500 people into our Diabetes Digital coach test bed with Swindon and Gloucestershire practices leading the way. Over the next two years we will recruit 12,000 people with diabetes in the West of England and encourage them to use a variety of digital self-management tools to support their self-care.

3. Future of AHSNs

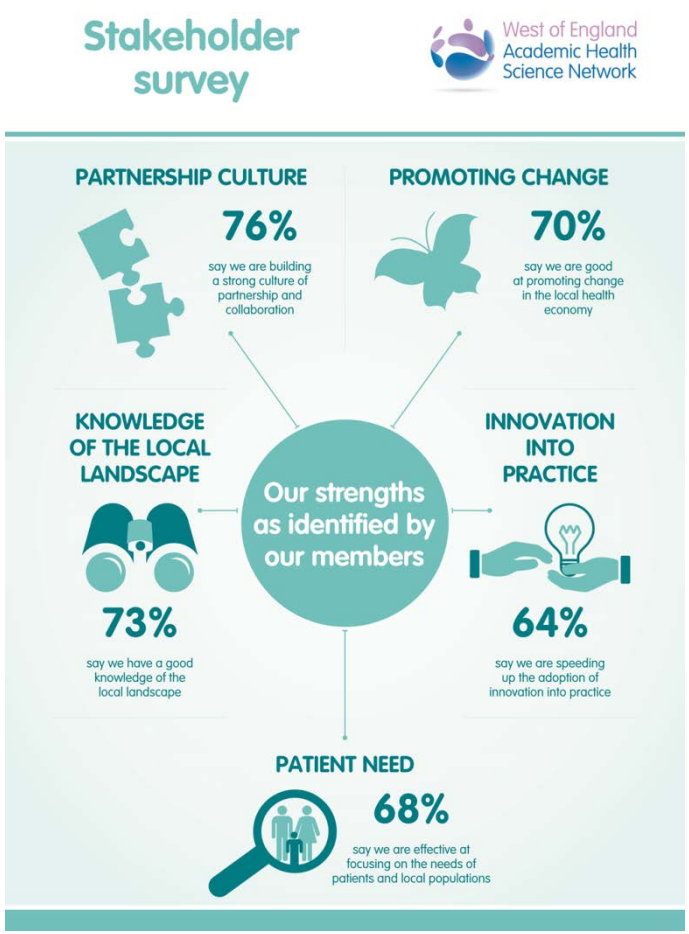
NHS England has confirmed that AHSNs will have a second five year licence running from April 2018. Discussions are underway about how we can support innovation and improvement into the future. At a national level, the Accelerated Access Review sets out many potential roles for AHSNs and NHS England is also keen to explore how we can support STPS as they develop.

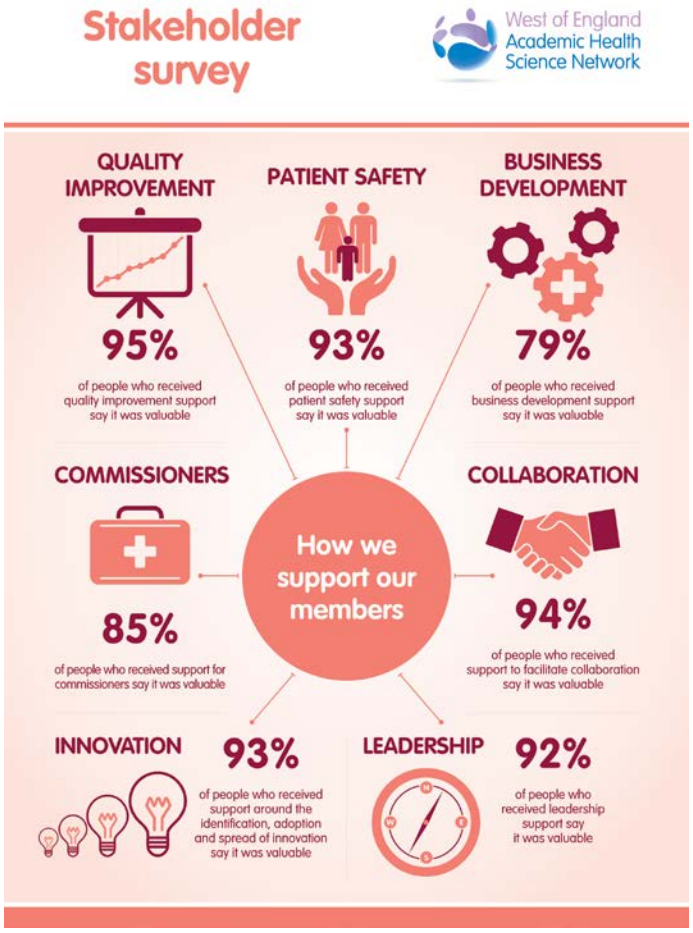
Patient Safety Collaboratives will continue their first mandate until March 2019 and are expected to continue beyond that, with closer involvement of NHS Improvement

4. Stakeholder survey

The AHSN had 212 responses to the stakeholder survey, which is almost double last year's numbers (125) and was the highest in the country. As was the case last year a very high percentages of people who had received patient safety, quality improvement or business development support said it was valuable. We had a wealth of free text comments which are highly positive and which recognise the contribution we are making to STPs in particular.
The infographic showing our results is attached.

Deborah Evans,
Managing Director
December 2016


Stakeholder survey
West of England Academic Health Science Network
PARTNERSHIP CULTURE
76%
say we are building a strong culture of partnership and collaboration
PROMOTING CHANGE
70%
say we are good at promoting change in the local health economy
KNOWLEDGE OF THE LOCAL LANDSCAPE
73%
say we have a good knowledge of the local landscape
Our strengths as identified by our members
INNOVATION INTO PRACTICE
64%
say we are speeding up the adoption of innovation into practice
PATIENT NEED
68%
say we are effective at focusing on the needs of patients and local populations


Stakeholder survey
West of England Academic Health Science Network
QUALITY IMPROVEMENT
95%
of people who received quality improvement support say it was valuable
PATIENT SAFETY
93%
of people who received patient safety support say it was valuable
BUSINESS DEVELOPMENT
79%
of people who received business development support say it was valuable
COMMISSIONERS
85%
of people who received support for commissioners say it was valuable
How we support our members
COLLABORATION
94%
of people who received support to facilitate collaboration say it was valuable
INNOVATION
93%
of people who received support around the identification, adoption and spread of innovation say it was valuable
LEADERSHIP
92%
of people who received leadership support say it was valuable

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 15

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Integrated Governance and Quality Committee (IGQC) minutes**
Executive Summary	The attached minutes provide a record of the IGQC meeting held on the 20th October 2016.
Key Issues	The following principal issues were discussed at this meeting: • Experience and Engagement Report; • Quality Report; • Primary Care Quality Report; • Stroke and Transient Ischaemic Attack Report; • Local Supervising Authority 2015/16 Annual Report; • Risk Register; • Assurance Framework; • Internal Audit Report on Clinical Governance; • Policies for Approval; • IGQC Terms of Reference; • Information Governance; • 2017/18 CQUINS; and • Complex Lower Limb Wound Care Service.
Risk Issues: **Original Risk** **Residual Risk**	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None

Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Julie Clatworthy IGQC Chair and Registered Nurse

NHS
Gloucestershire
Clinical Commissioning Group

Integrated Governance and Quality Committee (IGQC)

Minutes of the meeting held on Thursday 20th October 2016, Board Room, Sanger House

Present:		
Julie Clatworthy	JC	Chair
Dr Charles Buckley	CBu	GP Liaison Lead – Stroud and Berkeley Vale
Dr Caroline Bennett	CBe	GP Liaison Lead – North Cotswold
Marion Andrews-Evans *(part meeting)*	MAE	Executive Nurse and Quality Lead
Colin Greaves	CG	Lay Member – Governance
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Cath Leech	CL	Chief Finance Officer
Dr Tristan Lench	TL	GP Liaison Lead – Forest of Dean
Mark Walkingshaw *(part meeting)*	MW	Director of Commissioning Implementation

In Attendance:		
Craig Robinson (Item 8)	CR	Clinical Programmes Manager
Annette Blackstock (Item 9)	AB	Named Nurse Safeguarding
Debbie Sanders (Item 13.2)	DS	
Tony Ware (Item 13.1)	TW	Information Governance Manager, CSU
Diana Thomas *(part meeting)*	DT	Cross-border Commissioning Manager
Becky Parish *(part meeting)*	BP	Associate Director Patient and Public Engagement
Rob Mauler *(part meeting)*	RM	Patient Experience and Safety Manager
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, Sarah Scott and Dr Andy Seymour.

