NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 28 March 2019 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

AGENDA

No.	Item	Lead	Recommendation
1.	Apologies for absence	Chair	
2.	Declarations of interest	Chair	
3.	Minutes of the Meeting held on • 31 January 2019	Chair	Approval
4.	Matters Arising	Chair	Discussion
Standing Items and Update Reports			
5.	Patient Story		Discussion
6.	Public Questions	Chair	Discussion
7.	Clinical Chair's Update Report	Chair	Information
8.	Accountable Officer's Update Report	Mary Hutton	Information
9.	Finance & Performance Report	Cath Leech	Discussion
10.	Quality Report	Marion Andrews-Evans	Discussion
11	Integrated Locality Partnerships	Helen Goodey	Discussion
12.	ICS Update Report	Ellen Rule	Approval

Items for Approval			
13.	An Open Culture: Engagement – Equality - Experience	Caroline Smith	Approval
Items to Discuss / Note:			
14.	Governing Body Assurance Framework • Risk Report • GBAF	Cath Leech	Discussion
15.	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
16.	Quality and Governance Committee Minutes	Julie Clatworthy	Information
17.	Audit & Risk Committee Minutes	Colin Greaves	Information
18.	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 23 May 2019 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.

Gloucestershire Clinical Commissioning Group Governing Body
Minutes of the meeting held at 2:00pm on 31 January 2019
Board Room, Sanger House

Members Present:		
Dr Andy Seymour	AS	Clinical Chair
Mark Walkingshaw	MW	Deputy Accountable Officer, Director of Commissioning Implementation
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Dr Caroline Bennett	CB	GP Liaison Lead – North Cotswold
Dr Alan Gwynn	AG	GP Liaison Lead – South Cotswold Locality
Colin Greaves	CG	Lay Member, Governance
Alan Elkin	AE	Lay Member, Patient and Public Experience
Andrew Beard (*Deputising for Cath Leech*)	AB	Deputy Chief Finance Officer
Jo Davies	JD	Lay Member, Patient and Public Experience
Peter Marriner	PM	Lay Member, Business
Julie Clatworthy	JC	Registered Nurse
Dr Lesley Jordan	LJ	Secondary Care Doctor
Sarah Scott	SS	Director of Public Health, GCC
Dr Marion Andrews-Evans	TM	Director of Nursing and Quality Lead
Dr Sheena Yerburgh	SY	GP Liaison Lead – Shroud and Berkeley Vale
Dr Will Miles	WM	GP Liaison Lead – Cheltenham Locality
Kelly Matthews *(Deputising for Ellen*	KM	Deputy Director of Transformation and Service Redesign

Rule)		
Helen Edwards (*Deputising for Helen Goodey*)	HE	Associate Director of Locality Development and Primary Care
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Administrator (taking minutes)
Emma Savage (*Agenda Item* 5)	ES	Associate Director – Clinical Programmes
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Four members of the public attended the meeting		

1.	**Apologies**
1.1	Apologies were noted from Helen Goodey, Dr Lawrence Fielder, Cath Leech, Mary Hutton, Dr Will Haynes, Kim Forey and Margaret Willcox.
1.2	The meeting was confirmed as quorate.
2.	**Declarations of Interest**
2.1	No interests were declared.
3.	**Minutes of the Governing Body meeting held on 29 November 2018**
3.1	The minutes of the meeting held on Thursdays 29 November 2018 were approved as an accurate record subject to the following amendments: • Paragraph 4.1 had been corrected to read '**26/07/18, Item 4.1**: Performance Report. "*The Governing Body noted that the work on Improved Access to Psychological Therapies (IAPT) performance and data collection was progressing and a substantive report would be made available at the next Governing Body meeting to be held on 31 January 2019*". • The third line of paragraph 13.1 had been corrected to read

	'*One service user in their 50s defined health and wellbeing as good relationships, a balance achieved between what you have to do and what you want to do, avoiding unnecessary stress and capacity to manage life's challenges and to have or know you can call upon support when needed*".
4.	**Matters Arising**
4.1	**26/07/18, Item 4.1**: Originating from the Performance Report, Item 11.15 of the Governing Body meeting held on 24th May 2018; the performance data was being collected. It was noted that the work on Improved Access to Psychological Therapies (IAPT) performance and data collection remained in progress and a substantive report would be brought before the Governing Body meeting to be held in March 2019. **Item to remain open**.
4.2	**26/07/18, Item 16.3**: A request was made to place Adverse Childhood Experiences (ACEs) on the agenda for the Gloucestershire Strategic Forum (GSF) meeting. The outcome would be brought before the Governing Body meeting in March 2019. **Item to remain open.**
4.3	**26/07/18, Item 12.1**: EB highlighted that a public facing Operating Plan document, which would be easier to digest, would be created and published on the website and brought to a future meeting. Work was progressing and the Communications team was currently working on the graphics. The Operating Plan would be included in the March 2019 Governing Body papers. **Item to remain open.**
4.4	**26/07/18, Item 15.1**: SS described a new Children and Families Partnership Framework. This would be brought to a future development session by SS/CGi. **Item to remain open.**
4.5	**04/10/18, Item 5:10**: JH stated that alongside Public Health, a Frailty Needs Analysis for the county was being designed and developed. The outcome would be reported to the Governing Body

	in March 2019. **Item to remain open.**
4.6	**04/10/18, Item 9.14**: The Governing Body agreed that a message of thanks should be given to all practices for their work on prescribing through 'What's new this week'. Teresa Middleton agreed to action. **Actioned. Item closed.**
4.7	**04/10/18, Item 10.14**: AS advised that GHFT would be repeating the Point of Care Testing that had been undertaken during 2018 to test for flu and noted that this had a significant positive impact and the immediate diagnosis of a case of flu meant that rapid action could be undertaken to quarantine patient(s). It also meant that in cases where there was no flu the care homes did not need to close for admissions. AS explained that Point of Care System was being rolled out in care homes. **Item closed.**
	Emma Savage joined the meeting at 14:05pm
5.	**Patient Story**
5.1	ES introduced herself to the Governing Body and explained that the '*Patient Story'* referred to the diabetic pilot that had benefitted from the scheme provided by NHS England, which focused on diabetes prevention. ES added that the scheme was set up 18 months ago and the need for such a scheme was informed by the high rate of diabetes related amputations.
5.1.1	ES explained that the patient, who was the subject of focus, was diabetic and overweight. The patient's diabetes led to the swelling of legs and loss of sensation/ feeling in the feet. ES added that the patient had a history of not complying with treatment plans or attending hospital appointments.
5.1.2	ES also noted that the patient had lost his wife and mother, therefore lacked family support. The patient's level of hygiene was observed as low. He did not allow nurses or other healthcare

	professionals into his home. The patient developed an ulcer on his left foot and was seen and assessed by a team which included a vascular consultant. The medical team advised hospital admission. The patient refused to be admitted to hospital and 4 days later his condition had deteriorated.
5.1.3	It was then decided that the patient should get treatment as an outpatient by the multi-disciplinary foot service. At this point he did not show any improvement and the patient was at the point of risking the amputation of his foot. The patient eventually agreed to be hospitalised on 19th January 2018 and his toe was removed, which saved his foot /leg. By August 2018 the healing process was visible, which allowed him to be fitted with orthotic shoes
5.1.4	AS commented that within the new GP contract there was greater emphasis on diabetes prevention, care and treatment. PM asked if the multi-disciplinary service also provided social prescribing for patients who would benefit from it. ES commented that she had spent some-time with the diabetic foot clinic and used it as an opportunity to bring in information and leaflets about stopping smoking, the healthy lifestyle service and other important activities. ES reported that this was something that the CCG was seeking to promote. AS thanked ES for the patient story and commended the increased focus on diabetes care in Gloucestershire.
5.1.5	**<u>RESOLUTION</u>: The Governing Body noted the Patient Story**
	Emma Savage left at 14:30pm
6.	**Public Questions**
6.1	AS informed the meeting that two questions had been submitted, which required lengthy answers. Therefore, he would read out the question and precis the answer to both questions. The full response would be sent to Bren McInerney after the meeting, as requested.

6.1.2	Bren McInerney posed the question "*What joined up plan does NHS Gloucestershire Clinical Commissioning Group have to address health inequalities within the population of Gloucestershire. What joined up plan does NHS Gloucestershire Clinical Commissioning Group have for addressing health inequalities with their partner organisations covering the population of Gloucestershire?*"
6.1.3	AS provided the following summary. "The CCG had a Strategy for Promoting Equality and Valuing Diversity which included an action plan to ensure the commissioning of accessible services that responded to the diverse needs of communities in Gloucestershire. Reducing health inequalities was viewed as a key factor in all CCG decision-making. Working in partnership with colleagues in Public Health, Gloucestershire County Council, the Health and Wellbeing Board, and other statutory/non-statutory bodies such as the Community Safety Partnerships, increased the CCG's understanding of the needs and diversity of local communities and underpinned the CCG service development and design".
6.1.4	"The work to tackle inequalities in health in Gloucestershire was driven by the Health and Wellbeing Board. The CCG was an active member of the Health and Wellbeing Board. The Health and Wellbeing strategy was being revised. However, the existing strategy included a priority to tackle inequalities in health and an action plan to drive forward outcomes. The strategy would be finalised in the summer, 2019. The CCG work under the Prevention and Self-Care Plan had a clear focus on reducing the health inequalities gap. Reduction of health inequalities was a central driver to all the work commissioned to prevent ill health".
6.1.5	Bren McInerney had posed the following question: "*Does NHS Gloucestershire Clinical Commissioning Group have a clear narrative of diversity and inclusion that is agreed by the Board and effectively communicated to staff, and which staff at every level can have confidence in?"*

6.1.6	AS read out the CCG's summarised response. "NHS Gloucestershire CCG had a Strategy for Promoting Equality and Valuing Diversity and this strategy was being revised. The strategy included commitment to promoting equality and commissioning accessible services that responded to the diverse needs of communities in Gloucestershire. The strategy also established the CCG's commitment as an employer; to ensure staff had equal access to career opportunities and received fair treatment in the workplace".
6.1.7	"Equality Impact Assessments (EIAs) were undertaken to assess the impact of service review, design and delivery and ensure CCG services remained non-discriminatory. The EIA also identified particular communities who could be disadvantaged by any proposals for change and allowed the CCG to target its engagement activity, support and information to help mitigate against such risk. Staff were supported to deliver equality objectives through regular training, informal lunch and learn sessions and the guidance of the CCG Equality Lead".
7.	**Clinical Chair's Report**
7.1	**Primary Care**
7.1.1	AS presented the Clinical Chair's report. He explained that the application from Phoenix Surgery and Romney House Surgery to merge contractually into the Phoenix Health Group, from the beginning of April 2019, was approved by Primary Care Commissioning Committee (PCCC) at their November meeting.
7.1.2	AS added that the new state-of-the-art £3.8m health centre on Rudloe Drive, Kingsway had officially been opened. The centre had 10 consulting rooms and a capacity to cater for 13,000 patients. The centre adopted a new integrated approach to health delivery whereby other health and social care professionals and specialists engaged with the patients at the centre. In addition, the centre acted

	as a health education hub and provided training facilities.
7.1.3	AS reported that contrary to national trends, Gloucestershire was performing well in the recruitment of GPs into the county. There was an increase in GP headcount and increased nursing numbers. AS stated that the Newly Qualified GP Scheme was being promoted through CCG Live with a rolling application date. In addition, the CCG collaborated with practices and universities to increase student nurse placements.
7.1.4	PM asked about the recent national news stories which concerned lack of GPs and difficult with patients getting an appointment with their GP in a timely way. HE responded that every quarter the primary care team phoned each and every practice within Gloucestershire to assess the timescales for routine patient appointments. The vast majority of practices reported that they offered a routine appointment in 2 weeks. There were somewhere between 9-14 practices out of the 76 Gloucestershire practice where the wait for an appointment was longer than 2 weeks. AS commented that those practices were most likely to struggle with workforce issues.
7.1.4	AS stated that online services had been developed to allow secure electronic communication between patients and practices; an administrative functionality, which would reduce calls to practices and associated administrative burden.
7.2	**Children and Young People's Mental Health Trailblazers Project**
7.2.1	AS announced that Gloucestershire CCG had secured national funding to improve specialist mental health support in schools and reduce waiting times for other mental health services.
7.2.2	AS emphasised that there was a drive by the CCG and its partners to identify children and young people who needed more specialised help and ensure they received the support they needed. AS added

	that the CCG partnered with 2gether, the County Council and TIC+ to enter a bid for a Trailblazers project, which had been positively received.
7.2.3	**<u>RESOLUTION:</u> The Governing Body noted the Clinical Chair's report.**
8.	**Accountable Officer's Report**
8.1	**<u>CINAPSIS Advice and Guidance System</u>**
8.1.1	MW presented the Accountable Officer's report. He explained that Cinapsis was an Advice & Guidance and referral management system. It was a communication platform, which made it easy for GPs to talk directly to specialist consultants, on the phone or through a dedicated messaging service, and share patient data instantly and securely. MW explained that Cinapsis was being rolled out across Gloucestershire GP practices.
8.2	**<u>Joining Up Your Information (JUYI project)</u>**
8.2.1	MW reported that JUYI roll out was progressing well and it had been well received by the users, with users describing the system as accessible and easy to navigate. MW added that work was progressing to expand user groups and refine the information available with the JUYI portal.
8.3	**<u>Community Offer – Mental Health Care for Children and Young People. Trailblazer Programme</u>**
8.3.1	MW referenced the positive news that the CCG was among key leaders in delivering mental health services to children, nationwide. The CCG provided individual support, promoted independence and empowerment through mental health service delivery. MW reported that in December 2018, the Government selected national Trailblazer sites, of which Gloucestershire was one. MW stated that

	Gloucestershire successfully secured £5m funding until 2021. MW also clarified that the Trailblazer programme aimed to improve children's and young adults' quality of life.
8.3.2	MW stated that the funding would support the implementation of four Mental Health Support Teams in Gloucestershire. The CCG would help drive models of early intervention focusing on mild to moderate mental health issues, such as exam stress, behavioural difficulties or friendship issues faced by children and young adults in schools, colleges and special schools.
8.4	**Community Offer – Adult Carers Support Services**
8.4.1	MW stated that a contract to deliver a range of support services for adult unpaid carers, worth £1.77m a year went to tender and was awarded to PeoplePlus Group Ltd in December 2018. Carers Gloucestershire, holders of the current contract, were working with PeoplePlus Group Ltd to discuss and arrange the transitional arrangements. Further updates on the Carers programme would be given at future meetings.
8.4.2	JC asked if the Trailblazer programme interfaced with the existing services in supporting children and young adults in education settings. MW confirmed that this was the case.
8.4.3	**RESOLUTION: The Governing Body noted the Accountable Officer's Report.**
9.	**Performance & Finance Report:**
9.1.1	MW introduced the performance and finance report and discussed the CCG's Improvement and Assessment Framework which showed good performance in Better Health, Leadership and Sustainability, but highlighted the need for improvement in the Better Care domain.

9.1.2	MW stated that, in terms of leadership, the CCG had demonstrated to NHS England that there was a good governance framework and practices in place; along with robust staff engagement and effective working relationships with partners and service users.
9.1.3	MW expressed concern that in terms of performance against the Better Care domain, which generated an overall Amber rating, there continued to be significant areas of concern in terms of performance against key NHS constitution standards.
9.1.4	MW updated on ambulance performance and explained that Gloucestershire showed strong performance. Category 1 ambulances performance showed a year to date performance of 7.5 minutes against the national target of 7 minutes and a stronger December performance of 6.9 minutes was above the national target. MW stated that the 4 hour A&E performance for the year stood at 90.8%, although it showed deterioration in performance in December.
9.1.5	PM posed a question as to how recruitment was progressing in ambulance services. MAE responded that there was now an intake of paramedic students at Gloucestershire University. SWAST was also currently procuring new vehicles and recruiting new crews. MW added that Gloucestershire performance was better than that of other SWAST areas and he emphasised the need for continued monitoring of SWAST performance to ensure that improvements were made, as additional funding had been allocated to the service.
9.1.6	KM presented part of the report, which explained cancer and in national urology performance. KM stated that the CCG's November 2-week wait which was at 90% performance was moving closer to the 93% national target. KM added that the CCG cancer 62-day wait performance was 78.8%. It was noted that overall the CCG performance was negatively impacted, by the poor performance in urology, which distorted overall performance. KM pointed out that if urology was excluded, the CCG showed strong performance of

	87.7%.
9.1.7	KM explained that a range of actions had been taken to improve performance including securing funding for increasing imaging capacity/clearing backlog to support pathways in Lower GI, Prostate and Lung.
9.1.8	MW reported that the IAPT performance was on target to achieve the recovery and access targets for the full year. At the end of November, year to date access was 11.36% against a target of 10.97%. Recovery performance was showing tangible improvement, with the 50% target being met in each month. The current performance for patients moving to recovery was (52%) following intervention by an IAPT service.
9.1.9	MW covered Continuing Health Care performance. It was noted that performance was below the 80% target for assessments to be carried out within 28 days. National comparison data was collected quarterly – GCCG performance in Q1 was 35%, Q2 was 34% and Q3 was 28% (assessments completed within 28 days). This showed improved performance to 2017/18. The internal target to meet the 50% regional average had been reset to be achieved by end of Q4; the team was undergoing some restructuring in order to improve efficiency and was optimistic that the 50% target would be met in Q4.
9.2	**Financial Position**
9.2.1	AB presented the financial position of the CCG. AB reported Gloucestershire CCG was forecasting to achieve it's planned in year position of breakeven with a cumulative surplus of £21,465k. The CCG was forecasting material overspends in Continuing Health Care including learning difficulties and elective activity within its main acute trust contract, other acute and AQP providers. The Governing Body noted that there was a prescribing underspent of £3.5m and that all recurrent and non-recurrent reserves had been

	utilised to cover recognised pressures and risks. AB confirmed that the CCG's confirmed allocation at 31st December 2018 was £890.7m. He provided an overview of Inter Authority Transfers that had been actioned in November; these were all non-recurrent in nature.
9.2.2	AB stated that the CCG, with its maximum drawdown of £869.3m, had a block contract with a value of £316,765m with GHFT in year 2018/19 and a contract variation of £391,000 for the changed musculoskeletal phase 1 & 2 pathways had been added to the contract.
9.2.3	AB explained that at GHFT, elective activity was over performing and as a result the CCG agreed with the Trust a £1m extra provision for 2018/19. AB added that elective activity for GHFT required further performance review for 2019/20. AB stated that the CCG, despite facing operational pressures, planned to achieve a cumulative surplus of £21,465m.
9.2.4	AB commented that on a positive note, prescribing figures showed good performance and underspend of £3.5m. However, he highlighted potential cost pressures resulting from the drug price increase trend in the three month period preceding the report.
9.2.5	AB stated that cost pressures in mental health services were affected by the less predictable variables such as volume of patients and costs associated with each patient. It was noted that performance in primary health care showed encouraging forecasts.
9.2.6	With regard to the Better Payments Practice the CCG had performed well with 98% of invoices paid on time in line with national target.
9.2.8	**RESOLUTION: The Governing Body noted the Performance & Finance Report.**

10.	**<u>Quality Report</u>**
10.1	MAE provided an overview of the Quality Report. She explained that the CCG captured and reviewed incidents that had been reported via the Strategic Executive Information System (STEIS) which allowed the CCG to break down the incidents being reported into categories. It was noted that Quality and Governance Committee reviewed the incidents reported and ensured that any follow up that was required with providers was undertaken.
10.1.1	MAE stated that infection control was a high priority area and the CCG had recruited a senior nurse to help support infection control. MAE advised the Governing Body that the CCG was working with providers on the Point of Care Test (PoCT) pilot for care homes, which involved joint working between Gloucestershire Care Services (GCS), the county council, Public Health England and the CCG. The service was based in GCS Rapid Response team and worked closely with the Care Home Support Team (CHST). The service started on 28th December; testing was undertaken and the result provided within one hour giving information on whether the resident had Flu A, Flu B or neither. As at 18th January 32 tests had been undertaken in 8 care homes. There were 5 positive results for Influenza A for residents in the same unit of one care home; the outbreak was contained to this unit. The pilot had been successful to date, in terms of response times, speed of patient isolation, use of antivirals, accuracy of results and had been well-received by Care Homes.
10.1.2	MAE also stated that Point of Care testing for flu in the Emergency Department (ED) had led to there being no outbreaks identified at GHFT, and the majority of patients that had presented with flu like symptoms had been sent home with self-care advice. MAE added that Norovirus rates remained lower this year compared to last year, with currently no ward closures relating to infection control issues.
10.1.3	MAE gave an overview of practice prescribing support activities

	over the past two months. The CCG had added a further 3 pharmacy technicians to the current team in January 2019. Through expansion of this GP practice based pharmacy technician team, the intention was to improve the skill mix in the established GP practice based prescribing support pharmacist teams. The Prescribing Support Dietitian continued to advise the pharmacists/GPs on appropriate, cost-effective prescribing of nutritional products. This included the maintenance of the reduction in sip feed use and would shortly be followed by the launch of the new prescribing pathways for Vitamin B12 and Infant Formula. Following this, work would be undertaken on addressing the prescribing of laxatives, which would be facilitated when the Care Homes Support Team Dietitian (0.5WTE post shared with the Care Home Support Team) joined the team in February. The prescribing team was provided good support to GPs and had helped improve productivity and efficiency in general practice.
10.1.4	MAE commented that there continued to be significant vacancies in the District Nursing Service within Gloucestershire. Those District Nurses with high quality skills were attracted to new clinical posts that were higher pay and supported new schemes such as Complex Care at Home. She pointed out that training District Nurses was expensive but advised that GCS was running a strong programme.
10.1.5	**<u>RESOLUTION</u>: the Governing Body noted the Quality Report.**
11.	**Integrated Care Systems (ICS) Update**
11.1.1	KM delivered the report, which provided an update on Gloucestershire Integrated Care System. The report provided an overview of the current ICS programmes and progress to date. The report covered: • Enabling Active Communities. • Reducing Clinical Variation. • One Place, One Budget. • Clinical Programmes Group.

11.1.2	The report focused on One Place, One Budget and on areas that reduced clinical variation. KM described the development and implementation of the joint care strategy, primary care strategy, joint estates strategy and joint workforce strategy as the drivers for the ICS programme.
11.1.3	KM gave an overview of the 4 key ICS programmes with focused attention on End of Life Care. In particular she pointed out that: • Enabling Active Communities had a further 2,700 referrals to the weight management scheme. • The success of the Musculo-skeletal Service. • 'One Place, One Budget': The ICS was pleased to receive a visit from Chris Ham, Chief Executive of The King's Fund and Don Berwick, former advisor to Barack Obama and founding CEO of the Institute for Healthcare Improvement in October last year. Cheltenham Integrated Locality Partnership pilot had an opportunity to showcase their work during the afternoon. The frailty model for the Forest of Dean was currently being finalised which was based on the Complex Care at Home Model. • Reducing Clinical Variation: Key schemes such as the Prescription Ordering Line were reported as making good progress with improvements to standardising prescription ordering; the use of Advice and Guidance was increasing, nationally the CCG was one of the highest users. It was also reported that there was lots of work around the frailty model.
11.1.4	KM presented the End of Life Clinical programme. She stated that each year in Gloucestershire approximately 5,900 people died from a wide range of causes, and of that number 44.6% of deaths occurred in hospital settings; 25.2% of people died at home; 24.2% died in care homes; and 3.1% in hospices. KM added that the CCG aimed to ensure that the highest quality end of life care service was available to all who needed it through involvement of local people, patients and carers in the development and improvement of end of life care services.

11.1.5	KM reported that the CCG and its partners were working together to improve services for people who required palliative end of life care. KM added that an End of Life Care Strategy has been developed which was an important step in making improvements happen. The CCG and its partners aimed to achieve their goal through timely identification of end of life, education and training and stand-alone projects. *AE left the meeting at this point.*
11.1.6	**<u>RESOLUTION</u>: The Governing Body noted the Integrated Care Systems (ICS) Update**
12.	**Governing Body Assurance Framework**
12.1.1	CGi delivered the report and explained that the Governing Assurance Framework (GBAF), underpinned by Corporate Risk Register and Corporate Directorate Register provided details of high level risk rated 12 (Amber) and above.
12.1.2	CGi added that the Corporate Risk Register was reported to the Quality and Governance Committee with a particular focus on quality risks while the Audit & Risk Committee had taken on the assurance role for risk. The Governing Body was ultimately responsible for managing risk and ensuring that there was a pro-active risk culture within the CCG.
12.1.3	CGi stated that there were risk changes but none of them were significant. CGi added that new risks were recommended for inclusion in the CRR and GBAF. The Quality Directorate requested the inclusion of the Q22. MAE informed members that the risk was originally rated by SWAST as 22 but a careful review by a team from the Quality Directorate revised the risk to 12.
12.1.4	The Transformation Directorate requested the inclusion of risk T20 that delayed implementation of changes to pathways resulting in

	transformation projects that could not deliver the expected outcomes. All recommendations to approve new risk or close current risks were made to the Audit and Risk Committee and thereafter reported to the Governing Body.
12.1.5	**RESOLUTION: The Governing Body discussed and noted the Assurance Framework.**
13.	**Primary Care Commissioning Committee minutes 4 October 2018**
13.1	AE presented, before the Governing Body, the Primary Care Commissioning Committee (PCCC) minutes.
13.2	**RESOLUTION: The Governing Body noted the contents of the PCCC minutes.**
14.	**Quality and Governance Committee minutes 18 October 2018**
14.1	JC presented, before the Governing Body, the Quality and Governance Committee minutes.
14.2	**RESOLUTION The Governing Body noted the contents of the Quality and Governance Committee minutes.**
15.	**Audit & Risk Committee minutes 11 September 2018**
15.1	CG presented, before the Governing Body, the Audit & Risk Committee minutes.
15.2	**RESOLUTION: The Governing Body noted the contents of the Audit & Risk Committee minutes.**
16.	**Any Other Business**
16.1	There was no other business to consider.

	The meeting was closed at 15.35pm
	Date and time of the next meeting: **The next meeting would be held at 2:00pm on Thursday 28 March 2019, in the Board Room, Sanger House.**

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair):_____ Date:_____

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 4

Governing Body
Matters Arising –March 2019

Item	Description	Response	Action with	Due Date	Status
26/07/18 Item 4.1	24/05/201, Item 11.15, Performance Report – IAPT appointments – KF reported that performance data was being. AS requested that the data be brought to the next meeting	Follow up with Karen Robert.	KF	March 2019	Open
26/07/18 16.3	A request was made to place ACEs on the GSF meeting	After the conference in November it would be a better time – in 2019.	SS	March 2019	Open
26/07/18 Item 12.1	EB highlighted that a public facing Operating Plan document would be created that would be easier to digest and published on the website. This would be brought to a future meeting	That work is in hand and the communications team is working on graphics	EB	March 2019	Open

26/07/18 Item 15.1	SS described a new Children and Families Partnership Framework that will go out to consultation she will bring to a future development session	For March	SS/CGi	March 2019	Open
04/10/18 Item 5.10	JH stated that alongside Public Health, a Frailty Needs Analysis for the County was being designed and developed and was in the first draft. JH agreed to circulate to Governing Body members once this was agreed.	Frailty needs assessment to be agreed by CPG on 6th December and will then be circulated to Governing Body.	JH	May 2019	Open

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 7

Governing Body meeting

Meeting date	**28 March 2019**
Title	**Clinical Chair's Report**
Executive Summary	This report provides a summary of key issues and updates arising during January and February 2019 for the Clinical Chair.
Key Issues	Key topics for this report: • Primary Care Strategy progress including the NHS Long Term Plan and new Primary Care Network contract • Improved Access • Workforce • Care Quality Commission Inspections • Chair's action taken – Scheme of Delegation – waiver limits. • Meetings February – March 2019
Conflicts of Interest	None.
Risk Issues: Original Risk	None.
Financial Impact	None.
Legal Issues (including NHS Constitution)	None.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	
Impact on Sustainable Development	None.
Patient and Public Involvement	None.
Recommendation	This report is presented for information and Governing Body members are requested to note the contents.
Author	Andy Seymour
Designation	Clinical Chair

Agenda Item 7

Governing Body

28 March 2019

Clinical Chair's Report

1. Primary Care Strategy progress

1.1 The NHS Long Term Plan sets out the ambition for every practice to be part of a local Primary Care Network (PCN) which is a central foundation for the Integrated Care System (ICS). PCNs will be commissioned through a new Network Contract as a Direct Enhanced Service (DES) and include national Network Service Specifications that deliver the Long Term Plan through PCNs. The CCG must ensure 100% geographical coverage of PCNs by 31 May, ready for contract 'go live' by 1 July 2019. In Gloucestershire we have already made considerable progress, with practices working in sixteen cluster groups over the last two years. Working with our practices and clusters we anticipate a slight reduction in the number of Primary Care Networks.

1.2 In this period, the new GP contract framework was released (31 January) by NHS England and the British Medical Association (BMA). The Primary Care and Localities Directorate is working through all the implications of this, for practices, the CCG and the ICS. The team is developing project planning and scheduling to ensure all deliverables are captured and planned accordingly over the coming weeks and months.

1.3 Headlines include:

- CCGs must commission extended hours for 100% of the population (in addition to Improved Access).
- The following services will start by April 2020:
    - Structured Medications Review and Optimisation (increasing in scope and scale each year).
    - Enhanced Health in Care Homes.
    - Anticipatory Care requirements for high need patients typically experiencing several long-term conditions.
    - Personalised Care.

- Supporting Early Cancer Diagnosis.

1.2 Through a new Additional Roles Reimbursement Scheme, PCNs can receive (subject to delivery of new service specifications above) funding for up to an estimated 20,000+ additional staff by 2023/24:

- Clinical pharmacists (from 2019/20).
- Social prescribing link workers (from 2019/20).
- First contact physiotherapist (from 2020/21).
- Physician associates (from 2020/21).
- First contact community paramedics (from 2021/22).

1.3 Each Network will have a named accountable Clinical Director and from April 2020, every PCN will be able to see the benefits it is achieving for its population and patients through a new national Network Dashboard. As our geography is so large in Gloucestershire we envisage our Primary Care Networks coming together with partner organisations on a geographical basis to form place based Integrated Locality Partnerships (ILPs). We have piloted this way of working in Stroud and Berkeley Vale, Forest of Dean and Cheltenham over the last year. Building on our learning to date we would envisage county wide coverage of ILPs from early in the new financial year. ILPs will operate at a strategic level and operational level focussed on those areas of care, which require a solution that has a broader remit than solely health and social care.

1.4 In this reporting period the Care Navigation project team, including clinical lead Dr Olesya Atkinson attended presentations by providers and selected Conexus as the preferred supplier for the trial in North Cotswolds and Cheltenham Central PCNs. They will develop a training package for reception staff to navigate patients to the right service at the right time. Planning for implementation is now underway.

2. Improved Access

2.1 Between the start of April 2018 and the end of January 2019, 83,727 Improved Access appointments were available in Gloucestershire. Greatest availability was in January this year when 9,945 appointments were offered with a utilization rate of 85%.

2.2 Many Primary Care Networks deliver improved access through skill mix including paramedics, advanced physiotherapists and nurses and including Saturday morning nurse and phlebotomy clinics. The work our networks have already done on Improved Access gives them a secure basis from which to build their PCN workforce for the future.

3. Workforce

3.1 In my last report I updated on Our Health Inequalities Fellowship and our Newly Qualified GP Schemes. This time I am pleased to report that planning for the Next Generation GP Scheme is taking place. The line-up of speakers includes national high-profile GP speakers and local GPs who have been involved in inspirational projects. Promotions in What's New This Week, through the GP training school and GDoc, have resulted in over 40 initial expressions of interest from GPs in training, for this national scheme which encourages leadership for GPs in their early careers. This scheme has been developed at a national level and is being implemented in regional areas including London, Manchester and Bristol.

3.2 In addition, to date, one GP has been accepted onto the International GP Recruitment scheme. This individual will work at Partners In Health in Gloucester City.

3.3 One way to keep GPs informed about all of the opportunities in Gloucestershire is via a Primary Care Workforce Centre website, which is being developed by the Primary Care Training Hub (formally CEPN) and is predicted to go live during March 2019. The website will be a one stop resource, career information site, with case studies about new roles. Additionally it will have an interactive county wide training calendar, and locum advertising function for practices in the form of a calendar. It is based on a model used by Dorset CCG and will connect into existing ICS platforms such as Proud to Care Gloucestershire and the developing Proud to Learn Gloucestershire.

4. Care Quality Commission (CQC) Inspections

One CQC report has been published since my last update. In total 70 Gloucestershire Practices are rated "good", 4 are rated "outstanding" and one "requires improvement".

5. Chair's Action – Scheme of Delegation – waiver limits

5.1 Following on from the Audit and Risk Committee held in December 2018 a decision was taken by the committee to support the changes made to the Scheme of Delegation and in particular the waiver limits. Unfortunately, due to time constraints this item was not included in the January Governing Body meeting papers. As the finance and procurement teams were keen to progress with the new waiver limits, I was asked to consider taking Chair's action.

5.2 I would like to inform the Governing Body that I took Chair's action in relation to the Scheme of Delegation. The Governing Body is asked to note that the main area of change relates to an amendment of procurement limits. The current procurement limits (see table below) had been in operation since the inception of the CCG and were no longer deemed appropriate. A review of surrounding CCG's had shown that GCCG was currently operating lower procurement limits than the majority of other CCGs and the proposed changes would bring the CCG in line, with others. The proposed new limits were therefore approved (see t*able below*).

Table current and proposed procurement limits

The main changes on page 6/7 of Appendix 1 **Procurement Requirement**	**Current Limit**	**Proposed Limit**
No requirement to invite quotes for single items	Up to £1,000	Up to £5,000
2 written quotes	£1,000 to £5,000	£5,001 to £10,000
Invite a minimum of 3 written quotes	£5,000 to £50,000	£10,001 to £50,000

Invite a minimum of 3 written competitive tenders for goods/services	From £50,000	From £50,001

6. Meetings

Meetings attended and will attend since the last report made to the Governing Body on 31 January 2019.

6.1

- Monday 4 Feb Practice Visit Cirencester Health Group.
- Wednesday 6 Feb Interim ICS Independent Chair interviews.
- Thursday 14 Feb Gloucester City GP meeting.
- Monday 18 Feb A&E Delivery Board meeting.
- Thursday 21 Feb NHSE Roundtable Event, London.
- Monday 25 Feb Practice Visit Hucclecote Surgery.
- Tuesday 26 Feb Gloucestershire ICS Board.
- Thursday 28 Feb Leadership Gloucestershire.
- Thursday 28 Feb LMC Negotiators.
- Friday 1 March South West Health and Wellbeing Board Network, Taunton.
- Monday 4 March Practice visit Seven Posts Surgery.
- Tuesday 5 March Health and Care Scrutiny Committee, Shire Hall.
- Wednesday 6 March STP and ICS Leaders meeting, London.
- Monday 11 March Meeting with Roger Wilson, Shire Hall.
- Tuesday 11 March New Generation GP Scheme Gloucestershire.

6. Recommendation

The Governing Body is asked to note the contents of this report.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 8

Governing Body

Governing Body Meeting Date	**Thursday 28 March 2018**
Title	**Accountable Officer's Report**
Executive Summary	This report provides an update on some of the key programmes and initiatives within the CCG during February and March 2019. To note for this report items about quality issues appear in a dedicated report included in each Governing Body meeting and will no longer feature in the AO's report.
Key Issues	Key topics for this report: 1. **Dementia Services** 2. **New Carers system** 3. **Complex Care at Home** 4. **Cinapsis** 5. ***Stop! Think …* campaign A&E** 6. **National Diabetes Prevention Programme** 7. **Facts4Life** 8. **Long Term Plan** 9. **Appointment of a new interim Chair for the Integrated Care System (ICS)** **Meetings attended in February and March.**
Conflicts of Interest	None.
Risk Issues: Original 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	None.
Recommendation	This report is presented for information and Governing Body members are requested to note the contents.
Author	Mary Hutton
Designation	Accountable Officer

Accountable Officer's Report

28 March 2019

The following report provides an update on some of the key areas of the CCG's work during the last two months, since the last report on 31 January 2019,

1. **Dementia Services**

1.1 There have been some positive improvements in the way that local health and care services are shaping dementia services.

1.2 **Dementia Diagnosis Rate (DDR)**
We are pleased to report that the Dementia Diagnosis rate for Gloucestershire patients continues to be maintained at 67.4% (above the national target set by NHS England).

1.3 **Dementia Advisors**
During 2017/18 the CCG worked closely with the Alzheimer's Society's Dementia Advisor (DA) service to increase the support provided to families following diagnosis of dementia of a loved one. The Dementia Advisors have been working closely with the 2gNHSFT Memory Assessment Service (MAS) to ensure that patients who are diagnosed with dementia are referred to the Advisor at the point of diagnosis. So that key information and advice can be given to the patient and their family as quickly as possible.

1.4 The Dementia Advisory (DA) service focuses on addressing the public health priorities of reducing the dementia risk as well as providing support to people in their community. During 2018 the DA service significantly increased their caseload to 1,600 patients. They are now supporting approximately 27% of those diagnosed with dementia. There is work underway to establish Dementia Friendly Communities with health and social care partners along with the District Councils. A Dementia Strategy is currently being developed and will include 3 years funding for a county Dementia Action Alliance (CAA). This will help to support District Councils to set up networks and local Dementia Action Alliances. The county Dementia Action Alliance will be chaired by Cllr Williams and is supported by the Police, Fire & Rescue, District Councils and the Alzheimer's Society.

1.5 The clinical dementia pathway is also being reviewed to understand how services can improve the support given to families living with dementia, and provide better joined up care. This will build on the pilots currently running in Stroud and Berkeley Vale, where the Community Dementia Nurse (CDN) is responsible for the practice Dementia Quality and Outcomes Framework register, where dementia diagnoses are recorded. The CDN is working closely with primary care, Integrated Care Teams, the Care Home Support Team and the Alzheimer's Society. The practices are using a risk stratification process that matches the level of the patient's need/complexity to the appropriate service.

2. PeoplePlus to provide services to unpaid carers from 1 April

2.1 The provider for services to unpaid carers in Gloucestershire will change from Carers Gloucestershire to PeoplePlus on 1 April 2019. Providers are working together with Gloucestershire County Council and the CCG to have robust plans to ensure the transition of services are as smooth as possible for carers. Further information about the services PeoplePlus provide will be given in the May report 2019

3. Complex Care at Home

3.1 The Complex Care at Home Service has been running in Cheltenham and Gloucester since April 2018 is now being rolled out to the Forest of Dean Primary Care Network area. Work is underway to recruit a new team and plans are in place to work with GPs to deliver the service from April 2019. The new team will be meeting with local community support providers in April, to ensure there is a joined up approach with existing charities and other third sector organisations. This will provide better joined up care that supports people with complex health and wellbeing needs in the area.

4. Cinapsis – a new App for urgent and planned care referrals

4.1 The urgent care system in Gloucestershire is being redesigned and improved to provide services that provide patients with the best care in the most appropriate setting for their particular condition. As a part of this, Gloucestershire Hospitals NHS Foundation Trust (GHNFT) is

keen that clinicians who refer patients for tests and treatment speak directly to the relevant receiving clinicians, at Gloucester Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

4.2 A technological solution is available to assist referring and receiving clinicians and is being supported by the CCG. We are offering Cinapsis to GPs and nurse referrers. This is a new software platform for mobile and fixed devices, which can be developed to support both urgent and planned care referrals. The new interface has been developed together with local GPs in order to make it as quick and easy as possible for referring clinicians to discuss their referrals by giving them direct access to the right person from their mobile phones. It is initially being developed and rolled out for acute medical referrals and will later be extended to cover other urgent care specialities. We also plan to pilot the software for use in planned dermatology referrals. GPs from a number of practices have successfully been using Cinapsis for acute medical referrals, including Mythe, Brunston & Lydbrook, Mann Cottage, Price's Mill, Churchdown and The Aspen Centre.

4.3 Early feedback has highlighted a number of benefits for clinicians and patients including:

- It is quick and very easy to use.
- The average consultant call response time is 21 seconds.
- It helps consultants to control the flow of patients to CGH or GRH depending on demand, with the ability to stagger referrals so that patients can attend with an appointment time and spend less time in the department.
- By using this technology, most patients can appropriately bypass the Emergency Department and some patients can avoid unnecessary hospital admission.
- Patients are being better directed to the most appropriate healthcare setting within CGH or GRH, with fewer unnecessary overnight stays in hospital.

Cinapsis is being rolled out to all practices through pre-arranged demonstrations accompanied by video tutorials. Work on modules covering general surgery, orthopaedics, ophthalmology, dermatology and old age medicine/frailty is ongoing and will be phased in during the year.

5. *Stop! Think …* campaign
Keep Accident and Emergency clear for real emergencies

5.1 A new county-wide campaign was launched in December last year, which highlighted the need to keep Gloucestershire's two Accident and Emergency Departments clear for real emergencies.

5.2 The campaign highlights the different healthcare options available across Gloucestershire so people can access the right care and ease the pressure on A&E. If unwell, people are advised to *Stop! Think…* before they head to A&E and consider the following alternatives:

- Visiting their pharmacy for minor ailments and health advice.
- Calling their GP surgery if it is an illness that will not go away or the person is in need of urgent medical need.
- Phoning NHS 111 when their GP surgery is closed.
- Trying the ASAP Glos NHS App or asapglos.nhs.uk website which guide users through healthcare options.

5.3 Last year, there were more than 29,000 visits to A&E in Gloucestershire for ailments, which could have been safely treated elsewhere. The campaign has been running for a number of months and is receiving positive feedback from patients and staff.

6. National Diabetes Prevention Programme

6.1 Nearly 3,000 people have joined the National Diabetes Prevention Programme (NDPP). The NDPP was introduced in Gloucester City and Cheltenham last year, and is now being rolled out across the county, beginning with the Forest of Dean, Stroud and Berkeley Vale. The programme, Healthier You, is funded by NHS England, and targets individuals who have been identified by their GP surgery as having pre-diabetes (high blood sugar levels).

6.2 Patients are being routinely tested for pre-diabetes, and as a result, nearly 3,000 people have joined the programme to reduce their risk of developing type 2 diabetes, with associated complications such as heart disease and stroke. The programme comprises interactive group sessions where patients are given information about nutrition, exercise and suggested behavioural changes, and discuss ways to change their lifestyle habits. This helps participants to achieve and maintain a healthy weight and become more physically active,

thereby reducing their risk of developing heart disease and / or stroke.

7. Facts4Life reaching more schools and teachers

7.1 The University of the West of England has evaluated the Facts4Life programme in Gloucestershire schools and has found that the county's young people are becoming more responsible for looking after their own health.

7.2 The programme helps children and young people to understand why doing certain activities will lead to better health and good health and wellbeing. It is very much linked to their environment and the choices they make.

7.3 So far, Facts4Life has worked with more than 160 schools and trained more than 1,000 teachers in the county.

7.4 The study involved more than 400 primary and secondary aged school children over a three year period. It identified a significant improvement in resilience after six months among pupils in years 5 and 6. Younger pupils in years 3 and 4 reported improvements, a decreased need for medication when feeling unwell, new strategies for promoting mental health, and the usefulness of learning about illness. Teachers indicated a change in philosophy around the teaching of health and illness, with high levels of engagement that has impacted on the way children behave.

7.5 Facts4Life is funded by the CCG. The evaluation was funded by Gloucestershire County Council. The evaluation makes for interesting reading and can be obtained by following the link below along with an Executive Summary that highlights the key aspects.

- Full Evaluation Report – http://eprints.uwe.ac.uk/36934/
- Executive Summary - http://eprints.uwe.ac.uk/36935/

8. Big conversation gets underway on the local NHS Long Term Plan

8.1 We are urging staff, community partners and the public to get involved in the big conversation about the future of health and healthcare in Gloucestershire

8.2 The national NHS Long Term (10 year) Plan was published in

January with ambitions to make sure everyone gets the best start in life, to deliver world class care for major health problems and support people to age well.

8.3 Working closely with Healthwatch Gloucestershire, we are now seeking views to help shape the local version of the plan, which will be published later in the year. Building on our journey to date, the conversations will cover everything from helping people and communities to stay healthy and active, to developing support and services in people's homes, local GP surgeries, the community and specialist services in hospital. The conversations provide an opportunity for people to share their thoughts on how people get advice, support and services in their home, neighbourhood, community and county or discuss health priorities from their perspective at every stage of life. For example if they are pregnant, are living with a long term health condition, have experienced mental health issues or are trying to keep healthy in older age.

8.4 They can also share their views on how new technology, medical advances and working better together can transform the NHS for the better in the years to come.

A booklet, on-line survey and supporting information, including a live events listing can be found at: www.onegloucestershire.net. Local people can also follow @One_Glos on Twitter for regular updates.

The information booklet, 'Developing our local NHS Long Term Plan' – what matters to you?' will also be available shortly in pharmacies, GP surgeries, hospitals, at events and on the NHS Information Bus and Healthwatch Gloucestershire 'campervan'.

The closing date for feedback is ***19 May 2019.***

9. Nick Relph appointed as interim Integrated Care System (ICS) Chair

9.1 Nick Relph has been appointed as interim Chair of the 'One Gloucestershire' ICS following the retirement of Chris Creswick at the end of January 2019.

9.2 Nick is currently a Non-Executive Director of Gloucestershire Care

Services NHS Trust (GCSNT) and has extensive experience of healthcare having held a number of senior NHS roles covering community, mental health and acute services, including Director of Finance at a health authority, Chief Executive positions in three Primary Care Trusts in North London and Managing Director of the South East Commissioning Support Unit.

9.3 Nick took up his appointment at the beginning of February. A national recruitment process will now get underway to appoint to the role substantively. Further updates will be provided in this report over the next few months.

9.4 ICS partners have thanked Chris Creswick for his foresight, wisdom, experience and challenge that have helped to put the county in such a strong position.

10. Meetings

10.1 A list of meetings I have attended since 31 January 2019 are given below:

04 Feb	Practice Visit – Cirencester Health Group
05 Feb	Joint Out-patient Board
05 Feb	NHS Reference Group
06 Feb	Joint Commissioning Partnership Board (JCPB)
07 Feb	ICS Leads Day, London
12 Feb	Enabling Active Communities (EAC) Meeting
12 Feb	Practice Visit – Upper Thames Medical Group, Cirencester
12 Feb	Health & Wellbeing Board Strategy Steering Group
13 Feb	South West CEO Forum, Taunton
14 Feb	Governing Body Away Day
19 Feb	Practice Visit – Berkeley Place Surgery, Cheltenham

20 Feb	HCOSC Meeting
21 Feb	ICS Delivery Board
26 Feb	Gloucestershire Strategic Forum (GSF)
27 Feb	Local Workforce Action Board (LWAB
28 Feb	Leadership Gloucestershire
28 Feb	Meeting with MPs
28 Feb	Governing Body Business Session
04 Mar	Practice Visit – Seven Posts Surgery, Cheltenham
05 Mar	Health & Wellbeing Board Strategy Steering Group
05 Mar	Health & Care Scrutiny Committee (HOCSC)
06 Mar	Joint Outpatients Board
07 Mar	New Models of Care Board (NMOC)
07 Mar	Governing Body Business Session
18 Mar	Gloucestershire STP Operational Planning Review Meeting, Chippenham
19 Mar	Health & Wellbeing Board (HWB)
21 Mar	ICS CEO's meeting
21 Mar	Joint Commissioning Partnership Board (JCPB)
21 Mar	Priorities Committee
22 Mar	South West RTB Board
26 Mar	ICS Board
27 Mar	Interview with Peer Challenge Team, Stroud
28 Mar	Governing Body meeting.

11. Recommendation

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

NHS
Gloucestershire
Clinical Commissioning Group

CCG Monthly Performance Report

March 2019

Contents

This document is a highlight report which is presented to give the CCG Governing Body an overview of current CCG and provider performance across a range of national priorities and local standards.

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.

1.0 Scorecard: CCG Performance Overview

2.1 Executive Summary – Leadership

Green

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.

2.1.1	**Staff engagement :** Robust culture and Leadership Sustainability (OD Plan)
2.1.2	**Probity and Corporate Governance:** Full governance compliance
2.1.3	**Effectiveness of working relationships in the local system:** Effectiveness of working relationships in the local system
2.1.4	**Quality of CCG leadership:** Review of the effectiveness of culture, leadership sustainability and an oversight of quality assurance.

2.2 Executive Summary – Better Care

Amber

This domain focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas.		Overall Rating
2.2.1	Planned Care	
2.2.2	Unscheduled Care	
2.2.23	Cancer	
2.2.4	Mental Health	
2.2.4	Learning disability	
2.2.5	Maternity	

2.3 Executive Summary - Sustainability

Green

This domain 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		Rating
2.3.1	Year to date surplus variance to plan (%)	
2.3.2	Forecast surplus to plan (%variance)	
2.3.3	Forecast running costs in comparison to running cost allocation (%)	
2.3.4	Forecast savings delivery in comparison to plan (%)	
2.3.5	Year to date BPPC performance in comparison to 95% target (%)	
2.3.6	Cash drawdown in line with planned profile (%)	
2.3.7	Forecast capital spend in comparison to plan (%)	

2.4 Executive Summary – Better Health *(1 of 2)*

Green

These indicators show the latest known position from available data

This section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve.		Current CCG Performance				
		Period	National	Glos CCG	What is good?	Trend
2.4.1	**Smoking:** Maternal smoking at delivery: The percentage of women who were smokers at the time of delivery, out of the number of maternities	Q3 18/19 *new*	10.5%	12.1%	Low %	*Up from last quarter (-)*
2.4.2	**Child Obesity:** Number of children in Year 6 (aged 10-11 years) classified as overweight or obese in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England as a proportion of all children measured.	2017/ 2018	34.3%	32.1%	Low %	*Up from last year (-)*
2.4.3	**Diabetes:** Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children: The percentage of diabetes patients that have achieved all 3 of the NICE-recommended treatment targets – *New indicators being measured for 2017/18*	2016/ 2017	39.7%	36.4%	High %	*No change*
2.4.4	**Falls:** Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population *Indicator awaiting review – not updated*	Q3 17/18	2114	1,776	Low rate	*No change*
2.4.5	**Personalisation and choice**: Indicators relating to utilisation of NHS e-referral service to enable choice at first routine elective referral.	Dec 2018 *new*	80%	66%	High %	*Up from last month (+)*

2.4 Executive Summary – Better Health *(2 of 2)*

Green

These indicators show the latest known position from available data

This section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve.		Current CCG Performance				
		Period	National	Glos CCG	What is Good?	Local Trend
2.4.6	**Personal health budgets** Per 100k population	Q1 18/19	48	57.8	High rate	*Lower than Q4 (-)expected due to methodology*
2.4.7	**Percentage of deaths which take place in hospital**	2017/ 2018	45.9%	39.6%	Low %	*Lower than 2016/17 (+)*
2.4.8	**People with a long-term condition feeling supported to manage their condition(s).**	2017/ 2018	59.6%	64.1%	High %	*Lower than 2016/17 (-)*
2.4.9	**Health inequalities**: Inequality in avoidable emergency admissions for chronic ambulatory care sensitive conditions – *indicator not updated*	Q3 17/18	1992.07	1889.33	Low rate	*Indicator not updated* – to be retired
2.4.10	**Appropriate prescribing:** Prescribing of broad spectrum antibiotics in primary care (co-amoxiclav, cephalosporins, and quinolones as a percentage of total antibiotics prescribed)	12 months to July 2018	8.7%	9.3%	<10%	*No change*
2.4.11	**Carers:** Quality of life of carers *Indicator methodology has been updated for 2018*	2018	tbc	63.5%	High %	*No data*

3.0 Performance Dashboard

Amber

Unscheduled Care

4 Hour A&E Feb (System)	4 Hour A&E Feb (GHFT)	Category 1 Ambulance January 19 (Gloucestershire)	Category 1 Ambulance YEAR TO DATE (Gloucestershire)	Delayed Transfers of Care (DToC) January 19 (GHFT)
↑ 90.2%	↑ 86.0%	↑ 7.2 mins	● 7.5 mins	↓ 2.99%

Planned Care

RTT Incomplete <18 weeks	Diagnostics >6 weeks January 18 (Gloucestershire patients) (GHFT)		Diagnostics >6 weeks (YEAR TO DATE) (Gloucestershire patients) (GHFT).	
Reporting due to recommence Q1 2019/20	↑ 1.0% (all)	↑ 0.6% (GHFT)	● 1.2% (all)	● 0.6% (GHFT)

Cancer Dashboard (January 2019)

	2 Week Waits	2 Week Waits Breast	31 Day Waits	31 Day Waits Surgery	31 Day Waits Drugs	31 Day Waits Radiotherapy	62 Day GP Referral	62 Day Screening	62 Day Upgrade
Performance (all Gloucestershire patients)	↓ 91.8%	↓ 94.9%	↓ 91.7%	↑ 90.6%	● 100%	● 100%	↑ 75.6%	↓ 95.7%	↓ 72.7%
GHFT Performance	↓ 92.0%	↓ 95.5%	↓ 91.8%	↑ 94.8%	● 100%	● 100%	↑ 76.1%	↓ 93.9%	↑ 69.2%

IAPT (YEAR TO DATE) January 2019

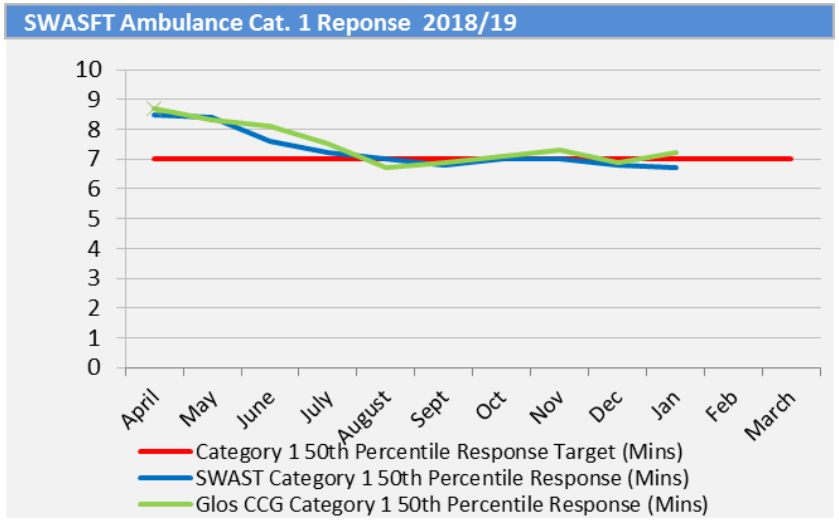
Access (target 13.81%)	Recovery (target 50%)
● 14.02%	● 51%

Dementia Diagnosis February 2019

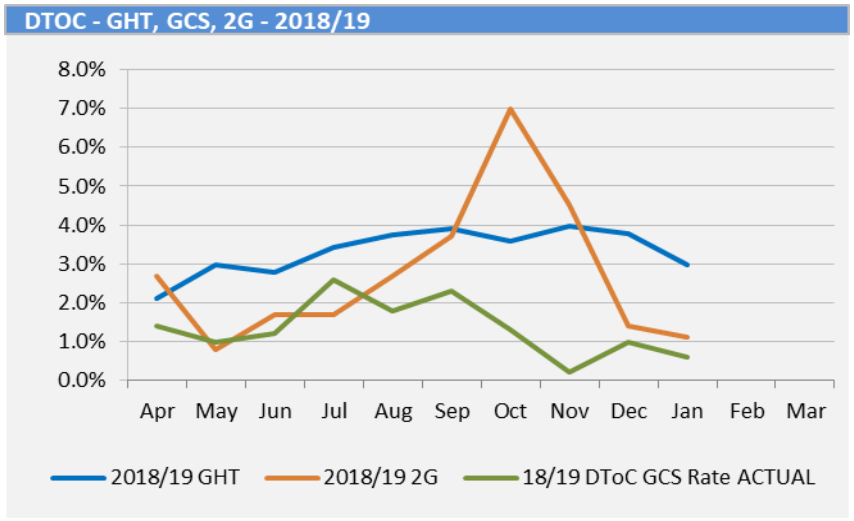
Estimated Diagnosis Rate (Target 66.7%)
● 67.4%

3.1 System Overview Unscheduled Care

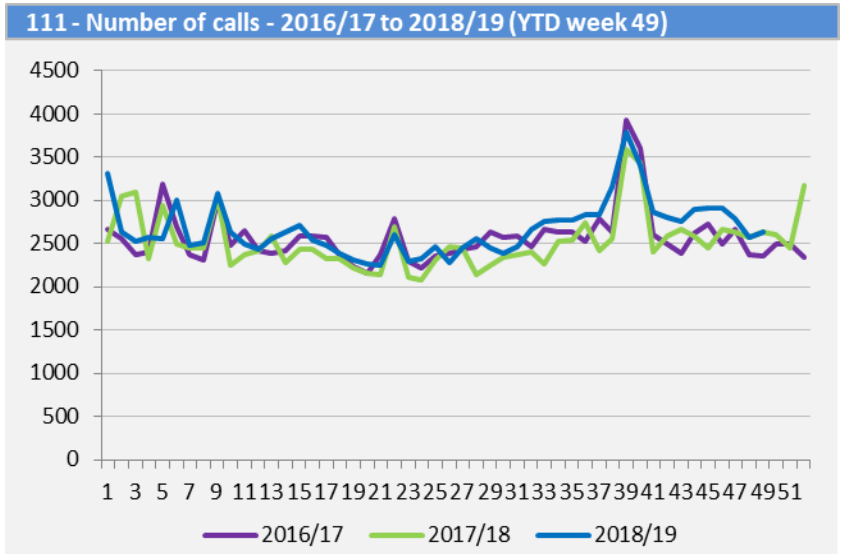
Ambulance – Category 1



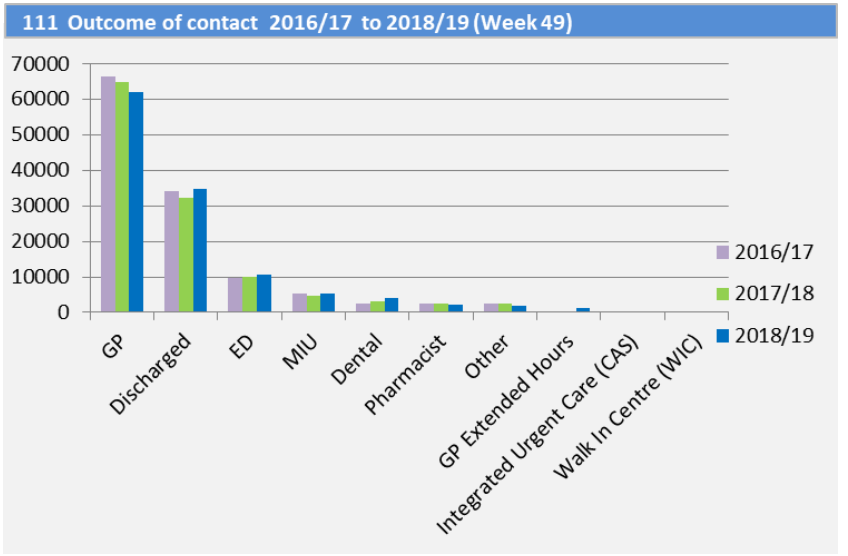
Delayed Transfers of Care



111 Call Volume

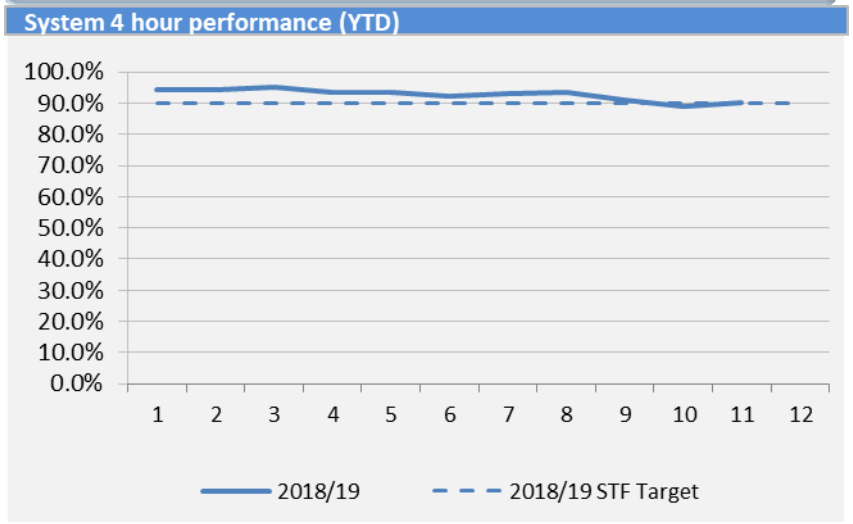


111 Disposition

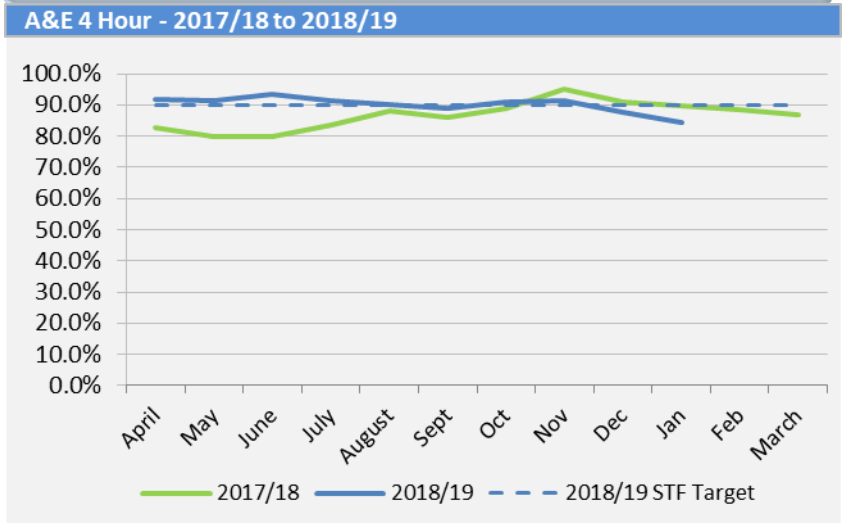


3.1 System Overview Unscheduled Care

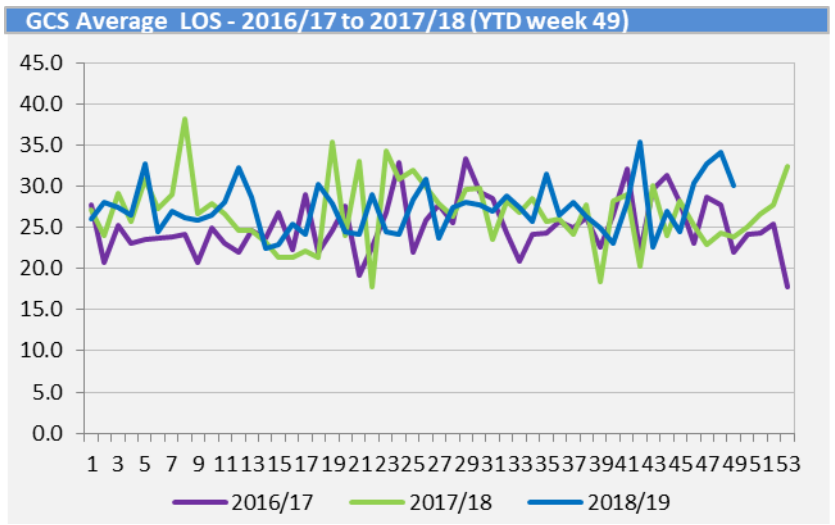
System A&E 4 hr Performance



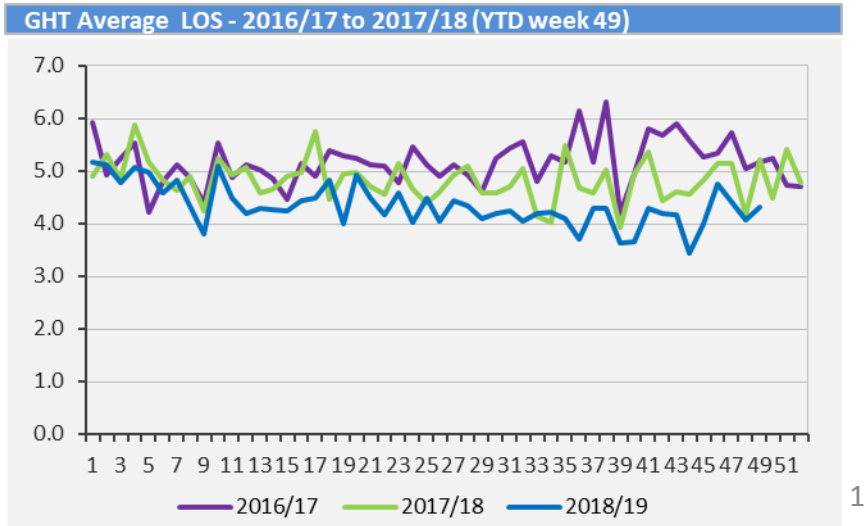
GHFT A&E 4 Hour Performance



GCS average Length of Stay

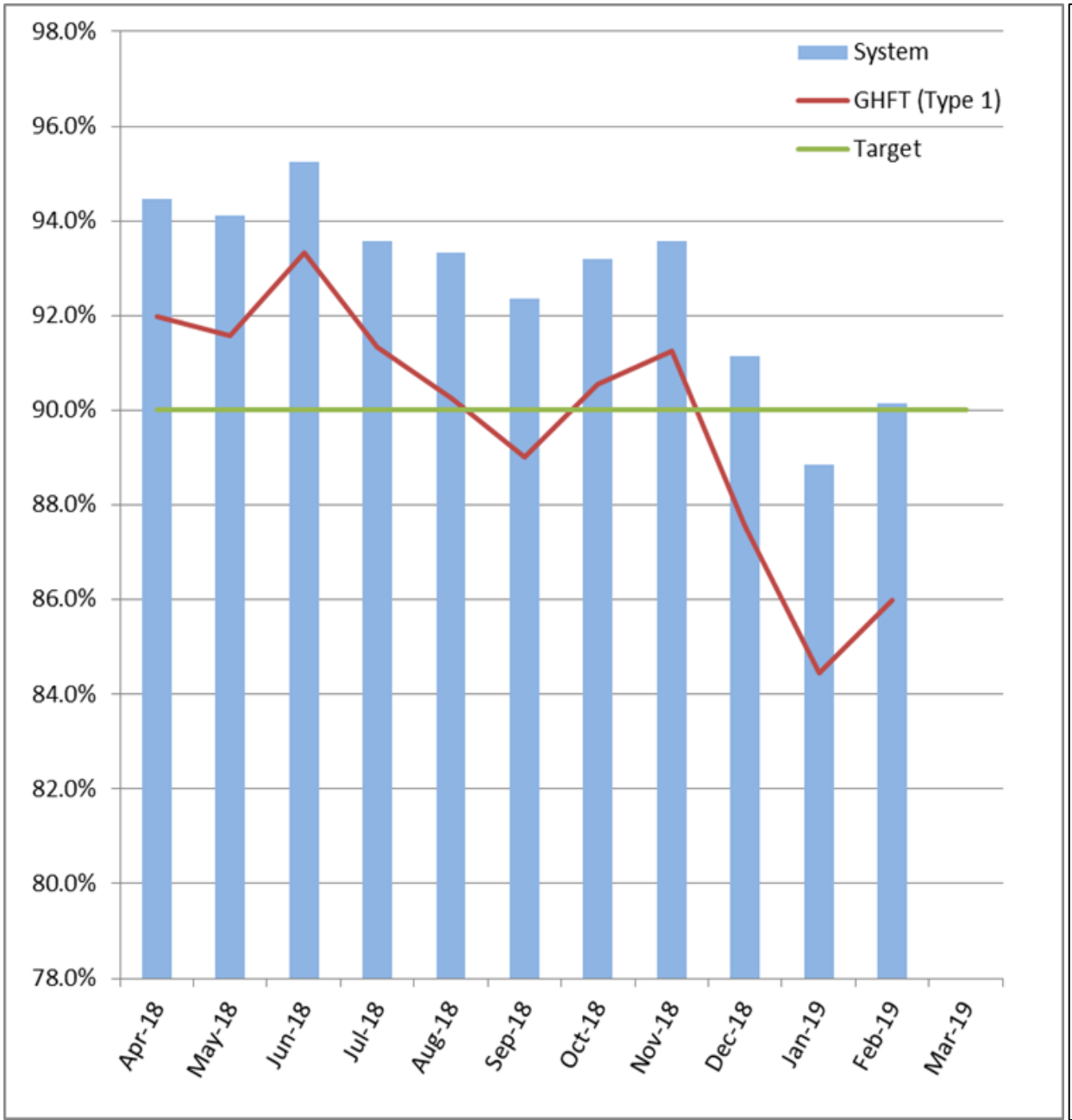


GHFT average Length of Stay



3.1 Unscheduled Care – 4 hour A&E

Amber



Top Line Messages:

System performance against the 4 hour target in February was 90.2%. This reflects performance of 86% at GHFT (GRH and CGH) and 99% at GCS (MIIUs).

The YTD average against the 4 hour target at GHFT has dropped below the STF target of 90% at 89.8% (as of 28th February 2019). February has been a challenging month, with below average performance against the 4 hour target reported nationally. Type 1 England average performance was 75.1%. GHFT performance was 26th out of 134 Type 1 departments.

Key schemes supporting Unscheduled Care:

- Acute Floor Model (AMIA).
- Frailty Assessment Service.
- Provision of advice and guidance via Cinapsis.
- Refinement to Primary Care Streaming model.
- IAT (Integrated Assessment Team)
- 1 hour Trop-T provision
- Complex Care at Home
- South Cotswold Frailty Service
- Mental Health Regular Attender service

3.1 Unscheduled Care – 4 hour A&E Key Updates

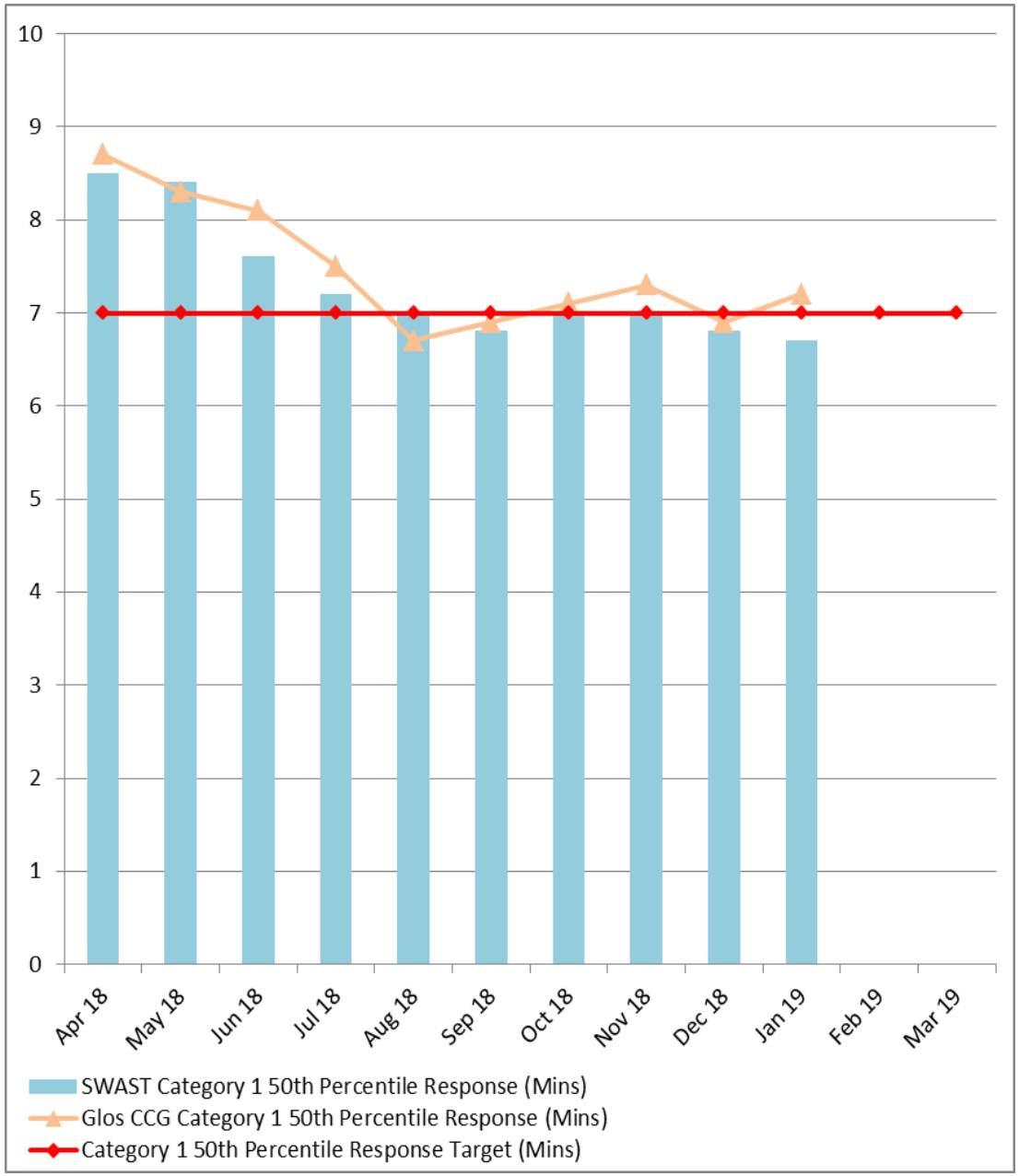
Amber

Actions and key updates:

- Clinical review of 50 cases has now been completed to assist with development of criteria for admission/assessment – this took place on 21st February. Discussions are continuing between GHFT and GCCG over the criteria for assessment/admission and this work will help to shape how future pathways will integrate with AMIA.
- NHS 111 are looking at pathway improvement for patients with mental health problems. They are trialling how access to a mental health worker earlier in the pathway will work – early results show up to 90% downgrade of ED attendance with mental health problems.
- NHS 111 call answering within 60 seconds (KPI) has seen persistent poor performance in recent weeks – this has been raised with the provider formally and a plan has been submitted for recovery. Despite this, call abandonment rate remains low (below the 5% threshold).
- Cinapsis (hot advice) is now operational in 6 practices, with a 21 second average response time from consultants. While most patients are being referred into hospital, the service is helping to stagger referrals in to ED, and the majority avoid same day ED attendance - going on to see the right clinician in the right place at the first opportunity. Further demos to GP practices have been booked and the roll out is continuing steadily.
- Test and Learn programme for urgent care – this comprises small scale tests for concepts of the One Place business case (portfolio of around 20). One of these will be GP in SPCA to take 111 calls, and support paramedics with HCP advice if access to patient's own GP is problematic. Another focuses on the concept of Urgent Treatment Centres – advocating and enabling improved administrative working across community services, MIIUS and OOH (direct 111 booking/ single reception point at facility/ mobilisation of care during OOH).
- Continued monitoring of flu and D&V: Flu A numbers are now starting to decline. All 3 main providers have declared upwards of 75% vaccination rates among their staff. Other community infections remain low.
- Focus on system flow: with focussed work around domiciliary care and care home availability, and provision of a medically fit ward at CGH (in addition to Gallery Ward at GRH). Additional bed capacity has been provided in community hospital and residential settings to support demand, in particular to support complex patient discharge. ECIST have assisted with reviews across the acute and community to ensure optimal use of pathways and resources.

3.2 Unscheduled Care – Category 1 Ambulance

Amber



Top Line Messages:

Gloucestershire performance in Category 1 for January was 7.2 minutes against the target of a 7 minute average response time.

The year to date position for Gloucestershire is 7.5 minutes. Performance has been relatively consistent around the 7 minute target since August 2018.

SWAST Performance across all geographical areas (South West) was 6.7 minutes in January, achieving the national target (YTD performance across South West is 7.4 minutes).

NHS Gloucestershire Clinical Commissioning Group

3.2 Unscheduled Care – Category 1 Ambulance

Green

Ambulance Response Programme

Updates to actions:

- iBCF funding is being used for additional capacity in Rapid Response (RR) to train care homes in direct referral to RR. This will reduce the use of ambulance services and conveyance level to the acute trust. High users of SWAST services have been identified and these homes are being targeted for training. Training is continuing through the winter and the effectiveness of the scheme will be monitored against both use of SWAST and RR.

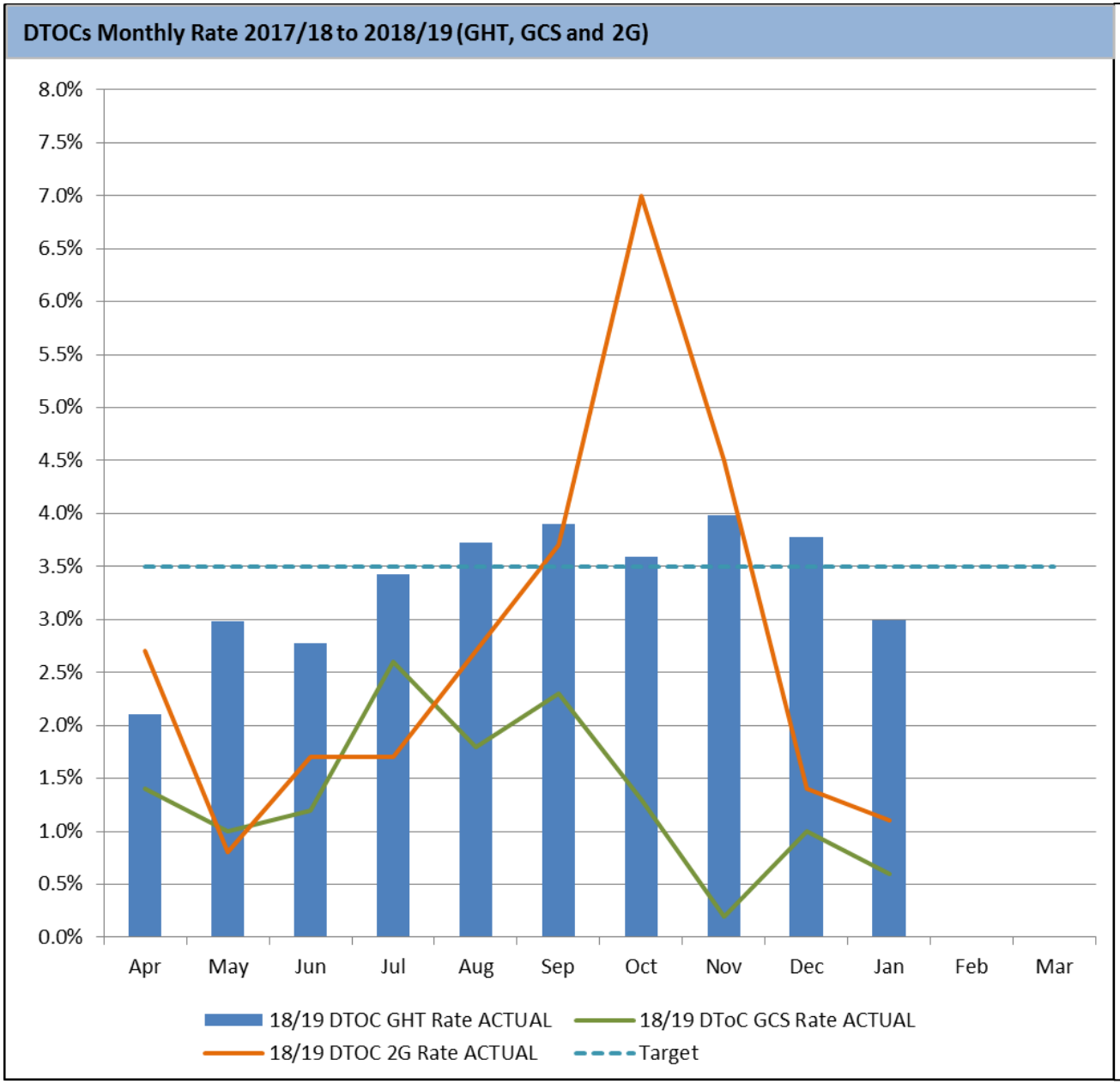
- Further development of falls deployment model has been agreed with first responders. This will provide a non-injurious falls lifting service, expected to avoid 20 unnecessary conveyances per month. Funding is now moving across to the service and will be operational in 2019/20.

- Cinpasis advice and guidance pilot for SWAST planned for Q4 2018/19 in line with overall Cinapsis roll out plan.

- New vehicles to SWAST in Gloucestershire will be 33 new capacity to the fleet, and 30 replacement vehicles to replace aging ambulances. Deployment of new vehicles has been put back to May to accommodate the refit schedule.

3.21 Unscheduled Care – Delayed Transfers of Care

Green



Top Line Messages:

The GHFT DToC rate has achieved the national target in January, with a rate of 2.99% (against the 3.5% target). This performance is expected to be sustained in February (unvalidated position currently stands at 2.84%).

GCS's DToC rate for January remained below target at 0.6%.

2Gether Trust's overall rate has maintained the improved performance seen in December reporting a DToC rate of 1.1% in January. This is partly due to the significant improvement in DToCs on wards that previously had very long delays. Willow ward (specialist dementia) is now only just above the central DToC target of 7.5% (for all 2g patients) at 8.8% which is a huge improvement on the 57% DToC rate seen earlier in the year (at the peak in DToCs in September).

3.21 Delayed Transfers of Care – Updates to actions

Green

- GHFT DToCs have improved due to winter planning system arrangements which have enabled a speedier recovery when DToCs begin to rise. Weekend staffing for Adult Social Care has improved the time taken for social care assessments to be arranged and carried out.
- Additional capacity in brokerage (both additional staff and extended hours) has also helped flow through the whole discharge pathway.
- The demand and capacity team within GCS have focussed on trust back door and community hospital delays.
- GHFT have reviewed their daily navigation process and instigated deep dives for complex patients in the partnership meeting which has representation from across the system.

Areas of concern:

- Surges in patients following “peak” days in ED attendance.
- Bariatric and dementia patients – complex discharge arrangements following a hospital admission.
- Patients who are homeless but require some short term ongoing care.
- Patients admitted for social reasons.
- Lack of alternative to acute admission for homeless patients and patients admitted for a social reason.

Long stay (>21 day patients)

Numbers of beds occupied by long stay patients have decreased in December and January, but have risen in February. Several contributing factors to the performance of the long stay metric have been identified:

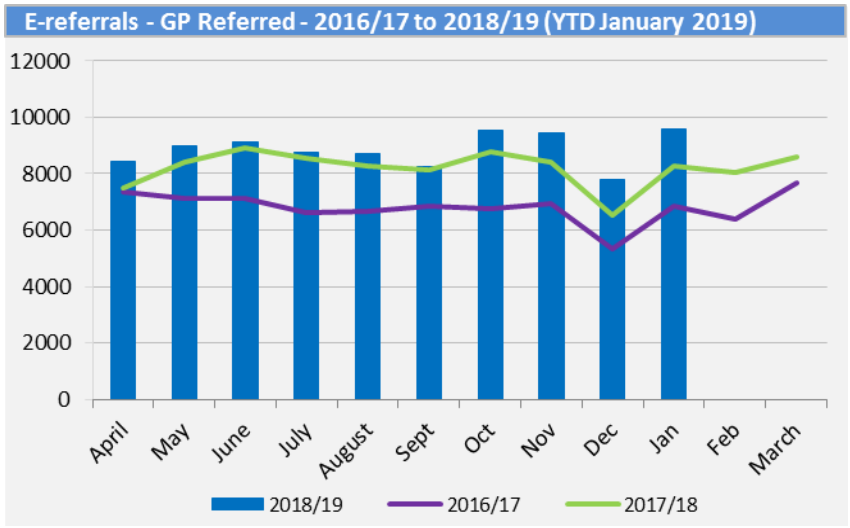
- Younger patients (under 60) do not always fit the current discharge pathways resulting in avoidable delays.
- Waiting for drugs on discharge.
- Ward to ward transfers.

These are being considered as individual teams and pathways are reviewed in collaboration with NHSI/ECIST.