2. Declarations of Interest

2.1 All GPs declared a general interest.

3. Minutes of the meeting held on 18th August 2016

3.1 The minutes of the meeting were accepted as a true and correct record.

4. Matters Arising

4.1 **IGQC155 Quality Report**
MAE advised that a summary explaining the definition of falls and how these were reported by providers would be included in the December 2016 Quality Report.

4.2 **IGQC170 Quality Report**
The Stroke and TIA improvement plan update would be covered under Agenda Item 8 (Stroke and TIA Progress Report). **Item Closed.**

4.3 **IGQC171 Primary Care Quality Report**
MAE advised that all positions had been filled for the practice nurse facilitators and that a General Practice Nurses local survey would shortly be undertaken.

4.4 **IGQC174 Seasonal Flu Planning Presentation**
CBu had followed up with NHS England and advised that the coding and dual reporting with ImmForm and Quality Outcomes Framework data was still an issue and advised that there had been an ongoing debate with NHS England regarding this. It was noted that this was a national issue and that further local action would be kept under review. Data broken down by individuals practices and long term conditions (LTCs) would be helpful but there were coding issues. **Item Closed.**

4.5 **IGQC181 Urology Update**
MW advised that an update would be presented at the December 2016 meeting.

4.6 **IGQC183 Quality Report**
MAE advised that Penny Fowler, Health and Social Care

Commissioning Manager, was in the process of developing a checklist for care homes.

4.7 **IGQC184 Quality Report**
The lessons learnt arising from the serious incident involving the Gloucestershire Diabetic Eye screening programme was included in Agenda Item 6 (Quality Report). **Item Closed.**

4.8 **IGQC186 Quality Report**
MAE advised that feedback had not been received from the unannounced CQC visit at GCS.

4.9 **IGQC187 Primary Care Quality Report**
It was confirmed that headings had been added to each page in the dashboard of the completed and published GP CQC inspection reports. **Item Closed.**

4.10 **IGQC188 Children in Care Annual Report**
It was noted that the response from the service regarding Children in Care was circulated on the 19th September 2016. **Item Closed.**

4.11 **IGQC189 Experience and Engagement Report**
It was agreed that the report relating outlining the response to the national cancer patient experience survey would be presented at the December meeting.

4.12 **IGQC190 Annual Sustainability Report**
Members were advised that the sustainability issues regarding Sanger House were raised with PropCo who had advised that they could not be implemented. **Item Closed.**

5. Experience and Engagement Report

5.1 BP presented the Experience and Engagement Report which provided information on engagement and experience activity. The report was taken as read.

5.2 BP drew attention to the new guide relating to Patient Reported Outcome Measures (PROM) and advised that

the guidance could be accessed on the link below:

https://www.england.nhs.uk/wp-content/uploads/2016/09/patient-reprtd-outcm-measure.pdf

5.3 JC advised that four surgical procedures were chosen to be included in the National PROMs Programme, mandated in the NHS Outcomes Framework. These were:

- total hip replacement;
- total knee replacement;
- varicose veins; and
- groin hernia surgery.

5.4 CBu queried the reason why patient satisfaction rates for hernia repair was consistently low compared to other treatments. BP stated that she was not aware of any particular themes identified from the national data and agreed that she would investigate further. BP

5.5 JC emphasised the importance of ensuring that PROM data was linked up appropriately i.e. infection control, pain, mobility issues.

5.6 BP updated members on the cross border issues and advised that positive feedback had been received for the Referral Assessment Service (RAS). It was noted that the RAS was launched in July 2016 to enable English residents registered with a Welsh GP to access local healthcare as set in the NHS Constitution.

5.7 The Committee formally thanked the teams involved in organising the CCG Commissioning Event held on the 27th September 2016.

5.8 MAE advised that an annual event was held at the Cheltenham Racecourse on the 19th October 2016 which was aimed at Gloucestershire nurses and carers working in care homes and noted that this was a successful event which included clinical updates e.g. continence, falls, infection control, wound care etc. CBu suggested that the

presentations from the event were publicised on CCG Live.

5.9 BP informed members that NHS England had produced engagement guidance for CCGs to use when developing the STPs. BP advised that the guide provided details of stakeholder involvement and the patient and public participation that should be undertaken.

5.10 BP updated members on the work being undertaken to embed lay voices within the STP processes and noted that the governance structure was updated to explicitly reflect this. BP advised that it was proposed that a 'People's Panel' would be established and that expressions of interests were being sought.

5.11 JC queried if there was sufficient capacity within the team to undertake the STP engagement work and was advised that there was.

5.12 RM gave a presentation, which covered:

- provider friends and family test;
- primary care friends and family test;
- themes of the contacts received;
- complaints 2015/16; and
- patient experience examples.

5.13 RM highlighted that the Friends and Family Test (FFT) for GHFT Emergency Department response rate had improved and reported that the August 2016 response rate was 26.7% compared to 0.8% in January 2016 and that the national average was 13.7%.

5.14 RM highlighted that the response rates for 2gether had dropped to 86% for August 2016. RM advised that he had spoken to a 2gether representative who considered that this was a seasonal effect for August.

5.15 RM provided an update on the primary care FFT response rate and advised that 43 practices had not submitted any data and that had been reminded that this

was a contractual requirement and also raised at the PPG Network meeting.

5.16 RM advised that fewer PALs contacts had been received compared to the previous year and that this primarily attributed to decrease in CHC claims as the deadline for submitting claims was imminent. MAE advised that a proposal for a further cycle of retrospective NHS Continuing Healthcare claims was being considered.

5.17 It was also noted that there was a reduction in patient transport complaints relating to Arriva. MW advised that there was a small improvement in performance particularly regarding on the day bookings.

5.18 The Committee discussed the Health Ombudsman's re 'problems with learning lessons' by Alison Rogers. TL debated the issue of accepting responsibility by apologising and was advised that a different approach would be used for any upheld complaints.

5.19 JC referred to the Healthwatch reports relating to Acute Hospitals and Community Hospitals and understood that Cheltenham hospital had not performed well. The Committee was advised that Helen Vaughan would be following this up. JC acknowledged the positive performance of the community hospitals.

5.20 AE expressed concerns regarding information not being provided prior to the meeting in order to ensure that focused discussions could be undertaken.

5.21 RECOMMENDATION: The Committee noted the contents of this report.

6. Quality Report

6.1 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.

6.2 CBu updated members on the work of the Clinical Effectiveness Group and advised that good progress was being made. MAE advised that the pink slips process had proved to be useful particularly raising the profile of the work of the Group.

6.3 MAE updated members on research and development and advised that a countywide “Joint Statement of Intent” agreement for the four main healthcare sectors to work more closely around research and development was in place. JC highlighted that the documents did not refer specifically to research governance but was advised that it was included. MAE agreed that she would feed this back.

6.4 MAE advised that she attended the opening of the Fritchie Centre in Charlton Lane by the 2gether Trust and noted that it would provide a dedicated base for dementia research. MAE advised that this would be a countywide resource centre.

6.5 MAE updated members on the annual NHS Emergency Planning Resilience and Response assurance process and it was anticipated that a ‘substantially assured’ (green) score would be received from NHS England.

6.6 JC requested that Serious Case Reviews were dated within the report.

6.7 RM updated members on serious incidents and advised that there had been an increase in incidents although no particular trends had been identified. It was noted that one Never Event had been reported by GHFT, but it was identified and clinically corrected at the time.

6.8 MAE provided an update on the two suicide cases at Wotton Lawn reported by the 2gether Trust.

6.9 MAE understood that the report from the staff homicide investigation had been issued and that further details around this would be given at the December meeting.

6.10 MAE provided an update on Fractured Neck of Femur

and advised that this was a high priority area for GHFT. It was noted that GHFT submitted 234 cases from the Cheltenham General Hospital site to the National Hip Fracture Database Annual Report 2016. It was noted that 10.3% of these cases had sustained a hip fracture whilst an inpatient and that GHFT would also be reviewing this. It was noted that NHS England had requested a quality assurance report on this area.

6.11 Members were informed that the CQC would be undertaking a repeat inspection at GHFT on the 23rd January 2017 focusing on the emergency department and the urgent care pathway.

6.12 MAE expressed concerns regarding the number of outstanding Technology Appraisals (TAs) and that a report addressing this issue would be presented at the December meeting. JC sought further assurance regarding GCS compliance with NICE TAs and was advised that GCS had established a database and reporting system to monitor these. It was noted that the CCG also had copies of these.

6.13 MAE advised that C.Difficile rates were closely monitored. CBu advised that he attended the Countywide Health Care Acquired Infection Group meetings and assured members that robust action plans were being implemented and that trends had not been identified.