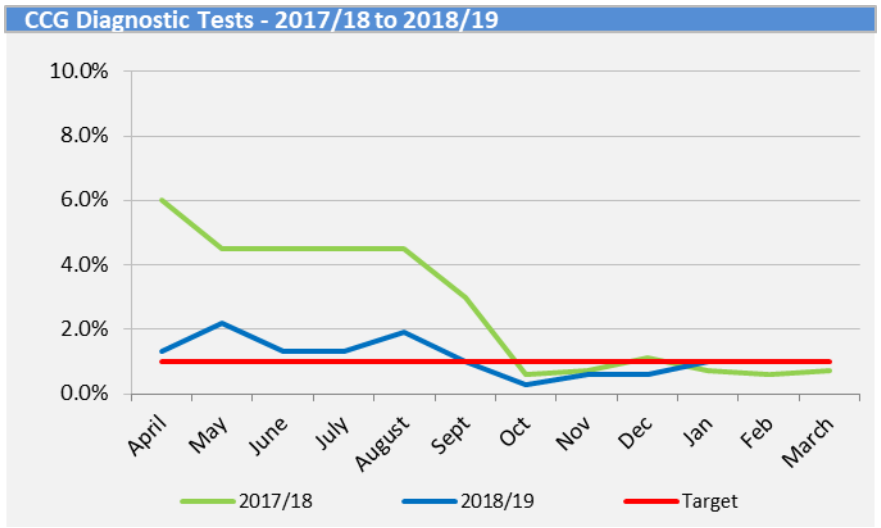
3.3 System Overview - Planned Care:

Green

Referral Trends



Diagnostics



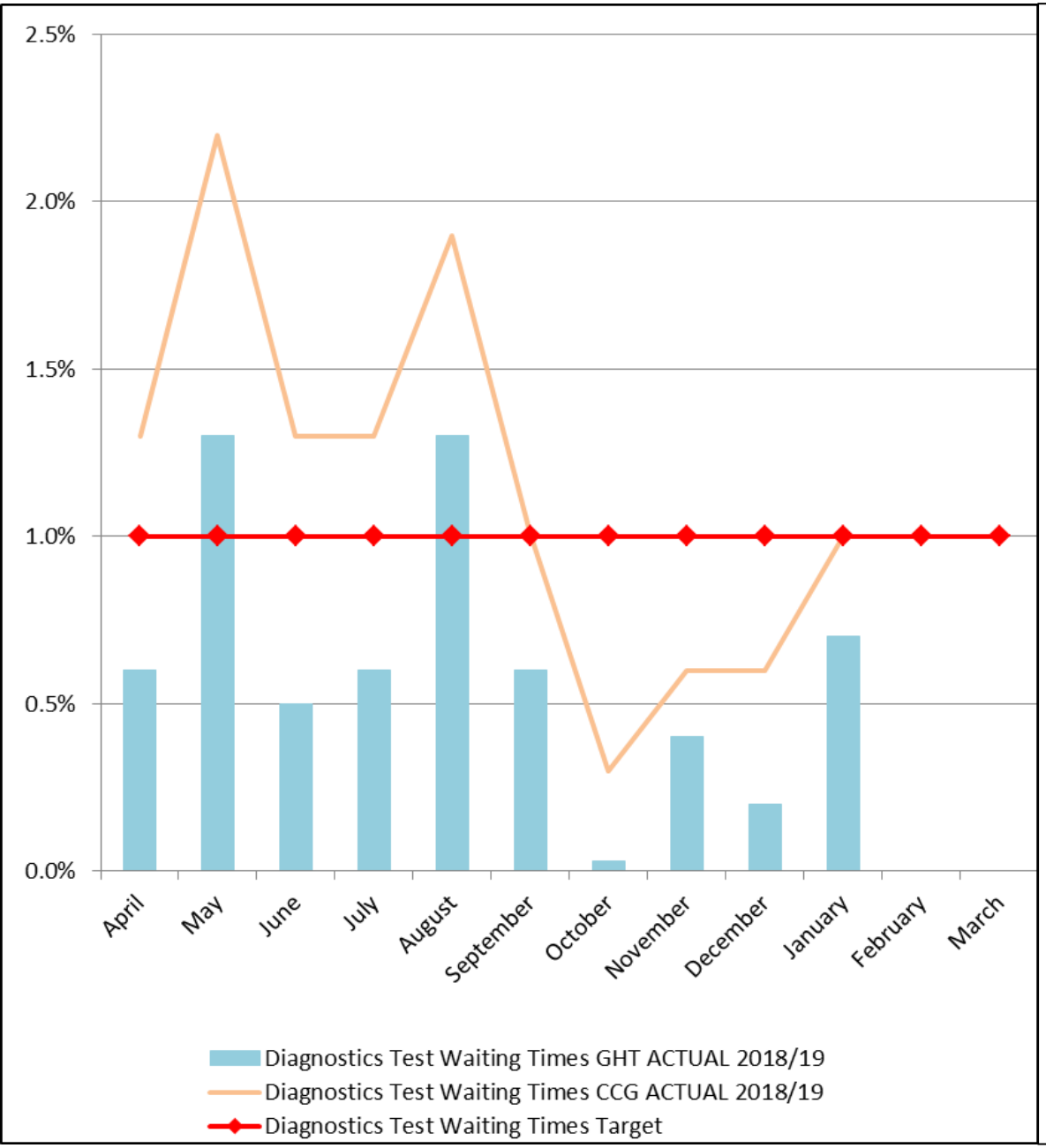
Due to the ongoing issues in relation the electronic Patient Administration System, RTT performance is not currently being reported nationally. GHFT expect to begin reporting nationally on RTT in Q1 2019/20.

NB – eRS only includes all referral activity from 4th June 2018 (paper switch off date)

NHS Gloucestershire Clinical Commissioning Group

3.4 Planned Care – Diagnostics >6 weeks

Green



Top Line Messages:

Both the CCG and GHFT achieved the Diagnostic performance target in January (GCCG at 1%, and GHFT at 0.6%). This is a slight decline in performance from December's position (0.6% for GCCG and 0.2% for GHFT).

85 over 6 week breaches in January 2019 of which 46 were at GHFT. The majority of the GHFT breaches took pace in endoscopy – with 13 colonoscopy breaches and 14 Flexi sigmoidoscopy breaches.

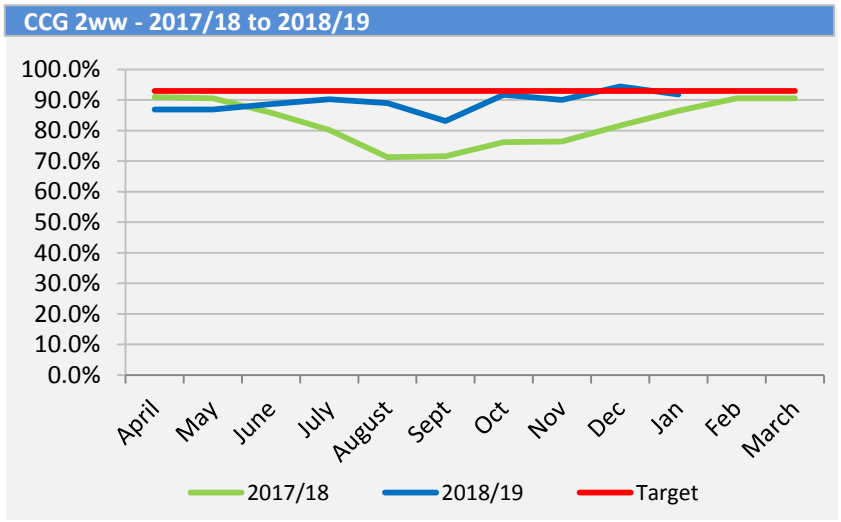
GHFT has had some capacity issues recently with CT/MRI machine failures which has not caused the national diagnostic target to be missed, however is putting some services under pressure. In particular, 4 of the 62 day breaches declared in January against the cancer treatment target were the result of delays for MRI in the diagnostic pathway. The capital plan for replacement of these machines is part of the GHFT capital programme.

NHS Gloucestershire Clinical Commissioning Group

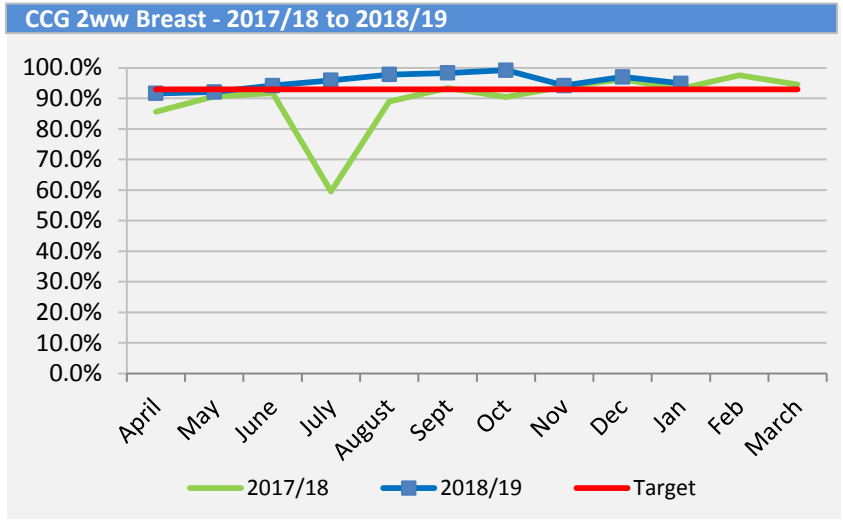
3.5 System Overview Cancer: YTD January 2019

Amber

2WW (GP Ref'd)



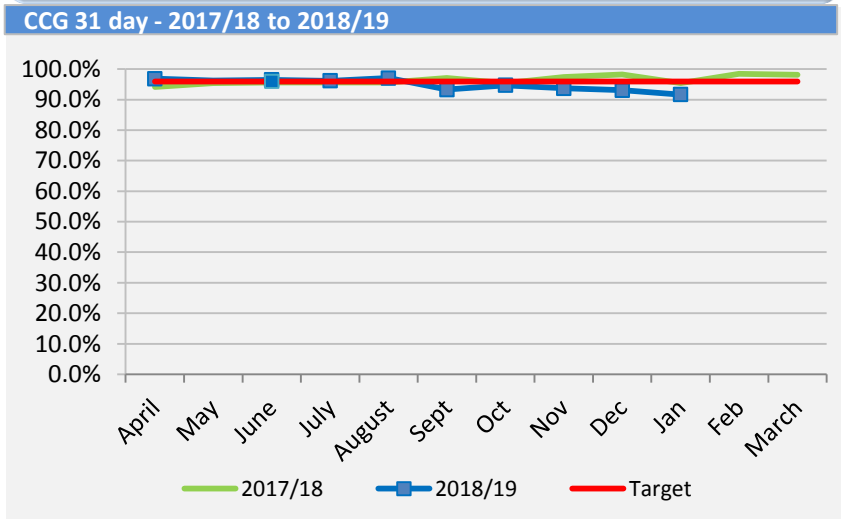
2WW (Breast)



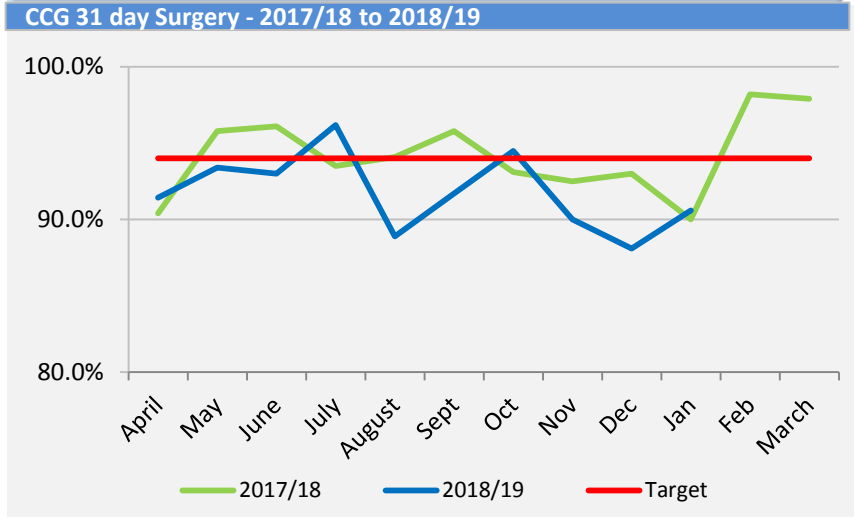
3.5 System Overview Cancer: YTD December 2018

Green

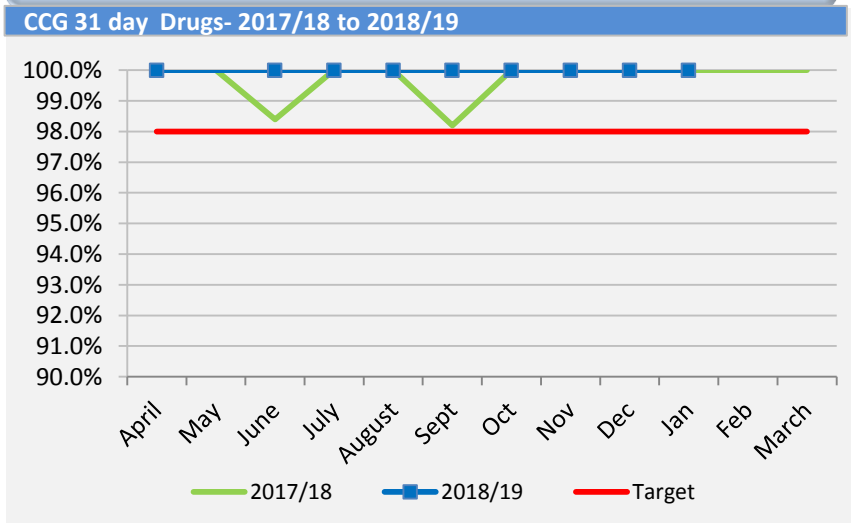
31 day



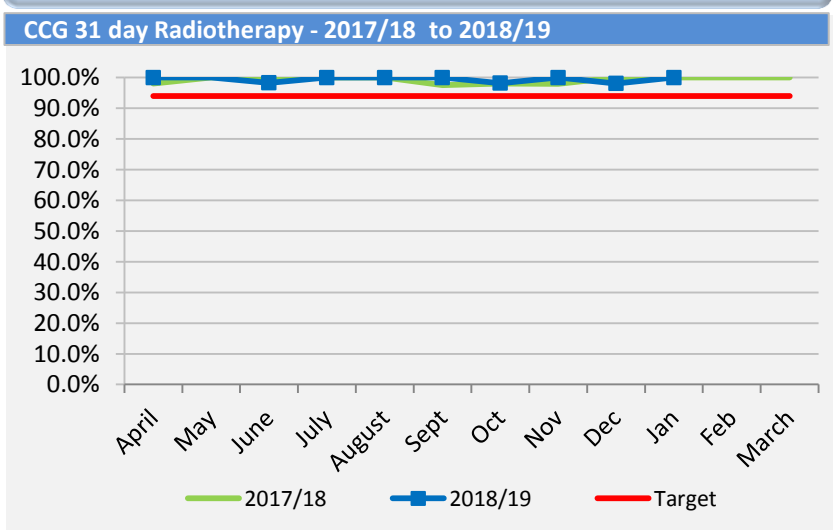
31 day subsequent treatm't: Surgery



31 day subsequent treatm't: Drugs



31 day subsequent treatm't: Radiotherapy

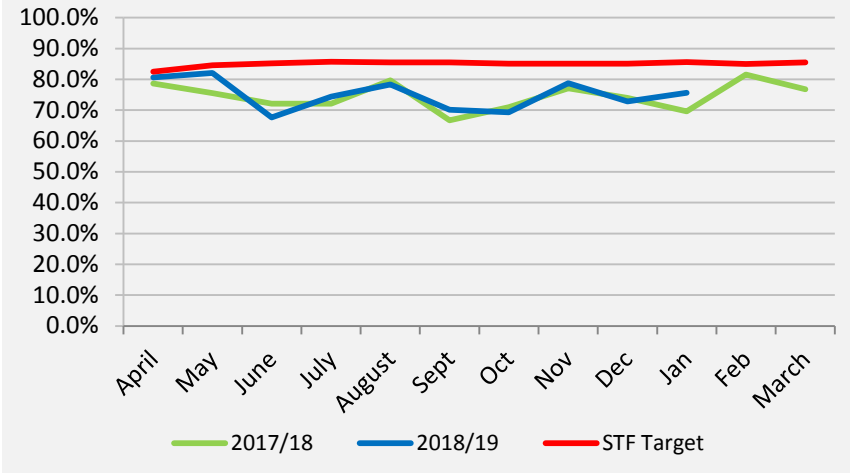


3.5 System Overview Cancer: YTD December 2018

Red

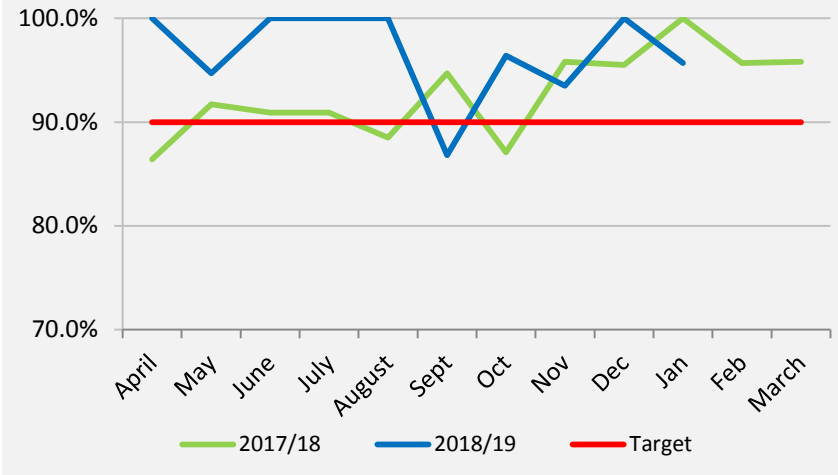
62 day: GP referral

CCG 62 day - 2017/18 to 2018/19



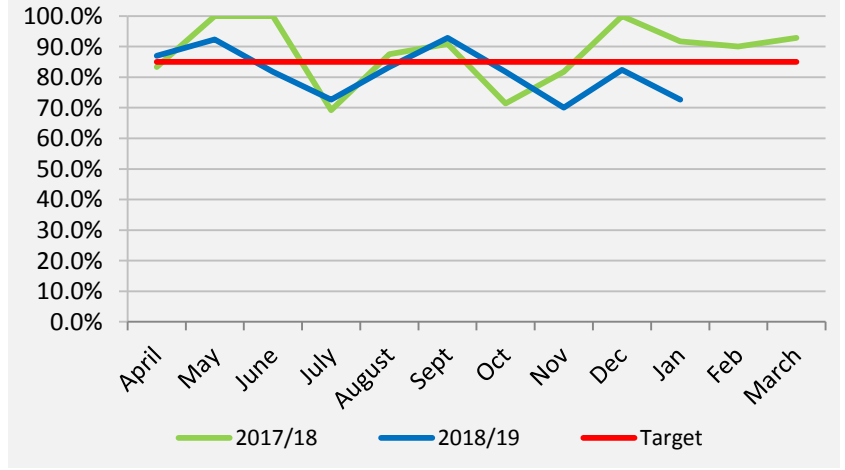
62 day: Screening

CCG 62 day Screening - 2017/18 to 2018/19



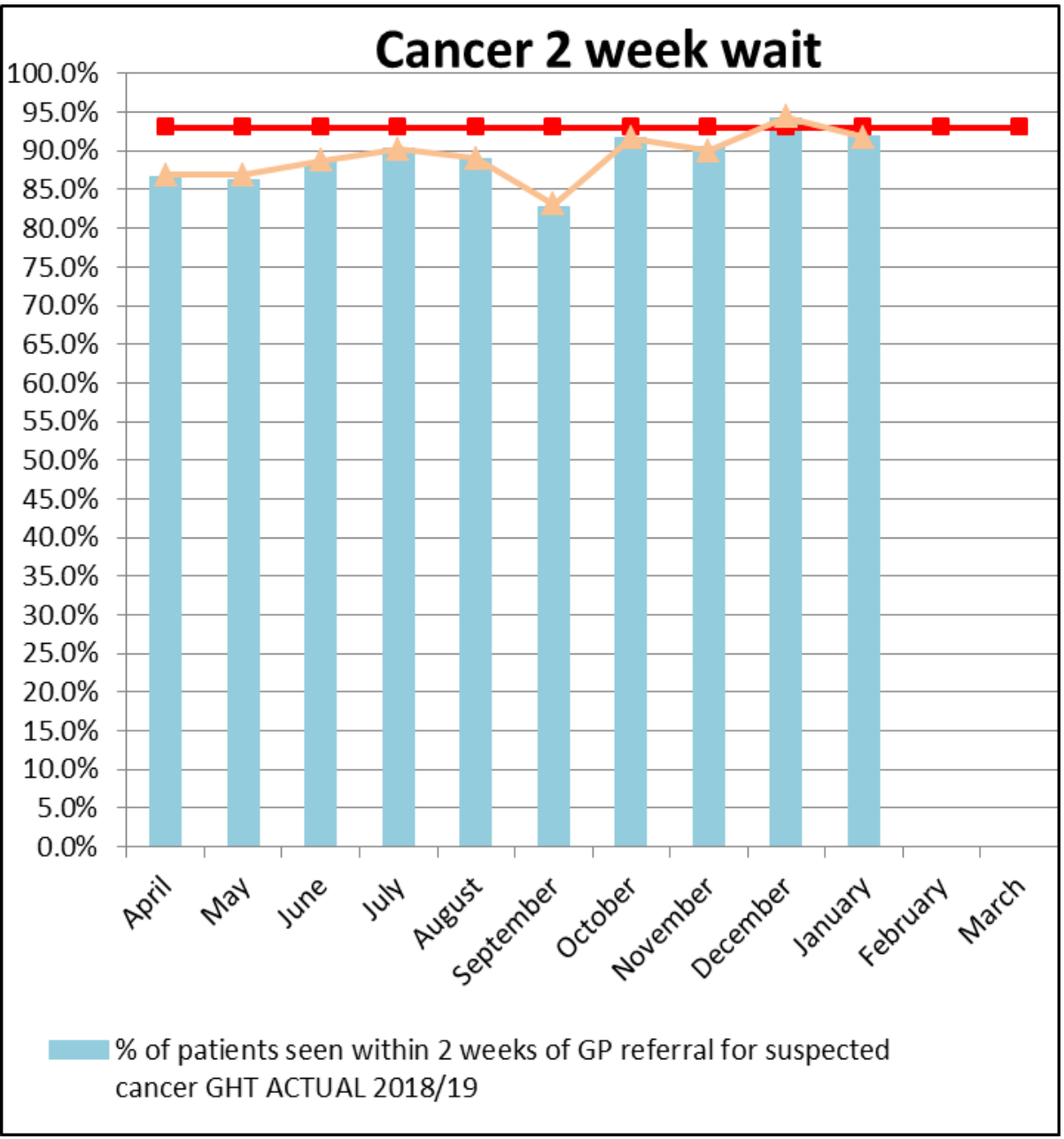
62 day: Consultant Upgrade

CCG 62 day Cons. Upgrade - 2017/18 to 2018/19



3.6 Cancer – 2 week waits

Amber



Top Line Messages:

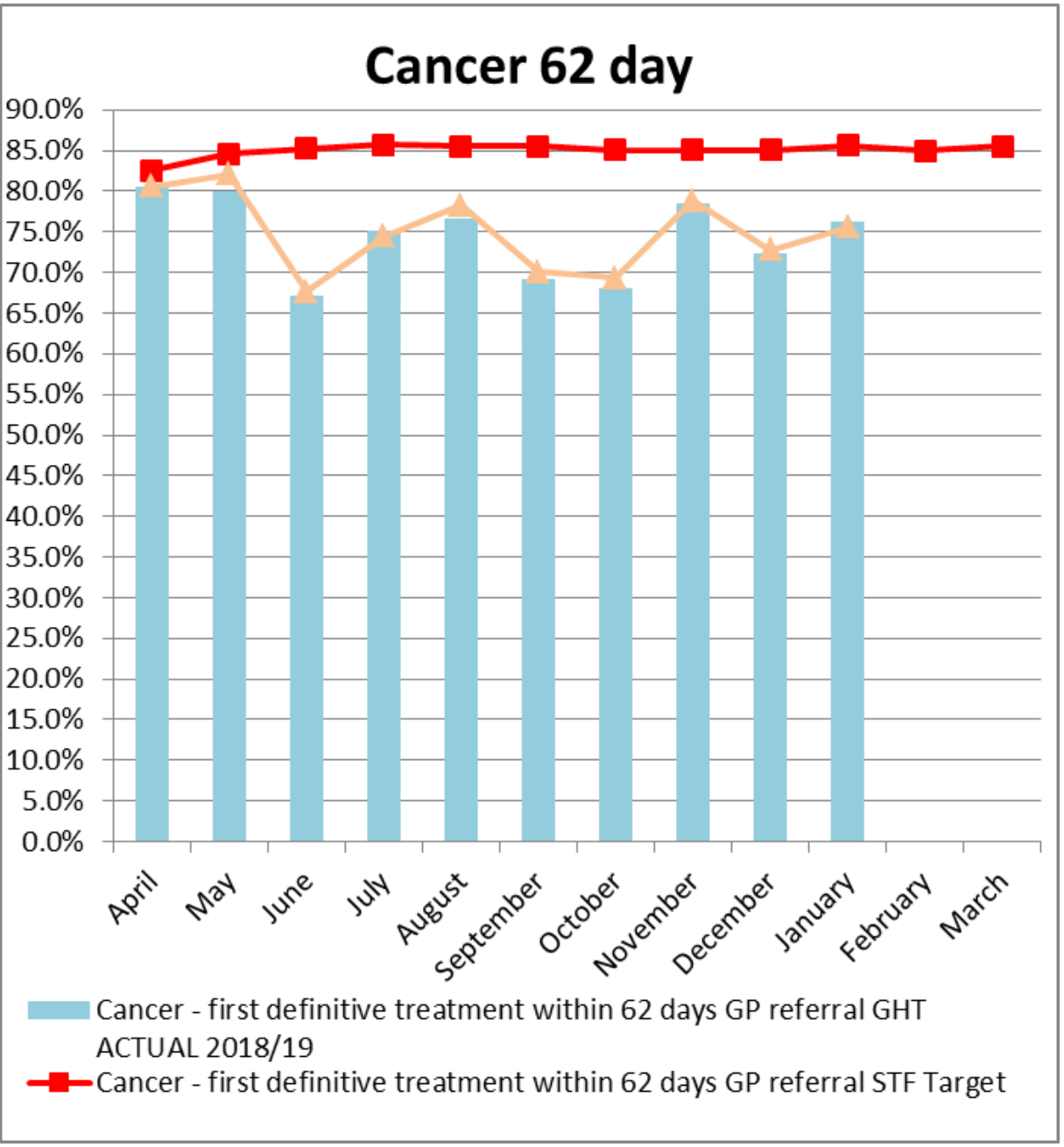
January 2 week wait performance just missed the 93% target, with CCG performance at 91.8% and GHFT performance at 92%. This is a slight decline on the December 2018 position where the 2ww target was met by both GHFT and the CCG overall.

Five out of eleven specialties missed the 93% target (for GCCG patients) in January, however of these only 2 were below 90% compliance. These were Lower GI (77.9%, with 65 breaches) and Haematology (80%, with 2 breaches). The remaining specialties that were just under the 93% threshold were Gynaecology (91.8%), Skin (92%) and Upper GI (92.2%). GHFT performance shows a similar position, however only 4 specialties missed the 93% target (Gynaecology (91.7%), Haematology (91.6%), Skin (92.2%) and Lower GI (78.2%)).

GHFT have highlighted the increase in patient choice breaches seen in January – 98, which is the highest number in the last 6 months. These breaches affected the Lower GI and Skin specialties in particular, with the holiday period thought to be primarily responsible.

3.7 Cancer – 62 days

Red



Top Line Messages:

Patients treated within 62 days of referral on a cancer pathway rose to 75.6% (for the CCG) and 76.1% (for GHFT), from the December position of 72.8% for GCCG and 72.2% for GHFT. The national target is that 85% of patients should being treatment within 62 days of referral.

For GCCG patients there were 48 breaches – a rise of 5 breaches from December 2018, however the total number of patients treated also rose to 197. Nine out of twelve specialties did not achieve the 85% target: Gynaecology (55.6%, 4 breaches), Haematology (70%, 3 breaches), Head and Neck (80%, 2 breaches), Lower GI (65%, 7 breaches), Lung (78.6%, 3 breaches), Upper GI (81.8%, 2 breaches), Urology (43.9%, 23 breaches), Brain/CNS (0%, 1 breach) and 'Other' (0%, 1 breach).

As in previous months, Urology is the specialty with the lowest performance; however performance is 20% higher than the lowest recorded performance this year of 22.2% (seen in June 2018). Performance excluding Urology is 84% for all GCCG patients and 84.4% for GHFT patients in January

3.7 Cancer – Programme Actions

Amber

104 day Cancer treatment breaches

There were 22 104 day waits for cancer treatment for Gloucestershire patients reported in January, 20 were first seen at GHFT, 1 at Great Western Hospital (GWH) and 1 unknown. 15 of these patients were Urology patients (14 GHFT, 1 GWH), 2 Head and Neck patients, 1 Lower GI patient, 1 Gynaecology patient, 1 Lung patient, 1 Skin patient and 1 Haematology patient.

Actions supporting time to treatment performance:

- Improvement of 2ww pathways, in particular Sarcoma, Gynaecology and Skin.
- MDT coordinators to be sited in one office (NHSI recommendation) has been agreed and scheduled for April 2019.
- NHS Elect workshop to be scheduled in this year to focus on tertiary referrals.
- NHS Elect deep dive session to be scheduled in this year to focus on one specialty.
- All patients reviewed weekly from Day 26 (larger specialties) and Day 15 (smaller specialties) – brought forward from Day 28 across the board.
- Additional clinics in focussed specialties, especially Urology (additional clinics booked throughout March and April to clear patient back log waiting for treatment.

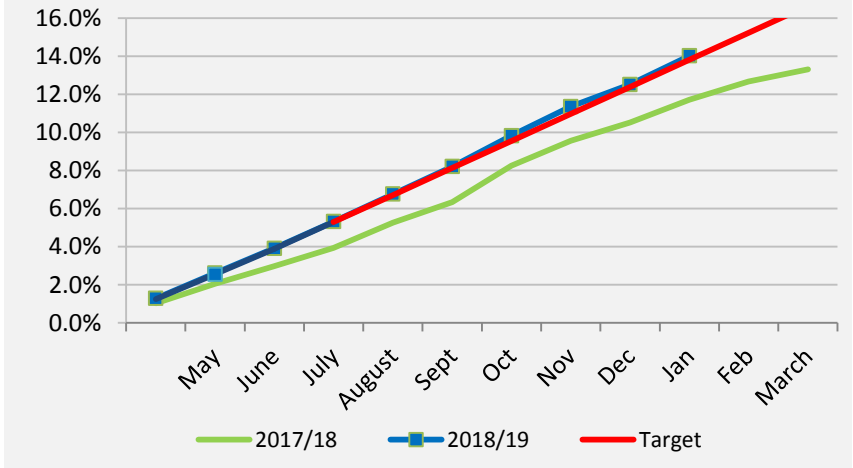
National clinical standards review has highlighted cancer targets for updating and optimising to improve patient experience. The key proposed changes are to introduce the 28 diagnosis target (where a patient will receive a diagnosis or confirmed “all-clear” within 28 days of referral. This will replace the existing 2 week wait target in time. The 62 day treatment target is proposed to be streamlined into a single measure, rather than splitting by treatment types as is currently the case.

3.8 System Overview: Mental Health - IAPT

Green

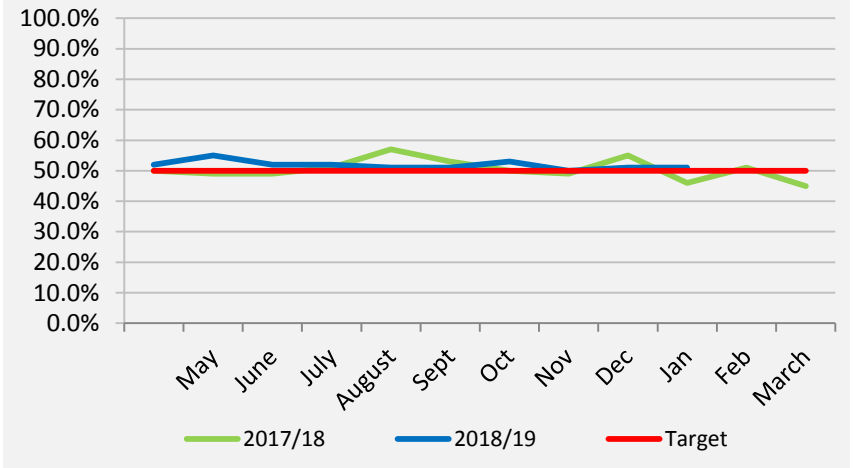
Access

IAPT Access - 2017/18 to 2018/19



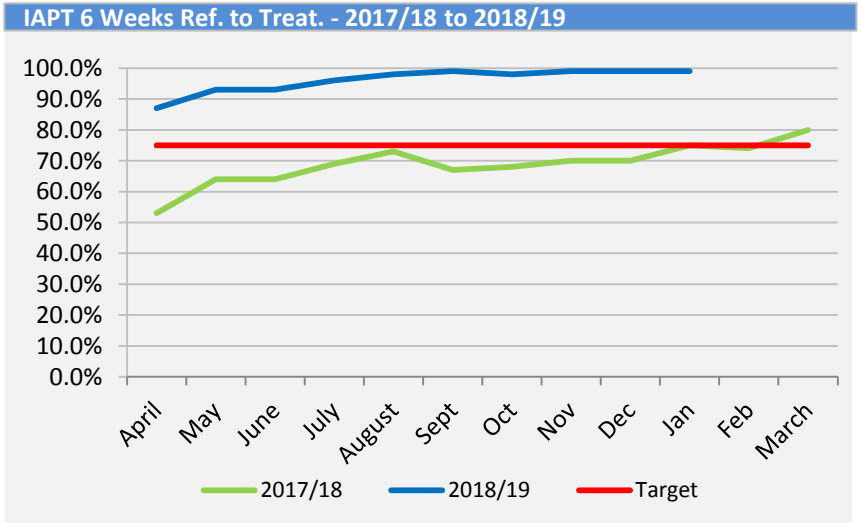
Recovery

IAPT Recovery - 2017/18 to 2018/19



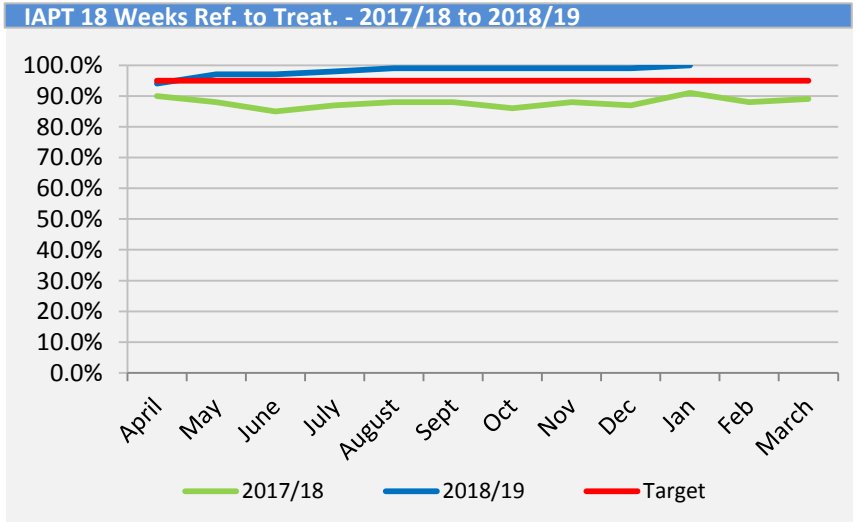
Referral to Treatment - 6 wks

IAPT 6 Weeks Ref. to Treat. - 2017/18 to 2018/19



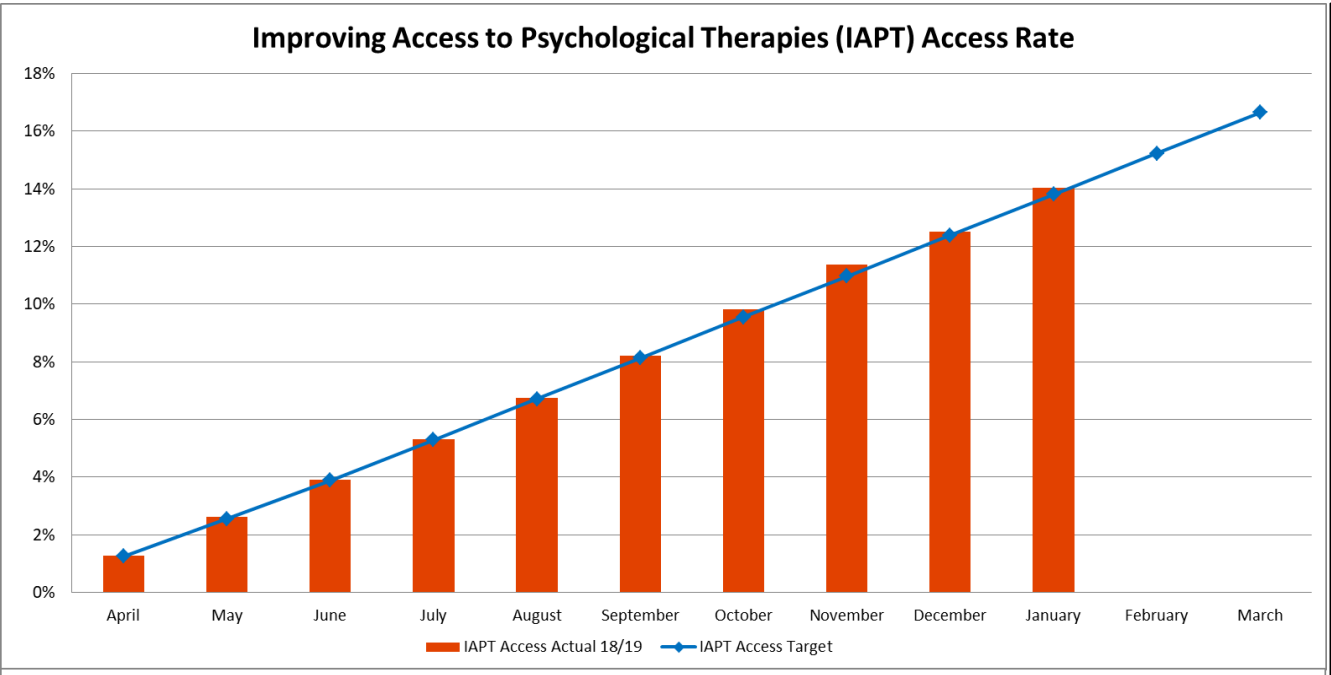
Referral to Treatment - 18 wks

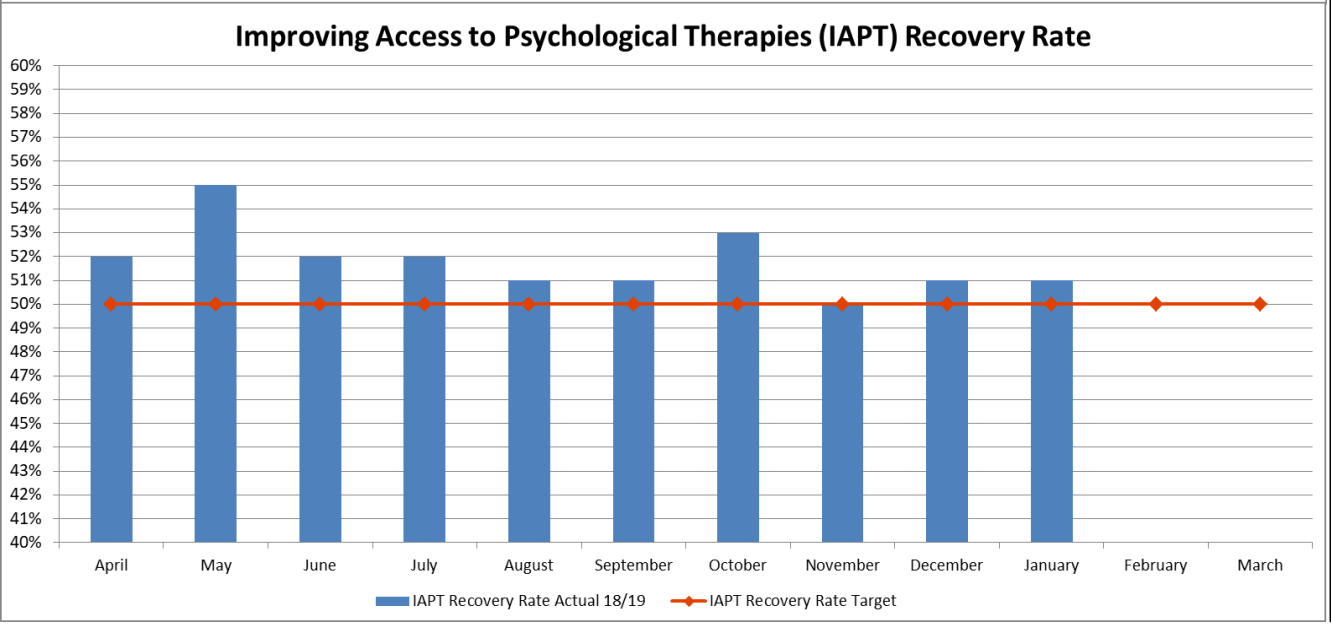
IAPT 18 Weeks Ref. to Treat. - 2017/18 to 2018/19



3.8 Mental Health - IAPT

Green





Top Line Messages:

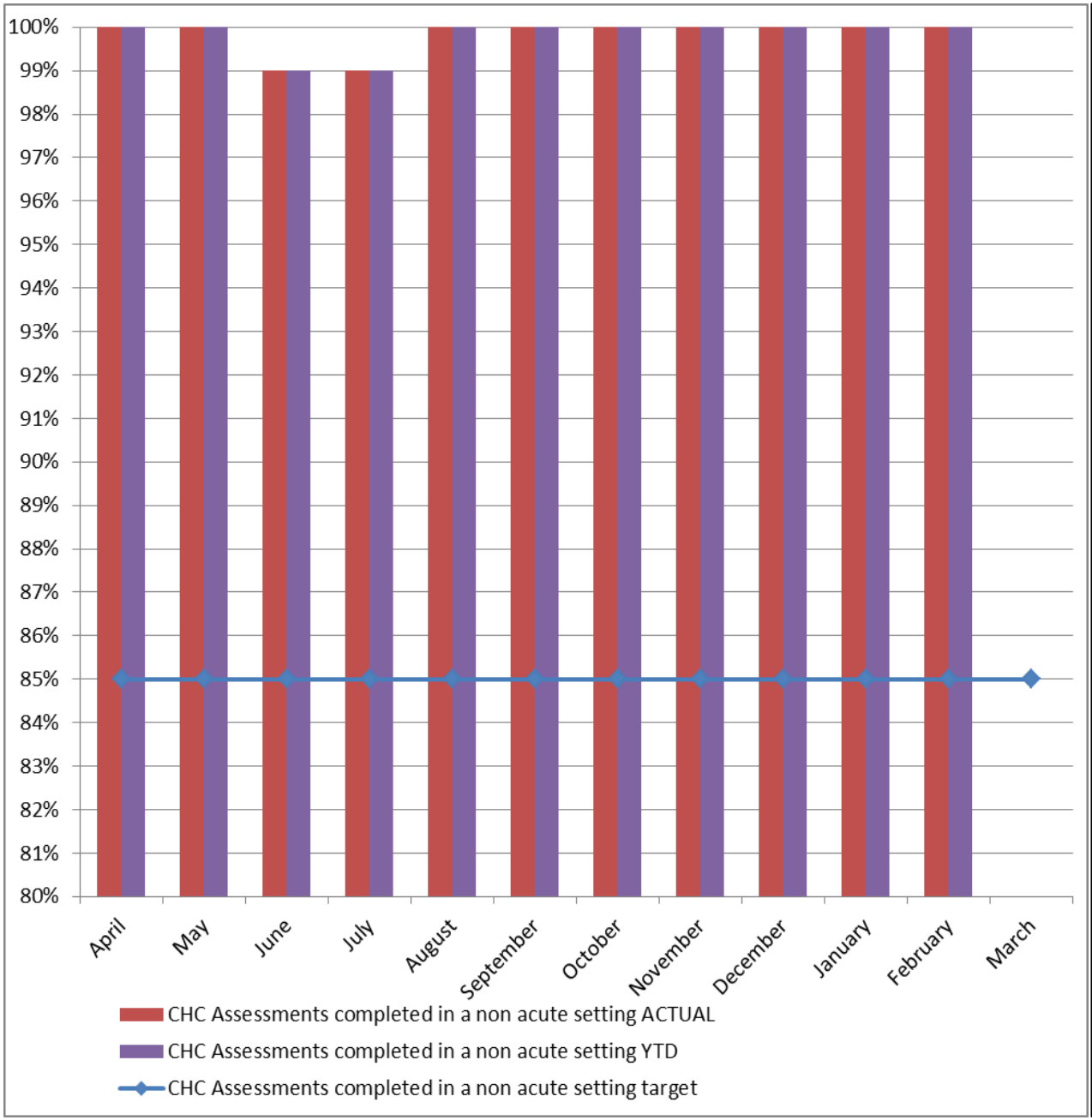
Current IAPT performance is on target to achieve the recovery and access targets for the full year. At the end of month 10 (January), the YTD access was 14.02% (cumulative) against a target of 13.81% to achieve the monthly 1.42% (17% total) by the end of the year.

Recovery performance has been excellent throughout the year, with the 50% target being met in each month. January performance was 51% and YTD performance is 52% patients moving to recovery following intervention by an IAPT service.

The national expectation is that 22% of patients will be accessing IAPT services by the end of the 2019/20 financial year. To reach this target, 2G will need to expand their service to include long term conditions, and a business case to support this is in progress.

3.9 Continuing Health Care – Location of assessment

Green



Top Line Messages:

NHS Continuing Healthcare (CHC) has national targets to ensure that the majority of referrals take place promptly and in an appropriate setting.

The 28 day referral time starts from the date the CCG receives any type of recorded decision that full consideration for NHS CHC is required i.e. a positive checklist or other notification of potential eligibility and ends at the point the CCG makes the decision. The location of assessment considers whether the assessment was carried out in an acute setting - which may not be appropriate due to a lack of clarity over a person's long term needs.

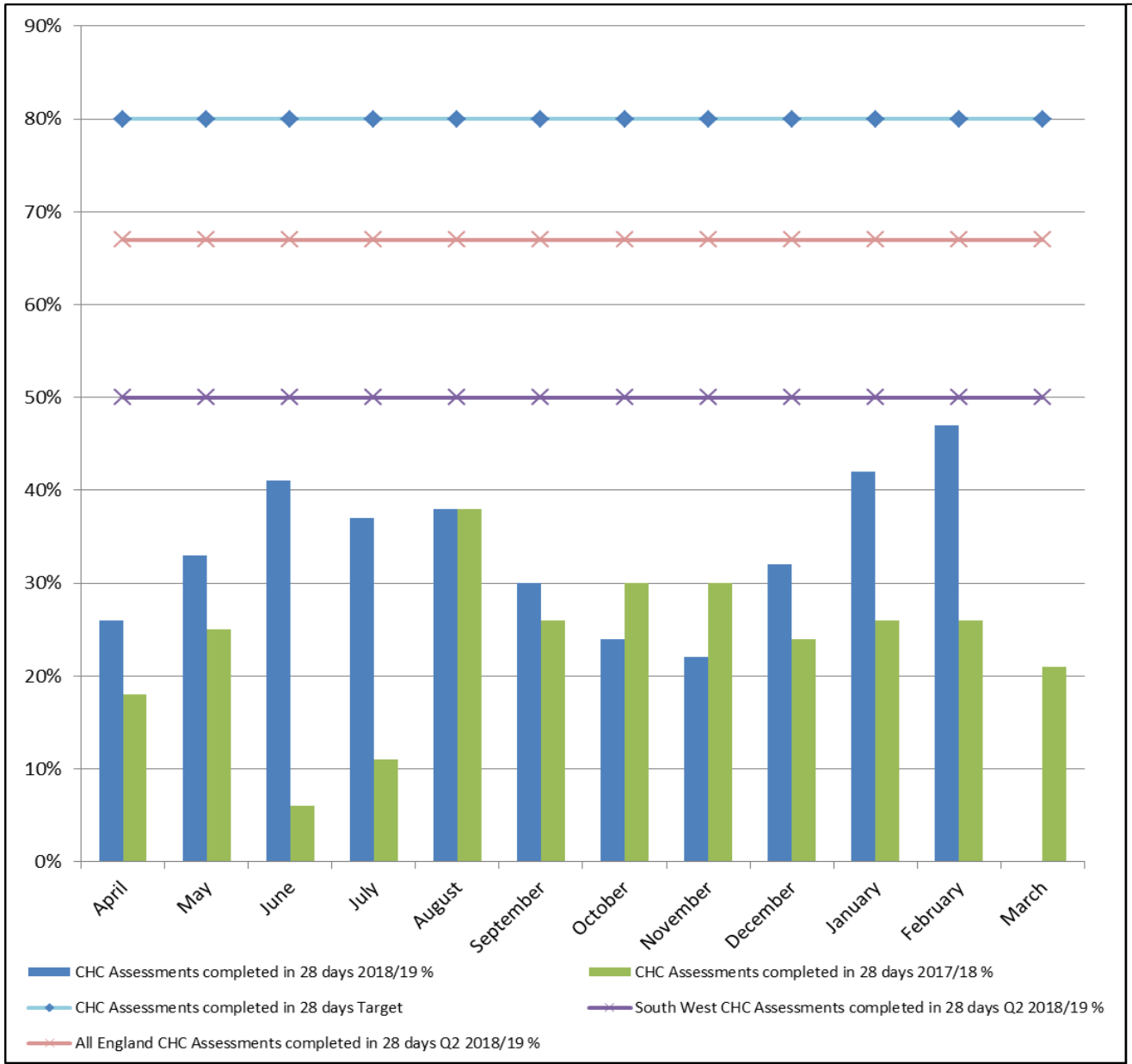
The Discharge to Assess pathway commenced on the 9th May 2016 and now only in exceptional circumstances does a CHC checklist and full assessment take place in an acute hospital setting within Gloucestershire as shown by the consistent performance YTD in 2018/19.

NHS Gloucestershire Clinical Commissioning Group

3.9 Continuing Health Care

Red

CHC Assessments completed in 28 days



Top Line Messages:

Current performance is below the 80% target at for assessments to be carried out in 28 days (47% of assessments were carried out in this timeframe in February 2019). However, this is the highest monthly performance achieved this financial year.

Progress against action plan:

- The CHC team is undergoing some restructuring in order to improve efficiency and are optimistic that the 50% target will be met in Q4. Current performance for Q4 is 45%.
- Agency nurses recruited to help with backlog of cases will remain in post until 31/03/2018.
- Positive checklists are now screened to ensure concerns are raised early with referrers.
- Joint training continues to be carried out with the LA.

NHS Gloucestershire Clinical Commissioning Group

3.10 Gloucestershire Care Services Performance

Positive Trends in January

Delayed Transfers of Care – Community hospital DTOC rate remains below the national target of 3.5% at 0.6% in January and a YTD performance of 1.3%.

MIIU – performance continues to be above the national target of 95% patients seen and discharged within 4 hours at 99.5%. The YTD average is 98.9%.

Mixed Sex – GCS have maintained 100% compliance throughout the financial year, with no mixed sex breaches occurring in community hospitals.

SPCA –The Single Point of Clinical Access have seen improved call answering within 60 seconds and call abandonment rates as the year has progressed. In particular, the % of abandoned calls to the service has now dropped below 1%.

TARGET		2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
% of calls abandoned	Target	<5%	<5%	<5%	<5%	<5%	<5%	<5%	<5%	<5%	<5%	<5%
	Actual	2.7%	1.6%	1.6%	1.4%	2.0%	1.2%	1.3%	1.0%	1.0%	0.9%	0.9%

NHS Gloucestershire Clinical Commissioning Group

3.10 Gloucestershire Care Services Performance

January performance challenges

Community Hospital Occupancy

Bed occupancy has risen to over 96% in January despite an increased average number of community beds open in the month:

TARGET		2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Occupancy (optimum 90%) - All Community Hospital Beds	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	92%
	Actual	96.7%	93.2%	95.1%	91.8%	90.2%	91.0%	94.3%	93.9%	95.6%	92.7%	96.2%

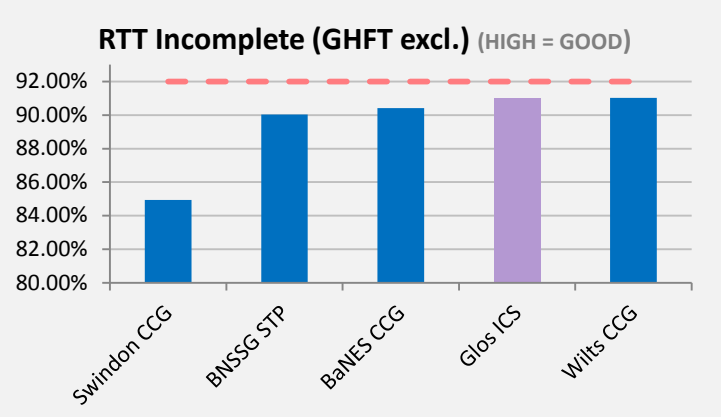
RTT in community services

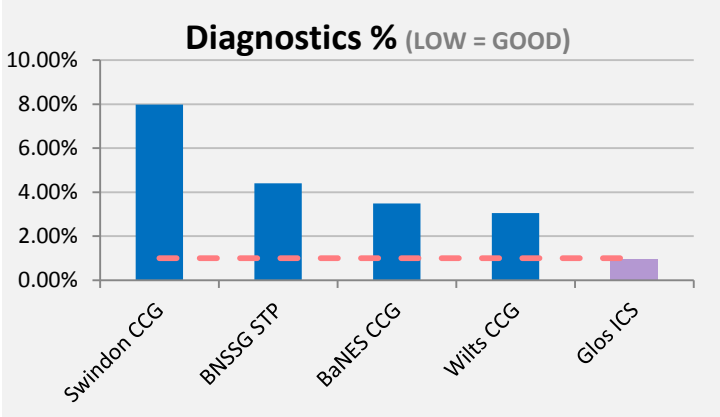
A number of community services have reported below target performance to referral to treatment targets in January:

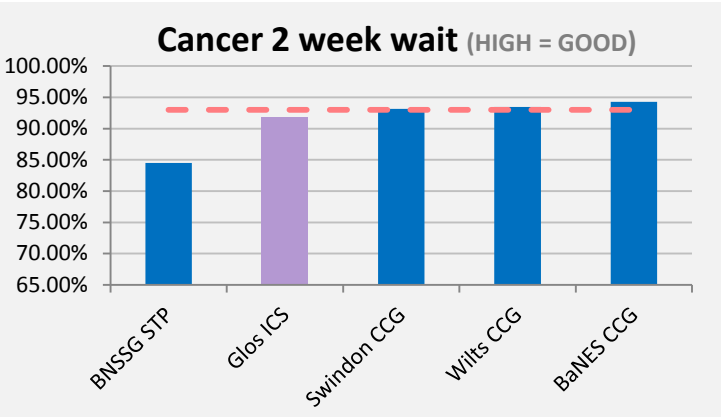
- Speech and Language Therapy
- Occupational Therapy
- MSK Physiotherapy
- ICT Physiotherapy
- Paediatric Physiotherapy
- Wheelchair service

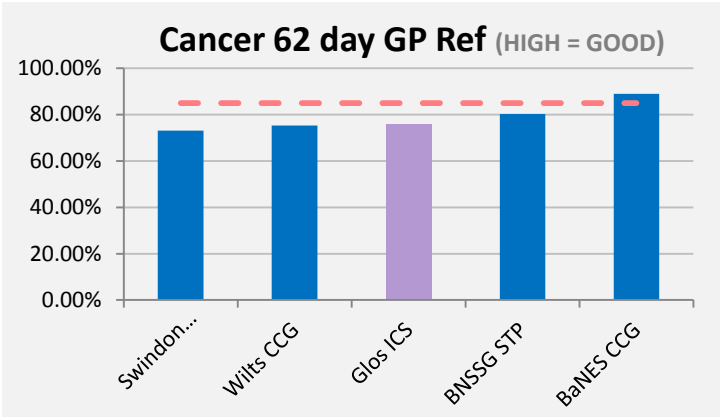
GCS is working on several service development plans (in particular around Speech and Language Therapy and Occupational therapy). The national requirement to improve performance around RTT in paediatric wheelchairs has been delayed to Q4 of 2019/20 (from Q4 2018/19), and the service is committed to improving performance to meet this target in line with national expectations.

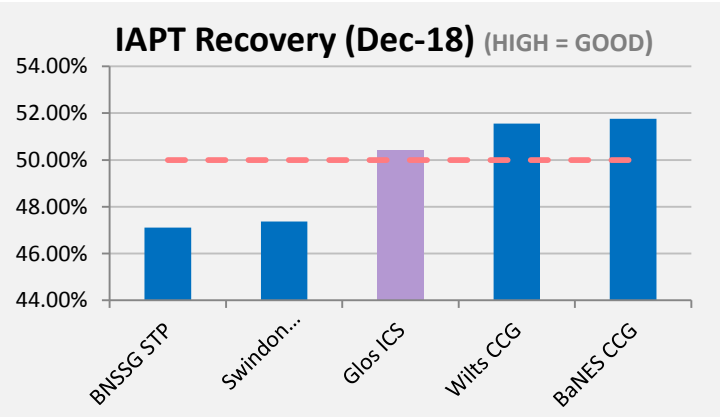
3.12 Performance – Regional Comparison January 2019











3.11 Performance – Patient Experience

Amber

FFT January 2019

Organisation	Service	Response rate	% recommend	% not recommend	National response rate	National % recommend	National % not recommend	change to last month*
GHFT	A&E	18.1%	82.7%	10.8%	11.9%	86%	8%	better
GHFT	Outpatient	8.1%	95.1%	2.0%	NA	94%	3%	better
GHFT	Inpatient	24.5%	91.9%	4.1%	24%	96%	2%	similar
Primary Care	GP practices	NA	91.5%	5.7%	NA	90%	6%	similar
GCS	Community	15.0%	94.0%	2.0%	NA	96%	2%	similar
2G	Mental Health	NA	96.4%	0.0%	NA	90%	3%	better

**over 1% difference to previous month*

Quality Review

Quality is reviewed by the Quality and Governance committee, with a particular focus on Primary Care quality at the primary care commissioning committee (PCCC).
Provider quality is monitored through individual clinical quality review groups.
Quality reporting provided to governing body bi-monthly highlights any particular initiatives or publications of interest to the board. FFT test results are provided for information as part of the performance report monthly.

National Review of FFT

Ipsos MORI have carried out a review of the national FFT, to which GCCG has contributed. New guidance around the test is expected in April 2019.

NHS Gloucestershire Clinical Commissioning Group

4.0 Leadership *(slide 1 of 3)*

Green

Indicator	Component Measure	Narrative
Staff and member practice engagement	OD Plan Staff Survey Turnover Vacancies Sickness PDP/Training	**Turnover Rate**: turnover for January increased slightly by 0.1% to 12.9%. Overall turnover has been constant throughout the last 12 months, other than the increase to 15% in April. There were 6 Leavers recorded in January. **Staff in Post and Starters and Leavers**: Staffing levels for January, 298.74 FTE equating to a total headcount of 364. This report confirms 10 new starters and 6 leavers for Jan 2018. Over the last 12 months there have been 45 leavers (36.82FTE) and 84 starters (68.89FTE). **Leavers by reason**: The report identifies 45 leavers over the 12 month period, the main reason for leaving was 17 being Promotion. **Sickness Absence Rate**: long term absence and short term absence has increased. Long term absence has increased from 1.34% to 1.44%, Short term absence has increased from 1.66% to 1.91%. The report confirms overall absence % FTE has increased from 3.01% in December to 3.36% in January. **Sickness by Reason**: for Jan 2019 absence due to anxiety/stress was 12.03% this has decreased from 14.2% in December The overall cost of absence for January was £48,270 with a total of 336 days lost (309.16 FTE). This equates to 133 days (6 occurrences) long term sickness and 203 days (53 occurrences) short term sickness. This equates to an average of 1.04 absence days per FTE (an increase from 0.93 in Dec 18).

4.0 Leadership *(slide 2 of 3)*

Green

Indicator	Summary and headline evidence/ examples
1. Probity and Governance	The CCG has put in place strong clinical and non clinical leadership across all areas of the ICS, recent developments include investment in GP Provider leads to support local delivery and Integrated Locality Partnerships and Primary care Networks. ICS governance structures include CCG staff in senior leadership roles in all areas of the programme alongside provider leadership roles ICS work programmes progressing with outcomes being seen in a number of areas, including cancer, MSK and eye health and also across health and wellbeing projects such as the daily mile and the community wellbeing service. HR and OD plan aligns to that of the ICS and is overseen by the HR/OD group who meet quarterly. There is a refreshed workforce and OD strategy, setting out establishment of the Gloucestershire Local Workforce Action Board (GWAB) to oversee the enabling workstream for the ICS. Further modelling is being undertaken on the current workforce and future changes and challenges, stage two of the workforce capacity plan has commenced.
2. Staff Engagement	The CCG effectively engages with staff members with a Joint Staff Consultative Committee and an annual staff survey. The 2018 survey had a response rate of 73% which was positive. Amongst the top scores was the % of staff that confirmed the CCG provided equal opportunities 93%, 88% knew the CCG's vision & values and 86% confirmed the CCG supported staff with their health and wellbeing. A robust action plan has been produced and a series of staff training, events and focus groups are taking place, staff engagement is aligned to the STP through the Social Partnership Forum and the Associate Director of Corporate Affairs leads on HR and OD internally, and attends associated ICS working groups to represent the CCG. Plans are linked to the overall ICS workforce development..
3. Workforce Race Equality	WRES data forms part of the CCG's annual Equality and Engagement report, reported to the IGQC. The 2018 annual report 'An Open Culture' will be considered by the Governing Body in March and published.
4. Effective Working Relationships	Due to consistent ratings as a top performing CCG in relation to effective working relationships, Ipsos MORI has invited the CCG to speak to them about its approach to working relationships as part of the national stakeholder survey report. The 2017/18 360 survey results show that 99% of respondents responded positively when asked to rate the effectiveness of their working relationship with the CCG, an increase from 92% in 2017. 100% of GP Member Practices feel that the CCG has an effective relationship with them, demonstrating the value of the primary care team. This is further supported by extremely positive verbatim comments as part of the survey.
5. Compliance with statutory guidance on patient and public participation	The CCG is committed to embedding involvement in all areas of its commissioning activity and is able to provide clear evidence of progress against the 10 key actions including through the annual report, feedback website pages, communication engagement strategies and plans, consultation report, AGM and equality impact assessments. STP engagement, first stage complete, Forest of Dean consultation completed and preparation underway for One Place Business case consultation, patient participation in urgent care pathway design workshops this spring secured.

4.0 Leadership *(slide 3 of 3)*

Green

Indicator:	Summary and headline evidence/ examples
6.1 Leadership	ICS five year plan, developed from the FYFV signed off by all partners. CCG operational & financial plans developed from the STP plan, start point April 2017. ICS work programme developing using the agreed governance structure. The CCG has 76 practices grouped into 7 localities with a strong relationship between the locality and the CCG through Integrated Locality Partnerships currently under development and the Primary Care Networks. Specific examples of good practice include several primary care events Commissioning event, Locum event, Productive Time etc. and an annual rolling programme of GP Practice visits and varied communication methods such as What's New This Week and G Care. CCG OD plan focus on staff development and includes strong emphasis on formal appraisal including PDPs. There is co-ordinated staff training including financial training at all levels including Governing Body and all budget holders. Gloucestershire health and social care partners have been awarded the status of an Integrated Care System in recognition of its mature and collaborative working relationships system wide.
6.2 Quality of Leadership	There is a clear governance structure in place which enables a focus on quality, performance delivery including contracts and finance within the Q&G, Audit & Risk Committee, Governing Body business meetings and the formal bi monthly Governing Body. Information is reported to each committee with a focus on key area of risk as well as the overall performance / finance position. The Governing Body is well sighted on financial and performance issues with regular informal and formal reporting. Meetings are well documented to evidence the level of discussion and challenge. Governing Body members expertise range from governance, clinical, financial, commercial and patient experience enabling a strong challenge.
6.3 Leadership Governance	The Governing Body has a clear constitution, policies, set roles and responsibilities which enable them to effectively challenge. A recent review has been undertaken of the risk management process with a dedicated Risk Management workshop organised for Governing Body members and senior managers, which focused on risk appetite. Further changes have been implemented with the Audit & Risk Committee taking responsibility for assuring the GB on risk management. Each committee carries out a self assessment annually to inform future development.. The CCG has a robust corporate governance framework including policies, committee structure and monthly reporting to the GB on financial & performance risk including those within providers and contracts. External expert advice is taken where required e.g. legal advice on a judicial review. Clean external audit reports since inception. Internal audit annually cover transactional areas as well as developmental areas and are reported to Audit & Risk Committee, clinical audits and internal audits focusing on clinical areas are reported to IQ&G ..
6.4 Transformational Leadership	The ICS has a clear governance structure supported by a MOU which has been agreed by all partners, this is currently being updated. The Governing Body receives bi-monthly ICS reports which provide updates on key achievements, performance and areas of focus. Providers also report on ICS achievements to their respective boards. For example, partners are involved in progressing the One Place programme to develop the urgent care system to improve the patient experience. A dedicated team has been put in place to drive this project. The Gloucestershire Local Workforce Acton Board is working through key workforce priorities, funding opportunities and evaluating R&R initiatives.

4.1 Performance – Quality Premium Overview 2018/19 *(1 of 3)*

2018/19 Quality Premium Calculator

£3,149,920 (Based on projected population 629,984)

Emergency Demand Management Indicators	Quality Indicators
Type 1 A&E attendances	National Measure 1: Early Cancer Diagnosis
	National Measure 2: GP Access & Experience
Non Elective Admissions with zero length of stay	National Measure 3: Continuing Healthcare
	National Measure 4: Mental Health
Non Elective Admissions with length of stay 1 day or more	National Measure 5: Bloodstream Infections
	Local Measure: Direct to Stroke within 4 hours
75.5% - £2,378,190	**24.5% - £771,730**

RTT - Incomplete pathways	62 day cancer
50% - £385,865	**50% - £385,865**

NB: Delivery of the constitutional RTT standard and the 62 cancer treatment target is required to gain the quality indicator premium which are both under target for 2018/19 (therefore Quality Indicator payment is likely not to be achieved).

NHS
Gloucestershire
Clinical Commissioning Group

4.1 Performance – Quality Premium Overview *(2 of 3)*

2018/19 Quality Premium Calculator

£2,378,190	

Emergency Demand Management Indicators		
Type 1 A&E attendances	**Non Elective Admissions with zero length of stay**	**Non Elective Admissions with length of stay 1 day or more**
Actual number of Type 1 A&E attendances to be no greater than the planned number of Type 1 A&E attendances.	Actual number of non-elective admissions with LOS =0 to be no greater than the planned number of non-elective admissions with LOS =0.	Actual number of non-elective admissions with LOS of 1 day or more to be no greater than the planned number of non-elective admissions with LOS of 1 day or more.
50% - £1,189,095		**50% - £1,189,095**

NHS
Gloucestershire
Clinical Commissioning Group

4.1 Performance – Quality Premium Overview

2018/19 Quality Premium Calculator

£771,730		
Quality Indicators		
National Measure 1: Early Cancer Diagnosis	**National Measure 2: GP Access & Experience**	**National Measure 3: Continuing Healthcare**
Cases of cancer diagnosed at stage 1 or 2 as a % of all new cases of cancer	Overall experience of making a GP appointment assessed through Question 18 of the GP Patient Survey	1. CCGs must ensure that more than 80% of all full NHS CHC assessments are completed within 28 days. 2. CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting.
17% - £131,194	**17% - £131,194**	**17% - £131,194**
National Measure 4: Mental Health	**National Measure 5: Bloodstream Infections**	**Local Measure: The percentage of applicable patients who go direct to a stroke unit within 4 hours**
Option a) A reduction in Out of Area Placements (OAPs) **Option b)** Addressing inequitable rates of Older People and people from Black and Minority Ethnic (BAME) communities accessing the Improving Access to psychological Therapies (IAPT) services **Option c)** Inequitable rates of access to Children and Young People's Mental Health services based on geography	Part a) reducing gram negative blood stream infections (BSI) across the whole health economy Part b) reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care Part c) sustained reduction of inappropriate antibiotic prescribing in primary care	The CCG will look to improve performance from the latest published figure year end 16/17 of 39.3% to 70% for 18/19 This will improve the outcomes for approx 100 patients.
17% - £131,194	**17% - £131,194**	**15% - £115,760**

RTT - Incomplete pathways	62 day cancer
50% - £385,865	**50% - £385,865**

NHS Gloucestershire Clinical Commissioning Group

5.0 Sustainability - Month 11

Green

Income and Expenditure	YTD surplus	FOV surplus	YTD Running costs	FOV Running costs
In Year	£0k	£0k	(£294k)	(£282k)
Cumulative	(£19,676k)	(£21,465k)	(£294k)	(£282k)

Savings Programme	YTD Savings	% YTD Savings	FOT Savings	% FOT Savings
	£15,774k	92.9%	£17,282k	92.9%

Other Metrics	BPPC	Cash drawdown	FOT Capital
	97.99%	84.17%	£70k

5.0 Sustainability – Executive Summary

Position

- Gloucestershire CCG is forecasting to achieve it's planned in year position of breakeven with a cumulative surplus of £21,465k.
- The CCG is forecasting material overspends in continuing healthcare including learning difficulties and elective activity within its main acute trust contract, other acute and AQP providers.
- A prescribing forecast underspend of £2.5m is included within the current forecast; this has reduced again by £0.5m in the last month. Work is ongoing to assess the implications and associated risk of NCSO, national Category M price increases and recent changes to over the counter prescribing medicines.
- All recurrent and non-recurrent reserves have now been utilised to cover recognised pressures and risks, hence additional mitigations will need to be identified to offset further pressures. A number of the in-year mitigations are non recurrent in nature, this means that additional savings will be needed in 2019/20 to cover this pressure.
- Funds allocated to the CCG to cover the costs of the 2018/19 pay award indicate a shortfall, in particular, primary care contractors paid under delegated primary care co-commissioning.
- Discussions are ongoing with providers regarding the 2019/20 financial year and the CCG's draft 2019/20 financial and operational plans were submitted on 12th February, followed by an ICS submission on 19th February.

5.1 Sustainability – Resource Limit

The CCG's confirmed allocation as at 28th February 2019 is £891m.

The following IATs (Inter Authority Transfers) have been actioned in February; those listed below were non-recurrent in nature except the Identification Rule (IR) adjustment which was recurrent

£'000	Description
(940)	Transforming Care funding transfers (repayment for transfers below plan)
650	Approved CCG-wide funding
3	CHAT Licences for STP
4	GHFT Wait List Validation
40	SW UEC Support to STPs to Enable Faster Implementation of Initiatives
4	GP workload tool backfill for GPs to test
24	ICS transformation funding - enhanced health in care homes
35	LD transforming care forensic support
4	Mth11 IR adjustment
(176)	**Total change in month**

5.2 Sustainability – Acute Contracts *(1 of 3)*

Acute NHS Contracts **Key** **Indicates a favourable movement in the month** **Indicates an adverse movement in the month**	**Trend**	**Year end Forecast £'000**
Gloucestershire Hospitals NHS Trust (GHNHSFT) The 2018/19 Contract value for GHFT is £316,765k. The original contract was a block contract for all points of delivery (POD) with the exception of elective PbR activity and some drugs. A contract variation of £391k for the changed musculoskeletal phase 1 & 2 pathway has also been added to the contract. The CCG has agreed an outturn of £1m over-performance with GHFT for 2018/19; this has mitigated the financial risk for 2018/19, however, this activity will need to form part of contract discussions for 2019/20. Actual performance activity showed over-performance against the contract in the early months of the year which has reduced in latter months. The provider anticipates elective activity will increase in the closing months of the year with a financial projection from GHFT of £1.0m above the contracted level, particularly in trauma & orthopaedics .	➔➔	1,000
South Warwickshire NHS Foundation Trust The current position has shown remained static this month with overspends in: • Non–elective activity for cardiology, care of the elderly, orthopaedics including major hip replacement, complex hip and knee joints • Day case activity for cardiology and trauma & orthopaedics	➔➔	355.0

5.2 Sustainability – Acute Contracts *(2 of 3)*

Acute NHS Contracts	Trend	Year end Forecast £'000
University Hospital Bristol NHSFT Performance against the contract continues to show an overspend within: • Non elective activity in cardiology and paediatrics • High cost drugs and devices, these include parenteral nutrition, Somatropin and Adalimumab • This is marginally offset by underspends within paediatric day cases	➔➔	750.0
North Bristol NHSFT The position is consistent with last month: • Underspending: elective activity in general surgery, urology & plastic surgery • Overspends in non elective activity within T&O, general surgery, Accident & Emergency (A&E) and obstetrics • There are still ongoing issues with data quality and challenges have been raised with the provider.	➔➔	(200.0)
University Hospitals Birmingham NHS Foundation Trust The contract overspend is maintained this month however overspends are showing within a number of areas including: • Elective pancreatic surgery • Non elective activity in cardiology, clinical haematology, general surgery and pancreatic surgery • Critical care activity	➔➔	280.0

5.2 Sustainability – Acute Contracts *(3 of 3)*

Acute NHS Contracts	Trend	Year end Forecast £'000
Ramsay Healthcare UK (Horton) Performance against contract has improved this month with an overall overspend within elective T&O activity for shoulder and feet above plan.	↑	76.6
Any Qualified Provider Contracts **Newmedica** – The activity for this contract has marginally increased again and the forecast overspend now totals £1.68m. Activity relates to ophthalmology ; predominantly cataract procedures. Waiting times for this provider are lower than alternatives; patients are therefore opting for this provider. A patient audit is being progressed and referral data is being assessed to more accurately predict future forecasts. **GP Care – Urology** – The £107k predicted overspend relates to activity increases above assumed contractual levels. **Care UK** – overspend of £200k in elective activity which is a slight improvement from the previous month, with overspends in T&O, ophthalmology and general surgery and out patient activity within ear, nose & throat (ENT) and general surgery specialties. **Oxford Fertility** – £128k underspend; this underspend has marginally decreased this month.	↑	1,992.0

5.3 Sustainability – Community

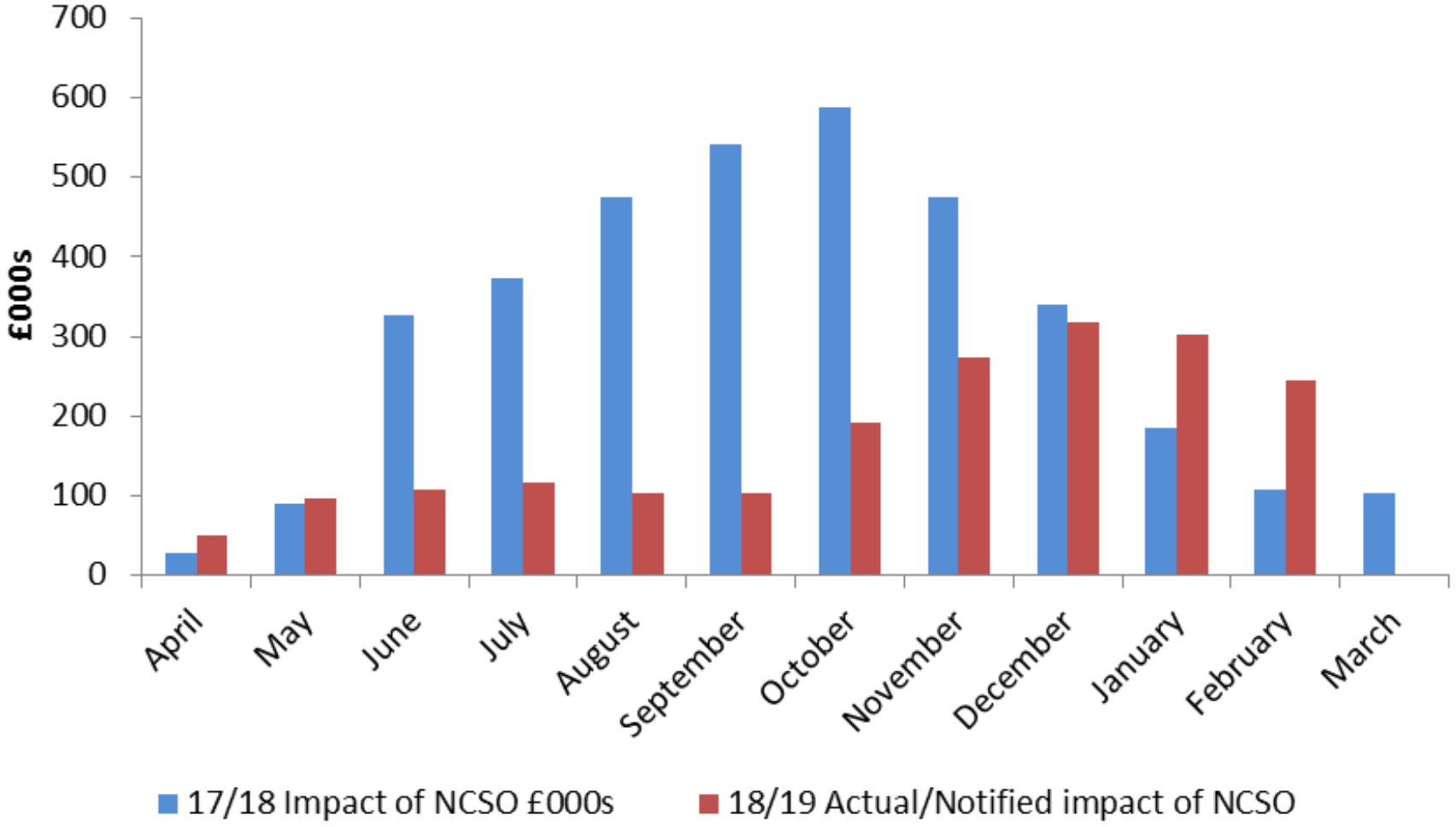
Community	Trend	Year end Forecast £'000
Gloucestershire Care Services NHS Trust ; the variable element of this contract is showing a forecast breakeven position There are overspends against Children in Care assessments which is mitigated by underspends in the Telehealth contract of £130k due to uptake being continually low.	↑	(61.5)

5.4 Sustainability – Prescribing

Primary Care Prescribing	Trend	Year end Forecast £'000
The latest data from the NHS Business Services Authority (NHS BSA) is for December. The prescribing costs when compared with the previous year, the cumulative position highlights a 4.0% reduction in spend (2.1% reduction in the month). The 2018/19 prescribing budget includes savings of £5m. As at December, Savings of £3.6m (71%) had been achieved which is slightly less than planned savings. There has been a significant increase in NCSO price concessions. The cumulative impact for NCSO is still less than previous years, the individual monthly impact is now higher in this financial year than the corresponding month for last financial year. A forecast underspend of £2.5m is currently included within the CCG's overall financial position, but, based on the BSA Forecast outturn, there is significant risk that this will be reduced further in March primarily due to increasing NCSO price concessions.	↓	(2,500)

5.4 Sustainability – Prescribing

Monthly Impact of NCSO on Drug Spend (January & February estimate based on known concession Price)



NHS Gloucestershire Clinical Commissioning Group

5.5 Sustainability – Mental Health

Mental Health	Trend	Year end Forecast £'000
Mental Health Services This area includes placement costs associated with patients with a learning difficulty and is characterised by low volumes of patients, each attracting a high cost and, therefore, fluctuations from the average can be significant. The current budget is predicated on the current number of patients in placements. A number of patients will transition as part of the Transforming Care agenda and funding has also been assumed, based on information from NHS England, to transfer in 2018/19 from specialist commissioners which will contribute to, but not wholly fund, the increased costs of care. The full impact of this potential cost pressure, although recognised as a risk, has not been included within the reported position at this stage. There has been an adverse movement due to an increase in Non contract activity and Learning Disabilities also continues to be overspent. Non contract activity predominantly relates to Birmingham & Solihull Mental Health Foundation. Contractual obligations are being reviewed to ensure compliance of the pre-notification process and, in particular, an agreement is being reached with AWPT regarding the CCG's liability for future costs.	↓	750.6

5.6 Sustainability – Primary Care

Primary Care	Trend	Year end Forecast £'000
Delegated Co-Commissioning – As anticipated last month, The forecast is showing an overspend of £641k relating to the pressure of the 1% general practice pay award. This is against a budget of £81.161m – Overspends for reimbursements to practices for maternity and sickness costs continues to be a growing pressure month on month.	➔➔	641.0
Other Primary Care – The reported position includes a forecast underspend of £641k which has been ringfenced to offset the overspend on delegated budgets relating to the practice pay award. – Underspends are forecast within the following budget areas: • Roche Diagnostics – There is new technology available which means the need for blood testing strips has been reduced. • Home Oxygen – is forecasting an overspend in contractual activity with Air Liquide. • Central Drugs prescribing is reporting an underspend due to reductions in non practice prescribing. • The primary eye care contract continues to report an underspend as activity is not reaching expected levels.	➔	(1,280.3)

5.7 Sustainability – Continuing Health Care

Continuing Health Care (CHC)/Funded Nursing Care (FNC)	**Trend**	**Year end Forecast £'000**
This area includes amounts for domiciliary care, nursing home placements, those in receipt of funded nursing care (FNC) and personal health budgets. The Learning Disabilities (LD) CHC service was transitioned into the wider CHC service in this financial year. As part of this process it revealed a number of LD cases (86) that were awaiting a full CHC assessment. Work is ongoing to clear this backlog; this is near completion. Procedures going forward have now been aligned to close gaps in process. The forecast on the backlog cases is based on a conversion rate from referral to assessment and uses an average cost per week based on current costs. For LD cases, the estimated conversion rate is subject to ongoing testing. Assessments continue to be monitored to test forecasted spend and assumptions are updated accordingly. A further process review has been commissioned and is ongoing in this area to ensure that the estimated potential cost of notifications of admissions received from nursing and care homes, prior to formal assessment, are fully reflected in the financial position.	↓	4,197.7

5.8 Sustainability – Other

Other	Trend	Year end Forecast £'000
• Estates budgets continue to show an underspend due to Property Services carrying out an annual review of estimated costs invoiced in 17/18 versus actual expenditure incurred; this exercise has resulted in credit notes being issued by NHSPS. • The non emergency patient transport contract is reporting an underspend relating to penalties being levied and non achievement of Commissioning for Quality and Innovation (CQUIN); both of these issues are currently under review. • NHS 111 continues to reporting an underspend which is predicated on an activity based contract. • This position has worsened in the Improved Better Care Fund (iBCF) which relate to placement costs from Gloucestershire County Council (GCC) for Older People and Physical Disabilities	↓	(210.8)

5.9 Sustainability - Savings Plan

- The 2018/19 savings plan totals £18.602m. Savings schemes developed, included opportunities identified through benchmarking including national RightCare comparisons.

- The savings plan for 2018/19 covers all the main STP delivery priorities. As at month 11, slippage amounted to 7.1% (£1,320k) of the programme after accounting for actions and mitigations. Main slippage areas are changes to policy (IFR / CBA), Pre-Op Healthy Lifestyles and Out of County Contracts.

- RightCare is an integral part of the savings programme for 2018/19 with a minimum of 38.7% (£7.2m) of the programme aligned to RightCare. Delivery is forecasted to be 76% of the RightCare Plan with the balance of 24% mitigated through risk share arrangements.

- The development of a savings plan for 2019/20 continues to be progressed with the focus now being on impact analysis (financial and quality outcomes) and benefits realisation ensuring robust KPIs are in place to monitor the impact of 2019/20 schemes. Saving plan alignment across the system is in progress.

5.10 Sustainability - Savings forecast delivery

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Savings Programme 2018/19

Area	Planned Savings 2018/19 £	Forecast 2018/19 £	Variance 2018/19 £
CPGs	3,882	4,086	205
Planned Care - Outpatients	1,131	1,385	254
Planned Care - Inpatients / Day Cases	1,318	244	(1,074)
Unscheduled Care	3,240	3,240	-
Prevention & Self-Management	375	361	(14)
Community & Other	1,966	1,616	(350)
Medicines Management	5,050	5,050	-
Other Secondary Care Medicines	250	250	-
Other	1,390	1,050	(340)
Grand Total	**18,602**	**17,282**	**(1,319)**

The main areas of slippage as at the end of M11 of 2018/19 after risk share and contract mitigations were as follows :

- Planned care changes (£687k), Out of County Contracts (£350k) and Pre-Op Healthy Lifestyles (£200k).