6.14 Members noted that further work to address concerns relating to surgical site infections would need to be undertaken. MAE to follow up and report back. MAE

6.15 MAE drew attention to the seasonal influenza rates for health care workers shown at Section 16 of the report. It was noted that further work was underway to promote immunisation although recognising that it would be a personal choice for staff. MAE also provided an update regarding immunisation issues for cross border patients, 400 children were affected as the Welsh School Nursing service was not commissioned to immunise children by the Local Health Board.

6.16 JC drew attention to the Quality Dashboard and highlighted that the low percentage of adult inpatients who have had a Venous ThromboEmbolism (VTE) risk assessment and queried the actions being undertaken to address this. MAE advised that this had been raised with the Trust and was being monitored.

6.17 JC also queried the anomalies of the performance data for the Transient Ischaemic Attack (TIA) patients between the Quality Dashboard and the Stroke and TIA Progress Report. It was noted that CR would be attending the meeting later and could confirm the current position.

6.18 The Committee reviewed the Clinical Effectiveness Group minutes held on the 18th August 2016. JC requested that the rationale where a decision was made not to adopt the NICE guidance should be explicit within the minutes.

6.19 The Committee also reviewed the Care Home Clinical Quality Review Group minutes from the 9th September 2016. JC requested that the governance arrangements for the Group were explicit within the Terms of Reference.

6.20 RECOMMENDATION: The Committee noted the contents of this report.

7. Primary Care Quality Report

7.1 MAE presented the Primary Care 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 noted that the December report would include a comprehensive review of the CQC inspection reports on Gloucestershire practices. MAE advised that she received a list of all the inspections undertaken by CQC and noted that most practices were rated as 'good' although there were three practices that required 'improvement'. It was noted that two practices had been

rated ‘outstanding’. The CCG provided support to those requiring improvement.

7.3 AE queried the meaning of Patient Group Direction (PGDs) and was advised they provided a legal framework that allowed some registered health professionals to supply or administer a specified medicine to patients, without having to see a doctor.

7.4 JC requested that the list of the approved PGDs were shared with IGQC for information. CBu advised that these were published on CCG Live.

7.5 AE drew attention to the CQC inspection dashboard in particular relating to Crescent Bakery Surgery and questioned the role of the CCG in terms of providing assurance that issues would be addressed. MAE advised that there was an agreed protocol with NHS England for the management of practices that required improvement. MAE advised that an approach would be agreed collaboratively with the Primary Care Team.

7.6 AE also queried the support available to Sixways Clinic as issues had been identified with patients’ satisfaction rates in terms of accessing care. MAE advised that further analysis of the patient survey would be undertaken in order to ensure that an effective action plan was developed. BP advised that a patient satisfaction survey had also been developed by the CCG for Sixways Clinic to pilot.

7.7 The Committee reiterated that all practices should have established a Patient Participation Group (PPG) as this was a contractual requirement. It was noted that 10% of the practices in Gloucestershire had not established a PPG. BP advised that support had been provided to those remaining practices.

7.8 CBu highlighted that CQC had published a guide which provided information on how providers could meet the regulations and comply with the fundamental standards. CBu suggested that this guide was widely shared with member practices. MAE

7.9 CBe queried if there was a prioritisation process of funding for those practices that required improvement identified by the CQC. MAE

7.10 MAE advised that she had received the final list of the practices that had CQC inspections outstanding.

7.11 AE highlighted the relaxation of the CQC inspection regime and queried how the assurance would be sought around the quality of the service. MAE advised that the Clinical Quality Review Group reviewed any areas of concern comprehensively and that the assurance would be received through this Group. Members also noted that the Practice Nurse Facilitators role would be to disseminate good practice.

7.12 CG requested that a formal inspection regime was established for practices. MAE advised that the CCG did not have any specific powers of entry unlike the CQC. However, if concerns were identified with a specific practice then a follow-up visit would be undertaken. CBu stated that the triangulation of information in order to identify any outliers was key to the assurance process and that targeting national funding to support practices would be constructive.

7.13 AE requested that further information on the CCG approach on engaging with practices was presented to the Primary Care Commissioning Committee in particular taking account the relaxation of the CQC inspection regime. MAE

7.14 RECOMMENDATION: The Committee noted the contents of this report.

8. Stroke and Transient Ischaemic Attack (TIA) Progress Report

8.1 CR joined the meeting and presented the report which focused on the management of Transient Ischaemic Attack (TIA) and Stroke Thrombolysis. The report was taken as read.

8.2 JC enquired of the discrepancies in the performance data between the Quality Dashboard and the above report. CR understood that there was disparity between GHFT reporting as it did not correlate with the information that the CCG received. CR informed members that this issue had been raised with GHFT who had agreed to revisit their reporting processes.

8.3 CR provided a background context to TIA and Stroke and advised that they were part of a family of diseases that sit under the 'overarching' term cardiovascular disease (CVD).

8.4 CR also explained that in order to determine a patient's level of risk, they were assessed by using the ABCD2 tool which measured the stroke risk which was categorised into higher or lower risk. It was noted that national quality markers indicated that 60% of high risk patients should be seen within 24 hours and the remainder within 7 days.

8.5 Members noted that it had been identified that TIA clinics were struggling to meet quality markers and a review of performance indicated that one of the factors influencing this was the number of patients being referred to clinics with non-vascular events.

8.6 CR explained that a new referral form was developed in order to reduce the impact of non TIA referrals and that Stroke Consultants also initiated a process of reviewing referrals prior to the patient being booked into clinics.

8.7 It was noted that plans were also in place to provide additional clinics at the weekend and it was felt that this would further improve performance and add a level of sustainability.

8.8 CBu understood that it was a whole system issue and that patients were referred to alternative pathways for urgent care as a mechanism to avoid long waiting times. CBu emphasised that rapid GP access was also critical to significantly reducing the risk of a major stroke and that

a whole system review was required.

8.9 CR advised that the TIA clinics had been valuable due to the quick access to consultants and CT scanning facilities etc. CBe felt that General Medical Clinics had great benefits and that services were now more specialised.

8.10 JC queried who would monitor performance and was advised that the Clinical Programme Groups (CPGs) would have this responsibility and would monitor any progress.

8.11 CBu considered that practice receptionists required training to identify any warning signs as they were often the first point of contact. TL considered that patient education was also important. CR concurred and suggested that education for staff and patients would be beneficial. CR

8.12 The Committee noted that the Thrombolysis performance was below the national average and advised that time was a critical factor for treatment. CR advised that work was ongoing with the Emergency Department (ED) to improve performance. It was noted that an ED Consultant had been identified who would take a lead for stroke to reinforce the stroke pathway requirements within the ED.

8.13 CR highlighted that there were only 2.0 WTE Stroke Nurses covering GHFT. JC queried if the new plan included weekend cover and was advised that there was insufficient capacity to cover this. CR noted that GHFT had submitted an internal business case and that this would be dependent on the outcome of the business case decision. JC queried if this could be identified within the planning round for 2017/18.

8.14 RECOMMENDATION: The Committee noted the report.

9. Local Supervising Authority 2015/16 Annual Report

9.1 AB presented the 2015/16 Local Supervising Authority (LSA) Annual Report. The report was taken as read.

9.2 AB explained that the LSA's primary role was the responsibility of safeguarding and protecting the public, meeting Nursing and Midwifery Council (NMC) Rule 13 standards and delivering local priority actions. It was noted that the NMC sets the rules and standards for the function of the LSAs and the supervision of midwives.

9.3 AB advised that the report identified 17 risks for the South West and South Central areas and there were insufficient numbers of supervisors to maintain statutory function which had increased the delays in the completion of supervisory investigations.

9.4 JC queried if robust plans had been developed locally and was advised that it was unclear where the pilot sites were located. It was noted that NHS England had implemented pilot sites working with LSA and across UK, supporting the development of the new model of midwifery supervision for England. GHFT activities were reported as good. A new model of supervision was proposed from 2017, but the current system would continue for now until new arrangements piloted/agreed.

9.5 DT confirmed that there was a robust ongoing programme of supervision of midwives at GHFT which was undertaken in collaboration with the University of the West of England.

9.6 JC requested that a progress report on the new model of supervision was presented at the April 2017 IGQC meeting and included any associated risks to GHFT. AB/MAE

9.7 RECOMMENDATION: The Committee noted the contents of this report and the presentation.

10. Risk Register

10.1 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 and included additional information regarding the red risks as

requested at the previous Committee.