NHS Gloucestershire Clinical Commissioning Group

5.11 Sustainability – Risks & Mitigations overview for year

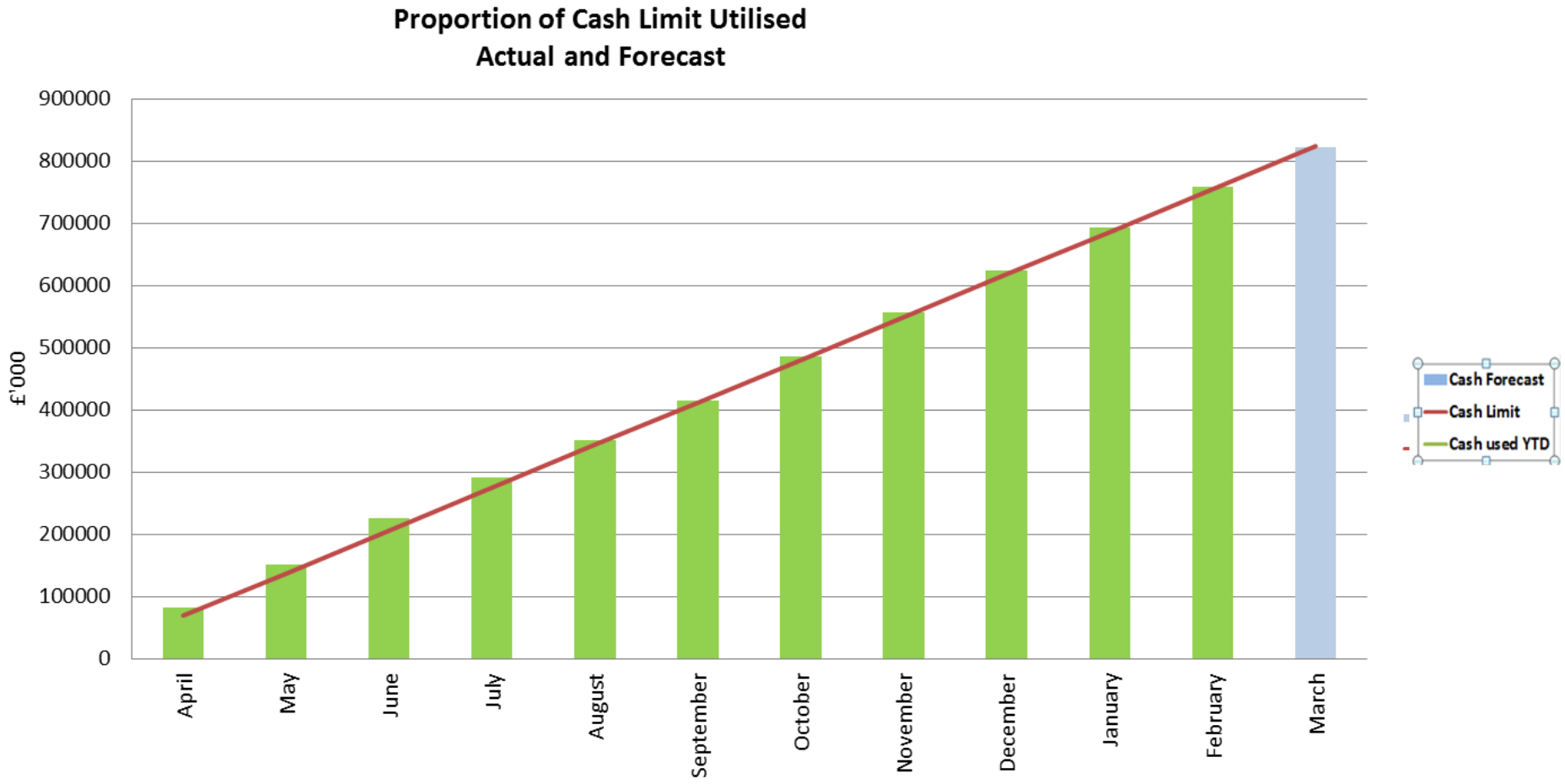
Risks

- Transforming Care/LD placements and CHC pressures (including backdated costs)
- Growth & demand pressures in acute contracts/AQP providers
- True impact of transfers of activity from Specialised Commissioning
- Limited reserves to cover additional cost pressures in year
- Slippage in delivery of saving solutions
- Prescribing volatility
- 2018/19 pay award costs exceed those funded centrally

Mitigations

- Slippage on developments – non-recurrently retained centrally
- Identify new savings schemes
- Urgent care reset plan
- Apply minimal contingency
- No controllable expenditure to be committed if no identified funding source
- Developments - release subject to business case sign off.

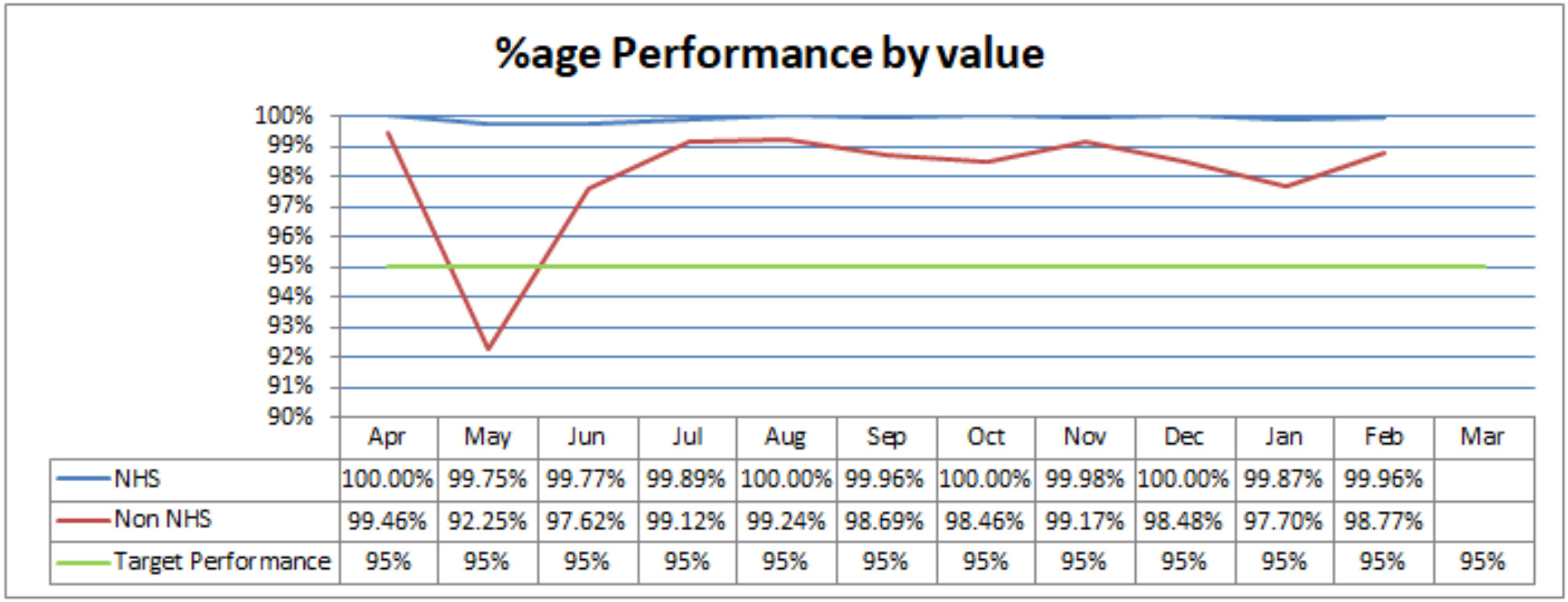
5.12 Sustainability – Cash Drawdown



At the end of February £807m had been drawn down (92.8%) of the maximum cash drawdown available of £869.6m.
The cash balance at 28th February 2019 was £13.3m.

NHS Gloucestershire Clinical Commissioning Group

5.13 Sustainability – BPPC performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS	100.00%	99.75%	99.77%	99.89%	100.00%	99.96%	100.00%	99.98%	100.00%	99.87%	99.96%	
Non NHS	99.46%	92.25%	97.62%	99.12%	99.24%	98.69%	98.46%	99.17%	98.48%	97.70%	98.77%	
Target Performance	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

NHS Gloucestershire Clinical Commissioning Group

5.14 Sustainability – I&E Position for Month 11 - February

Level 3 name	Level 4 name	Total Budget	YTD Budget	YTD Actual	YTD Variance	TOTAL Forecast Variance	Prv Mth Forecast Variance
PROGRAMME	ACUTE	398,405,405	365,086,597	370,052,442	4,965,845	5,702,655	5,566,099
	COMMUNITY HEALTH SERVICES	83,080,218	76,334,522	76,174,963	(159,559)	(61,533)	38,609
	CONTINUING CARE	44,161,671	40,480,821	44,536,410	4,055,589	4,197,693	4,144,890
	MENTAL HEALTH	85,440,189	78,355,112	79,168,029	812,917	750,622	687,463
	OTHER	31,896,559	29,204,205	28,919,737	(284,468)	(210,813)	(422,428)
	PRIMARY CARE	197,386,863	180,870,044	178,946,908	(1,923,135)	(3,139,385)	(3,730,385)
	RESERVES	15,430,096	14,152,946	6,980,073	(7,172,873)	(6,957,133)	(6,004,297)
PROGRAMME Total		**855,801,000**	**784,484,247**	**784,778,563**	**294,316**	**282,105**	**279,950**
ADMIN	CORPORATE	13,982,318	12,814,206	12,275,934	(538,272)	(551,423)	(544,487)
	RESERVES	(269,318)	(243,956)	0	243,956	269,318	269,318
ADMIN Total		**13,713,000**	**12,570,250**	**12,275,934**	**(294,316)**	**(282,105)**	**(275,169)**
SURPLUS	SURPLUS	21,465,000	19,676,250	0	(19,676,250)	(21,465,000)	(21,465,000)
SURPLUS Total		**21,465,000**	**19,676,250**	**0**	**(19,676,250)**	**(21,465,000)**	**(21,465,000)**
Grand Total		**890,979,000**	**816,730,747**	**797,054,497**	**(19,676,250)**	**(21,465,000)**	**(21,460,220)**

NHS Gloucestershire Clinical Commissioning Group

Statement of Financial Position
As at 28th February 2019 (Month 11)

	Opening Position as at 1st April 2018	Closing Position as at 28th February 2019
	£000	£000
Non-current assets:		
Premises, Plant, Fixtures & Fittings	369	265
Total non-current assets	**369**	**265**
Current assets:		
Trade and other receivables	5,667	8,144
Cash and cash equivalents	6	13,294
Total current assets	**5,673**	**21,438**
Total assets	**6,042**	**21,703**
Current liabilities		
Payables	(47,188)	(53,935)
Provisions	(2,637)	(1,853)
Total current liabilities	**(49,825)**	**(55,788)**
Non-current assets plus/less net current assets/liabilities	**(43,783)**	**(34,085)**
Non-current liabilities		
Total non-current liabilities	**0**	**0**
Total Assets Employed:	**(43,783)**	**(34,085)**
Financed by taxpayers' equity:		
General fund	(43,783)	(34,085)
Total taxpayers' equity:	**(43,783)**	**(34,085)**

If you require more information than the data provided in the Monthly Performance Report or Accompanying Scorecard please contact:

Performance Department - GLCCG.GCCGperformance@nhs.net

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Governing Body

Meeting Date	**Thursday 28 March 2019**
Report Title	**Quality Report**
Executive Summary	This report provides assurance to the Governing Body that quality and patient safety issues are given the appropriate priority.
Key Issues	The Quality Report provides an overview of activity undertaken within the CCG to monitor and improve quality of commissioned services. . The report highlights areas of strong performance and areas which may require increased surveillance.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	Failure to secure quality, safe services for the population of Gloucestershire
Management of Conflicts of Interest	Not applicable
Financial Impact	There is no financial impact
Legal Issues (including NHS Constitution)	Compliance with the NHS Constitution, NHS Outcomes Framework and recommendations from NICE and CQC.
Impact on Health Inequalities	A focus on the delivery of equitable services for the residents of Gloucestershire and which will reflect the diversity of the population served.
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	There is no impact
Recommendation	The Governing Body is asked to note the contents of this report.
Author	Marion Andrews-Evans
Designation	Executive Nurse and Quality Lead
Sponsoring Director (if not author)	Not applicable

NHS
Gloucestershire
Clinical Commissioning Group

Quality Report

28 March 2019

1	**Introduction**
	The Governing Body Quality Report is produced to provide assurance of the quality monitoring and support work being undertaken by GCCG with providers in county. Formal assurance of the quality of NHS services is by way of the Quality and Governance Committee, minutes of which are received by the Governing Body. This report provides succinct detail on activity undertaken and areas of strong performance or concern.
2	**Summary Serious Incidents & Never Events**
2.1	A 'Serious Incident' is defined by the National Patient Safety Agency (NPSA) as an incident that occurred in relation to NHS-funded services and care. These are often referred to as STEIS incidents after the reporting system. The Strategic Executive Information System (STEIS) allows us to break down the numbers being reported into categories.
2.2	Each reported incident and subsequent action plan is reviewed by the Quality Lead for that specific provider. This allows for identification of any potential themes or trends and can inform more in-depth discussions at the relevant Clinical Quality Review Group (CQRG). Full details, split by category, are provided to Quality and Governance Committee.
2.3	

Gloucestershire Hospitals NHF FT	Q3 17/18	Q4 17/18	2017/18 (Full Year)	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19 Jan & Feb
Never Event	2	1	7	1	1	0	0
Serious Incidents	3	16	34	11	6	5	3
	5	**17**	**41**	**12**	**7**	**5**	**3**

2.4

Gloucestershire Care Service NHS Trust	Q3 17/18	Q4 17/18	2017/18 (Full Year)	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19 Jan & Feb
Never Event	1	0	1	0	0	0	0
Serious Incidents	5	9	26	3	1	5	1
	6	**9**	**27**	**3**	**1**	**5**	**1**

2.5

[2]gether NHS FT	Q3 17/18	Q4 17/18	2017/18 (Full Year)	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19 Jan & Feb
Never Event	0	0	0	0	0	0	0
Serious Incidents	10	6	32	7	3	10	2
	10	**6**	**32**	**7**	**3**	**10**	**2**

2.6 **Themes identified from reported SI's Quarter 3**

GHNHSFT

GHNHSFT SIs appear to relate to poor systems rather than poor care. Themes include delays, patients being lost to follow up and missed opportunities.

GCS

GCS SIs themes include infection and poor catheter care. As numbers are low, this may be coincidence, but is something the Quality Lead is monitoring.

2g

Reporting follows the usual seasonal pattern- sadly the majority of SIs relate to self-harm events involving hanging and jumping.

3 Patient Advice and Liaison Service (PALS) Activity

Jan & Feb Q4 2018/19 not a complete quarter (PC) - numbers relating to GP Primary Care

3.1

Type	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Advice or Information	58 (PC16)	63 (PC20)	111 (PC 27)	1 (PC 12)	110 (PC 22)	31 (9 PC)
Comment	7	0	11		11 (PC 4)	0
Compliment	3	2 (PC1)**	4	2	2	1
Concern	41	55	*97*	110 (PC	75 (PC 22)	50 (10

	(PC15)	(PC 19)	(PC 23)	14)		PC)
Complaint about GCCG	5	2	2	5	7	5
Complaint about provider	21 (PC4)	9 (PC2)	22	18	18 (PC 5)	16
NHSE complaint responses copied to GCCG PALS	1	0	1	0	0	1
Other	8	68	32 (PC 4)	52 (PC 5)	34 (PC 4)	40
Clinical Variation (Gluten Free)	0	3	0	2	0	0
Total contacts	**144**	**202**	**280**	**288**	**257**	**144**

3.2 **Themes identified from PALS Contacts**

PALS have received several contacts relating to the Aspen Medical Centre. These have been with regards to accessing appointments, prescriptions, and excessive waiting times on the telephone. Two of the patients PALS have spoken with said they are considering registering somewhere else. The CQC have also been contacted by patients and this formed part of their recent inspection.

There has been no particular themes identified from PALS contacts. The above figures for Quarter 4 are for January and February 2019 only.

4 Infection Control

4.1 **Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections**

NHS Improvement (NHSI) has set a countywide threshold target of six MRSA Bacteremia infections for 2018/19. From 1 April 2018 to 10

March 2019 there have been thirteen cases. Seven cases have been attributed to community acquisition and six cases have been attributed to hospital acquisition. Five of these cases are linked to intravenous drug misuse. A review group is in place. It is led by a Public Health consultant and has countywide representation from health providers. As a result of changes to the needle exchange service there has already been a reduction in the number of cases in IV drug users.

4.2 **Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia Infections**

During the period 1 April 2018 to 28 February 2019 122 MSSA Bacteraemia Infections cases were reported. 87 cases (71%) were community acquired and 35 cases (29%) hospital acquired infections. Currently there is no threshold target for MSSA.

4.3 **Clostridium difficile Infections (CDI)**

The threshold set by NHS Improvement (NHSI) for Gloucestershire countywide is 156 cases of CDI in 2018/19. From 1 April 2018 to 28 February 2019 there were 173 CDI cases reported countywide. Of these 173 cases 55 cases (32%) were hospital acquired and 118 cases (68%) community acquired.

4.3.1 **Data from Public Health England (PHE)**

It is known that a percentage of the cases currently described as community onset had a recent hospital admission. However from 1st April 2019 changes are being made to the data capture system to report cases differently. After this date the percentage of people with a hospital onset is likely to increase with a decrease in community onset, due to patients who have recently been in hospital and an active CDI when they are at home will now be counted as hospital acquired.

4.3.2

CDI cases in Gloucestershire 2015/16 – 2018/19					
CDI	**Threshold 2018/19**	**2018/19 Up to 28/02/19**	**2017/18**	**2016/17**	**2015/16**
Community onset		68	127	121	108
Hospital onset (CGH &		55	77	44	48

GRH)					
Total no.	156	173	204	177	157

4.3.3 **Data from Post Infection Reviews (PIR)**

The two key risk factors highlighted are hospital admissions and antibiotic use.

- Hospital Admission
  There is a strong association between hospital admission and the onset of CDI. During 2018/19 the Countywide Action Plan to reduce CDI has had a hospital focus including improving the environmental hygiene.

- Antibiotic Use
  The Post Infection Reviews (PIR) demonstrated a link between co-amoxiclav use and CDI.

4.3.4 **Risk Factor analysis**

An analysis of risk factors in primary care shows the need to;

- Manage CDI risk factors as part of a comprehensive CDI reduction strategy. Examples include compliance with antibiotic PPI and loperamide prescribing guidelines

- Best Practice guidelines for treatment/management of CDI are not met consistently. Examples include delays in stool sampling, delays in commencing treatment until a stool test result received from lab confirming CDI and not using a severity rating scale to determine severity of illness and treatment required.

4.3.5 **What can be done to reduce the number of CDI cases with a community onset**

- Action Plan to reduce CDI in Gloucestershire
  During 2018/19 the CCG has led on the formation of the CDI Assurance Group to coordinate a countywide strategy to reduce CDI in Gloucestershire. A monthly meeting is held with representation from all the health providers. The strategy includes surveillance, Post Infection Reviews, lessons learned, risk factor management, promoting best practice, audit and widely disseminating learning.

- Examples of actions taken in response to learning during 2018/19 include;
    - The Hospital and Primary Care prescribing guidelines have been changed for antibiotics to lower the use of co-amoxiclav and improve compliance with guidelines for PPIs and loperamide
    - Promoting best practice for treatment/management of CDI. Specific issues addressed include responding promptly with CDI suspected and following the guidelines
    - A focus on environmental cleaning in hospitals

- Actions planned for 2019/20
    - Continued leadership by the CCG for the CDI Assurance Meeting. The strategy being reviewed to include latest guidance from NHS Improvement.
    - Training for Practice Nurses in Infection Prevention and Control.
    - Development of a Primary Care Infection Prevention and Control Group to support Infection Control Champions.

4.4 **Escherichia coli (E.coli) Infections**

The Quality Premium for 17/19 (two years) includes an annual threshold target of 257 incidences of E.coli Bloodstream infections.

To date in 18/19, the number of cases 267 cases is above the trajectory of 148 cases. Of the 267 cases 82% were community acquired and 18% hospital acquired. In 17/18, the threshold was exceeded by 19 cases. A key are of focus to reduce the incidence of E.coli is improvement in catheter care.

4.5 **Flu vaccinations**

The County-wide Health Care Acquired Infection Group, chaired by the GCCG, has been holding weekly telephone conferences in response to an increase in the numbers of Care Homes and hospital beds closed with respiratory outbreaks and information that influenza was circulating more widely. The call involves local providers, Care Home Support Team, local Public Health team and Public Health England.

The CCG continues to support GP Practices by monitoring issues related to accessing vaccines and acting as the local co-ordinating lead following NHSE guidance. The CCG supported local re-distribution of

	the aTIV vaccines for people aged 65 years and over, and also liaised with NHSE who sourced surplus aTIV across the South West. Preliminary data from 'ImmForm' on Gloucestershire flu vaccination rates show that most care groups are within 5% of figures from last year. The CCG launched an 'It's Not Too Late To Vaccinate' campaign and more targeted comms for people in high risk groups via social media. However, GP Practices are to be commended for the higher rates of vaccinations for 2 and 3 year olds.
4.6	**Flu Vaccination Evaluations** Evaluation on the effectiveness of the flu vaccination campaign is currently being undertaken. Results should be available in April/May and will be shared with relevant CCG Committees. The outcomes from these evaluations will inform future planning.
5	**CQC**
5.1	**Gloucestershire Hospitals NHS FT** The CQC inspection of GHNHSFT took place in October 2018 with a CQC 'Well Lead' visit in November. The subsequent report being published in January 2019. The overall rating for the Trust is 'Good' with 'Responsiveness' identified as 'Requires Improvement'. GHNHSFT have commenced work on a Quality Improvement Action Plan relating to the themes identified.
5.2	**Gloucestershire Care Services** **GCS CQC action plan (QIP)** GCS have informed the CCG that they are unlikely to meet their improvement target in relation to mandatory training and completion of PDR's and are in dialogue with CQC about this. The CCG anticipate that the plan will be formally agreed as complete and signed of at the March CQRG and any remaining items will be monitored via the usual quality monitoring processes.

5.3	**2g NHS Foundation Trust** 2g report that good progress was being made on the implementation of identified actions in relation to the CQC Action Plan, and all the remaining actions were now on course and classified as amber. It is anticipated that the action plan will be closed down at the end of March 2019 and any remaining actions will be mainstreamed into the relevant areas of business as usual. CQC have informed the Trust that they will be undertaking a thematic review in respect of restraint, seclusion and segregation. This visit will take place on 3rd April 2019
5.4	**Care Homes** Information from the CQC website shows current ratings for Gloucestershire Care Homes (Nursing and Residential, all adult Ages and Care Groups): • Outstanding 5% • Good 83% • Requires Improvement 12% • Inadequate 0 This continues to be an improving picture and slightly better than the National figures. It is significant that there are no Gloucestershire Care Homes with an overall CQC rating of Inadequate and commendable that there are 12 Care Homes with an overall CQC rating of Outstanding. There is local multiagency approach for support and training for quality improvements for Care Homes to meet CQC requirements
5.5	**Primary Care CQC Inspections** Four GP Practices in Gloucestershire have a current CQC overall rating of 'Outstanding'; the majority have a rating of 'Good' and 2 have a rating of 'Requires Improvement'. Included in these figures are the 2 GP Practice CQC ratings published in the last 3 months: 1 with overall rating of 'Good' and 1 with an overall rating of 'Requires Improvement'. The 'Requires Improvement' report contains an 'Inadequate' rating for 'Safe' with medicines management highlighted as a key issue. The CCG is supporting this Practice with Pharmacist assistance.

6	**Provider Updates**
	Gloucestershire Hospitals NHS FT
6.1	**Safe Staffing.** The Chief Nurse reported at the November 2018 Quality and Performance Committee that overall staffing fill rates had improved when compared with previous months, particularly for the medical division. It was also reported that the move between bank and agency nursing staff use had improved and the Trust are also continuing work on the long-term plan to reduce agency staff use in 2019. Concerns have been noted about the Acute Medical Unit (AMU) bank and agency use which has been reported as 52%. This has raised concern about staff morale especially over the winter period. Assurance has been sought by the CCG around agency staff induction and monitoring to which the Chief Nurse has advised that agency staff working a number of shifts on AMU were being treated as though they were permanent staff. This concern has also been added as an agenda item for the Trust's People and Organisational Development Committee to review as an issue. It has also been noted by the Chief Nurse that there is a correlation between higher Nursing Assessment and Accreditation System (NASS) scores on wards with higher substantive fill.
6.2	**Cancer Performance** Cancer performance remains a priority for the operational teams and there continues to be a significant concern relating to the 2 week wait (2WW) and 62 day pathway. The Trust have seen increased referral rates for gynaecology and urology remains a speciality of concern with the greatest under-delivery. Monthly performance meetings with the CCG are in place through the standard contractual route. Joint 2WW quality improvement projects are ongoing especially associated with the dermatology referral surge over the summer. Monthly requests for all patients over day 75 are provided to NHSI. The Trust are continuing to work with the CCG on a joint project working with Primary Care to assess the quality of referrals

	received under the 2 week wait and an audit on patient information leaflets.
6.3	**2g NHS Foundation Trust** **PLACE Assessment Report 2018** The Trust reported positive feedback on the above report. They achieved very positive results placing 2g above the UK national average for Mental Health and Learning Disability settings in all of the six domains for the first time since PLACE began in 2013. Performance against cleanliness was reported as good this year and the Trust overall score was 1% higher than the National average, with four of the seven sites assessed scoring 100%. 2g scored well this year against the Food assessment and the Trust overall score was 4% higher than the National average. The ward 'food tasting' scored particularly well this year with four out of their six sites scoring 100% for taste, texture, temperature and appearance. In comparison with their local healthcare partners in Gloucestershire the Trust achieved a higher average domain score than GCS and GHT in all domains. In terms of individual site ranking Charlton Lane achieved the highest site average score of 97.14 followed closely by Berkeley House who achieved 96.87%. This year 2g reported that the Mental Health / Learning Disability average is higher than the national average in most domains. The overall results clearly demonstrate how as a Trust they are improving the quality of the non-clinical services to their patients and are to be commended on this performance.
7	**Quality Team Activity**
7.1	**Dysphagia Management** The NHS issued a Patient Safety Alert in June 2018 requesting NHS organisations eliminate imprecise terminology including 'soft diet' and 'thickened' for those receiving modified texture foods and fluids for the management of dysphagia. To do this, the PSA recommended the implementation of the IDDSI framework by 1st April 2019.

	The International Dysphagia Diet Standardisation Initiative (IDDSI) http://iddsi.org/ developed standardised terminology and definitions for texture modified foods and fluids for people with dysphagia. The framework consists of a continuum of eight levels (0-7). The CCG Dietitian has been supporting GHT, GCS and 2g to implement this framework and will be fully compliant by 1st April 2019. GP practices will be made aware of IDDSI and that new patients will be assessed by Speech and Language Therapy using the IDDSI descriptors. To further support improvements in patient safety in the management of dysphagia, the One Gloucestershire Medicines Optimisation Group has approved the implementation of a 'one thickener' policy to standardise the preparation of modified texture fluids. All appropriate inpatients will be prescribed Nutilis Clear (Nutricia) from 15th March 2019 and new patients in the community will be issued with this as well.
7.2	**Gloucestershire CCG Primary Care Prescribing Costs Position (ePACT prescribing data to Dec 2018).** The CCG's overall prescribing cost for 2018-2019 is forecast to be on track to achieve the £5m savings plan, as well as delivering a surplus. This "surplus" has reduced compared with earlier surplus forecasts in the Autumn due to changes in the "No Cheaper Stock Obtainable" (NCSO) inclusion/price lists, which fluctuate frequently, and over which CCGs have no control. The Annual Prescribing Improvement Plan (PIP) review meetings have recently occurred within many localities. The meetings have been well attended, and representatives of the GP practices have discussed their savings and improvement outcomes in general. These meetings allow a good opportunity for Practices to share their experiences with colleagues, often identifying mitigating circumstances and finding out how colleagues have approached and managed similar challenges.

Agenda item 11

Governing Body

Meeting Date	**28th March 2019**
Title	**Proposal to establish Integrated Locality Partnerships (ILPs) across Gloucestershire**
Executive Summary	This purpose of this paper is to appraise the Governing Body of the CCG on the development of our thinking on our place based approach and to update on the three Integrated Locality Partnership (ILP) Pilots in the county. This papers seeks authorisation for the introduction of ILPs across Gloucestershire following: National recognition of Gloucestershire as an Integrated Care System in May 2018; Governing Body's mandate to work with partners to agree the number and boundaries of ILPs given in October 2018 and; the formalisation of GP practice clusters to Primary Care Networks as outlined in the Long Term Plan launched in January 2019. The content of this paper and thinking contained within it have been developed from the learning from the three pilot sites in Forest of Dean, Stroud & Berkeley Vale and Cheltenham. A considerable number of meetings, conversations and presentations have been given across the county on place based and a list of the majority of these is included below: • ICS Delivery Board – 17th January 2019 • 2g and GCS Executives – 23rd January

	2019 • GCS and 2g senior leadership network – 29th January 2019 • Countywide Patient Participation Group (PPG) meeting – 8th February 2019. • GSF – 26th February 2019 • Tewkesbury Borough Council – 28th January 2019 • Gloucester City Council – 20th February 2019 • Cotswold District Council – 26th February 2019 • FOD District Council – 26th February and 25th March 2019 • Cheltenham Borough Council – 6th March 2019 • Joint meeting with all district council Chief Executives – 18th March. • 2g Board –27th March • GCS Board –28th March • Stroud District Council due on 24th April.
Key Issues	This paper covers the following key issues: • Our approach to place based through Primary Care Networks and Integrated Locality Partnerships; • Proposed number of ILPs and their boundaries; • Staffing to support to ILPs; • Budgetary responsibility; • Funding; • Governance; • Evaluation; • Risks and mitigations;

	• Next steps.
Risk Issues: **Original Risk** **Residual Risk**	Risks and mitigations are included as Appendix E of this document.
Financial Impact	Yes. For ILPs, GCCG will make funding available for the ILP GP Chair, administration function and any other associated (e.g. venue) costs.
Legal Issues (including NHS Constitution)	The proposal included within this document will require a change to the CCG's NHS Constitution, predominantly the dissolution of Locality Executive Groups. The Constitution will undergo a substantial revision later in the year and the impact of the ILP changes will be incorporated into the revised Constitution.
Impact on Health Inequalities	Yes. Working in a place-based integrated way, with a focus on population health management, will accelerate the pace of service improvement to deliver programmes to address health inequalities.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	Yes. Working in a place-based integrated way, with a focus on population health management, will accelerate the pace of service improvement to deliver high quality out of hospital care for the local population in turn contributing to a sustainable model of care provision.
Patient and Public Involvement	Yes. Attendance and presentation at countywide Patient Participation Group in February 2019. PPG representatives attend ILP meetings in Stroud and Berkeley Vale and Forest of Dean.
Recommendation	CCG Governing Body is asked to approve the introduction of ILPs across the county from April

	2019. The Boards of 2gether NHS Trust and Gloucestershire Care Services NHS Trust will be asked for approval at their respective meetings in March 2019.
Author	Helen Edwards
Designation	Associate Director of Primary Care and Locality Development
Sponsoring Director (if not author)	Helen Goodey Director of Primary Care and Locality Development

Proposal to establish Integrated Locality Partnerships (ILPs) across Gloucestershire

1. Introduction

This purpose of this paper is to appraise the Governing Body of the CCG on the development of our thinking on our place based approach and to update on the three Integrated Locality Partnership (ILP) Pilots in the county. This papers seeks authorisation for the introduction of ILPs across Gloucestershire following national recognition of Gloucestershire as an Integrated Care System in May 2018; Governing Body's mandate to work with partners to agree the number and boundaries of ILPs given in October 2018 and the formalisation of GP practice clusters to Primary Care Networks as outlined in the Long Term Plan launched in January 2019.

The content of this paper and thinking contained within it have been developed from the learning from the three pilots sites in Forest of Dean, Stroud & Berkeley Vale and Cheltenham. A considerable number of meetings, conversations and presentations have been given across the county on place based and a list of the majority of these is included on the cover sheet.

2. Context

We know that to have sustainable health and care services in Gloucestershire we need to work collaboratively as one integrated system to deliver the vision and ambitions we set out in our Sustainability and Transformation Plan (STP). As an Integrated Care System (ICS) we will take collective responsibility for managing resources, delivering NHS standards, and improving the health and wellbeing of the population we serve - breaking down barriers to deliver better health and care.

As an ICS we have a real opportunity to do more at pace and at scale in Gloucestershire than ever before. We want to continue to encourage a population based approach to improving health and care through the delivery of place based care. This will include the alignment with the other public services working across Gloucestershire in order to address the wider social determinants of physical and mental health. We will build on the Health and Wellbeing Strategy using Population Health Data to drive the identification and prioritisation of the most appropriate

response to the management of care. By removing silos of provision, we will incentivise providers over health outcomes not levels of activity, working together in an integrated delivery model.

We want to deliver place-based care by moving fully to a neighbourhood model. This will see multi-disciplinary teams working together to serve natural populations of around 30,000-50,000 people, and making the most of the many supportive 'community assets' such as voluntary and community groups that also work within our neighbourhoods.

We are proposing a placed based, person-centred model of proactive community based care, closer to home, with primary care at its heart. This entails not just integrating health and social care but a joined-up approach with education and skills, welfare and benefits, leisure, housing and community safety programmes to deliver a more appropriate mix of medical and social interventions to tackle the root cause of health inequalities.

We want to strengthen our wider primary care provision so that we can pro-actively more manage patients in the community and see the shift in people attending hospital who could be better supported in the community.

In working together, the partners will have greater freedom and control to make decisions about services and their use of the Gloucestershire pound, meaning services and support can be best targeted towards local needs. The seven partners in our ICS - Gloucestershire County Council (GCC), Gloucestershire Care Services (GCS) and 2gether NHS Trust (2GNHST), Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), Primary Care, South West Ambulance Service NHS Foundation Trust (SWASFT) and the CCG - are committed to moving forward with system-wide models of care, making sense of the problems we face together and encouraging innovative solutions at all levels.

We believe that uniting as an Integrated Care System will enable the acceleration of the benefits realisation we are already seeing from the more integrated whole system working we have progressed to date.

3. Background

The development of Integrated Locality Partnerships (ILPs) and Primary Care Networks (PCNs) will be the mechanism through which we deliver place based care, underpinning a fundamental shift in the delivery of care within the community. PCNs and ILPs are our "system architecture" to enable delivery of the Long Term Plan.

Our vision for General Practice is that it will continue to be the foundation of the health system, maintaining its position as the leaders of primary care, retaining its identity and registered list. It will build on these strengths by working in larger groups as part of wider primary and community teams, across a range of sites delivering care with improved access, quality and outcomes, as close as possible to people's homes. These larger partnerships of GP practices working together alongside other community health services such as the voluntary sector will be known as Primary Care Networks.

PCNs will enable the provision of proactive, accessible, coordinated and more integrated primary and community care improving outcomes for patients. They will be formed around natural communities based on GP registered lists, often serving populations of 30,000 to 50,000.

There are currently 16 PCNs (previously known as clusters) across Gloucestershire, although some of these collaborate to deliver services such as Improved Access. They are made up of groups of GP practices that are geographically close and that share similar patient boundaries, often with a long history of working together. We may see a revision to a lower number of PCNs especially in Gloucester City and Stroud.

4. Integrated Locality Partnerships – how will they work?

During 2019-20 we aim to develop ILPs across Gloucestershire building on the current ILP pilots we implemented in 2018-19. ILP's will have a key role in bringing together health and social care at a district level. Initially they will be an Operational and Strategic partnership of senior leaders of health and social care providers and local government, supporting the integration of services and teams at PCN level. Their role will be to unlock issues for PCNs and share responsibility, working with

PCNs, to find local solutions to delivering ICS priorities and tackling issues which arise locally which can only be resolved collectively. Integrated Locality Partnerships (ILPs) and Primary Care Networks (PCNs) will be where health and care organisations come together to develop and deliver coordinated and integrated care using population health management to ensure appropriate joined up local services for patients.

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

Based upon learning from the pilots we envisage that ILPs will have the following characteristics and responsibilities:

- Operational and Strategic partnership of senior leaders of health and social care providers and locally elected government and lay representatives informing and supporting integration at PCN level, unlocking issues and sharing responsibility for finding local solutions to deliver ICS priorities and tackling issues which arise locally which can only be resolved collectively.
- Clinically-led integration, involving staff and local people in decisions, to support more people in the community and out of hospital.
- An ILP Plan to deliver improved population health including prevention and public health and reduced inequalities with aligned priorities agreed to improve outcomes.
- Develop multidisciplinary workforce models which will operate at PCN level with staff empowered to work in new and innovative ways to meet the needs of patients regardless of organisational boundaries.

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

ILPs will hold monthly meetings but may prefer to hold a quarterly strategic meeting with more operational meetings in between designed to focus on and support the PCNs.

Our ambition is that each ILP will benefit from interaction with a local Lay Reference Group or ILP Assembly, with representatives from practice Patient Participation Groups (PPGs), community and voluntary groups and Healthwatch Gloucestershire volunteers. ILP Assemblies will ensure that the patient and carer voice is heard and influences ILPs' objectives. ILP Assemblies will have representation on ILPs and the network of ILP Assemblies will have the opportunity to inform the countywide ICS Assembly.

5. Integrated Locality Partnerships – what will they do?

ILPs will develop a plan to deliver a defined population strategy including prevention and public health and reduced inequalities, with aligned priorities to improve outcomes, informing 'upwards' for contractual incentive alignment, and supporting 'downwards' to Primary Care Networks through, for example, developing multidisciplinary workforce models. While this work will be clinically led it will reach out to other local agencies, for example third sector, and will also involve staff and residents in decisions.

From our existing ILP pilots we have already seen some exciting developments which have only been achievable through working closely together, as follows:

Working with Care Homes: in Stroud and Cheltenham, networks have built closer relationships with care homes by agreeing which GP practice covers which care home. The ultimate aim is to better support residents who are at risk of deteriorating by: using an MDT approach, advanced care planning, using the "red bag scheme" and "orange folder" and joint training on the Rapidly Deteriorating Patient which is delivered by GCS staff.

Workforce Models: networks have a range of new professionals in their practices, many of whom are employed by one of our ICS partners. For example paramedics, employed by SWAST, who undertake home visits and Advanced Physiotherapist Practitioners from GCS who see and treat patients who are care navigated directly to them from reception.

Dementia: Stroud Rural Network developed a pilot in conjunction with 2gether, whereby Community Dementia Nurses coordinated all annual reviews of the network's patients, recording information only the practice's respective clinical system. This reduced duplication, reduced the cost of prescribing and reduced the length of time some people stayed in hospital.

Utilising Existing Services Better: A part of the role of the ILP is to ensure constituent networks are aware of and utilise existing services such as the Ambulatory Emergency Care Unit at the hospital as an alternative to admission. Cheltenham ILP, for example, has embraced the new Complex Care at Home Service and worked actively with GCS to refer the most appropriate cohort of patients. 10 people need to be referred to Complex Care at Home from Cheltenham GP surgeries each week, to help us meet our ICS solutions. This service will commence in Forest of Dean early in 2019.

Introduction of Multi Disciplinary Teams (MDT) meetings: MDT meetings are operational in Berkeley Vale, Cheltenham St Paul's and the Forest of Dean. MDTs include staff from primary care, the Community Wellbeing Service, GCS (or a mixture of Complex Care at Home, Integrated Community Team, Rapid Response) and 2gether as a minimum, and pull in staff from other organisations, including district councils, on a case by case basis. The MDTs meet monthly to review cases and nominate a coordinator for each patient's care. In these pilots the administrative work has been undertaken by GCS.

6. Number of ILPs and their boundaries

A considerable amount of engagement has taken place particularly with our council colleagues over the number of ILPs, their boundaries, PCNs and their constituent practices. As a result of these conversations the proposal is for us to move to 6 ILPs that contain PCN collaborations as follows:

- Forest of Dean ILP – 1 PCN (as is plus Newent and Staunton): Attended by Forest of Dean LA.
- Gloucester City ILP – 5 PCNs (as is; although the number of PCNs is likely to reduce from 5 to 4): Attended by Gloucester LA
- Cheltenham ILP – 3 PCNs. Attended by Cheltenham LA
- Stroud & Berkeley Vale ILP – 4 PCNs (as is; although the number of PCNs is likely to reduce to 3). Attended by Stroud LA
- Cotswolds - 1 ILP and 2 PCNs. Attended by Cotswold LA
- Tewkesbury ILP – 1 PCN (Tewkesbury town centre practices plus West Cheltenham Practice). Attended by Tewkesbury LA with communication links to practice populations in Gloucester, Forest and Cheltenham.

The above is shown pictorially in Appendix A.

Our proposal is to move to geographical coverage of ILPs in April 2019.

7. Staffing to support ILPs

Dedicated project management support will be provided to each ILP via a named manager (currently termed Locality Manager). Whilst employed and managed by the CCG and retaining current terms and conditions, it is anticipated that these staff will work far more closely with clinical leaders in their ILP and constituent PCNs to support projects based on the needs of each PCN\ILP which involve system-wide partners.

Administration of ILP meetings will be provided either by administrative staff who currently service Locality Executive Groups or by new appointments as appropriate in each geographical area.

Information, population health management and finance resource will be provided by CCG staff and Public Health colleagues who will support the projects that each ILP is delivering.

A People Framework for Integrated Services was agreed by Gloucestershire's Local Workforce Action Board (LWAB) in July 2018. The framework describes the principles and arrangements for the delivery of an integrated service by staff who are employed by different organisations.

8. Budgetary Responsibility

The ILPs, as they mature, may seek to be empowered to independently manage a capitated budget for their registered population for specific pathways or entire settings of care for the registered population of that geographical area. In addition the new GP contract framework makes provision for a Network Impact Fund commencing in 2020. The fund will be linked to performance against metrics in the Network Dashboard. PCNs will need to agree with the ICS how funding is re-invested with an intention for it to be used for additional workforce and service expansion. Further governance will be developed for any such arrangements by the ICS.

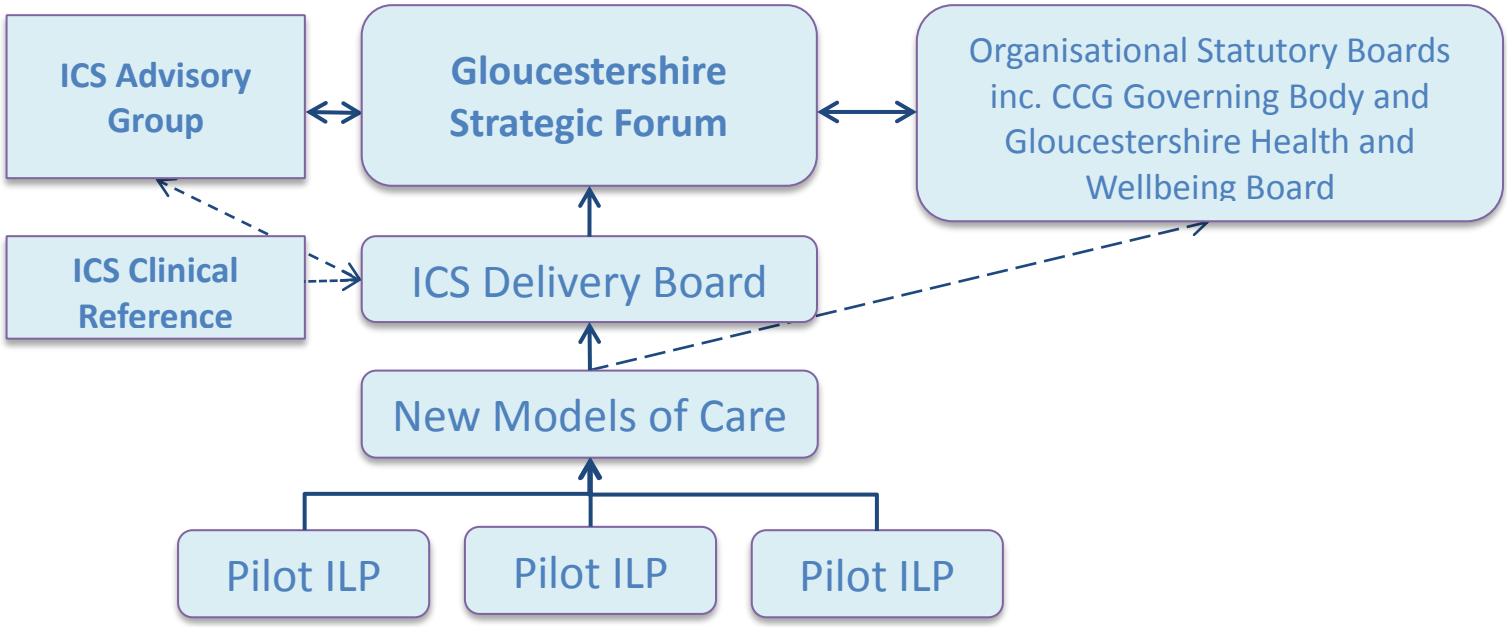
9. Funding of Primary Care Network and Integrated Locality Partnership development

PCNs are entitled to a range of additional national funding to support their development. The CCG will follow national contractual guidance on this matter.

For ILPs, GCCG will make additional funding available for the ILP GP Chair, administration function and any other associated (e.g. venue) costs.

10. Governance arrangements

As with the three pilots, ILPs will report to the ICS Board via the New Models of Care Board (NMOC Board) and Governing Body, as shown below.



The diagram at Appendix B shows reporting arrangements of ILPs and function by geographical area.

It is envisaged that GP Clinical Commissioning Leads will continue to be members of the GCCG Governing Body. Engagement responsibility regarding commissioning rests with the GP Clinical Commissioning Leads on the Governing Body and it remains their responsibility to liaise with practices. GP Clinical Commissioning Leads will attend ILP meetings to update on changes to commissioning arrangements and to receive feedback from system partners. ILP members would need appraise the GP Clinical Commissioning Lead of any potential changes to commissioning arrangements identified locally and seek CCG agreement. There will be a clear demarcation of the agenda to distinguish between commissioning and service provision. An example agenda is shown as Appendix C.

Locality Executive Groups will no longer exist as ILPs emerge in each area. Responsibility for the arrangement of educational events and particularly Protected Learning Time events will move to PCNs. PCNs

can work collaboratively across an ILP for ILP wide learning events as determined by local priorities. The proposal to stand down the Locality Executive Groups will require a change to the CCG's NHS Constitution which will undergo a substantial revision later in the year. The ILP changes will be incorporated into the revised Constitution.

11. Evaluation

All of the projects within the remit of the ILPs are subject to evaluation. The individual projects are overseen by the One Place Evaluation Steering Group, chaired by the CCG's Director of Nursing and Quality, with system wide representation including Public Health. The projects use consistent evaluation and Clinical Governance frameworks which were included as appendices in the original ILP paper approved by Governing Body members in December 2017.

It would be prudent to evaluate how effective the ILPs are in terms of functioning as a shared decision making forum across the ICS. Attached as Appendix D, is a draft self-assessment ILP Effectiveness Template which could be introduced and used by ILPs.

12. Risk and mitigation

There are a number of key risks associated with the introduction of Integrated Locality Partnerships countywide which are described in Appendix E. High level major risks will be incorporated into the CCG's Corporate Risk Register and Governing Body Assurance Framework as appropriate.

13. Next Steps

The opportunity to establish ILPs countywide has been developed following extensive discussion with Provider Chief Executives including the County and district councils, CCG Governing Body members, Provider Lead GPs, cluster lead GPs and Locality Executive Group GPs across the county.

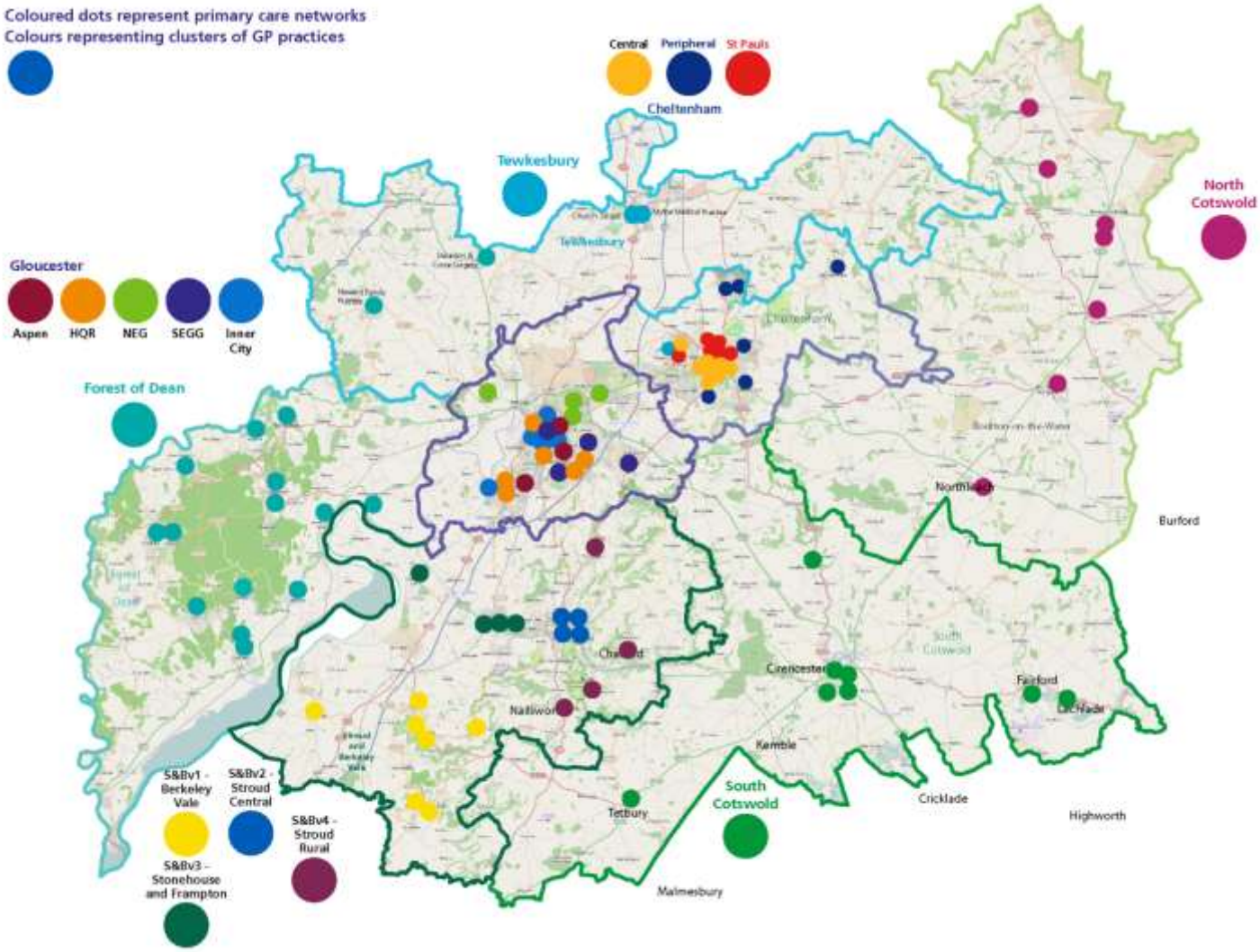
Specific next steps are to:

- seek agreement from the CCG Governing Body, 2g and GCS Boards to roll out ILPs across Gloucestershire.
- commence ILP meetings in Tewkesbury and Cotswolds,
- develop the Gloucester City Pilot Board to a Gloucester City ILP
- remove the pilot status from the partnerships in Stroud and Berkeley Vale, Forest of Dean and Cheltenham.
- issue revised Terms of Reference to all the partnerships
- revise the CCG Constitution.

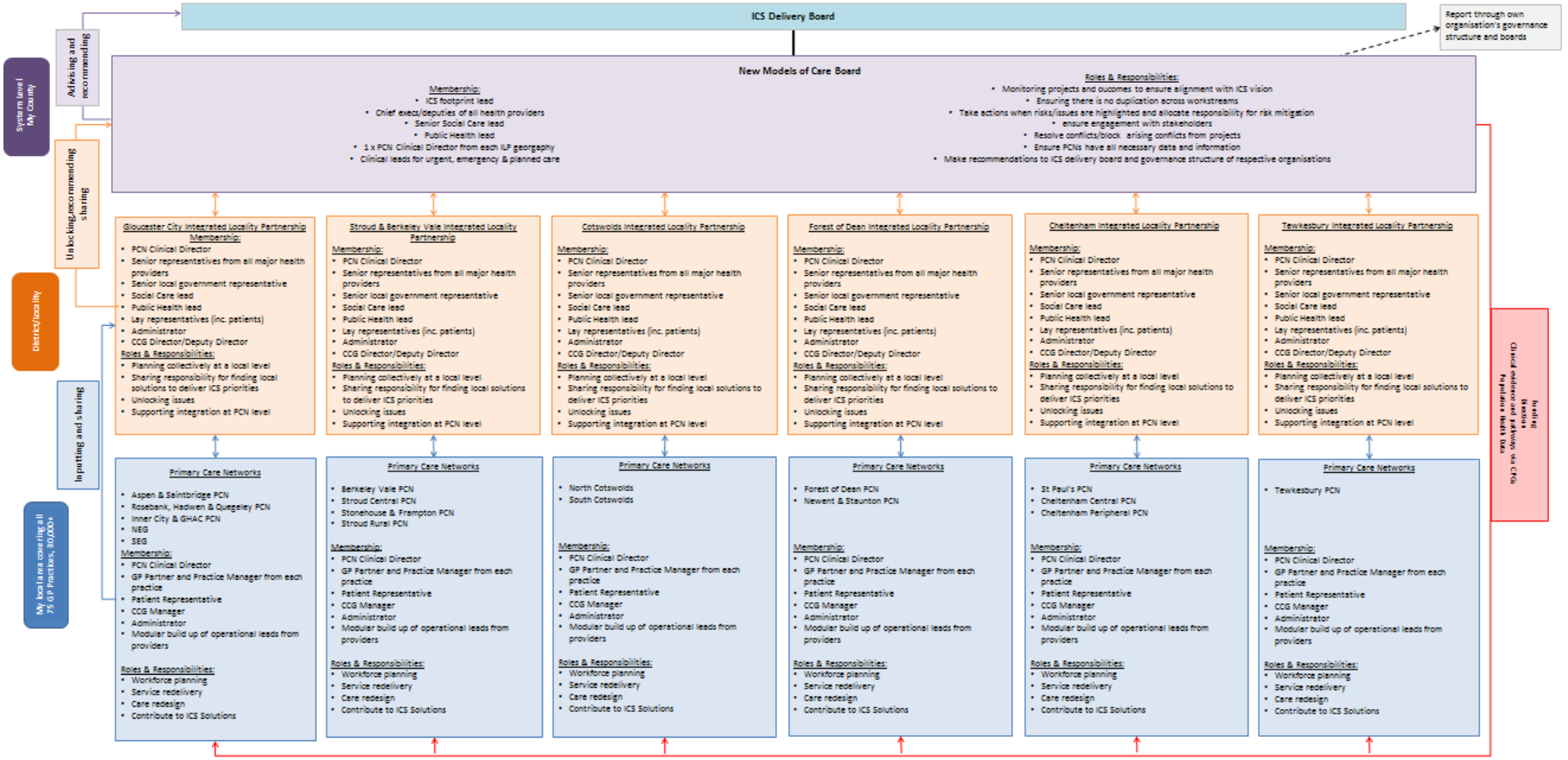
14. Conclusion and Recommendations

CCG Governing Body is asked to approve the rollout of ILPs to cover all geographical areas of the county from April 2019. In addition the Boards of 2gether NHS Foundation Trust and Gloucestershire Care Services will be asked to approve the same proposal at their respective meetings on 27th and 28th March.

Appendix A


Coloured dots represent primary care networks
Colours representing clusters of GP practices
Central
Peripheral
St Pauls
Cheltenham
Tewkesbury
North Cotswold
Gloucester
Aspen
HQR
NEG
SEGG
Inner City
Forest of Dean
Burford
Cirencester
Fairford
Cricklade
Highworth
Kemble
South Cotswold
Tetbury
Malmesbury
S&Bv1 - Berkeley Vale
S&Bv2 - Stroud Central
S&Bv3 - Stonehouse and Frampton
S&Bv4 - Stroud Rural

Appendix B Governance Structure for ILPs



Appendix C: Example ILP Agenda

Stroud & Berkeley Vale
Integrated Locality Partnership
Thursday 21st February 2019

09.00-11.00
Redwood House (F10), Stroud

Agenda

Item	Description	Time	Presenter
1	Welcome, Introductions & Apologies		Chair
2	Declarations of Interest		Chair
3	Minutes & matters arising from the last meeting (24.01.2019)	*5mins*	Chair
Commissioning			
4	Locality Liaison GP update	*10mins*	SY
Service Delivery			
5	Outpatients Clinic Data	*5mins*	KY
6	GHFT update	*15mins*	SE
7	Social Care Discharge Process	*10mins*	KW
8	Workforce Transformation learning from across the county	*15mins*	KY
9	Partner Updates: - PPGs - Public Health - SDC		SH KH EKC/HD
10	Early thinking on Primary Care Networks in the light of new contract	*20mins*	SO/VB
11	Dementia Project Group update	*5mins*	JF/AH
12	Frailty: • Information team frailty presentation • Review of work to date on frailty pathways & MDTs	*20mins* *15mins*	CR ALL
13	AOB		ALL

Next S&BV ILB Meeting – Thursday 21st March 2019

Appendix D GLOUCESTERSHIRE INTEGRATED LOCALITY PARTNERSHIP SELF-ASSESSMENT - 2019

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/Action
Theme 1 - ILP focus						
The ILP has set itself a series of objectives it wants to achieve this year which support the delivery of ICS solutions						
The ILP has made a conscious decision about the information it would like to receive.						
ILP members contribute regularly to the issues discussed.						
Equal prominence is given to both quality and financial assurance.						.
Theme 2 - ILB team working						
The ILP has the right balance of experience, knowledge and skills to fulfil the role.						
The ILP has structured its agenda to cover, quality, data quality, performance targets and financial control.						
There is a mechanism to share and provide timely and clear information between each						

ILP.						
The ILP meeting environment enables people to express their views, doubts and opinions.						
ILP Members ensure the governance arrangements of their own organisation are taken into account.						
Decisions and actions are implemented in line with expected timescales.						
Theme 3 - ILP Effectiveness						
The quality of ILP papers received allows ILP members to perform their roles effectively.						
Members provide real and genuine challenge - they do not just seek clarification and/or reassurance.						
Debate is allowed to flow and conclusions reached without being cut short or stifled.						
Each agenda item is 'closed off' appropriately so that the ILP is clear on the conclusion; who is doing what, when and how, and how it is being monitored.						
At the end of each meeting the ILP discuss the outcomes and reflect on decisions made and what worked well, not so well etc.						.

The ILP provides a written summary of progress to the NMOC Board						
There is formal appraisal of the ILP's effectiveness each year.						
Theme 4 - ILB Engagement						
The ILP actively challenges NMOC Board and other assurance providers to gain a clear understanding of expectations.						
The ILP is clear about its role in relationship to other ICS Partnerships.						
Theme 5 - ILB leadership						
The ILP chair has a positive impact on the performance of the ILP.						
ILP meetings are chaired effectively.						
The ILP chair is visible and is considered approachable.						
The ILP chair allows debate to flow freely and does not assert his/her own views too strongly.						
The ILP chair provides clear and concise information to the NMOC Board on ILB activities and gaps in control.						

Appendix E: High Level Risk Analysis

Risk description	Proposed mitigating action	Controls	Current risk rating	Target risk rating	Risk review date
Risk that the governance structures fail to reflect existing accountabilities while also creating a basis for collective action amongst partners.	Clear understanding that all organisations will retain their own statutory functions for which they are responsible. Governance arrangements via the ICS	Revised ToR created by senior leaders within partner organisation including LEG GPs and GP Provider Leads. ILP projects report to NMOC Board and to ICS Board	2x4 (8)	1x4 (4)	September 2019
Risk that the leadership of the ILPs fails to promote collaborative, innovative delivery	Agreed ToR state Clinical Leader as Chair: Senior membership from other organisations. Function of ILPs is local delivery of ICS Solutions and local priorities GP Provider leads on each ILB.	ILP projects report to NMOC Board and to ICS Board	2x4 (8)	1x4 (4)	September 2019
Risk that partners fail to agree key priorities for delivery and	Priorities based on ICS solutions and population health	Reporting will include any areas of dispute and	1x4	1x4	September 2019

investment, taking account of ICS Solutions and Individual Trust's CIPs.	management data.	resolution. Reports include a risk register. Gloucestershire wide MOU contains dispute resolution procedures.	(4)	(4)	
Risk that ILPs develop without effective evaluation agreed and implemented to determine if they have met their objectives / delivered improved patient outcomes.	ILPs to agree an evaluation and review process.	Continue to horizon scan and review national reports on evaluation.	3x3 (9)	1x3 (3)	September 2019
Risk of inconsistency and lack of standardisation across ILPs as some localities / clusters are further advanced than others	ILPs recognised as delivery arm of ICS solutions. CCG Locality Development team instrumental in all ILPs and able to share best practice and issues.	Adequate staff in post. ILP projects report to NMOC Board and to ICS Board.	3x3 (9)	2x3 (6)	September 2019
Risk of poor communication between those designing new pathways and programmes at	ILPs recognised as delivery arm of ICS solutions	ILP projects report to NMOC Board and to ICS Board.	3x3 (9)	2x3 (6)	September 2019

countywide level and those implementing/delivering ICS solutions in ILPs					
Risk that there is a lack of coordinated commissioning feedback and liaison with localities due to the abolition of LEGs	Use a different mechanism of having this conversation, for example Practice only meetings or PLT events	Practice only meetings and/ or PLT events occur in each “Place”.	2x4 (8)	1x4 (4)	September 2019

NB. The above table includes high level risks which will be more precisely articulated for inclusion in the Primary Care Directorate Risk Register and Corporate Risk Register.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Governing Body

Meeting Date	**Thursday 28 March 2019**
Report Title	**Integrated Care System (ICS) Update**
Executive Summary	This report provides an update on Gloucestershire Integrated Care System. The report provides an insight into reorganising & supporting pathways, supporting places & communities and supporting employees' wellbeing.
Key Issues	This report provides focus in the main programme areas; • Enabling Active Communities; • Reducing Clinical Variation; • One Place, One Budget, One System • Clinical Programme Groups. • Enabler Programmes. The report provides a focus on the Gloucestershire's Mental Health Trailblazer Programme, Quality and also on the NHS Long Term Plan (LTP).
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	ICS programme risks are regularly reported to ICS Executive as a standing item. Further consideration is being given to the development of a view of system-wide risk.
Management of Conflicts of Interest	N/A
Financial Impact	N/A
Legal Issues (including NHS Constitution)	N/A
Impact on Health Inequalities	The report supports the effort to reduce health inequalities
Impact on Equality	The report positively impacts on improving

and Diversity	equality and diversity
Impact on Sustainable Development	N/A
Patient and Public Involvement	The report considers the matters of public engagement and is also submitted to the Health and Care Overview and Scrutiny Committee.
Recommendation	Governing Body is asked to note the content and the progress that has been made.
Author	Ryan Brunsdon, PMO Co-ordinator
Sponsoring Director (if not author)	Ellen Rule: Director of Transformation & Service Redesign

Gloucestershire Clinical Commissioning Group Governing Body

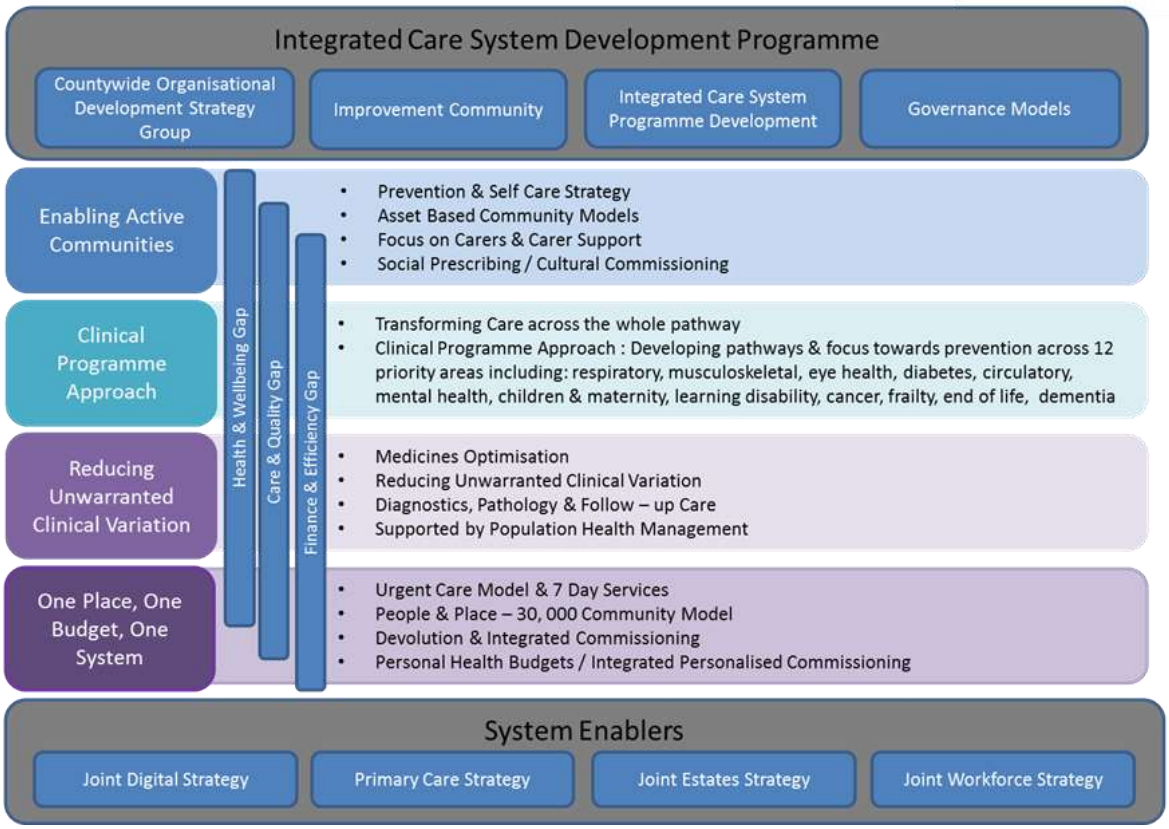
March 2019

One Gloucestershire ICS Lead Report

1. Introduction

The following report provides an update to HCOSC members on the progress of key programme and projects across Gloucestershire's Integrated Care System (ICS) to date.

Gloucestershire's Sustainability & Transformation Plan commenced year two of four in April 2018, since then we have made progress in embedding and delivering key schemes outlined within the plan, in an increasingly challenging health and care environment. We continue to develop our delivery plans against our main priority programmes. In this report we provide an update on 2018/19 progress made against the priority delivery programmes and supporting enabling programmes included within Gloucestershire as we transition to an Integrated Care System (ICS).



Gloucestershire's ICS Plan on a page

2. Enabling Active Communities

The Enabling Active Communities programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector.

The development of the Gloucestershire Prevention and Shared Care Plan, led by Public Health, aims to reduce the health and wellbeing gap and recognises that more systematic prevention is critical in order to reduce the overall burden of disease in the population and maintain financial sustainability in our system.

Key priorities for 2018/19 are:

- Reach the target of over 5,000 patients being on the National Diabetes Prevention Programme
- Appoint a GP Clinical Champion in Diabetes to further raise the profile of diabetic care in general practice (completed)
- Commission a new Child Weight Management Service and implement our new adult Weight Management Service Model to support people to reduce their weight in a sustainable way
- Continue to deliver an early identification and intervention model for victims of domestic abuse
- Develop a Breastfeeding Social Marketing campaign
- Progress the Gloucestershire Moves project (getting 30,000 inactive people active) and see the first pilots underway; including 'Beat the Street' and older people at risk of falls
- Launch a new postpartum contraception service
- Launch our new Gloucestershire Self-Management Education Programme called 'Live Better, Feel Better' and Support over 200 individuals through our new Self-Management Service
- Create a direct route into the community wellbeing service from urgent care (A&E, urgent treatment centres) to support people who attend for non-medical reasons
- Expand the arts on prescription service
- Increase our focus on support the following pathways with self-care and prevention schemes: adult mental health; paediatric epilepsy; paediatric Type 1 diabetes; Tier 3 obesity, adult chronic pain and adult respiratory pathways

Update on progress over the last two months:

Supporting Pathways

- There have been a total of 2819 referrals onto the National Diabetes Prevention Programme (NDPP) in Gloucestershire to date. Initial data for Gloucestershire show an average weight loss over 6 months of 4.6kg as a direct result of the NDPP, which again is better than the national picture (-3.4kg).
- Additional funding has been secured which will allow investment in the development of self-care resources that will complement the Tier 2 Child Weight Management Pilot.
- The number of interventions delivered by the Postpartum Contraception Team is increasing. The 'contraceptive counselling' approach has been particularly successful in supporting women making postpartum contraception decisions.

Supporting People

- 59 professionals have taken on the Domestic Abuse (DA) Champion Role across the county's 76 surgeries and in total, 1387 health professionals have been trained across 70 DA

workshops and learning events covering all localities.

- A new version of hospital food standards is due to be published in 2019; this will include substantial restrictions on High in Fat, Sugar or Salt (HFSS) foods and beverages. All Trusts will be required by the NHS standard contract to deliver against these standards.
- Patient Activation Measures (PAM) continue to be used in early adopter sites mainly around frailty and in group education sessions delivered by Gloucestershire Care Services NHS Trust (GCS). The Living Well with Pain programme has commenced a short life initiative to use PAM to segment the waiting list. If successful, this new approach will mean that patients who are currently waiting for pain management support may be able to receive their care more quickly as they can be directed to a range of appropriate support services based on their level of personal activation, rather than waiting to see a consultant before other support services can be accessed.

Supporting Places & Communities

- Identification of potential community leaders, who are keen to set up various community groups, is occurring across all the delivery pilots as part of the Strengthening Local Communities Projects.
- There have been over 4129 referrals into the Community Wellbeing Service (CWS). Data shows a reduction in primary care attendances for those using the service. Local social prescribing work was filmed for an ITV feature at the request of NHS England. Gloucestershire's social prescribing outcome framework is being adopted by NHS England for all NHS funded schemes.
- The Gloucestershire Moves steering group have agreed to re-run the Beat The Street game in Gloucester in the summer 2019, a successful initiative that got young people and their families more active across Gloucester city when piloted in the summer of 2018.

Supporting Workforce

- Public Health England are in the process of commissioning guidance for workplace wellbeing accreditation schemes. The Gloucestershire scheme being created by the Gloucestershire County Council Public Health team and Healthy Lifestyles provider is due to 'go live' in April 2019. Work continues on this and will incorporate any Public Health England guidance when available.
- A business wellbeing network event is planned for February. A number of speakers have already been confirmed for this event. This will bring businesses together to receive information and discuss health and wellbeing in the workplace
- A workshop event called 'sharing the learning' is being developed and will be held during March and will involve partners across the health and care system. This event will help to inform the evaluation and subsequent recommendations for taking health coaching forward across the ICS.

3. Clinical Programme Approach

The Clinical Programme Approach has been adopted across our local health care system to ensure a collaborative approach to systematically redesign the way care is delivered in our system, by reorganising care pathways and delivery systems to deliver right care, in the right place, at the right time.

	Priorities 2018/19	Progress So Far…
Respiratory	Deliver a comprehensive education and training package for health care professionals working in primary care and managing long term respiratory conditions, to improve care outcomes for patients. Support primary care to stop prescribing steroids where they are not having a significant impact on an individual's quality of life Continue to bring together the hospital and community respiratory teams together into one integrated team	The detailed implementation plan for integration is agreed which includes impact measures. An integrated approach to referral management and clinical triage has been developed. A working group has been established to agree the patient pathway and pharmaceutical regime supporting IV antibiotics in the community / at home for the Bronchiectasis including IV Therapy patient cohort. Once delivered it will mean more patients can be supported at home as an alternative to a hospital admission.
Circulatory	The circulatory clinical programme is working to develop improvements to heart failure care for people living in Gloucestershire, to develop additional cardiac rehabilitation places to extend cardiac rehabilitation to all heart conditions not just patients who have heart attacks, and to progress our local proposals for community based stroke rehabilitation.	Cardiovascular Disease Prevention blood pressure community testing programme is on track and feedback on our public awareness materials are currently being gathered from the HealthWatch team. Gloucestershire Hospitals NHS Foundation Trust (GHFT) now have a full rota of specialist nurses which will support the 1 Hour Troponin pathway. This pathway enables patients who go to hospital with a heart attack to be diagnosed more quickly so they can be provided with optimal care. The roll out of the new Stroke Rehabilitation model is now on track against key milestones with the service going live at the Vale hospital in February.
Cancer	Progress towards the 2020/21 ambition for more cancers to be diagnosed at the earliest stages Deliver the Prostate Cancer Surveillance Project	Meeting held with Public Health & Information Team, working in collaboration with CA/Macmillan/CRUK partners, to provide Cancer CPG updated health needs assessment to support programme planning for better early diagnosis performance and health inequality focus. Data requirements and next steps agreed

Musculoskeletal (MSK)	Embed the Advanced Practitioner Service (APS) providing physiotherapy support to patients in primary care. Roll out MSK triage service which provides expert clinical review at the point of referral. Design and implement a countywide integrated approach to falls prevention	83% of referrals for APS and Orthopaedics are now going through MSK Specialist Triage and 88% of GHFT referrals are via MSK Specialist Triage. There continues to be an overall reduction in direct orthopaedic referrals for other orthopaedic providers. The first two Risk of Falls training events will be delivered in Gloucestershire via the GP/ Nurse PLT events in Gloucester. This will provide primary care clinicians with additional skills to help prevent patients from having falls in the future.
Eye Health	Develop the enhanced community eye care offer to provide additional eye care services for patients in the community rather than in hospital. Implement the new NICE guidelines within Ophthalmology	The Eye health Clinical Programme continues to work to expand the range of conditions that optometrists can manage in the community to provide an alternative to hospital based care in people's local communities. In the next couple of months, new expanded services for minor eye conditions will be available. Within the hospital, we have a valuable service provided by the Royal National Institute for the Blind (RNIB). The Eye Care Liaison Officer service provides patients who have recently developed low vision holistic support and guidance of how to access low vision support available in the community. Following fantastic feedback from patients, carers and staff we have extended the funding from 5 days to 6 days at both of our main hospital sites in Gloucester and Cheltenham.
Diabetes	Our diabetes clinical programme continues to focus on improving outcomes for people living with diabetes in our county. To support our ambitions we have identified a number of new ways of working, To support these we need to recruit a part-time Consultant Diabetologist, to work with care homes to provide training to staff on "caring for patients with diabetes" and working closely with primary care to improve primary provision for this patient group. We are also rolling out structured education programmes for patients recently diagnosed with diabetes to support self care.	Diabetes Enhanced Service practice performance against the 8 care processes has improved by 11.5% and is above the England average. · GP Clinical Champion visits have been organised across the county as part of service improvement of 8 care processes in order to reduce variation in care. 178 professionals (GPs, nurses, podiatrist, SWAST and other AHPs) now signed up to the online Cambridge Diabetes Education programme in order to improve competencies and reduce variation across practices, with a total of 389 topics already completed by candidates.

Children & Maternity	Develop community hubs and integrate better together services that support women and families in the early years Implement our 'Safer Maternity Care' Action plan Develop models of care supporting women to have the same carer throughout pregnancy, birth & post-natal care Aim to have 30 to 40 children who live with a long term condition supported with Personalised Care Plans by Mar 19	Good progress being achieved in all areas, momentum maintained and work being driven forward with Better Births Team through each of the workstream's. The workstream's within the Better Births Programme include; • Transforming the workforce • Postnatal & Transitional Care • Safer Care • Perinatal Mental Health • Choice & Personalisation
Learning Disability	Enabling individuals with a Learning Disability to use Personal Health Budgets to ensure they have control of the support they receive Embed the "Stopping Over Medication of People with LD" campaign to reduce the prescriptions of anti-psychotic drugs where they are not clinically recommended Ensure that 75% of people with a LD on the GP LD Register receive an Annual Health Check by Quarter 4 19/20	The Learning Disability and Autism Clinical Programme Group has highlighted the need for a better understanding of people living in Gloucestershire to give them a more robust evidence base for planning future commissioning activities in line with the Building Better Lives & Building The Right Support Vision. The output from this project will be an evidence base which we are calling a Learning Disabilities & Autism Joint Strategic Needs Analysis (JSNA). Inclusion Gloucestershire have been commissioned to run co-produced engagement events and input into the development of the survey.
Mental Health	Continue to take steps to Improve Access to Psychological Therapies (IAPT), to ensure we meet standards for access, recovery and waiting times to treatment Make further improvements to the Eating Disorder Pathway Implement an all age Autism strategy Roll out mandatory mental health training for staff in schools Improve support to foster carers and children entering the care system Procure emotional support for children who have experienced sexual assault / abuse	The Cavern continues to be attended regularly every evening by up to 50 people. The Cavern provides 3 members of staff to support people in the evenings and has employed security staff on the entrance to ensure that all individuals are accessing the service appropriately. They are currently reporting positive outcomes in improved quality of life for the people accessing the service. Glos County Council have funded non-recurrently a workforce development lead for crisis care. This position will be embedded within 2gNHSFT training department working closely with their Mental Health Acute Response service. Priority group for training will initially be police with a view to reducing s136 detentions. The post will also lead on the development of the multi-agency training plan for crisis care.

Dementia	Develop a countywide approach to improve community dementia services Implement the Community Hospital Mental Health Liaison Team pilot	The Dementia Advisor caseload has significantly increased from 500 a year in 2017, to 1600 a year in 2018. This ensures that more people have access to information and support from diagnosis, with a focus on modifying/reducing dementia risk factors. The Diagnosis Rate (DDR) has maintained above NHSE target position of 68.4% December 2018. Significant progress has been made in describing a county integrated model for dementia that uses a key worker approach and case management
End of Life	Our aim is to improve end of life care for people in Gloucestershire by working with stakeholders across our system and learning from patient and carers stories. We have developed an End of Life strategy for the county and aim to roll out standardised guidance for all clinicians to work to, to improve care. This will be launched through our countywide care pathways system G Care.	We have finalised the new EoL G-Care page which will be launched in February. In addition our EoL project support officer has commenced her role and is a support to the whole Clinical Programme team. Her first job is to develop a bi-monthly Gloucestershire EoL newsletter for all stakeholders and members of the public, to improve communication and therefore outcomes for patients. .

Focus On: Gloucestershire's Mental Health Trailblazer Programme

The Green Paper, published in December 2017, detailed proposals for expanding access to mental health care for children and young people by providing additional support through schools and colleges and reducing waiting times for treatment. The new services are expected to be rolled out to between a third and a fifth of the country by 2023-24, with further improvements for children and young people's services promised in the NHS long-term plan.

In December 2018, the Government announced Trailblazer sites, and Gloucestershire was successful in securing £5m funding up until 2021. This funding will support the implementation of four Mental Health Support Teams (MHSTs) in Gloucestershire to develop models of early intervention on mild to moderate mental health issues, such as exam stress, behavioural difficulties or friendship issues, as well as providing help to staff within a school and college setting. As well as piloting Mental Health Support Teams, 12 sites across the country including Gloucestershire have been selected to trial a four-week waiting time for referral to treatment for specialist children and young people's mental health services, building on the expansion of NHS services already underway.

The Model in Gloucestershire

Based on a local needs analysis, we are delighted that 72 schools have signed up and have subsequently identified as a Mental Health Trailblazer Lead. The four MHSTs will be working with selected schools, colleges and special schools chosen in three locality areas; Cheltenham, Forest of Dean and Gloucester City.

Each team will cover a population of 8000 students aged between 5-18 years. Mental Health Support Teams will build on support already in place from services in place including school counsellors, support children and young people with mild to moderate mental health issues and help children and young people with more severe needs to access the right support, and provide a link to specialist NHS services.

Each designated team will comprise of:

- 4 Education Mental Health Practitioners (EMHPs)
- 2 Primary Mental Health Practitioners (PMHPs)
- 0.5 Team Manager
- Additional Face to Face Counselling

Four Week Wait (4WW)

In developing and delivering our Future in Mind Long Term Plan (LTP) the overwhelming feedback from stakeholders was around providing earlier intervention with children and young people directly reporting “waiting times need to be reduced”. We believe that providing earlier intervention through reduced waiting times will support children and young people to achieve in all parts of their lives and prevent issues escalating.

Our proposal is to have a gradual improvement over 18/19 and 19/20 to a sustainable position by the end of April 2020 where our local provider 2gether NHS Foundation Trust has committed to achieving:

- 100% of CYP have initial access appointment within 2 weeks.
- 50% of CYP have access and have a second appointment within 4 weeks.
- 100% of CYP have access and a second appointment within 6 weeks

Progress so far

Mental Health Support Teams (MHSTs)

Education Mental Health Practitioners (EMHP’s) will be practising one day per week from the end of April 2019 and training will be graduated until November 2019 at which point EMHPs will be fully operational. We therefore plan to use a “test and learn” approach with ten Early Adopter Schools for the Spring & Summer school terms so that we can receive feedback and refine the **core offers**, **referral pathway** and **training matrix** as necessary.

Working towards formal launch to all Trailblazer Schools during Autumn Term 2019, a complimentary **communication and engagement** plan informed by the staff, parents and children & young people from our Early Adopter schools will be developed.

A working group to focus on **evaluation** of the programme has been established and a framework is being developed.

Four Week Wait (4WW)

Our local provider, 2gether NHS Foundation Trust, has begun recruitment of additional Therapists and has commenced refinement of the operational model in order to meet national targets.

4. Reducing Clinical Variation

The Reducing Clinical Variation programme looks to elevate key issues of clinical variation to system level and have a new joined up conversation with the public around some of the harder priority decisions we will need to make. This includes building on the variation approach with primary care, promoting 'Choosing Wisely' and a Medicines Optimisation approach and undertaking a diagnostics review.

Key priorities for 2018/19 are

- The successful Prescribing Support dietetics role will be expanded to support change in the recommendation of oral vitamin B vs Vitamin B injections, advice and support around optimising the use of calcium and vitamin D, as well as reviewing and producing infant milk guidance to ensure appropriate support to patients via primary care
- Continue to support, develop and extend the Repeat Prescription Ordering Service for Gloucestershire patients to support the reduction of prescribed waste medication.
- Continue to support reducing Polypharmacy (the use of multiple medications at the same time) in patients, initial focus on frail patients, and extend it to groups such as those in care homes with the aim of reducing unwanted side effects
- Implement a paper referral switch off so that all referrals to consultant led services are made via an electronic system by October 2018 (in line with national guidance.)
- Implement patient led booking to give patients more control over their follow up care.
- Implement GP peer review of referrals to support consistency of patient management at a locality level.
- Continued development of alternatives to face to face follow up outpatient appointments
- Reducing the number of people who failed to attend a booked hospital appointment through a public awareness campaign and by establishing a reminder services
- Continue to make improvements to Operating Theatre, Radiology and Pathology pathways to reduce waste

What we've achieved so far:

- The 2018/19 Savings Plan supports a saving opportunity of £5m across a range of prescribed medicines. . The Prescribing Improvement Plan (PIP) continues within practices.
- Work continues in practices around the medicines management elements of the Primary Care Offer included in the Primary Care Offer (PCO)18/19
- Reviews continue for prescribing for "Conditions for which over the counter items should not routinely be prescribed in primary care".
- The extra Prescription Ordering Line (POL) staff are trained and now operational.
- The team of practice based pharmacists and technicians continue to expand in response to requests where funding has been approved. We are now developing a "short notice short term support team" who are able to support practices for short but intensive periods of time when need arises.
- Advice & Guidance (A&G) requests continue to be well above target levels with a total of 9,675 requests received, compared to the target of 6,484. All planned specialties are now live with the exception of Ophthalmology. NHS England/ NHS Digital have highlighted Gloucestershire as the third highest user of the electronic referral system (eRS) A&G in the country, and as a result the national lead for eRS will be visiting Gloucestershire in March.
- G-care site (website for GPs on clinical pathways) views continue to exceed 2017/18 levels with 50,045 site views in 2018/19 The G-care search function has been updated and re-launched to address technical issues and improve usability and GP feedback has been positive. A number of other potential developments to G-care are being reviewed in order to further enhance the platform.
- Inpatient/Day Case efficiency project: The Did Not Attend reduction campaign launched on 11th

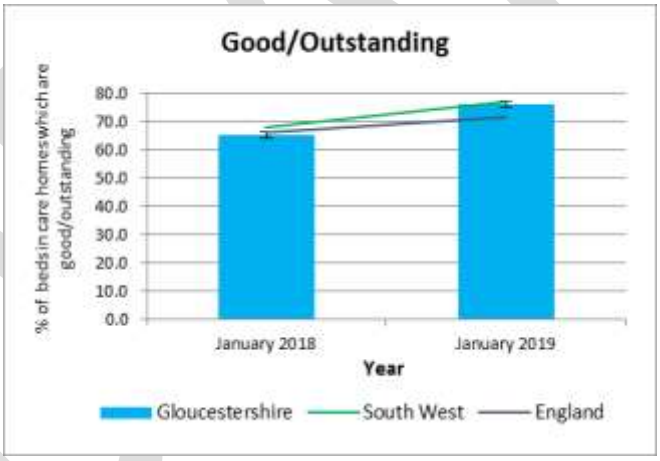
December through social media. Posters have also been circulated to GP practices, GHFT, and pharmacies and the local media has picked up the campaign and provided some coverage. The first social media video had 125,000 views and reached almost 70,000 people.

Focus on Quality

As our Integrated Care System matures we are developing a Quality Framework; whilst the Framework is currently in the early stages it aims to set out our ambitions for the future and emphasis quality as a central pillar of the ICS.

The three main NHS providers in Gloucestershire, as well as the South West Ambulance Service, are all now rated 'Good' by the Care Quality Commission (CQC). Primary Care is also positively rated by the CQC. Out of the county's 75 practices, two 'Require Improvement' 69 are rated 'Good' and four are 'Outstanding'. While this is a commendable position to be in, the system continues to strive for improvement.

Care Homes in Gloucestershire have also fared well with the CQC, with overall ratings being slightly better than the National figures. It is significant that there are no Gloucestershire Care Homes with an overall CQC rating of Inadequate and commendable that there are 12 Care Homes with an overall CQC rating of Outstanding. The graph below shows the increase in care homes rated as good/outstanding between 2018 and 2019. We have a collaborative partnership approach for support and training for quality improvements for Care Homes to meet CQC requirements. Central to this, the Care Home Support Team (CHST) offer a range of bespoke training, support and advice. 67% of Gloucestershire's domiciliary care providers are rated as good/outstanding in line with England rates.



Using the learning from last winter's seasonal influenza programme, we are working together on a number of pilot schemes. We have strengthened, via the CHST, our local response to support for Care Homes in early identification of, and response to, respiratory outbreaks. Gloucestershire County Council Public Health are leading a pilot to improve uptake of flu vaccinations in care home staff by testing out two additional service models; an integrated pilot project for Point of Care Testing (PoCT) for seasonal influenza in care homes which aims to shorten the time from when flu is suspected to the test result and therefore administration of antiviral medication if indicated. Early findings are showing a beneficial impact and the pilot is to be formally evaluated.