10.2 The Risk Register comprised a total of 36 risks, one of which was graded as 'red' as outlined in Appendix 1. In addition, the Committee were asked to consider the addition of the one new risk detailed on Appendix 2 and approve the closure of a risk detailed on Appendix 3.

10.3 AP advised that the new risk (No C36) related to the Emergency Department performance and that the closed risk related to Risk No L6 relating to delegated commissioning relationships.

10.4 JC highlighted Risk No C3 relating to Procurement Strategy and requested that the risk rating was downgraded as the Procurement Strategy was approved at the July 2016 Governing Body meeting. MW

10.5 JC highlighted that GHFT had been placed in financial special measures and requested that this was reflected within the Risk Register.

10.6 AE commented that Appendix 5 had proved to be useful due to the additional information on the red risks. CBu was disappointed with the generic responses from NHS England relating to Risk No T13 (specialised services for children and young people) and requested for a further qualitative update. MW

10.7 RECOMMENDATION: The Committee:

- **reviewed the paper and the attached Risk Register;**
- **approved the addition of the new risk (Risk No C36) detailed on Appendix 2; and**
- **approved the deletion of a risk (Risk No L6) detailed on Appendix 3.**

11. Assurance Framework

11.1 AP presented the Assurance Framework for 2016/17 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.

11.2 AP informed members that only high level risks with a rating above 12 were included within the Assurance Framework in order to provide focused discussions.

11.3 RECOMMENDATION: The Committee noted this paper and the attached Assurance Framework.

12. Internal Audit Report – Clinical Governance

12.1 AP presented the internal audit report on Clinical Governance. It was noted that the report had been issued by the CCG's internal auditors following a review of the Clinical Governance processes. The report was taken as read.

12.2 AP advised that an action plan had been developed with target dates assigned to each finding.

12.3 AP advised that one of the findings related to the membership of the committee and had been reflected in the revised Terms of Reference (TOR) which was being presented later on in the agenda.

12.4 JC commented that the GP and lay membership required review and that an annual self-assessment of the Committee's work and performance should be undertaken. The Committee agreed that this should be undertaken during April 2017.

12.5 RECOMMENDATION: The Committee noted the report.

13. Policies for Approval

13.1 Acceptable Use of IT Policy

13.1.1 AP presented the Acceptable Use of IT policy which outlined the CCG's approach regarding the use of IT. AP advised that the Policy had previously been presented at the March and June 2016 IGQC meeting. The Policy was

taken as read.

13.1.2 TW advised Appendix 2 provided guidance on the categories of Apps that were permitted for download which also included social networking sites for work use.

13.1.3 RECOMMENDATION: The Committee approved the Policy.

13.2 Operational Policy for Continuing Healthcare and Funded Nursing Care (Adults)

13.2.1 DS presented the Policy which provided guidance to Health and Social Care practitioners and managers in relation to NHS Continuing Health Care (CHC) and Funded Nursing Care (FNC). The policy was taken as read.

13.2.2 DS explained the main changes to the policy included providing information on processes i.e. application, appeals, complaints, etc. Additionally, it also included further information on personal health budgets and Section 117 aftercare.

13.2.3 JC highlighted Section 6.2.9 and requested that a cross-reference to the fast track process was specified within this section.

13.2.4 JC highlighted that Section 17.1 should state how often the training should be renewed. DS advised that there were no specific directives which stated the frequency of the training. However, CHC Nurse Assessors were required to complete a CHC online training which was in the process of moving to competency based training which should be renewed once a year. JC requested that this was specified as good practice within the Policy

13.2.5 CBe queried if the assurance of competence would be identified via the appraisal process and was advised that the quality of assessments would also be reviewed. CBe queried if peer review would be undertaken on decisions. DS advised that a peer review group of Nurse Assessors had been established where cases were reviewed and

learning shared.

13.2.6 CG informed members that an internal audit review of CHC had presented an overall high risk rating. CBe enquired if the quality assurance measures sought by the Audit Committee could be shared with IGQC. It was agreed that this would be shared. AP

13.2.7 CBu enquired if the administrative process could be reviewed as it was considered to be a lengthy process. DS emphasised the importance of ensuring that a thorough and robust assessment was undertaken for patients. It was also noted that Kim Forey was undertaking a review to streamline processes.

13.2.8 CG requested that Section 16.1 was amended to read *'consider requests for Retrospective Reviews for periods of care post 1st April 2012 and where **it is** satisfied that one…'*

13.2.9 RECOMMENDATION: The Committee approved the Policy subject to the above comments.

13.3 Shared Parental Leave Policy

13.3.1 AP presented the Policy which provided a framework across the organisation for a consistent approach to the consideration and provision of shared parental leave, whereby employees may take time off work to look after a child or make arrangements for a child's welfare. The Policy was taken as read.

13.3.2 JC drew attention to Section 7.3 and felt that the maternity pay rate of time was ambiguous and suggested that this was clarified.

13.3.3 JC highlighted Section 13.5 relating to leave notification and felt that 14 days were harsh. CL considered that this could be due to national legislations. AP agreed to clarify. AP

13.3.4 JC queried if the Policy had been reviewed by the Policy Working Group and the Joint Staff Consultative Committee Staff and it was confirmed that it had been. AP

JC requested that this should be indicated within the Policy.

13.3.5 RECOMMENDATION: The Committee approved the Policy subject to the above comments.

14. IGQC Terms of Reference

14.1 AP presented the IGQC TOR and explained that a small number of recommendations were made following the internal audit review of the CCG's Clinical Governance function. As a result of this review, the TOR of the Committee had been reviewed and a number of changes proposed.

14.2 Members noted that the revised Terms of Reference would be submitted for formal approval to the November meeting of the Governing Body.

14.3 AP advised that the proposed changes were outlined by 'tracked changes' and explained the key changes. These were:

- section 2 Core Membership - reduce the GP membership from 4 to 3;
- section 8.1.3 - reference has been made to the responsibilities of both the IGQC and the PCCC in relation to the quality of primary care services; and
- section 12.1 - the listing of the sub-committees reporting to the IGQC had been reviewed to reflect the current structure.

14.4 JC requested that the reporting structure of the Locality Groups was clearer within the Constitution.

14.5 JC enquired if the new Lay Member (Business) would be included within the IGQC membership and was advised that they should be. JC highlighted that the CCG was lacking in an Equality and Diversity Lead (which was led by the previous Lay Member).

14.6 CBe suggested that the membership should comprise of AP

the Clinical Chair or Deputy Clinical Chair.

14.7 JC drew attention to Section 6.1 of the TOR relating to remit and responsibilities of the Committee and highlighted that this should also include clinical governance. AP

14.8 JC requested that Section 8.2 included reports on the quality of services for primary care.

14.9 JC also commented that the national Clinical Audit Programme should be shared with the Committee.

14.10 CG considered that the PCCC should be responsible for the improvement in the quality and monitoring of primary care services as the PCCC was directly responsible for providing assurance to NHS England. It was agreed that a further discussion was required. The IGQC should provide assurance to the Governing Body on the quality of primary care.

14.11 CG requested that the reference to the Audit Commission was removed in Section 7.2 of the document as it had now closed.

14.12 RECOMMENDATION: The Committee deferred the approval of the Terms of Reference.

15. Information Governance Update

15.1 CL presented the paper which provided an update on the organisation's information governance arrangements. The paper was taken as read.

15.2 CL advised that the work on the IG Toolkit was progressing. CL informed members that the compliance with the online training was currently at 84% and that reminders were being sent to those staff that were still yet to complete the training.

15.3 Members noted that an Information Governance training session had been arranged for Governing Body Members on Thursday 1st December 2016.

15.4 CL advised that NHS Digital had undertaken a review of all CCG fair processing notices and had issued a checklist to CCGs. It was noted that the CCG's fair processing notice had been updated in line with this checklist and had been published on the CCGs website.

15.5 RECOMMENDATION: The Committee:

- **noted the Information Governance Working Group notes;**
- **noted the Gloucestershire Information Governance Working Group notes; and**
- **noted the contents of this report**

16. 2017/18 CQUINs – verbal update

16.1 MAE provided a verbal update on the Commissioning for Quality and Innovations (CQUINS). It was noted that draft guidance had been published by NHS England for consultation. MAE explained that there would be no flexibility to agree local CQUIN variations and were primarily based on national indicators.

16.2 MAE advised that she was part of a national commissioning forum where a response was sent to the consultation document. The general consensus from the forum was that the CQUIN should be abolished as it did not provide any significant purpose.

16.3 JC requested that a further update was provided at the December IGQC meeting. MAE

16.4 RECOMMENDATION: The Committee noted the verbal update.

17. <u>Complex Lower Limb Wound Care Service</u>

17.1 The Committee received the report which was taken as read. It was noted that the Complex Leg Wound Service was commissioned from Gloucestershire Care Services.