5. One Place, One Budget, One System

New Models of Care & Place Based Model

The One Place, One Budget, One System programme takes a place based approach to resources and ensures we deliver best value. 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 healthy communities, benefitting from strong networks of community support and being able to access high quality care when needed. New locality led 'Models of Care' pilots commenced in 2016/17 to 'test and learn' from their implementation and outcomes, working across organisational boundaries, and leading to the formation of 16 locality clusters across the county.

Key priorities for 2018/19 are

- Led by ICS partners, pilot three Integrated Locality Partnerships in both rural and urban areas. The pilots will be in Stroud and Berkeley Vale, Forest of Dean and Cheltenham. These aim to give more control to local GPs to develop and tailor services to best meet the needs of people in the local area.
- Increase the range of roles in primary care available to support GPs and patients including the use expanding paramedics, clinical pharmacists and mental nurses
- Support the roll out of the Community Dementia pilot across the county, following the completion of evaluation and a feasibility study.
- We will continue to work with practices to support them through merger or federation conversations as required.

What we've achieved so far:

- Cross City Multi-Disciplinary Team (MDT) approach commenced in January 2019 following development and testing in North East Gloucester and South East Gloucester. Early feedback is that GP engagement has improved, with plans in place to further support GPs and other providers to take part in the MDT via a videoconferencing system.
- A case management model is to be developed with three levels of stratification for dementia patients to reduce future inappropriate admissions.
- Stroud & Berkeley Vale Dementia Working Group presented their progress to date on the phase two roll out of the community dementia service to the whole Locality. The new model will include colocation of community team staff, use of a joint clinical system & risk stratification of the dementia cohort to align appropriate staff; this will be tested during quarter 4 with aim for wider roll out at the start of 2019/20. The Dementia Working Group are working closely alongside the Dementia CPG who will learn from the key fundamentals of this model to develop a county solution.
- Skype is being piloted in Stroud Rural & Berkeley Vale MDTs to enable easier access to the meeting for all members of the multi-disciplinary team
- Implementation meetings have been held with Care homes under the Admission reduction project in Cheltenham. This has included introduction of the red bag scheme. The offer will be implemented in other homes in due course.
- The South Cotswolds Frailty Service continues to build positive working relationships with Great Western Trust, GHFT, South West Ambulance Service in addition to other professionals.
- Evaluation of the service is being undertaken by the University of Gloucestershire, gaining feedback from both stakeholders and patients, and a final report is due early 2019.

5. One Place, One Budget, One System

Urgent Care

Our vision for Urgent Care will deliver the right care for patients, when they need it. In order to make this vision a reality and provide safe and sustainable services into the future, we need to consider how to make best use our resources, facilities and beds in hospitals and in 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. We propose potentially changing the way some care and support is organised in Gloucestershire to meet changing demands, make best use of our staff, their skills and the money we have.

Regular updates on the One Place Programme have been shared with HCOSC, describing how the programme aims to deliver an integrated urgent care system and hospital centres of excellence to ensure we realise the vision for urgent care. Since this update work has continued to develop the programme timetable, engaging with clinicians, patients, and staff and community partners to develop the proposals for consultation.

Throughout December and January there has been careful review of the work that has taken place and the progress made. In particular we have received strong feedback that we need to build in more time for engagement in advance of formal consultation and that people want to understand the whole model. In response to this the ICS Delivery Board has agreed that more time is needed to focus on co-designing options and proposals with clinicians, community partners, patients and the public before we move to consultation. The Communication and Engagement Strategy and Plan has been developed which includes clear processes from the NHS Long Term Plan (LTP) engagement through to One Place consultation. Further discussions around the Communication & Engagement Strategy are being held during the ICS Delivery Boards.
A new scope, co-production approach, governance and timeline will be finalised shortly. In the meantime the current pilots within Trauma & Orthopaedic, Gastroenterology and General Surgery will develop as agreed.

Alongside this we will progress the commissioning of a new NHS 111, Clinical Advice and Assessment Service. This will be informed by learning from the current ‘test and learn’ initiatives and ensuring the critical links with other parts of the urgent care system are maintained.

The Urgent Treatment Centre test and learn project has refocused on achieving compliance with the NHS England national standards and agreeing priorities for implementation before Winter 2018/19.

6. Enabling Programmes

Our vision is underpinned by our enabling programmes which are working to ensure that the system has the right capacity and capability to deliver on the clinical priorities.

Joint IT Strategy – Local Digital Roadmap Patient Online has been rolled out to 96% of Gloucestershire practices, and currently Gloucestershire has 22.31% of patients with an online account. eConsultation procurements are complete for a patient triage application for primary care which will begin in 5 pilot practices. Wi-Fi infrastructure software upgrade has been completed; initial testing suggests a number of outstanding issues have been resolved as a result of this. Gloucestershire signed up to the South West Local Health Care Record Exemplar (LHCRE) bid and we have been told that, subject to a successful plan, the South West LHCRE will receive some capital funding in 2018/19. There are 130+ users now live on JUYI, with an average of 50 accesses per day.

Joint Workforce Strategy –The first two cohorts of the ICS-wide '5 elements for successful leadership' programme have been successfully completed and have received a highly positive evaluation. A One Gloucestershire expression of interest to participate in a national High Potential Talent Scheme that was submitted in October was successful. There are seven pilot sites and it will be rolled out in three phases. One Gloucestershire has requested to participate in phase three; planning will commence around August 2019. System-wide workforce planning is progressing well supported by the 2019/20 Operational Plan process.

Joint Estates Strategy – the estates strategy is moving forwards with a number of strands of work. Within Primary Care, planning permission has been granted for a new Cinderford Health Centre and Practices within Coleford have decided to proceed to develop a new GP Led business case for a single site within the town. There have been Initial meetings held with Lydney and Severnbank Practices to set out a way forward for the potential development of a new primary and community facility aligned to wider Forest of Dean Community Infrastructure Programme. A new Cleevelands Medical Centre opened in Bishops Cleeve on January 14th. There has been agreement that organisational Estates Strategies to be updated and subsequent ICS strategy to be completed for March 2019 with 2031 as the planning timeline. The Business case programme for GHFT strategic site development in also line with plan.

Primary Care Strategy – the Primary Care Strategy works alongside One Place, One Budget, One System to ensure we have really high quality primary care provision. Improved access has been successfully rolled out across all seven localities within Gloucestershire and in addition to improved access, clusters have been able to utilise funding to support additional workforce innovations across the ICS.

7. Integrated Care

A national announcement was made by NHS England that Gloucestershire in June 2018 to confirm that Gloucestershire was now designated as one of only 14 Integrated Care Systems (ICS) across the country.

Building on the success of the recent system visit from Don Berwick, President of the Institute for Healthcare Improvement (USA), the system hosted another successful visit from NHS England's Chief Information Officer Will Smart. Will is responsible for providing strategic leadership across the whole of the NHS to ensure that the opportunities that digital technologies offer are fully exploited to improve the experience of patients and carers in their interactions with health and social care; the outcomes for patients; and improved efficiencies in how care is delivered. The key messages demonstrated during the visit was around;

- Differing digital maturity amongst the partners to explore Global Digital Exemplar Fast Follower status;
- A modern architecture on public cloud hosted clinical records sharing system – Joining Up Your Information (JUYI); and
- Committed to Local Health Care Record Exemplar and working closely with partners to ensure cross border patient care is managed effectively.

8. NHS Long Term Plan (LTP)

On 7th January 2019 the NHS long-term plan (formerly known as the 10-year plan) was published setting out key ambitions for health services over the next 10 years. In June 2018, the Prime Minister made a commitment that the Government would provide more funding for the NHS for each of the next five years, with an average increase of 3.4% a year.

In return, the NHS was asked to come together with wider partners to develop a long term plan for the future of the service, detailing our ambitions for improvement over the next decade, and our plans to meet them over the five years of the funding settlement. That plan has now been published.

How the NHS Long Term Plan was developed

Working groups made up of local and national NHS and local government leaders, clinical experts and representatives from patient groups and charities were formed to focus on specific areas where the NHS could improve over the next ten years.

They then engaged extensively with stakeholders to come up with and test practical ideas which could be included in a plan.

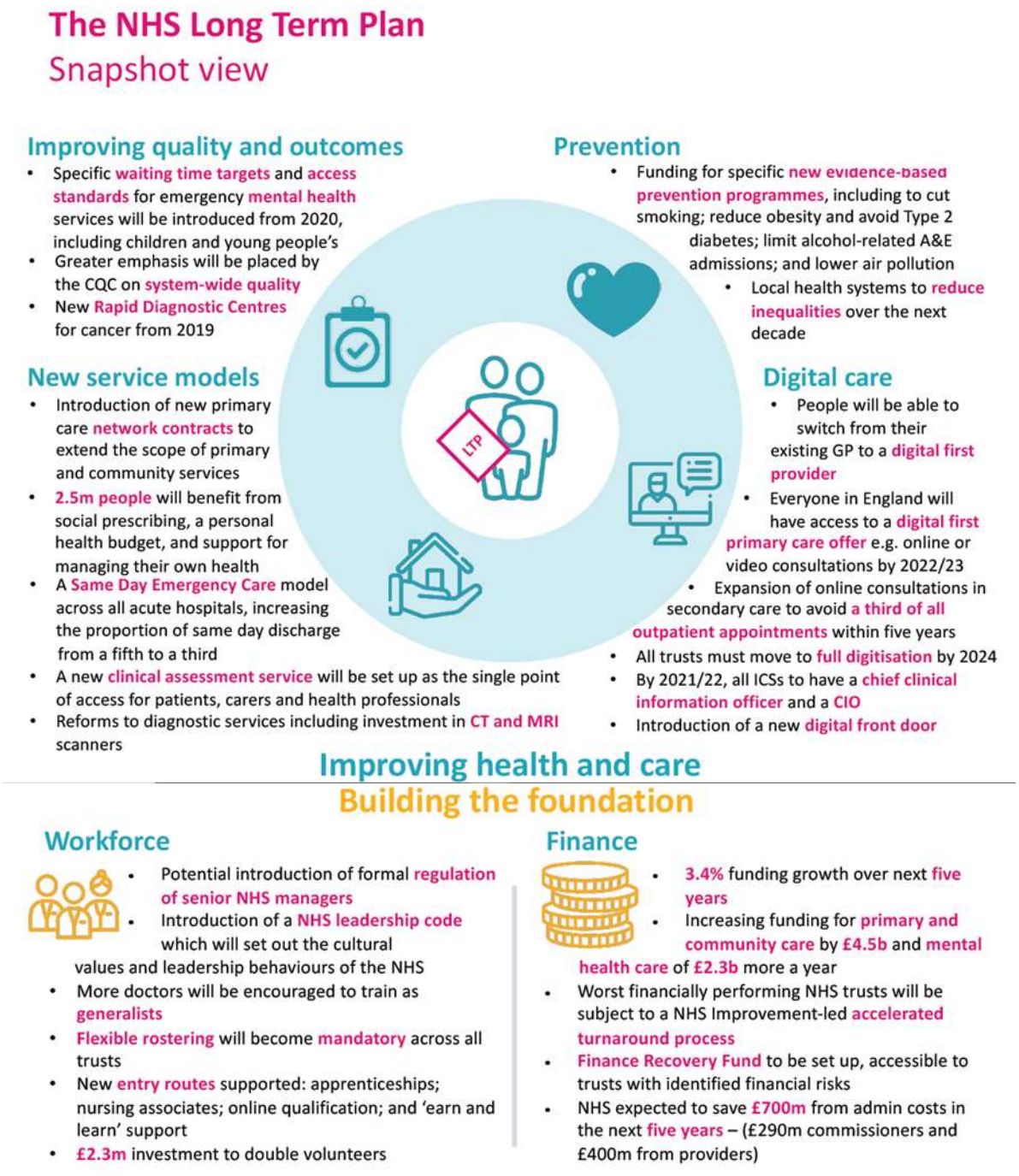
Over Autumn, working group members organised or attended over 200 events to hear a wide range of different views, and received over 2,500 submissions from individuals and groups representing the opinions and interests of 3.5 million people.

What the NHS Long Term Plan will deliver for patients

The working groups have developed a range of specific ideas and ambitions for how the NHS can improve over the next decade, covering all three life stages:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well

The diagram below show a short overview of the commitments within the plan. One Gloucestershire ICS is just beginning a series of engagement events to talk to public, staff and strategic stakeholders about what the plan means for the development of services in Gloucestershire. There is already good alignment between the outcomes within the plan and our strategic direction and this is a positive confirmation of the journey we are on. The refresh of the system plan is a good opportunity to review and confirm our plans with the public and stakeholders and review "what matters" to support our prioritisation of objectives for the year ahead. .



9. Recommendations

This report is provided for information and HCOSC Members are invited to note the contents.

Mary Hutton
ICS Lead, Gloucestershire ICS

Agenda Item 14

Governing Body meeting

Meeting Date	**28 March 2019**
Report Title	**An Open Culture: Engagement –Equality - Experience** Annual Report: 2018
Executive Summary	The 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	The 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 (CxL)** **Residual Risk (CxL)**	
Management of Conflicts of Interest	
Financial Impact	
Legal Issues (including NHS Constitution)	The CCG is required to publish an annual report, 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	
Patient and Public Involvement	
Recommendation	Paper for information and approval.
Author	Becky Parish and Caroline Smith
Designation	Associate Director, Patient Engagement & Experience; Senior Manager, Engagement & Inclusion
Sponsoring Director (if not author)	Marion Andrews-Evans

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 14

Governing Body

28 March 2019

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. As in previous years, we have 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 2018

NHS
Gloucestershire
Clinical Commissioning Group

An Open Culture

Engagement – Equality – Experience

Annual Report 2018

To discuss receiving this information in large print or Braille please ring 0800 015 1548.

To discuss receiving this information in other formats please contact:

এই তথ্য অন্য ফর্মাটে পেতে আলোচনার জন্য দয়া করে যোগাযোগ করুন

如需以其他格式接收此信息，请联系

V případě, že potřebujete obdržet tuto informaci v jiném formátu, kontaktujte prosím

આ માહીતી બીજા ફોરમેટસમાં મળાવાની ચર્ચા કરવામાટે કૃપાકરી સંપર્ક કરો

Aby uzyskać te informacje w innych formatach, prosimy o kontakt

По вопросам получения информации в других форматах просим обращаться

Ak si želáte získat túto informáciu v inom formáte, kontaktujte prosím

FREEPOST RRYY-KSGT-AGBR,
PALS, Gloucestershire Clinical Commissioning Group, Sanger House, 5220 Valiant Court, Gloucester Business Park, Gloucester GL3 4FE

0800 015 1548

NHS
Gloucestershire
Clinical Commissioning Group

An Open Culture: Engagement – Equality - Experience

Annual Report 2018

Content

Foreword

This report sets out our continued progress against our equality objectives and highlights the future direction of our work to promote equality and reduce health inequalities. It also gives some examples of how NHS Gloucestershire CCG is working hard to 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. Highlights this year include our first experience of engaging a Citizens' Jury to assist with our commissioning decisions; and as an employer, achieving Disability Confident Employer status.

Looking ahead, our aims remain 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.

We want to strengthen our partnership working in relation to equality and engagement, working together to develop closer links with our "communities of interest". We will also ensure that we continue to develop our understanding of our local communities, and proactively engage with them, as we move forward as an Integrated Care System.

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 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 and established 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. GCCG adopted the following Equality Objectives, when established in 2013:

- 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 is currently being refreshed, with a new Action Plan being developed from April 2019. The revised strategy will be closely linked to our updated Strategy for Engagement and Experience, which is currently in draft form. The existing Strategy documentation can be found on the CCG website at: http://www.gloucestershireccg.nhs.uk/about-us/equality-diversity/

3. 'Our Open Culture': A Strategy for Engagement and Experience

3.1. Since NHS Gloucestershire CCG was formed in 2013, we have aspired to ensure that the 'quiet voices' are heard and that we are recognised as 'commissioners on the ground'. Building on these ambitions, our current Clinical Chair, Dr Andy Seymour, recognises that the CCG '*values and*

seeks to learn from the experiences of everyone involved in promoting, delivering and receiving health, wellbeing and care in Gloucestershire'.

3.2. 'Our Open Culture' describes how by using a simple Framework, underpinned by three enabling principles and three methods of delivery, we achieve these ambitions. This 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[2] 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;
- ensure equity of access to health services and support;
- 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 2017,* 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: https://inform.gloucestershire.gov.uk/understanding-gloucestershire-a-joint-strategic-needs-assessment-jsna/
Public Health England also provides an annual Health Profile for each county. A copy of the profile for 2018 is included in Appendix 1.

[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

5.3 An overview of our county population, by each of the protected characteristics is given below. Further detail can also be found on the Inform Gloucestershire website: https://inform.gloucestershire.gov.uk/

5.4 **Current Population: Age**

In 2016 the resident population of Gloucestershire was estimated to be 623,129 people, of which:

- 22.6% are aged 0-19
- 56.6% are aged 20-64
- 20.8% 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 25.0% Gloucester has the highest representation of children and young people and exceeds the county and national average.
- At 58.9% 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 25.2% 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 approx. 9,500 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 approx. 11,750 people aged 18+ living with a learning disability in Gloucestershire.
- Sensory impairment: In 2016/17 approximately 1.0% of the 18+ population in Gloucestershire reported blindness or severe visual impairments. During the same period 3.8% of the adult population reported deafness or severe hearing impairments.

5.6 **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 (GIRES) 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 3,070 and 5,120 adults.

GIRES also reported in 2011 that approximately 100 children and adolescents are referred annually to the UK's specialised gender identity service, compared with 1500 adults. However, presentation amongst younger people is growing rapidly and could accelerate if young people feel increasingly able to reveal their gender variation.

5.7 **Current population: Marriage and Civil Partnership**

The 2011 Census recorded that among residents of Gloucestershire:

- 30.5% were single and had never married, or registered a same-sex civil partnership
- 50.2% were married

- 0.3% were in a registered same-sex civil partnership
- 2.3% were separated but still legally married or still legally in a same sex civil partnership
- 9.5% were divorced or had formerly been in a same sex civil partnership which was now legally dissolved
- 7.2% were widowed or a surviving partner from a same sex civil partnership

At that time, Gloucestershire had a lower proportion of people who were single or separated when compared to the national average. In contrast the proportion of people who were married, divorced or widowed exceeded the national average.

5.8 **Current Population: Pregnancy and Maternity**

There were 6,739 live births in Gloucestershire in 2016. Gloucester and Cheltenham continued to account for the largest numbers of births in Gloucestershire, representing 26.8% and 18.6%. Births to mothers aged 30-34 accounted for 33.3% of total births in Gloucestershire, followed by births to those aged 25-29 (29.1% of total births). This reflects the national trend for England.

Compared to the county and national averages, Gloucester and the Forest of Dean have a higher proportion of births to mothers aged under 20 and Cheltenham, Cotswold and Stroud have a higher proportion of births to mothers aged 35+.

5.9 **Current Population: Race**

Gloucestershire is characterised by a comparatively small Black and Minority Ethnic population (England average of 14.6%):

- The 2011 census showed that overall, 4.6% of the population were from Black and Minority Ethnic (BME) backgrounds; this figure increased to 8.4% when the Irish, Gypsy or Irish Traveller and 'other White' categories were included.
- There is a wide variation at district level in the proportion of the population who are not White British. At the time of the 2011 Census,

Gloucester and Cheltenham had the highest proportions at 15.4% and 11.7% respectively, whilst the Forest of Dean had the lowest proportion at 3.3%.

5.10 **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.

5.11 **Current Population: Sex**

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 2016, 53.0% of people in Gloucestershire aged 65-84 are female, while for people aged 85+ the difference is even more marked with females accounting for 64.8% of this age group. These gender differences have resulted in the majority of single pensioner households being headed by a woman. Females are also more likely to head lone parent households with dependent children.

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 (LGB), generating a range of different results.

A recent estimate from the 2016 ONS Annual Population Survey (APS) suggests that nationally 1.9% of the population is LGB; if this figure was applied to Gloucestershire it would mean that there are approximately 9,700 LGB people 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. We 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.

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**

We collect information about our workforce to enable us to monitor and investigate any disparities in outcomes for our different employee groups, and identify where we may need to act.

An overview of this information is presented below (source: Electronic Staff Records as at 31 December 2018):

- The CCG has 298.7 full time equivalent (FTE) employees.
- 49% of our staff work full time while 50% work part time
- 73.7% of our workforce are female
- 1.8% of our workforce describe themselves as having a disability; 12% of our staff have not declared whether or not they have a disability
- 8.4% of our workforce declared that they are from ethnic minority groups; 8.4% of our staff have not specified their ethnicity
- 61.5% of our workforce are aged under 50
- 72.7% per cent of our workforce declared a religion or belief
- 79.6% of our workforce declared they are heterosexual; 0.8% per cent of our workforce declared that they are lesbian, gay or bisexual; 19.6% 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 annual staff survey helps us to monitor equality issues, identify areas for action and evaluate support mechanisms available to our staff. Over time, 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 3 July 2018

Smoking prevalence in adults (18+) local count revised 10 July 2018

Local Authority Health Profile 2018

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.

Health in summary

The health of people in Gloucestershire is generally better than the England average. Gloucestershire is one of the 20% least deprived counties/unitary authorities in England, however about 12% (13,100) of children live in low income families. Life expectancy for both men and women is higher than the England average.

Health inequalities

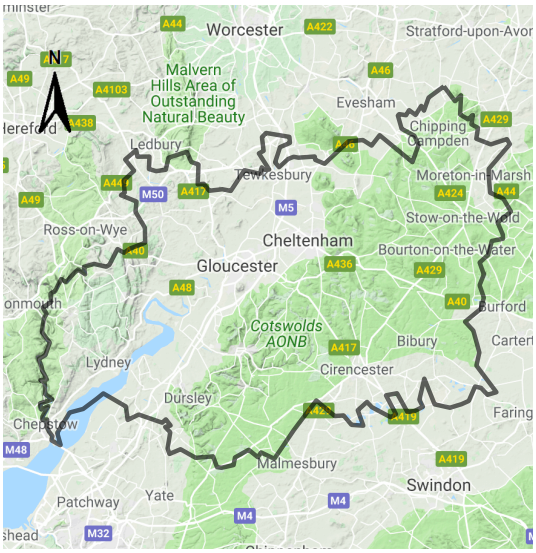
Life expectancy is 8.1 years lower for men and 5.3 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.**

Child health

In Year 6, 17.1% (1,000) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 38*. This represents 48 stays per year. Levels of teenage pregnancy, GCSE attainment and smoking at time of delivery are better than the England average.

Adult health

The rate of alcohol-related harm hospital stays is 600*, better than the average for England. This represents 3,784 stays per year. The rate of self-harm hospital stays is 214*, worse than the average for England. This represents 1,287 stays per year. Estimated levels of adult physical activity are better than the England average. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime, early deaths from cardiovascular diseases, early deaths from cancer and the percentage of people in employment are better than average.



For more information on priorities in this area, see:

- https://inform.gloucestershire.gov.uk

Visit www.healthprofiles.info for more area profiles, more information and interactive maps and tools.

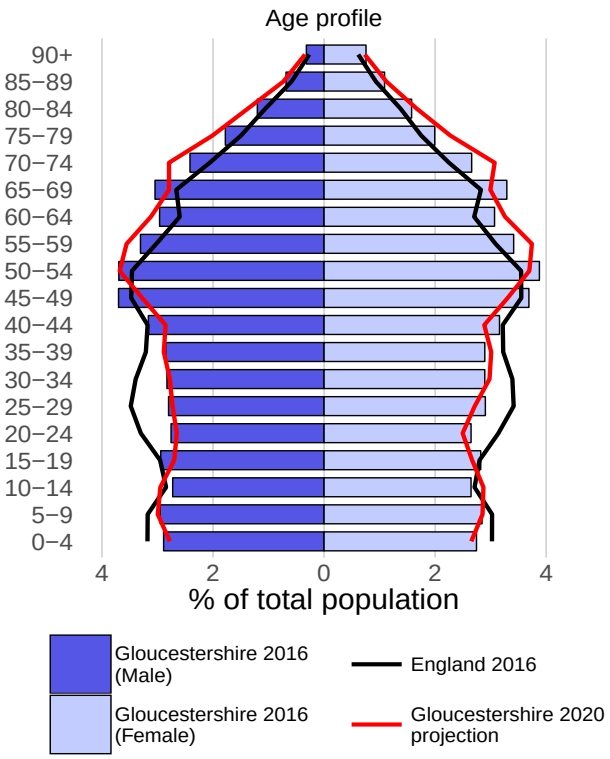
Local Authority Health Profiles are Official Statistics and are produced based on the three pillars of the Code of Practice for Statistics: Trustworthiness, Quality and Value.

Follow @PHE_uk on Twitter

* rate per 100,000 population

** see page 3

Population



Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

	Gloucestershire (persons)	England (persons)
Population (2016)*	623	55,268
Projected population (2020)*	642	56,705
% population aged under 18	20.3%	21.3%
% population aged 65+	20.8%	17.9%
% people from an ethnic minority group	4.2%	13.6%

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence
Ethnic minority groups: Annual Population Survey, October 2015 to September 2016

Deprivation

The level of deprivation in an area can be used to identify those communities who may be in the greatest need of services. These maps and charts show the Index of Multiple Deprivation 2015 (IMD 2015).

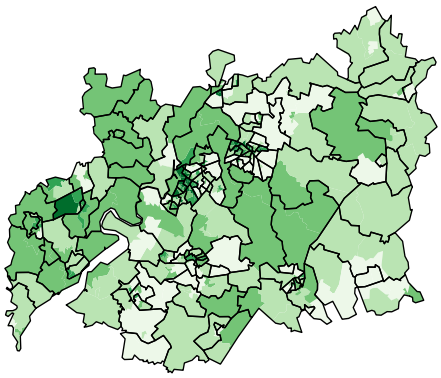
National

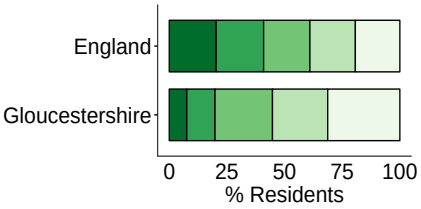
The first of the two maps shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of IMD 2015, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

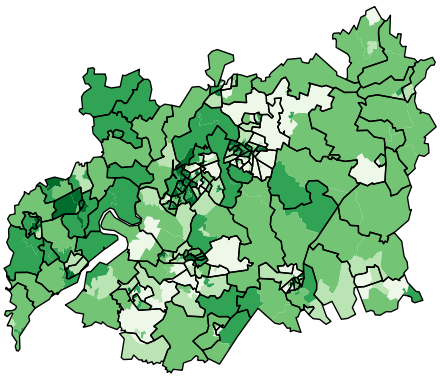
The chart shows the percentage of the population who live in areas at each level of deprivation.

Local

The second map shows the differences in deprivation based on local quintiles (fifths) of IMD 2015 for this area.







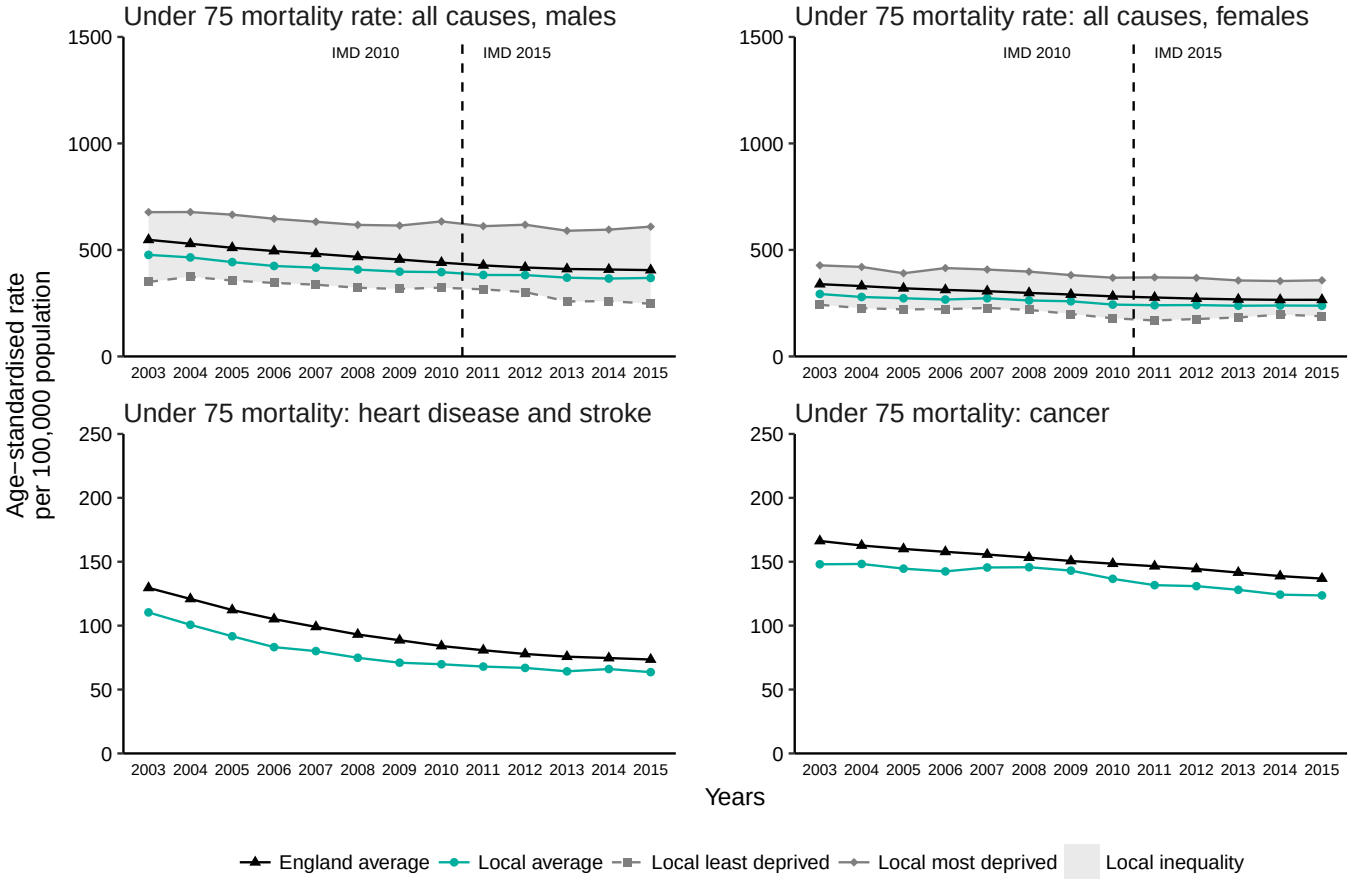
Lines represent electoral wards (2017). Quintiles shown for 2011 based lower super output areas (LSOAs). Contains OS data © Crown copyright and database rights 2018. Contains public sector information licensed under the Open Government Licence v3.0

Health inequalities: life expectancy

The charts show life expectancy for males and females within this local authority for 2014-16. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015). The life expectancy gap is the difference between the top and bottom of the inequality slope. This represents the range in years of life expectancy from most to least deprived within this area. If there was no inequality in life expectancy the line would be horizontal.

Trends over time: under 75 mortality

These charts provide a comparison of the trends in death rates in people under 75 between this area and England. For deaths from all causes, they also show the trends in the most deprived and least deprived local quintiles (fifths) of this area.



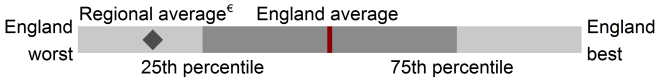
Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with the time period of the data. This provides a more accurate way of examining changes over time by deprivation.

Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

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 value for each indicator is shown as a circle. The England average is shown by the red 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



	Indicator names	Period	Local count	Local value	Eng value	Eng worst	Eng best
Life expectancy and causes of death	1 Life expectancy at birth (Male)	2014 – 16	n/a	80.0	79.5	74.2	83.7
	2 Life expectancy at birth (Female)	2014 – 16	n/a	83.6	83.1	79.4	86.8
	3 Under 75 mortality rate: all causes	2014 – 16	5,220	301.4	333.8	545.7	237.8
	4 Under 75 mortality rate: cardiovascular	2014 – 16	1,104	63.6	73.5	141.3	45.6
	5 Under 75 mortality rate: cancer	2014 – 16	2,154	123.6	136.8	195.3	100.0
	6 Suicide rate	2014 – 16	176	10.8	9.9	18.3	6.1
Injuries and ill health	7 Killed and seriously injured on roads	2014 – 16	756	40.8	39.7	71.3	13.5
	8 Hospital stays for self−harm	2016/17	1,287	214.3	185.3	578.9	50.6
	9 Hip fractures in older people (aged 65+)	2016/17	713	538.8	575.0	854.2	364.7
	10 Cancer diagnosed at early stage	2016	1,313	50.4	52.6	44.7	60.0
	11 Diabetes diagnoses (aged 17+)	2017	n/a	78.4	77.1	54.3	96.3
	12 Dementia diagnoses (aged 65+)	2017	5,823	68.2	67.9	53.8	90.8
Behavioural risk factors	13 Alcohol−specific hospital stays (under 18s)	2014/15 – 16/17	144	38.4	34.2	100.0	6.5
	14 Alcohol−related harm hospital stays	2016/17	3,784	600.4	636.4	1,151.1	388.2
	15 Smoking prevalence in adults (aged 18+)	2017	71,233	14.3	14.9	23.1	8.1
	16 Physically active adults (aged 19+)	2016/17	n/a	69.2	66.0	53.3	78.0
	17 Excess weight in adults (aged 18+)	2016/17	n/a	59.8	61.3	74.9	40.5
Child health	18 Under 18 conceptions	2016	157	14.9	18.8	36.5	4.6
	19 Smoking status at time of delivery	2016/17	302	8.6 ^78	10.7	28.1	2.3
	20 Breastfeeding initiation	2016/17	2,758	*68	74.5	37.9	96.7
	21 Infant mortality rate	2014 – 16	63	3.1	3.9	7.9	1.6
	22 Obese children (aged 10−11)	2016/17	1,000	17.1	20.0	29.2	11.3
Inequalities	23 Deprivation score (IMD 2015)	2015	n/a	15.0	21.8	42.0	5.7
	24 Smoking prevalence: routine and manual occupations	2017	n/a	27.8	25.7	38.9	13.9
Wider determinants of health	25 Children in low income families (under 16s)	2015	13,080	12.4	16.8	30.5	6.1
	26 GCSEs achieved	2015/16	3,711	61.4	57.8	44.8	74.6
	27 Employment rate (aged 16−64)	2016/17	303,900	80.8	74.4	60.9	82.4
	28 Statutory homelessness	2016/17	110	0.4 ^86	0.8	9.6	0.0
	29 Violent crime (violence offences)	2016/17	6,810	11.0	20.0	42.2	7.0
Health protection	30 Excess winter deaths	Aug 2013 – Jul 2016	938	16.4	17.9	28.9	7.4
	31 New sexually transmitted infections	2017	2,000	514.5	793.8	3,215.3	329.4
	32 New cases of tuberculosis	2014 – 16	71	3.8	10.9	69.0	1.3

For full details on each indicator, see the definitions tab of the Health Profiles online tool: www.healthprofiles.info

Indicator value types
1, 2 Life expectancy - Years 3, 4, 5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population 9 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 12 Proportion - % recorded diagnosis of dementia as a proportion of the estimated number with dementia 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population 15, 16, 17 Proportion - % 18 Crude rate per 1,000 females aged 15 to 17 19, 20 Proportion - % 21 Crude rate per 1,000 live births 22 Proportion - % 23 Index of Multiple Deprivation (IMD) 2015 score 24, 25 Proportion - % 26 Proportion - % 5 A*-C including English & Maths 27 Proportion - % 28 Crude rate per 1,000 households 29 Crude rate per 1,000 population 30 Ratio of excess winter deaths to average of non-winter deaths (%) 31 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 32 Crude rate per 100,000 population

€"Regional" refers to the former government regions.
*68 Value not published for data quality reasons ^78 There is a data quality issue with this value ^86 Aggregated from all known lower geography values

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk

Information and Communication

1. Frailty Information Bus and Frailty Wheel

1.1 Background to the project

The CCG is using its Information Bus to host a frailty roadshow around the county, providing resources to increase knowledge and confidence in manage frailty.

The specific areas were chosen to reflect SWAST data regarding the highest admission rates for people with frailty: Cirencester, Stroud, Bishops Cleeve, Coleford, Cinderford and Lydney. Further venues will be booked for 2019.

Key messages for the bus include:

- Frailty is often a combination of long-term conditions that can reduce your ability to manage well, and increase the likelihood of you going into hospital unexpectedly;
- There are different degrees of frailty - it is possible to recognise how frail you are;
- Frailty can be prevented, delayed and reversed through proactive action.

1.2 Local Engagement

The bus is specifically targeting people with disabilities and long-term conditions, and their families and friends.

Over the six sessions, the bus has representation from a large number of organisations/providers: Carers Glos, Age UK, Telecare, Community Wellbeing Services (GRCC & Independence Trust), Self-Management, 2gether, Shared Lives and the Fire Service in addition to CCG and Council staff.

Leaflets from the above organisations are available in addition to P3 Community Based Support (Cirencester) and Shared Lives as well as postcards for Your Circle. Healthwatch End of Life and Care Homes surveys are also being distributed.

A survey of 7 questions and a ‘myth buster’ leaflet to complement the survey will be used to help educate people about frailty as a condition. The leaflet is available on request in different languages.

In addition, a “frailty wheel” (see below) is being used as an educational tool to help people understand their level of frailty and ways of preventing it getting worse.

1.3 What we learned/outcome

Having a clinician on board has been beneficial as we have been able to offer blood pressure checks which has been popular and gives the opportunity to talk about improving wellbeing although, it is just a guide and where there are any concerns the individual will be referred to their own GP.

The bus has helped the CCG and partners to engage with those who have concerns about family members or would like to start thinking about themselves or family members own health and wellbeing and what they can do to prepare for the future.

1.4 Next Steps

We will now be reviewing the feedback received during these sessions and considering how we broaden our reach and share information across the county.

2. LGBT Partnership Cheltenham/Time to Talk Day

2.1 Background to the project

Time to Talk Day 2019 provided the perfect opportunity to work in partnership with 2gether NHS Foundation Trust and the LGBT+ Partnership Cheltenham on this awareness-raising event in the town centre.

Mental health problems affect one in four of us, yet people are still afraid to talk about it. Time to Talk Day encourages **everyone** to talk about mental health and challenge stigma.

Established in 2015, the LGBT Partnership is a group of Gloucestershire based organisations working together to increase people's awareness of the LGBT community, its heritage, challenges and hopeful future. The purpose of the Partnership is to bring together relevant organisations and individuals to deliver strong action around:

- Promoting and advancing LGBT diversity, equality and inclusion;
- Educating, informing and including key groups, allies, services and businesses; and
- Focusing activities and events on Cheltenham and connected areas.

One of the Partnership's aims for 2019 is to celebrate key events across the year including LGBT History Month, which falls annually in February. The two events provided the perfect opportunity to hold a combined event, with a common goal of breaking down barriers and reducing stigma

1.2 Local Engagement

The event built on the developing working relationship between 2gether NHS Foundation Trust and the LGBT Partnership, but brought in other partners from the CCG and University of Gloucestershire.

A range of materials were made available at the day: the CCG provided an eye-catching banner to promote the event that was suitably generic to support other events with the LGBT Partnership.

The Information Bus was in a prominent place in Cheltenham town centre and attracted a good volume of visitors during the day.

1.3 Next steps

As a result of this engagement we are now planning to support the LGBT Partnership to reach local communities at a number of high profile events this year including Gloucester Pride and Cheltenham Pride.

We are also meeting members to discuss the “what matters to you” engagement relating to the NHS Long Term Plan, ensuring that the voice of our LGBT community is represented in the development of our future services.

Patient Experience

1. End of Life Clinical Programme Group

1.1 Background

The End of Life Care Clinical Programme Group (CPG) was created 18 months ago to deliver the priorities set out in the End of Life Care Strategy 2016-19. This strategy made a commitment to ensure the highest quality end of life and palliative care services are available to all who need it irrespective of diagnosis, age, gender, ethnicity, religious belief, disability, sexual orientation and socio-economic status.

Integral to any service improvement or re-design work is listening to people with experience; this is particularly true in relation to end of life care services. Dame Cecily Saunders, the founder of the Hospice movement, said “How people die remains in the memory of those who live on”.

We will only die once which means there is only one chance to ensure people, and those closest to them, have a ‘good’ experience at the end of their life and in death. To support the delivery of the End of Life Care Strategy the CPG decided, therefore, to recruit two people with experience (they cared for loved ones who died in Gloucestershire) along with a Healthwatch representative, to be members of the End of Life Care CPG.

1.2 Local engagement

The first two CPG meetings were workshops that explored what a ‘good’ experience of end of life care might look and feel like for people, their carers and families. In these workshops, patient representatives were able to share their experiences, both good and bad, with health and social care professionals.

An End of Life Care programme of work, with many service improvement projects, was developed following the workshops. Patient and Healthwatch representatives are included on many of these projects as part of the Project Team. They choose which projects they want to be involved with, usually as a result of their individual experiences, where they feel they will most add value and make a difference, for example:

- Involved in project to record and share electronic DNACPR (Do Not Attempt Resuscitation) and other end of life care preferences, to prevent inappropriate resuscitation. This was because a person they cared for was so worried about being resuscitated against their wishes they wrote DNACPR on post-it notes and stuck them around their bed and throughout the house in case emergency services were called;

- Involved in project to roll-out anticipatory (or 'Just in Case') end of life care medication because the person they cared for wasn't able to access timely pain relief when it was needed.

Of particular note was a project supported by patient representatives but more extensively, by Healthwatch. The CPG wanted to understand what holistic (non-clinical) support at end of life was available locally and what people thought was needed (i.e. where the gaps were). Healthwatch Gloucestershire undertook a range of engagement exercises (including a survey) with people who were caring for, or who had cared for, people at end of life. The resulting report was published on their website: https://www.healthwatchgloucestershire.co.uk/reports-publications/

1.3 What we learned/outcome

Having patient and Healthwatch representation on the CPG ensures that the members of the CPG (i.e. health and social care professionals, commissioners and colleagues from the voluntary and community sector) remain grounded and sighted on what is important and makes a difference to people, their carers and families at end of life.

The Healthwatch engagement work contributed to the final report from the holistic support project. The key themes emerging were:

- Information in the same place where it is easy to find and navigate;
- Information on the physical changes at the end of life and what carers and families might expect;
- Psychological and emotional support available to carers/family as well as patient;
- Post death practical advice and bereavement support (not just immediately after the death but ongoing to help the person cope with loneliness etc.);
- Even when information is given it may not always be taken in or remembered at a time when people are in such stressful and upsetting circumstances.

1.4 Next steps

The CPG has developed leaflets offering good practical advice including information about the physical changes which might be expected at the end of life, but these are not being accessed by those who may have benefitted from them. The CPG will, therefore, undertake a review of:

- where we are locating copies of the leaflet and how we can ensure these are more accessible; and
- how we can raise awareness of this information amongst professionals.