17.2 JC requested that a further update was presented at the MAE

February IGQC meeting.

17.3 RECOMMENDATION: The Committee noted the report.

18. Any Other Business

18.1 AP provided an update on the Standards of Business Conduct Policy. The Committee noted the update.

19. The meeting closed at 12.00pm.

Date and time of next meeting: Thursday 15th December 2016 in the Board Room at 9am.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 16

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Audit Committee minutes**
Executive Summary	The attached minutes provide a record of the Audit Committee meeting held on the 20th September 2016.
Key Issues	The following principal issues were discussed at the meeting: • Internal Audit; • External Audit; • Counter Fraud; • CHC Action Plan; • Sponsorship and Hospitality Registers; • QIPP; • Summaries of Procurement Decisions; • Waivers of Standing Orders; • Aged Debtors; • Debts Proposed for Write-off; • Losses and Special Payments Register; • Assurance Framework; and • Audit Committee Self-Assessment
Risk Issues: Original Risk Residual Risk	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality and Diversity	None

Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Colin Greaves Audit Committee Chair and Lay Member

NHS
Gloucestershire
Clinical Commissioning Group

Audit Committee

Minutes of the meeting held on Tuesday 20th September 2016
Prout Room, Sanger House

Present:		
Colin Greaves (Chair)	CG	Lay Member, Governance
Alan Elkin	AE	Lay Member, Patient and Public Experience
Dr Hein Le Roux (part meeting)	HLR	Deputy Clinical Chair
Dr Will Haynes	WH	GP Liaison Lead – Gloucester

In Attendance:		
Andrew Beard	AB	Deputy Chief Finance Officer
Liz Cave	LC	Director, Audit, Grant Thornton
Michelle Burge	MB	External Auditor, Grant Thornton
Lynn Pamment	LP	Audit Partner, PWC
Lee Sheridan	LS	Local Counter Fraud Specialist
David Porter (part meeting)	DP	Head of Procurement
Kim Forey (Item 8)	KF	Associate Director – Partnership, Joint Commissioning and Community Services
Miriam Street (Item 8)	MS	Senior Commissioning Manager
Kelvin Edge (part meeting)	KE	Head of PMO
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Corporate Governance Support Officer

1. Apologies

1.1 There were no apologies received.

2. Declarations of Interests

2.1 HLR and WH declared a general interest as their respective practices received payments for the prescribing incentives scheme.

3. Minutes of the meeting held on 12th July 2016

3.1 The minutes of the previous meeting held on 12th July 2016 were

approved subject to the amendments below:

- LC to be omitted from the list of attendees.
- Section 6.2 to be amended to read *'LH advised that an amendment to the Value for Money **commentary** was made regarding the GP Co-commissioning…'*

3.2 CG drew attention to section 2.2 of the minutes which requested a list of enhanced services payments. It was noted that this information had been forwarded although it was felt that further detail was required.

WH joined the meeting at 9.20

4. Matters Arising

4.1 **29.09.15 Item 18.7** – AB advised that the feedback from the Bath and North East Somerset (BaNES) and Wiltshire CCGs indicated that the Finance Committee was a useful function which had prompted robust discussions particularly in terms of challenging any QIPP projects. CG felt that the current mechanisms for disseminating financial information to the Governing Body and the benefits of establishing a Finance Committee required further investigation. **Item Closed.**

4.2 **08.12.15 Item 5.1.5 –** AB highlighted that the planning process had been brought forward and that it was proposed that a summary of the lessons learnt would be detailed in a slide pack.

4.3 **08.3.16 Item 5.2.2.4** – AB advised that discussions with NHSE had taken place regarding accessing financial information and highlighted that an internal audit review on Primary Care Co-commissioning was being proposed. **Item Closed.**

4.4 **24.05.16 Item 4.9** – CG advised that a meeting between external audit and the Audit Committee had been held prior to the Audit Committee meeting that day. **Item Closed.**

4.5 **12.07.16 Item 2.2** – The list of the enhanced services payments was circulated on the 13th September 2016. **Item Closed.**

4.6 **12.07.16 Item 7.6** – LS advised that the Counter Fraud Training

provided by the Council was of an excellent standard and highlighted that the risks were similar to the NHS and that they were governed by the same criminal legislations and processes. LS also highlighted that this was operational training provided specifically for the Counter Fraud staff and that the training for the NHS would be tailored to meet the organisational needs. **Item Closed.**

4.7 **12.07.16 Item 11.2** – AB advised that a 12 month pilot for current Home from Hospital, Assisted Discharge and Night Sitting Services had been delivered by Age UK Gloucestershire and British Red Cross via an NHS standard contract. AB advised that several extensions had been applied for in order to allow for a formal tender process to be undertaken and noted that the existing contracts would terminate on the 31st October 2016 and that the new service would commence on the 1st November 2016 for a three year period. AB advised that the additional cost of the extension equated to approximately £104K. The Committee expressed concerns regarding the additional costs and questioned if lessons could have been learnt. DP added that there was additional value resulting from the pilot. **Item Closed.**

HLR left the meeting at 9.33

5. Internal Audit Update

5.1 Progress Report

5.1.1 LP presented the Internal Audit Progress report. The report was taken as read.

5.1.2 LP advised that there was good progress against the 2016/17 internal audit plan. LP advised that the summary of individual audit assignments was outlined on pages 4 and 5 of the report.

5.1.3 LP drew attention to page 6 of the report which outlined the changes to the Internal Audit Plan. LP advised that the key changes included a follow up of the Continuing Health Care (CHC) review and a jointly funded review with the GHFT on Clinical Coding. Members also noted that there had been an increased coverage on the Conflicts of Interest review due to the impact of the NHS England guidance.

5.1.4 CG questioned the rationale for deferring the Corporate Governance review as he felt that the review would be pertinent to the

Sustainability and Transformation Plan (STP) process. LP stated that there would be an increased focus on the conflicts on interests and advised that there were additional contingency days which could be expended on the STP process review. The Committee felt that the STP governance arrangements were complex and that a review should be considered. LP agreed that a high level review could be planned and that she would discuss with management.

5.1.5 <u>Recommendation:</u> The Committee noted the contents of the report.

5.2 <u>Recommendation Tracker</u>

5.2.1 LP presented the tracker which included a total of 19 recommendations. LP advised that the area with the most recommendations in progress related to CHC and noted that there was a follow up review planned.

5.2.2 <u>Recommendation:</u> The Committee noted the tracker.

5.3 <u>Procurement Review</u>

5.3.1 LP presented the report and advised that the audit had presented an overall low risk rating. The review identified a total of five findings; one medium, three low and one advisory findings

5.3.2 LP advised that the medium risk finding related to conflicts of interests; it was identified that the procurement team was reliant on the bidder supplying this information and that the conflicts of interest were also not noted on the waiver register. The audit had recommended that the CCG developed a robust process for managing conflicts of interests.

5.3.3 LP highlighted that one of the low risk findings related to waiver issues particularly regarding the volume of the contracts awarded via this mechanism and suggested that a rigorous challenge on the use of a waiver at the procurement stage should be undertaken by the Procurement Team.

5.3.4 AE expressed concerns regarding the administration process for managing waivers as these represented 79% of the total number of contracts awarded. AE also expressed concerns regarding the lack of awareness of the procurement process by the CCG staff. DP

added that this represented 31% in financial terms and that the figures also excluded the award of any major contracts as these would not be subjected to a waiver process i.e. GHFT main contracts.

5.3.5 DP advised that he was concerned regarding the number of clinical pilots being undertaken as a number of these had been high value and felt that an alternative process should be established for entering into these trials. DP also felt that regular review periods should be built into the process in order to measure the effectiveness of the pilot.

5.3.6 CG expressed concerns regarding the lack of the business planning process and queried if there was a database detailing all the contracts. DP advised that a database had been developed and noted that it was evolving as it had only recently been established.

5.3.7 WH felt that efficient working was vital and that a smooth process should be key to ensure that there was increased focus on delivery; and that there should be a balance between the two.

5.3.8 WH questioned if a small team could be established to scrutinise pilots ensuring that a measurement mechanism was in place. AE enquired who was responsible for initiating the pilots and suggested that they should be responsible for measuring the success criteria as part of the business case process. Members noted that the Clinical Programme Groups (CPG) initiated the majority of the pilots in conjunction with the Programme Management Office (PMO).

5.3.9 AE requested that the PMO provided details of their involvement in scoping the business case process in conjunction with the CPG.

5.3.10 WH suggested that an audit of previous pilots was undertaken in order to identify any learning which could inform future processes. LP highlighted that a lessons learnt process had been recommended in the audit report. DP agreed to undertake a retrospective review of previous pilots. DP

5.3.11 <u>Recommendation:</u> The Committee noted the report.

DP left the meeting at 10.05

6. External Audit update

6.1 MB presented the progress report which was taken as read. MB advised that the progress as at September 2016 was highlighted on page 5 of the report.

6.2 MB advised that the 2015/16 Annual Audit letter had been issued and that work on the 2016/17 audit was underway and noted that a meeting with the finance team had been arranged to discuss the approach.

6.3 MB drew attention to the following reports that had been published:

- Shaping the future direction of primary care (Grant Thornton);
- Partnership working in mental health (Grant Thornton); and
- The commissioning of specialised services in the NHS (National Audit Office)

6.4 LC advised that Our Health was a multispecialty community provider (MCP) in Birmingham and that the engagement lead for this organisation could visit the CCG to share any learning points. The Committee suggested the CFO liaise with LC on this matter. CL

6.5 <u>Recommendation:</u> The Committee noted the report.

7. Counter Fraud update

7.1 LS presented the report which outlined the progress on the action plan. It was noted that the majority of actions were rated as green with the remaining as amber. The report was taken as read.

7.2 LS advised that he was liaising with AP regarding organisational policies and ensuring that the policies process had Counter Fraud input going forward, where appropriate.

7.3 LS advised that one of the objectives was to raise awareness levels of counter fraud amongst staff and noted that a number of fraud awareness sessions had been undertaken.

7.4 Members noted that a draft communication strategy had been agreed with the Communications Team and HR although it was noted that there had been issues with circulating the previous

newsletter to staff.

7.5 Members were advised that an additional member of staff, Paul Kerrod, had been recruited into the Local Counter Fraud Service in order to strengthen the service provision. It was noted that he would be fully qualified by the end of December 2016.

7.6 LS advised that a fraud awareness month had been scheduled for February 2017 and that it had been suggested that this should be re-branded to further emphasise the initiative.

7.7 LS advised that the results from the data matching exercise undertaken by the National Fraud Initiative would be available during April 2017. It was noted that this was an exercise that matched electronic data within and between public and private sector bodies to prevent and detect fraud.

7.8 <u>Recommendation:</u> The Committee noted the reports.

MS and KF joined the meeting at 10.17

8. CHC Action Plan Update

8.1 MS presented the report which provided a summary of the progress against the action plan resulting from a review of the CHC service by Internal Audit.

8.2 MS advised that there were two items outstanding from the action plan but noted that the remainder of the actions had been completed.

8.3 MS provided details of the outstanding actions to the Committee and advised that these related to management accounting and highlighted that Care Track was being used to report all activity.

8.4 Members noted that the second outstanding action relating to the joint piece of work being undertaken with the Council and that an external consultant had been appointed to map the end-to-end process. KF explained that the end-to-end process was a comprehensive piece of work to review the value for money assessments.

8.5 MS informed members that a follow up audit was being undertaken

by Internal Audit on the week commencing 14th November 2016.

8.6 CG questioned when the Care Track issues would be resolved. MS advised that this would be addressed via the end to end project mechanisms. MS also advised that several meetings had been held with the brokerage team in the Council in order to establish an efficient process and noted that the Council had a deadline until the end of the month to address any backlogs and ensuring that all providers had implemented rate cards. KF explained that the Council had a complex process and that the aim was to ensure that standardised rates were implemented.

8.7 CG enquired if the CHC Operational Policy was being presented to the Integrated Governance and Quality Committee (IGQC) and it was noted that this was scheduled for the October IGQC.

8.8 CG also enquired if there were sufficient resources within the team to manage the additional demand. MS advised that additional resources was being sought in order to manage the workload within the team. KF highlighted that there was further work to undertake in completing the outstanding Previously Unassessed Periods of Care (PUPoC) cases which had been stipulated by NHS England to be completed by March 2017. WH articulated that the resources should be used effectively within the CCG due to the nursing shortages within the county.

8.9 <u>Recommendation:</u> The Committee noted the CHC Action Plan.

MS and KF left the meeting at 10.35

9. Registers

9.1 <u>Commercial Sponsorship and Rebates</u>

9.1.1 AP presented the Commercial Sponsorship and Rebates Register. The Register was taken as read.

9.1.2 AE queried the new entries which dated back to 2015 and was advised that this resulted from a letter received from the Association of the British Pharmaceutical Industry (ABPI) which disclosed details of payments and other benefits in kind made by the industry.

9.1.3 AE queried the policies in place within the CCG around sponsorship and it was recognised that there was further work to undertake to address this issue particularly within the Standards of Business Conduct Policy. AP

9.1.3 <u>Recommendation:</u> The Committee noted the register.

9.2 <u>Gifts and Hospitality</u>

9.2.1 AP presented the Gifts and Hospitality Register. The register was taken as read. It was noted that one new entry had been declared.

9.2.2 <u>Recommendation:</u> The Committee noted the register.

KE joined the meeting at 10.40

10. QIPP Report

10.1 KE presented the QIPP report which provided an overview of the 2016/17 QIPP Programme delivery at Month Four.

10.2 KE advised that the overall forecast financial delivery at month four was £14.54m out of a total QIPP target of £18.04m.

10.3 KE advised that the main risks to financial delivery were:

- follow-up reduction (£3.8m);
- primary care prescribing (£3.5m); and
- Integrated Community Teams (ICTs) – High Intensity Service (HIS) (£1.3m).

10.4 It was noted that a detailed review of the schemes had been undertaken with the recommendations being reported to the Core Team.

10.5 AE queried the term ‘active’ which was listed on the Scheme Detailed Summary table on page 4 of the report. KE explained that this meant that the scheme was still in progress.

10.6 CG expressed concerns regarding the progress of the HIS scheme delivery. The Committee concurred and agreed that there was further work to do.

10.7 **<u>Recommendation:</u> The Committee noted the 2016/17 QIPP programme position at Month Four.**

KE left the meeting at 10.45

11. Summaries of Procurement Decisions

11.1 AB presented the procurement decisions paper which outlined all CCG decisions relating to the procurement of services between the 29th June 2016 and 5th September 2016.

11.2 **<u>Recommendation:</u> The Committee noted the report.**

12. Procurement Waiver of Standing Orders

12.1 AB presented the waivers report and requested comments from the Committee on specific waivers.

12.2 AB highlighted that there was a typographical error with 212/07/2016 and that the period to date should read as 31/05/2017.

12.3 **<u>Recommendation:</u> The Committee noted the paper which was provided for information.**

13. Aged Debtor Reports

13.1 AB tabled the Aged Debtor Report which provided a summary of the aged debt as at 6th September 2016.

13.2 Members noted that the outstanding debt, as per the Sales Ledger, was approximately £1m and that the majority of outstanding debt was with Non-NHS organisations.

13.4 AB also discussed the Non NHS Debtors and highlighted that the major debt related to Gloucestershire County Council (GCC). It was noted that GCC had improved the rate in which they paid invoices within the 0-30 days' timescale. The Committee welcomed this approach as they had previously raised concerns.

13.5 **<u>Recommendation:</u> The Committee noted the paper on the current level of invoices on the Sales Ledger of NHS Gloucestershire and the actions being taken to recover the**

outstanding debts.

14. Debts Proposed for Write-Off

14.1 There were none to report.

14.2 <u>Recommendation:</u> The Committee noted the verbal update.

15. Losses and Special Payments Register

15.1 There were none to report.

15.2 <u>Recommendation:</u> The Committee noted the verbal update.

16 Audit Committee Self-Assessment

16.1 CG presented the paper and the attached self-assessment which was produced using the HFMA guidance template.

16.2 <u>Recommendation:</u> The Committee accepted the assessment.

17. Any Other Business

17.1 There were no items of any other business.

The meeting closed at 10:51am.
Date and time of next meeting: Tuesday 13th December 2016 at 9:00am in the Wheatstone Room, Sanger House

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 17

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Primary Care Commissioning Committee (PCCC) minutes**
Executive Summary	The attached minutes provide a record of the PCCC meeting held on the 29th September 2016.
Key Issues	The following principal issues were discussed at the meeting: • General Practice Forward View; • Delegated Primary Care Commissioning Financial Report; • Smaller Improvement Grant Proposals; and • Primary Care Quality Report.
Risk Issues: **Original Risk** **Residual Risk**	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Alan Elkin PCCC Chair and Lay Member

NHS
Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee

Minutes of the Meeting held on Thursday 29th September 2016 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Alan Elkin	AE	Lay Member – Patient and Public Engagement (Committee Chair)
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Julie Clatworthy	JC	Registered Nurse
Joanna Davies	JD	Lay Member – Patient and Public Engagement
Colin Greaves	CG	Lay Member - Governance
Cath Leech	CL	Chief Finance Officer
Dr Andy Seymour	AS	Clinical Chair
Mary Hutton	MH	Accountable Officer
In attendance:		
Helen Goodey	HG	Director of Primary Care and Locality Development
Cllr Dorcas Binns	DB	Chair of the Health and Wellbeing Board
Andrew Hughes (Item 7)	AH	Locality Implementation Manager
Declan McLaughlin (Item 7)	DM	Primary Care Project Support Manager
Jeanette Giles	JG	Head of Primary Care Contracting
Stephen Rudd	SR	Head of Locality and Primary Care Development
Claire Feehily	CF	Chair of Healthwatch Gloucestershire
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Corporate Governance Support Officer
There were 3 members of the public present.		

1 Apologies for Absence

1.1 There were no apologies received.

2 Declarations of Interest

2.1 AS declared the following interests:

- general interest as a GP member; and
- agenda item 5 - General Practice Forward View Update.

2.2 AE declared that the meeting was quorate and that he felt that AS should not be excluded from any discussions on Agenda Item 5 as there were no direct conflicts of interests.

3 Minutes of the Meeting held on Thursday 28th July 2016

3.1 The minutes were approved subject to the amendment below:

- section 5.7 to be amended to read *'DB suggested that statistics and graphs were included within Annex 3'*

4 Matters Arising

4.1 28.01.2016 Item 9.1 – Any Other Business - AE advised that he had circulated a self-assessment questionnaire to members and asked members to reflect on the proposed questions and make suggestions for their modification or additions. AE advised that a formal request for members to respond to the questions would be issued following this.

4.2 28.07.2016 Item 5.7 – Primary Care Strategy – HG confirmed that the statistics and graph had been included within Annex 3. **Item Closed.**

4.3 28.07.2016 Item 8.12 – Sevenposts: Bishops Cleeve premises development – The premises development training seminar had been held prior to the meeting that day. The Committee thanked AH for his effort in arranging the seminar. **Item Closed.**

5 General Practice Forward View update

5.1 SR provided a presentation relating to the General Practice Forward View (GPFV). The presentation covered:

- history of GPFV;
- NHS England announcements;
- general practice resilience programme;

- general practice development programme;
- Multispecialty Community Provider (MCP) care model framework;
  - MCP stages of development;
  - MCP contract;
  - MCPs – support from NHS England
  - MCP – what is success;
  - MCPs – commissioner role;
  - NHS England MCP contract timescales;
- CCGs response to the GPFV;
  - primary care strategy;
  - GP locality provider leads;
  - Sustainability and Transformation Plan;
  - practice collaboration
  - primary care bids;
  - general practice resilience; and
  - work programme governance.

5.2 It was noted that Gloucestershire would receive £132k funding for the General Practice Resilience Programme in 2016/17.

5.3 Members also noted that Gloucestershire would receive £55k funding for the General Practice Development Programme in 2016/17 and £110k for the following year.

5.4 SR advised that as part of the planning guidance issued by NHS England, CCGs must produce GPFV plans by the 23rd December 2016.

5.5 JC suggested that the work should be linked with the local quality improvement academy. MAE advised that the current Quality Academy was situated within GHFT and was funded by the Academic Health Science Network (AHSN). It was noted that it was proposed to establish a wider Gloucestershire Quality Academy as part of the STP which Deborah Lee was leading on this area.

5.6 JC also queried the impact of the British Medical Association action advising GPs to consider mass resignation. AS advised that he was meeting with the Local Medical Committee (LMC) to discuss this issue although it was felt not to be a significant risk within Gloucestershire.

5.7 AE queried how Gloucestershire was positioned in relation to the MCP and was advised that Gloucestershire was in a good position and that a place based approach was being implemented. HG felt that the GPFV had initiated vigorous discussions within Gloucestershire.

5.8 AE queried the progress of developing the locality plans by the GP Locality Provider Leads. HG advised that good progress was being made particularly in Forest of Dean and Cheltenham.

5.9 CG emphasised the importance of educating and influencing GPs going forward as MCPs could be perceived to be negative and present considerable challenges. HG did not consider this to be an issue.

5.10 DB enquired if the Gloucestershire boundary changes being proposed in 2020 had been considered as part of the overall proposal. HG advised that it had not been considered as the clusters were based on the current structures and the relationship between practices. AS highlighted that the current locality structure was not entirely based on district boundaries.

5.11 CF emphasised the importance of ensuring that the services were scoped around the local population and that the packaging was right to fit around the needs of the population whilst considering the national guidance during the evaluation process. MH agreed that there was learning to be gained from the national process and that the focus should be on ensuring that the process was mapped around the local population.

5.12 <u>RESOLUTION:</u> The Committee noted the presentation.

6 <u>Delegated Primary Care Commissioning Financial Report</u>

6.1 CL presented the report which outlined the financial position on delegated primary care co-commissioning budgets as at the end of August 2016.

6.2 CL advised that the CCG had reported an underspend against delegated budgets as at the end of August and anticipated that the

CCG would be forecasting a breakeven position by the year end.

6.3 CG felt the finance table on page 3 of the report was excellent and commended the finance team for producing this report.

6.4 RESOLUTION: The Committee noted the report.

7 Smaller Improvement Grant Proposals

7.1 AH presented the report and provided a background context to the report. The report was taken as read.

7.2 AH advised that there were four key elements to consider as part of the premises workstream. These were:

- day to day property issues;
- delivering legacy schemes;
- delivering key major priorities as outlined in the infrastructure plan; and
- working with practices on smaller schemes.

7.3 AH advised that the report outlined the process undertaken for smaller improvement grant proposals. AH explained that these were for improvements to existing primary care premises.

7.4 Members noted that practices were given the opportunity to apply for a smaller Improvement Grant by way of a letter sent by the CCG in March 2016 inviting bids from practices where the practice was not currently engaging in, or had recently completed a capital improvement project.

7.5 AS advised that NHS England had invited CCGs to apply for additional premises related funding where Gloucestershire had requested £242k and that the CCG were awaiting confirmation of this funding.

7.6 Members noted that, subject to the approach being agreed, funding would be 1/3rd of the total project costs and no greater than 2/3rd. AH tabled an updated list of the grant proposals and advised that the Primary Care Operational Group had agreed that the CCG would contribute 44% of the total project costs.

7.7 It was noted that if the schemes were not being proceeded with, then there would be a process for reallocation. AH advised that the proposal was subject to the CCG obtaining funding from NHS England.

7.8 CG understood that the previous mechanisms for improvement grants had ceased and that the process outlined replaced this. AH advised that the CCG may choose to consider setting up a separate budget for improvement grants going forward and noted that the proposal was predicated on the funding being confirmed by NHS England. CL advised that this would be considered as part of the overall primary care delegated budgeting process for next year.

7.9 CG highlighted that the Culverhay, Lydney and Springbank proposals had been submitted for the Estates and Technology Transformation Fund as well as the smaller improvement grants and questioned the rationale for the duplication and the timescales associated with the funding. AH provided an update on the prioritisation process. DM advised that further direction regarding the smaller improvement grant process was still awaited.

7.10 MH felt that all schemes would not be delivered by March 2017. CG queried if there was a priority list if schemes could not be proceeded with and was advised that the funding process had been challenging and that schemes should be allocated on a case by case basis.

7.11 CL drew attention to the statement in the report that a smaller proportion of the project costs would be funded via the CCG if funding applications were unsuccessful and articulated that this would be subject to the overall financial position.

7.12 JC queried if this linked with the CQC visits where practices had been identified as requiring premises improvements. AH advised that practices had been invited to submit bids and that the proposal was to fund the majority of the schemes and highlighted that there was no financial risks to the CCG as the schemes were subject to this funding and reiterated that schemes would not progress if the funds were not received.

7.13 HG advised that the approach for agreeing the process once the funding had been received was the key issue and that the final position would be reported following this. HG

7.14 <u>RESOLUTION:</u> The Committee:

- **agreed the approach described in this paper;**
- **approved the individual proposals and noted the amended proposals which were tabled at the meeting;**
- **noted the proposed level of funding for each proposal;**
- **noted that approval was subject to the CCG obtaining funding from NHS England; and**
- **delegated authority to AE and MH to make the final decision.**

8 Primary Care Quality Report

8.1 MAE presented the Primary Care 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.

8.2 MAE provided an update on the areas discussed at the Primary Care Clinical Quality Review Group and advised that immunisations performance had been reviewed at the meeting. It was noted that support would be provided to practices to promote uptake. MAE also advised that a short film was being produced in conjunction with the Communications Team which would be shared with practices.

8.3 MAE advised that the CCG had not been alerted to any new serious incidents from primary care. It was highlighted that the low reporting theme was common across England. MAE advised that further work with the AHSN was being undertaken in order to understand and improve the reporting levels.

8.4 Members noted that the responsibility for complaints and concerns in relation to primary care remained with NHS England. It was noted that the NHS England national complaints team were developing an approach which would allow some information to be shared with CCGs and that this was being discussed further.

8.5 MAE updated members on the Care Quality Commission (CQC)

inspections of Gloucestershire practices and noted that the dashboard of published CQC inspections reports was summarised in Appendix 1 of the report. Members noted that there had been three practices that required improvement and that concerns had been identified around the administration processes. It was noted that additional support would be provided to those practices that required improvements. MAE highlighted an example of a practice who had been rated as 'good' but had been found to be in breach of registration requirements as the practice's procedure for storing prescription pads had been insecure. CG expressed concerns regarding the marking regime used by CQC.

8.6 MAE advised that the 2016/17 internal audit of the clinical governance process had been completed. It was noted that the outcome of the audit would be reported to the Integrated Governance and Quality Committee.

8.7 CG expressed concerns regarding the 10% of the practices who had not established a Patient Participation Group (PPG) and understood that this position had remained unchanged for some time. CG reminded members that this was a contractual requirement. AE queried the support available for these practices and it was advised that support was available and that further action would be considered if necessary.

8.8 CF felt that there were insufficient lay representatives in a primary care setting when compared to the acute sector and questioned the risks associated with this. CF also felt that the triangulation of data was incomplete in primary care and if additional measures should be considered. MAE stated that the CCG were reliant on data intelligence from other sources and that this was being discussed with NHS England in order to ensure that information could be shared. MAE also understood that many practices had internal groups that reviewed their serious incidents. AS advised members of the process implemented by the practices and noted that this would be reported to NHS England. JC acknowledged that the IGQC had limited assurance available in terms of the quality of the primary care data. HG advised that the Primary Care Team attended the Performers Advisory Group and noted that this provided a further opportunity to triangulate data.

8.9 DB drew attention to the national GP patient survey particularly

regarding the lack of qualitative information that it provided. The Committee acknowledged that the national survey had limitations and highlighted that there were other mechanisms to capture information.

8.10 <u>RESOLUTION:</u> The Committee noted the report.

9 **<u>Any Other Business</u>**

9.1 There were no items of any other business.

10 The meeting closed at 12:30.

11 Date and Time of next meeting: Thursday 24th November 2016 in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Primary Care Commissioning Committee:

Signed (Chair):_____ Date:_____

DRAFT

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 18

Governing Body

Meeting Date	**Thursday 26th January 2017**
Title	**Priorities Committee minutes**
Executive Summary	The attached minutes provide a record of the Priorities Committee meeting held on the 22nd September 2016.
Key Issues	The following principal issues were discussed at the meeting: • 2016/17 Priorities; • scheme updates; and • the updated investment position.
Risk Issues: **Original Risk** **Residual Risk**	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Alan Elkin Vice Chair and Lay Member

NHS
Gloucestershire
Clinical Commissioning Group

Priorities Committee

Minutes of the Meeting held at 2.00 p.m.
On Thursday 22 September 2016 in the Board Room, Sanger House

Present:	
Alan Elkin (AE) *Chair*	Lay Member - PPE and Vice Chair
Mary Hutton (MH)	Accountable Officer
Marion Andrews-Evans (MAE)	Executive Nurse and Quality Lead
Julie Clatworthy (JC)	Registered Nurse
Dr Raju Reddy (RR)	Secondary Care Doctor
Sarah Scott (SS)	Director of Public Health
Joanna Davies (JD)	Lay Member - PPE
Dr Malcolm Gerald (MGe)	GP Liaison Lead – South Cotswolds Locality
Colin Greaves (CG)	Lay Member - Governance
Dr Will Haynes (WH)	GP Liaison Lead - Gloucester City Locality
Dr Charles Buckley (CBu)	GP Liaison Lead - Stroud and Berkeley Vale Locality
Dr Hein Le Roux (HLR)	Deputy Clinical Chair
Ellen Rule (ER)	Director of Transformation and Service Redesign
Mark Walkingshaw (MW)	Director, Commissioning Implementation
Dr Jeremy Welch (JW)	GP Liaison Lead - Tewkesbury Locality

In Attendance:	
Zoe Barnes (ZB)	Corporate Governance Support Officer
Di Thomas (DT)	Cross Border Commissioning Manager
Alan Potter (AP)	Associate Director of Corporate Governance
Sadie Trout (ST)	Head of Planning

1. Apologies for Absence

1.1 Apologies were received from Dr Andy Seymour, Dr Tristan Lench, and Margaret Wilcox.

2. Declarations of Interest

2.1 There were no declarations of interest.

3. Minutes of the Meeting held on the 7 July 2016

3.1 The minutes of the meeting were accepted as an accurate record subject to the adjustment of ‘diabetic’ to be changed to ‘diatetic’ on

page 4.

4. Matters Arising

4.1 **28 Apr 2016 Item 6 North Cotswold Clinical Pharmacists** – **Item to remain open.**

4.2 **19 May 2016 Item 6.7.9 SIP Feeds** – MH noted that it was suggested within the Governing Body papers to press ahead with this matter therefore this item could be closed. **Item closed.**

4.3 **19 May 2016 Item 10.4 Improving Access to Psychological Therapies (IAPT)** – MW advised that the team were starting to see an impact following recruitment and that funding would be looked at at a future meeting. **Item to remain open.**

5. Presentation

5.0.1 ER outlined the focus of the meeting which was to provide ideas of areas to progress, noting that no prioritisation decisions would be made at this time.

JW left the meeting at this point.

5.1 Update on 16/17 priorities

Priorities Committee Presentation 220916

5.1.1 ST presented from the PowerPoint and gave an update which included the following points:

- 20 proposed schemes to be implemented in 2016/17 following prioritisation process;
- 13 schemes authorised to date to proceed to business development, 7 funded from alternative sources, 1 scheme not prioritised;
- £1.497m (recurrent) committed of the £1.5m investment fund available;
- Due to implementation slippage/planned PYE there has been a noted delay in investments being released.

5.2 Scheme Updates

5.2.1 ST outlined the progress of each of the schemes including the

investment figures.

5.2.2 The investment of IAPT staffing was queried in terms of how much was committed. It was confirmed that the decision was made for this year only. MH noted that the Priorities Committee needed to acknowledge if a further investment of the same figure would be needed.

5.3 Updated Investment Position

5.3.1 ST described the updated financial position including agreed commitments, recurrent and non-recurrent spend and remaining balance.

5.4 Summary 16/17

5.4.1 The summary to date included:

- Review has demonstrated 'time to delivery' can be a significant challenge for programmes;
- Internal approval processes need a refresh to ensure they are responsive and fit for purpose;
- Planning round will have a very different look and feel for 2017/18; any business cases will be developed at a programme level and co-ordinated through STP programmes.
  - ER stressed that this does not mean that the STP can commit to any resources.

5.4.2 AE advised that the members should agree on a direction of travel and MH suggested a template outline of 'must dos' for business cases.

5.4.3 CG queried the responsibilities of the Oversight Board and ER confirmed that they observe the resources plan.

5.4.4 JD wondered when the impact evaluation in terms of engagement was completed for the schemes and ER advised that the type of KPI would depend upon the scheme but evaluation would be included within the business cases.

5.4.5 ER noted that the Engagement and Consultation Strategy was in draft and that this could be sent out to the group for information.

5.4.6 MGe queried the STP group responsibilities and how much the

CCG sets for them. The Members discussed the STP further and it was noted that the idea of the STP was to create congruence and shared ownership amongst partners.

5.4.7 It was advised that the progress of SIP feed and Gluten free foods would be included within the Accountable Officer's report at Governing Body on 29 September and that Dieticians would be commencing on 7 October.
CBu requested that further time and development be given to communications and engagement regarding this issue.

5.4.8 Paracetamol prescribing would be given further focus as part of the next steps as discussed at the last Priorities Committee.

6.0 Any Other Business

6.1 There were no items of any other business.

The meeting closed at 3:00pm

Date and time of next meeting: Thursday 19 January 2017 at 2pm in the Boardroom, Sanger House.