Patient and Healthwatch representatives are about to start a new project which will provide a great opportunity to improve awareness about end of life care in the community. This project will enable people who are caring for someone at the end of life to be more informed and better prepared about what to expect in the final few weeks and days.

Working with a local domiciliary care provider, they will develop a 2 hour education and training session to be delivered in community settings to people who are caring for someone at end of life. The patient representatives have often told the CPG "If I had known …....., then I would have been better prepared as to what was going to happen next". Their experiences and insight into what they would have found helpful and useful to know in the last few weeks and days will be invaluable in developing this resource.

The CPG is extremely grateful to the patient and Healthwatch representatives for their desire to make a difference, their courage to speak openly and freely about their deeply personal experiences and for the time they are prepared to give to support the work of the CPG.

2. Primary Care Patient Advice and Liaison Service

2.1 Background

NHS Gloucestershire CCG (GCCG) was established in 2013. At that time GCCG had a Patient Advice and Liaison Service (PALS) transferred from the Gloucestershire Primary Care Trust, providing advice and support to local people in relation to problems they might be experiencing relating to commissioning decisions or primary care services. However, in 2013 responsibility for commissioning primary care services became the responsibility of NHS England and a decision was taken nationally for a central all-England PALS to be set up to handle all primary care enquiries.

A local decision was required regarding handling of PALS enquiries related to our residents' experience of local primary care services and our Governing Body took the decision in 2013 to invest in the continuity of a local PALS service; which also offer a formal commissioning complaints handling service; maintaining a responsive local offer for Gloucestershire residents.

Member practices recognised at the earliest stage of the establishment of the CCG the importance of local resolution for patients' concerns and the potential to learn from the experiences of local people collected through PALS.

2.2 Local Experience

The number of contacts to GCCG PALS has steadily increased during 2018, with just over 800 people contacting the service – a rise of almost 25%. PALS Case studies are a routine feature of Quality Reporting to the GCCG Integrated Governance and Quality Committee. The three examples below highlight the range of experiences shared with PALS and action taken:

Case Study 1: PALS supported a Patient who had been struggling to get their medical records updated following gender reassignment. PALS contacted the practice and supported them with submitting the required documentation to Primary Care Support England. As a result of this enquiry appropriate information and weblinks have been added to g-care to ensure that practices follow the appropriate processes in a timely manner.

Case Study 2: Over the last twelve months there have been some significant changes in the prescribing of some over the counter medications. There have also been other national changes in prescribing practice, for example FreeStyle Libre flash glucose monitoring systems, which have resulted in a flurry of calls to GCCG PALS.

In the case of FreeStyle Libre monitoring, this was made available via NHS prescribing across the UK, but with access to the device subject to local CCG Guidance. NHS Gloucestershire CCG does not recommend the routine NHS provision of the FreeStyle Libre system, or the prescribing of FreeStyle Libre sensors/strips in Gloucestershire. The NHS Gloucestershire CCG Prescribing Guidance recommends that adult patients are only initiated on Freestyle Libre by a Hospital Specialist and that they meet the clinical criteria set. GCCG PALS received well over 50 enquiries relating to the prescribing policy for this product.

In dealing with this type of enquiry, GCCG PALS ensure that the patient has access to all of the relevent information and policy documentation, facilitates personal written responses or call backs from pharmacy leads as appropriate and provides advice on appeals process and Individual Funding Requests where required.

2.3 What we learned/outcome

As the three examples above demonstrate we recognise that retaining a local PALS service for commissioning and primary care in Gloucestershire is crucial. Patients acknowledge that PALS intervention has helped them and they say they have felt supported at an earlier stage, negating the need for formal complaints to be made.

2.4 Next steps

Opportunities in 2019 to be explored include introduction of a more systematic evaluation of the experience of users of the PALS service and collection of more detailed demographic information about those individuals who proactively access the service, based on the NHS England Surveying complainants Toolkit https://www.england.nhs.uk/surveying-complainants/. This will enable us to develop targeted communication and promotional materials to reach groups which may currently not be aware of, or are choosing not to access, the service.

Primary Care

1. Countywide Patient Participation Network

1.1 Background to the project

NHS Gloucestershire CCG established a Countywide Patient Participation Group Network in 2015/16. The PPG Network was established to provide a regular forum for PPGs from approximately 75 GP practices to come together four times a year to receive information, to share learning and to network, all with the purpose of improving patients' experience of primary medical services in Gloucestershire.

National GP Patient Survey (GPPS)

The GP Patient Survey (GPPS) is an England-wide annual postal survey, which has been running since 2007. The survey asks about patient experiences of local general practice services.

GPPS produces data on over 7,000 GP practices and 195 CCGs and the results are weighted to population profile for age and gender. In 2018, the 2,221,068 questionnaires were sent out nationally, and 758,165 were returned, a response rate of 34.1%. In Gloucestershire CCG area, 20,334 questionnaires were sent out, and 8,987 were returned, a response rate of 44%.

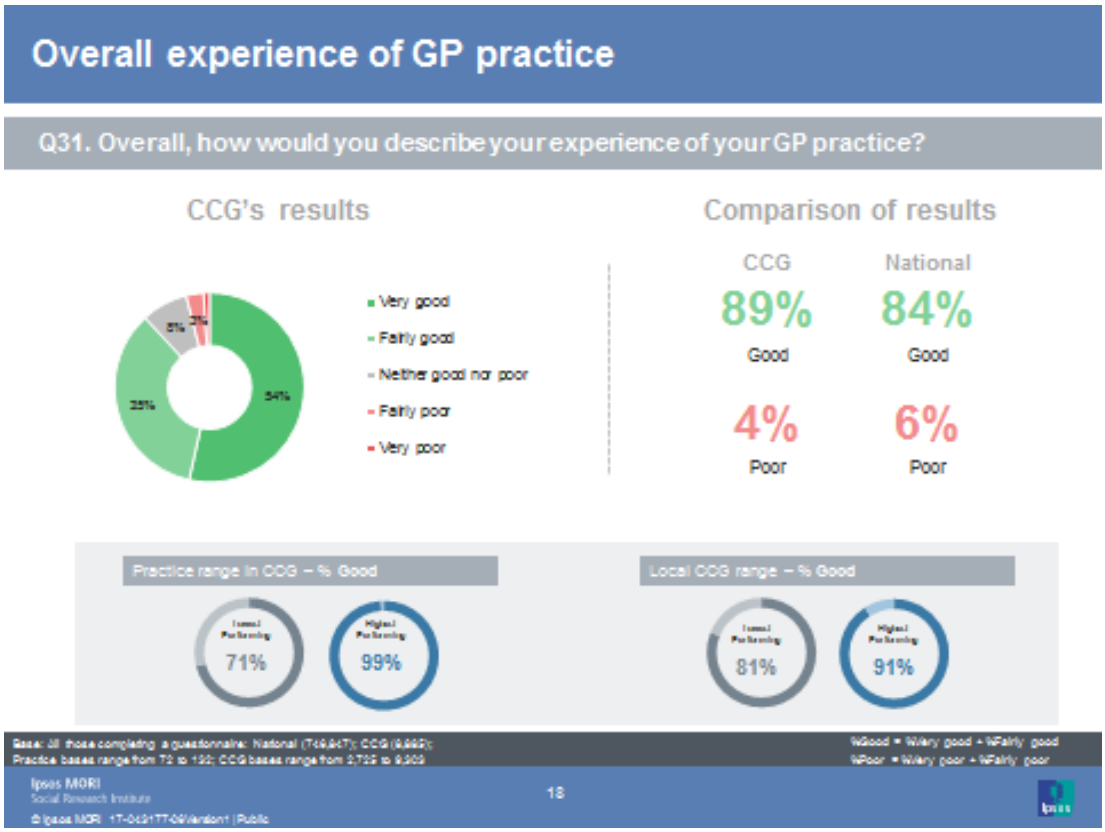
GPPS is Accessible

GPPS is available in a range of accessible options:

- Freepost and Online completion
- 14 foreign languages
- BSL, Braille, Large print
- There is a telephone helpline to support individuals with completion of the survey.

National Headline findings 2018

NHS Gloucestershire CCG – overall experience of GP practice 2018



What is the GPPS used for nationally?

- Used to review national policy
- Shapes decisions about investment
- Identifies health inequalities
- Used to understand and support local organisations better
- Can help to better understand different long term conditions
- Used by national bodies to monitor experience
- Data is shared with organisations who are looking to undertake research
- Used as a key source of data for the NHS Long Term NHS Plan

Locally, the CCG uses GPPS data to monitor performance of practices within our area to help make commissioning decisions and to support PPGs and practices to use the GPPS data, together with other patient feedback such as Friends and Family Test to improve patient experience.

1.2 Local Engagement

For the past two years, PPG members have received an annual presentation on GPPS. The first year's presentation, made by the CCG's lead for engagement and experience, who is a member of the National GPPS Steering Group, focussed on the CCG's overall performance and encouragement for PPGs to go back to their individual practices to discuss their local results with the practice team to identify areas for improvement focus.

This year's (2018) presentation, made by members of the NHS England national GPPS team, again looked at the CCG's overall results, but also provided a live demonstration of the GPPS analytical tool. The presentation focussed in particular on the changes to GPPS in 2018 and the rationale for the changes. PPG members were encouraged to take part in a lively Q&A session and provide feedback to the national team about potential improvements to the GPPS next year.

1.3 What we learned/outcome

The PPG Network has been a great way for the CCG to engage PPGs in using survey data. Following the presentation and live demonstration of the analytical tool by the national NHSE GPPS Team, PPGs took away an increased understanding of how to best use the survey data, as well as about the running of the survey.

The national team received constructive and practical feedback from the PPGs, which will be used to inform future developments of the GPPS. For example, suggesting ways the GPPS practice comparison tool could be improved to make it more helpful to PPGs.

1.4 The next steps

The PPG Network continues to meet quarterly, the focus of the last event held in February 2019 being the NHS Long Term Plan.

The CCG continues to play a strategic role in the development of the GPPS through its membership on the national GPPS Steering Group. The CCG looks forward to seeing the publication of this year's results this summer and sharing these with the PPG Network and individual practices.

2. Supporting the development of Primary Care estate

2.1 Background

Across England, 40% of GP practices surveyed by the British Medical Association felt their premises were not adequate to deliver existing services and 70% were too small to deliver extra services.

Against this backdrop, GCCG recognised the need to ensure sufficient local capacity for the future, whilst maximising the use of the county's existing facilities and delivering value for money. With a focus on enhancing patients' experience and improving the environment for staff to provide the best care, GCCG commissioned an estates survey in the Spring of 2015, which highlighted constraints in some buildings: the condition of some buildings was no longer suitable for the long term, others presented challenge due to the functionality, or existing layout.

At this stage there were a number of committed developments and improvements underway in Gloucestershire, but a structured programme to improve the quality and capacity of primary care buildings was subsequently developed. .

2.2 Local Engagement

In respect of a proposed primary care premises development, the CCG sees two key stages when practices should be working with their patients and communities:

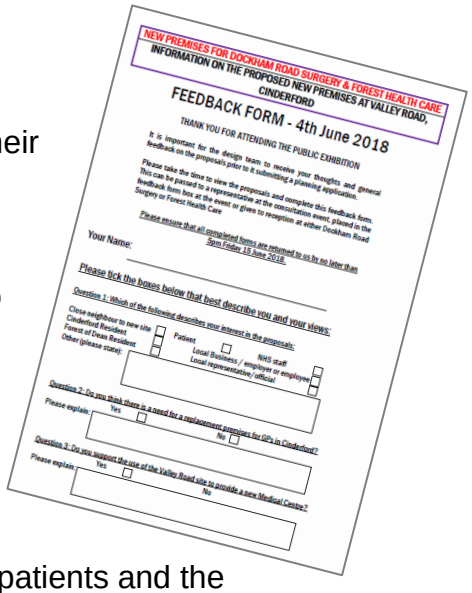
- Engagement during the completion of a business case where options are being considered
- Following approval, continued engagement through the detailed design and construction period.

The CCG's Patient Engagement Team has supported a number of practices over the last year to engage their Patient Participation Groups (PPGs) and wider practice population. This support has included:

- the facilitation of patient surveys/feedback forms and reporting on feedback received;
- supporting engagement events which provide an opportunity for patients to view and comment on plans and proposals; and
- liaison with local stakeholders and elected representatives.

2.3 What we learned

An example of good practice, has been the engagement undertaken by Forest Health Care and Dockham Road practices in Cinderford. Both practices are finding it increasingly difficult to provide high quality services from their existing site and were looking to develop new premises.


NEW PREMISES FOR DOCKHAM ROAD SURGERY & FOREST HEALTH CARE
INFORMATION ON THE PROPOSED NEW PREMISES AT VALLEY ROAD, CINDERFORD
FEEDBACK FORM - 4th June 2018
THANK YOU FOR ATTENDING THE PUBLIC EXHIBITION
It is important for the design team to receive your thoughts and general feedback on the proposals prior to it submitting a planning application.
Please take the time to view the proposals and complete this feedback form. This can be passed to a representative at the consultation event, placed in the feedback form box at the event or given to reception at either Dockham Road Surgery or Forest Health Care
Please ensure that all completed forms are returned to us by no later than 5pm Friday 15 June 2018.
Your Name:
Please tick the boxes below that best describe you and your views:
Question 1: Which of the following describes your interest in the proposals:
Close neighbour to new site
Cinderford Resident
Forest of Dean Resident
Other (please state):
Patient
Local Business / employer or employee
NHS staff
Local representative / official
Question 2: Do you think there is a need for a replacement premises for GPs in Cinderford?
Please explain:
Yes
No
Question 3: Do you support the use of the Valley Road site to provide a new Medical Centre?
Please explain:
Yes
No

Working with the appointed developers, both practices invited their Patient Participation Group (PPG) members to a joint meeting. At the meeting, members took part in a site options appraisal that reviewed a number of potential sites around the town. They reached consensus on a preferred site and their feedback was used to inform the final decision making by the practice partners.

PPG members subsequently supported drop-in events for patients and the wider community and continue to be involved in the project as progresses.

2.4 Next steps

Over the coming months, we will continue to support practices to engage patients in projects that improve and/or redevelop their premises. It is important that the PPE team is involved in the early stages of these projects, and in recognition of this we will be enhancing the PPE toolkit available to practices.

Agenda Item 15a

Governing Body meeting

Meeting Date	**Thursday 28 March**
Title	**Risk Management paper** **Governing Body Assurance Framework**
Executive Summary	This Risk Management paper has been updated to reflect the risks that have been reviewed and changed since the last report to the Governing Body on risk management. Audit and Risk Committee has delegated responsibility to review and challenge the risks reported to the CCG. The Audit and Risk Committee receives assurance and / or concerns raised with regard to clinical risks that have been reviewed by the Quality and Governance Committee. The Audit and Risk Committee provides assurance to the Governing Body in terms of the quality of risks, how they have been articulated along with controls and assurances and risk rating. The Governing Body is ultimately responsible for risk management and ensuring that the CCG has a risk aware culture that is embedded across the organisation.
Key Issues	See narrative report.
Management of Conflicts of Interest	None identified
Risk Issues: **Original Risk** **Residual Risk**	The absence of a fit for purpose GBAF and could result in risks not being identified, acted upon and reported and gaps in control / assurances not being identified and addressed. 12 (3x4) 4 (1x4)
Financial Impact	Not applicable
Legal Issues	Not applicable

(including NHS Constitution)	
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 asked to discuss and note the report.
Author	Christina Gradowski
Designation	Associate Director of Corporate Affairs
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

Agenda Item 16a

Governing Body meeting
28 March 2019

1. Introduction

1.1 Each directorate has a risk register that is updated on a monthly basis and should be used as part of directorate meetings to shape discussions on emerging and current risks that need to be effectively managed / mitigated. The risk registers also include guidance on how to succinctly identify and describe risk, how to score risks and the trend arrow to be included (indicating an upward / downward / same trajectory).

1.2 The Corporate Risk Register is reported to the Quality and Governance Committee with a particular focus on quality risks while the Audit and Risk Committee has taken on the assurance role for risk and receives the Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF). The Governing Body reviews the Assurance Framework. The Governing Body is ultimately responsible for managing risk and ensuring that there is a pro-active risk culture within the CCG.

1.3 The Audit and Risk Committee has been delegated the responsibility to draft the CCG's Risk Appetite statement. At its meeting on 12 March 2019, consideration was given to a 'very' draft statement outlining 4 risk appetite statements. Committee members were asked to consider the statements and provide feedback. The final statement will be produced and approved at the committee's next meeting in May once all feedback have been given. The statement will be included in a new Risk Management Strategy which will replace the Risk Management Policy to be completed by the summer 2019.

January / February 2019 review

Each directorate was asked to review its risk register (in January and again in February). Some of the directorates submitted their risk registers in January and confirmed that there were no changes to be made in February:

- Finance and information (no updates)

- Commissioning Implementation (update given in Jan)
- Transformation and Service Redesign (update given in Jan)

In February the following directorates submitted further changes to their risk registers on top of the changes that were made to these directorates in January.

- Quality
- Primary Care
- Integration

At the Audit and Risk Committee the Corporate Risk Register and Governing Body Assurance Framework were scrutinised and challenged particularly around the articulation of risk, updated actions and clarity around controls and assurances. The committee approved the following new risks which are included in the CRR and GBAF. This feedback has been communicated to directorate risk leads.

The Quality Directorate requested the inclusion of the following risks.

- Q22 SWAST has identified a risk in the South West to patients, due to 'call stacking'. In Gloucestershire the risk is in category 2 patients where waits are longer than target times. However, Category 1 patients are responded to within the required times. There are delays in responding to Category 4/5 health professional calls; but this is not considered to pose a risk to the patients. The risk is rated as 12 (Amber). Actions have been included in the GBAF.
- Q23 EU Exit. Due to the uncertainty surrounding EU-Exit arrangements there is a risk that some areas of healthcare delivery will be affected. These include the supply of medicines and vaccines. This risk is rated as 12 (Amber).

The Transformation Directorate had requested the inclusion of the following risk:

- T20 Risk that delayed implementation of changes to pathways through the Clinical Programme Approach fails to deliver the anticipated benefits. Resulting in transformation projects that may not deliver the expected outcomes for patients and the whole system. This risk is rated as 12 (Amber).

Highest risks RED

There is one red rated risk regarding SWAST see Q22, which will be recommended to the Audit and Risk Committee at its next meeting for inclusion in the CRR / GBAF. Please see GBAF where it is included but waiting for formal committee approval.

All February updates are marked in red on CRR and GBAF

Amber risks

Objective 1: Commission high quality, innovative services

- L2 There is a risk to the quality, resilience and sustainability of Primary Care. The risk has been re-articulated and the actions and controls have been updated. The risk remains unchanged since the last report at 8 (Amber) from an original risk rating of 12 (Amber).

- L5 (including L8) Clusters are unable to deliver Improved Access Pilots sustainably). L5 there is a potential risk about the roll out of the Improved Access Pilots across the clusters. Resulting in the GCCG's inability to commission Improved Access and patients unable to access a National requirement for urgent and routine appointments 6.30pm and 8pm and at weekends. The action plan has been updated and the risk remains the same as the previous report 12 (Amber).

- K1 / K2 Impact on discharges re-enablement. The April report showed that the risk had originally increased from 6 (Yellow) to 12 (Amber) and has remained unchanged. It should be noted that K1 *and K2 Impact on discharges* have been amalgamated as they are essentially the same risk around discharges. However the delays are caused by the re-enablement service (K1) and the availability of independent sector domiciliary care (K2). For this report the progress on actions has been updated and the risk rating remains the same at 12 (Amber).

- L9 There is a risk that clinical tasks are missed in Improved Access pilots where pilots are using Information systems to send clinical tasks. This risk was originally rated as 12 (Amber) but has been reduced to 8 (Amber). Actions were updated in January.

- T15 Risk around the lack of a detailed plan for specialised services transfer resulting in uncertainty in relation to future plans. This risk was identified in January 2018 and originally rated as 12 (Amber) it then increased to 16 (Red) in February and for the June report was reduced to 12 (Amber). This has been split into two risks, one solely around the role in PMO to have specialised commissioning liaison incorporated rated as 12 (Amber), the other around Diabetes see (T18). This risk was reviewed in January and the risk rating remains unchanged as 12 (Amber).

Objective 2. Engage and involve, patients, carers, staff and the public in shaping services

- Ext 1 One Place Programme. The risk is that members of the public and their representatives may not support some of the options which may be included in the public consultation document. This risk has been reduced as the changes to urgent care will be phased starting with the CAAS. Public consultation is scheduled for autumn 2019. Therefore at this present time the risk is rated at 4 (yellow).

- Q21 Risk of a Judicial Review. This risk was originally rated as 12 (Amber) based on the pre-action protocol letter received from Leigh Day. The action has been dropped for the time being based on the assurances given by the CCG pertaining to the work currently being undertaken (transport study; EIA; additional engagement). The risk will be kept at 8 (Amber), as there are a further two decision points within the financial year which could give rise to other JR applications (location of the new community hospital and the number of beds within the hospital). However the important decision as to when to close the two community hospitals, which will take place once the FBC is fully approved is yet to be determined. This

may well prompt a JR. At this point in time the risk has been reduced to 4 (yellow).

Objective 3. Transform services to meet the future needs of the population, through the most effective use of resources

- C27 Non-emergency patient transport. Actions and assurances have been updated, risk remains unchanged at 12 (Amber) since the last report but has decreased from an original risk score of 16 (RED).
- C5 Discharge. This risk has been updated and the risk score remains unchanged at 12 (Amber) down from an original risk rating of 16 (Red).
- C6 A&E target 4 hour wait. This risk has been updated and the risk score remains unchanged for most of the year, at 12 (Amber). The original risk was 16 the risk target is 8 (Amber).
- T18 Lack of a detailed plan for specialist services transfer. CCG commissioners monitoring the situation. NHSE recommissioned diabetic eye screening for April 2019 onwards**.** This was a new risk added in December 2018 and rated as 12 (Amber) and remains unchanged for this report.
- C15 Constitution targets - cancer. Risk has been reviewed and actions updated. The risk remains unchanged at 12 (Amber)
- C8 (including C28). Risk of failure to reduce demand and prevent unnecessary acute attendances has been updated. The risk remains unchanged at 12 (Amber).

Objective 4: Secure continuous improvement in the quality of services, tackling health inequalities and ensuring parity of esteem in mental health

- T11 Risk of financial cuts to public health services. Due to reduced budgets. Resulting in: likelihood of having a medium and long-term impact on population health and NHS resources. This risk has been spilt into two risks see below risk T19. The risk has been reappraised following on from a Governing Body Business Session where Public Health attended and where the cuts to services were

discussed. This risk has been reappraised and is now rated at 12 (Amber).

- T19 Risk of financial cuts to public health information. CCG has re-instated CCG/Public Health interface meetings to oversee delivery of the Public Health Core Offer and keep abreast of any funding cuts to Public Health budget and impact on service delivery. These will re-commence from January 2019. This risk has been reduced further to 4 (yellow).
- Q20 Mortality review. Risk remains unchanged at 12 (Amber). This risk has remained unchanged for this report.

Objective 6: Deliver strong leadership as commissioners ensuring good governance and financial sustainability

- K6 There are new legal duties for GCCG that can be challenged and potentially taken to tribunal / tested by case law. The risk was reviewed and has decreased from an original risk rating of 12 (Amber) to 8 (Amber) in December and is remains unchanged. However the actions have been fully reviewed and updated.
- K9 Risk that the CCG is unable to meet the national target for CHC. Due to: Currently there are 42 CHC funded individuals with a Learning Disability, a piece of work has been undertaken to identify when this cohort of individuals last had a review in line with the National Framework for Continuing Healthcare. The actions have been updated and the risk has been rated as 12 (Amber) and remains unchanged.
- C3 Procurement – risk of legal challenge. This risk has been re-articulated with clearer details on the impact of the risk. The actions have been updated and the risk rating has been reviewed and is unchanged at 12 (Amber).
- C16 & F11 There is a risk that activity will be at variance with plan at Gloucestershire NHS FT and other providers including AQP contracts. This risk has been reviewed; this risk continues to be rated 12 (Amber). F11 has been amalgamated with C16 Rising demand above planned levels as they are duplicates.
- Q12. Risk that CCG staff may be inappropriately holding patient identifiable information. This risk remains unchanged since the last

report, it was originally rated as 9 (Amber) and has been reduced to 6 (yellow).

- T10 (including F12) Risk that delayed implementation of ICS Solutions and/or failure of projects to deliver anticipated benefits, this risk remains unchanged at 12 (Amber).
- Q5 Risk to financial performance if prescribing costs are in excess of the agreed budget. This risk is rated as 8 (Amber) and remains unchanged since the last report.
- F16 Potential transfers of commissioning responsibilities and service lines from/to CCG may lead to cost pressures. The risk rating remains unchanged at 12 (Amber)
- F24 Implementation of the electronic patient record system now incorporates K7 (Maternity Data). This risk has decreased to 12 (Amber) from 16 (RED). For this report the actions have been updated and the risk has been reviewed and remains unchanged.
- F20 Shared Record Project - It will not be possible to get real time data from SystmOne practices in the short-term. The risk rating of 9 (Amber) has reduced from its original score of 12 (Amber).
- F26 Local Digital Roadmap. Resources may not be available to deliver the programme. Actions have been updated and the risk remains unchanged at 12 (Amber).
- F27 Risk of Cyber Attack. The actions have been updated and the risk remains unchanged at 12 (Amber)
- F28 Overall financial risk of the CCG not delivering the financial position resulting in the CCG not achieving its statutory duty. The risk has been reviewed, actions updated and the risk remains unchanged at 12 (Amber).

Objective 7: Develop plans for proactive care with partners that focus on early intervention, prevention and detection of physical and mental health conditions

- Q19 Health needs of children in care. This has been reviewed and the risk remains unchanged at 12 (Amber).

3. Recommendation

3.1 The Audit and Risk Committee is asked to review, discuss and identify where improvements can be made to risk identification, reporting, grading and action plans.

4. Appendices

Appendix 16b Governing Body Assurance Framework

Governing Body Assurance Framework **Agenda Item 9.3**

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating LxS	Current risk rating LxS	Trend	Progress with actions
Strategic Objective	**Objective 1: Commision high quality, innovative services**								
Date added 23.11.17 **Directorate** **L5 now Inclu L8 Primary Care** **Executive Sponsor** Helen Goodey **Lead Manager** Helen Edwards / Jeanette Giles **Lead Committee** Audit & Risk Committee **Review date**	There is a risk that the CCG may not be able to commission improved access pilots from all cluster. Due to: Choice+ ceasing on 31.3.2018 and issues relating to OOH. Resulting in: GCCG inability to commission Improved Access pilots from all clusters by 1.10.2018 and patients unable to access a National requirement for urgent and routine appointments between 6.30pm and 8pm and at weekends.	Monthly Improved Access meetings between clusters and CCG in place. Weekly Directorate meeting. Weekly phone calls between commissioner and clusters where rota fill remains problematic. GP Improved Access cluster leads in place in each cluster. Each cluster has a working group which includes GPs and Practice Managers.Gloucester City re-considering the number of Primary Care Networks which will better enable	None	Weekly CCG IA Meetings in place. Monthly cluster IA meetings led by cluster lead GP. Monthly report to ICS Delivery Board and bi-monthly to NMOC Board. Primary Care Operational Group and the Risk and Issues log.	None	**2x4=8**	**3x4=12**	→	Letter received from provider 15.1.2018 stating support for 17/18 and response sent 16.1.2018. All clusters have finalised their models and all have completed Due Diligence. All clusters have plans in place. Two clusters returned their contracts to the CCG. CCG has commissioned "shared provision" from GDoC for these clusters. Extension to contracts sought from PCCC for 2019/20 for cluster delivery and delivery of weekend and bank holiday appointments."Shared Provision" in place for NEG and Inner City and for North Cotswolds (the latter on Friday evenings only). Shift fill monitored weekly. Gloucester City GPs in conversation regarding the number of Networks across the city. PCCC approval given to extend the contract for weekend and BH IA provision for 2019/20 and for Network delivery for 2019/20.
Date added 21.03.2019 **Directorate** **T20 Transformation** Executive Sponsor **Ellen Rule** **Lead Manager** Kelley Matthews **Review date** 31.03.19	Risk that delayed implementation of changes to pathways through the Clinical Programme Approach fail to deliver the anticipated benefits Resulting in: transformation projects may not deliver the expected outcomes for patients and the whole system.	Robust project management planning by the Tranformation Team supported by the PMO, Information & BI Teams.	None	Progress of pathway changes reported through to CPB on a bi-monthly basis along with the benefits realised from pathway transformation	None	**3x4=12**	**3x4=12**	**NEW**	1. KPIs developed with baselines developed. 2. Ongoing monitoring of each scheme with a view to assessing optimium pathways and benefits realisation from changes to pathways through transformation. 3. Dashboards developed eveloped to inform and report on pathways along with soft measures & intelligence. 4. Regular monthly meetings with service leads. 5. Regular discussion regarding delivery with the Clinical Programme Board (CPB) and Core Team with a focus on escalation of risk and issues.
Date added 01.04.2018 **Directorate** **T 15- Transformation** **Executive Sponsor** Ellen Rule **Lead Manager** Kathryn Hall **Lead Committee** Audit & Risk Committee **Review date**	Risk around lack of detailed plan for specialised services transfer. Resulting in: uncertainty in relation to future plans	1.CCG specialised commissioning lead to monitor the situation.	None	Assurance from NHS England's Area Team	None	**4x4=16**	**3x4=12**	↓	It is the intention for a member of the CPG team to take on specialised commissioning on their return from maternity leave in early 2019
Date added 01.04.2018 **Directorate** **T18 Transformation** **Executive Sponsor** Ellen Rule **Lead Manager** Emma Savage **Lead Committee** Audit & Risk Committee **Review date** 31.03.2019	Lack of a detailed plan for specialist services transfer. CCG commissioners monitoring the situation. NHSE recommissioned diabetic eye screening for April 2019 onwards	1.CCG specialised commissioning lead to monitor the situation.	None	Assurance from NHSE Area Team	None	**4x4=16**	**3x4=12**	↓	1. CCG proposing to re-configure Tier 4 weight management service (bariatric surgery) to ensure the greatest health gain within the finite resource 2. Reprocurement of diabetic eye screening service. NHSE confirmed GHFT will be the provider from April 2019, who is also the current provider.
Date added 01.04.18 **Directorate** **K1 including K2 Integration** **Executive Sponsor** Kim Forey **Lead Manager** Donna Miles **Lead Committee** Audit & Risk Committee **Rev date: 30.09.18**	Risk that discharges are being delayed in the acute sector. Due to delays with the re-enablement service and delay with sourcing independent sector domicillary care. This leads to a disruption of patient flow and pressures placed on urgent care and meeting the 4 hour target, increased length of stay and poor patient experience.	JCPE QIPP Board Reports GCCG Board Reports USC Briefing Report Performance reports and action plans monitored through contract quality monitoring groups.	None	Performance Reports to Governing Body	None	**3x4 = 12**	**3x4=12**	↔	Update 27.02.19 Draft Target Operatin Model in development due to be presented at May 2019 JCPE.
Objective 3. Transform services to meet the future needs of the population, through the most effective use of resources									
Date added 01.02.14 **Directorate** **C27 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Gill Brigland **Lead Committee** Audit & Risk Committee **Review date** 30.11.17	Risk to Non Emergency Patient Transport KPI delivery and Patient experience. Due to: Operational issues, financial sustainability of the Non-Emergency Patient Transport contract and procurement risks for new contract due to commence June 2019.Resulting in: Poor patient experience.	Risk to be managed consistently across Gloucestershire, Swindon, Wiltshire and BaNES CCG	None	Monthly Contract Board Meetings and ad hoc meetings with ATSL and other commissioners. Ad hoc performance reports to Governing Body and HCOSC	None	**4x4=16**	**3x4=12**	↓	Monthly Contract Board Meetings and ad hoc meetings with ATSL and other commissioners. 6 month contract extension agreed to allow time for development of a revised service specification, procurement and mobilisation (avoiding winter implementation of new service). Procurement process completed and mobilisation arrangements for the new provider are well underway. .
Date added 01/04/2018 **Directorate** **C5 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Maria Meatherall **Lead Committee** Audit & Risk Committee **Revi ew Date**: 31.03.19	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. Due to: Operational pressures. Resulting in: Poor patient experience.	A&EDB, weekly partnership meeting & bi-weekly oversight meeting	None		None	**4x4=16**	**3x4=12**	↓	1. Weekly partnership meeting reviewing all stranded and super-stranded patients. Meeting representatives are senior operational staff able to unpick complex cases. 2. System wide review of existing bed base including acceptance criteria and outcomes. 3. Review of letterbox pilot with aim to roll out wider for winter. 4. Further development of sub acute skills across Community based services to allow additional patients to be supported safely within the Community. 5. Review existing D2A provision with development of processes,pathways and therapy provision. 6. Develop Community based IV provision to support early patient discharge and admission avoidance. 7. Review of transport offer to ensure robust provision to support appropriate hospital discharge. 8. Development of system wide escalation measures to ensure timely response to extremis with actions to address any discharge delays. 9. Identification of additional Nursing Homes that can support patients with higher acuity needs. 10. Extending roles to cover 7 day working including Adult Social Care and Onward Care Team.
Date added 01/01/2017 **Directorate** **C6 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Maria Meatherall **Lead Committee** Audit & Risk Committee	Non-delivery of the Constitution standard for maximum wait of 4 hours within the emergency department. Due to: Operational pressures. **Resulting in:** Negative patient experience.	A&EDB & Attendance Avoidance sub-group	None	Reports to GB at Business Sessions; GB meetings	None	**3x4=12**	**3x4=12**	↔	1. Roll out of Cinapsis to support admission avoidance and ensure patients progress through the most appropriate pathway in a timely manner. 2. Further devlopment of admission avoidance pathways including Ambulatory Emergency Care, Surgical Assessment unit and Acute Medical Initial Assessment service. 3. Roll out of Frailty Assessment service supporting early discharge from hospital and support within the Community. 4. Development of Communications strategy to support people in identifying the most appropriate service to meet their needs. 5. Roll out of NHS111 on line 6. New ways of working being developed within the Emergency Department with GP led streaming to increase number of patients appropriately streamed to primary care 7. Working with Acute and Ambulance Trust to reduce handover delays. 8. NHS111 undertaking validation of 999 and ED dispositions with positive impact upon demand management. 9. Work underway to identify system wide high intensity users to provide support packages to reduce demand on services and improve outcome for patients.

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating	Current risk rating	Trend	Progress with actions
Date added 01.04.2017 **Directorate** **C15 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Christian Hamilton **Lead Committee** Audit & Risk Committee **Review date** 31.03.18	Failure to fully comply with all NHS constitution standards. **Due to:** Delivery of changes required to recover performance and address issues related to capacity and demand. **Resulting in:** Potential delays to patient care	Acute provider contracts, including AQP.	None	Reports to GB at Business Sessions; GB meetings	None	**3x4=12**	**3x4=12**	⟺	Progress with actions 1. Significant improvement in performance continues – including IAPFT, Ambulance Category 1, ED 4 hours standard, diagnostics, cancer 2 ww and DTOCs. 2. Further concentrated work on delivering recovery plan for cancer 62 day standard, to reduce number of over 52 ww breaches and to recommence national RTT reporting. 3. Service re-design led by Clinical Programme Groups continues – including focus on demand management initiatives. 4. Sharing of information with GP Localities. 5. Clinical validation undertaken at 52weeks and >62 days which includes harm review. 7. Good progress made on joint STP elective care programme aimed at reducing demand, managing follow ups and improving efficiency.
Date added 01.04.2018 **Directorate** **T11 Tranformation & Service Redesign** **Executive Sponsor** Ellen Rule **Lead Manager** Emma Savage **Lead Committee** Audit & Risk Committee **Review date** 31.03.18	Risk of financial cuts to services provided by public health. This includes, and is not limited to, public health campaigns, smoking cessation services etc. Resulting in: likelihood of having a medium and long-term impact on population health and NHS resources	Regular joint meetings and agreement of joint work plans with links to H&WB Board	None	Assurance from NHSE Area Team	None	**2x4=8**	**3x4=12**	↓	1. PHE appointed 2 substantive public health consultants one of which is an additional post. 2. CCG has re-instated CCG/Public Health interface meetings to oversee delivery of the Public Health Core Offer and keep abreast of any funding cuts to Public Health budget and impact on service delivery. These will re-commence from January 2019.
Date added 01.04.17 **Directorate** **C8 & C28 Commissioning** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Maria Meatherall **Lead Committee** Audit Committee Haydn Jones **Lead Committee** Audit & Risk Committee **Review date** 30.09.17	(Signposting & Admission Avoidance) High Impact Action 2: Risk of failure to reduce demand and prevent unnecessary acute attendances and emergency admissions. (Signposting & Admission Avoidance) High Impact Action 2: Risk of failure to reduce demand and prevent unnecessary acute attendances and emergency admissions. **Due to**: Failure to implement agreed plans to reduce unnecessary ED attendances and emergency admissions. **Resulting in**: ED attendances and emergency admissions above planned levels.	A&EDB, Attendance & Admission Avoidance Task & Finish Group, Urgent Care Strategy Group	None	Performance Reports to Governing Body, weekly situation report, project status updates	None	**3x4=12**	**3x4=12**	⟺	1.Roll out of Cinapsis to support admission avoidance and ensure patients progress through the most appropriate pathway in a timely manner. 2. Further devlopment of admission avoidance pathways including Ambulatory Emergency Care, Surgical Assessment unit and Acute Medical Initial Assessment service. 3. Roll out of Frailty Assessment service supporting early discharge from hospital and support within the Community. 4. Development of Communications strategy to support people in identifying the most appropriate service to meet their needs. 5. Roll out of NHS111 on line to support people in identifying alternatives to attending ED. 6. New ways of working being developed within the Emergency Department with GP led streaming to increase number of patients appropriately streamed to primary care. 7. Work to further develop falls pathways to avoid patients being unneccessarily conveyed to ED. 10.Ongoing work with the Directory of Service to ensure all alternative services are clearly mapped to support ED attendance avoidance. 11. Work within Out of Hours to enhance staffing skill mix to assure robust cover.
Objective 4. Secure continuous improvement, in the quality of services, tackling health inequalities and ensuring parity of esteem in mental health									
Date added 01.04.18 **Directorate** **Q20 Quality** **Executive Sponsor** Marion Evans Andrews **Lead Manager** Julie Symonds **Lead Committee** Audit & Risk Committee **Review date:** 31.03.2019	There could be a risk of high mortality rates at the GHFT. Due to: The HSMR (Hospital Standardised Mortality Ratio) and SMR (Standardised Mortality Ratio) are statistically significantly higher than expected within GHNHSFT overall and individually at both acute sites. Resulting in: potential higher mortality rates	Monthly mortality briefings provided by Dr Foster. Trustwide mortality strategy reviewed at CQRG.	None	Reviewed by IGQC on behalf of the Governing Body	None	**3x4=12**	**3x4=12**	⟺	The SHMI is being driven by out of hospital deaths within 30 days of discharge. A decision was made to undertake a joint provider, morality review on a a number of these deaths. Data on the detail of these is not easily accessible and it is being explored how this data can be obtained. This review will report to STP clinical reference group. MI position improved. Establishment of STP mortality group to align mortality review policies. Multi-agency reviews have commenced The LeDeR mortality review is driving the systemwide process and as such GCCG is producing information for primary care. To date the LeDeR mortality review process has not identified significant concerns
Objective 6. Deliver strong leadership as commissioners ensuring good governance and financial sustainability									
Date added 24.05.13 **Directorate** **C3 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** David Porter **Lead Committee** Audit & Risk Committee **Review date:** 31.03.2019	Increased risk of CCG receiving legal challenge. **Due to:** 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). **Resulting in:** Could result in any contract that has been negotiated / signed being 'set-aside' by the courts and / or a fine being levied against the CCG which may be equivilent to the loss of profits for the challenging organisation.	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. Continued risk which applies to all procurement process but particularly those which exceed the Light Touch Regime threshold (£615,278.00 total	None	Project reports to Core Executive Team and Governing Body	None	**3x4=12**	**3x4=12**	⟺	A revised CCG procurement strategy was approved by the Governing Body (November 2018).
Date added 01.04.2018 **Directorate** **C16 combined with F11 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw / Cath Leech **Lead Manager** Christian Hamilton / Andrew Beard **Lead Committee** Audit Committee **Review date** 31.03.19	There is a risk that activity will be at variance with plan at Gloucestershire NHS FT and other providers including AQP. Resulting in the failure to deliver financial targets.R Due to: Providers taking up activity under AQP contracts where previously they had not. Also driven by long waits at GHFT. Results in: contract over-performance creating a financial pressure for the CCG.	Robust financial plan aligned to commissioning strategy. QIPP plans developed with appropriate governance processes including monitoring. CCG constitution including Standing Orders, Prime Financial Policies and Scheme of Delegation approved. Monthly contract monitoring in place	None	Reports to GB at Business Sessions; GB meetings, specifically around savings plans and updates on contracts	None	**3x4=12**	**3x4=12**	⟺	1. Acute provider contract monitoring 2. To review activity associated with all AQP contract on a monthly basis. 3. Develop care pathway approach to demand management. Communication with Primary Care and acceleration of advice & guidance for key specialties. 4. Focus on IFR/CBA policy compliance to minimise low value activity 5. Evaluation of the impact of introducing direct access diagnostics 6. Development of more detailed service specifications where possible
Date added 01.04.2018 **Directorate** **K9 Integration** **Executive Sponsor** Kim Forey **Lead Manager** Miriam Street & Debbie Sanders **Lead Committee** Audit & Risk Committee **Review date** 31.03.2019	Risk that the CCG is unable to meet the national target for CHC. Due to: Currently there are 42 CHC funded individuals with a Learning Disability a review conducted showed that there are 28 individuals who have not had a review. Resulting in missed target and poor patient experience for the actual patient and their family	Monthly perfromance reports reported to the Core Leadership team and to the Governing Body at the Business Sessions and formally as part one of the Governing Body meeting.	None	Governing Body Performance Reports; reports to the Audit and Risk Committee and performance monitoring by NHS England	None	**4x4=16**	**3x4=12**	↓	Update: 20.02.19 Several unsucessful recruitment campaigns with only one individual appointed (due to commence in April 2019). Review of cases continues with 15 outstanding cases to be completed. Monitoring of all LD CHC cases continues on a weekly basis to ensure the CCG meets the 28 day timeframe.
Date added 01.04.2018 **Directorate** **T10 including F12 All Directorates** **Executive Sponsor**	Risk that delayed implementation of ICS Projects and/or failure of projects to deliver anticipated benefits **Due to:** **Resulting in:** under-delivery on planned care QIPP savings target. Therefore transformation projects may not deliver the expected outcomes.	Robust project management planning and reporting to the PMO.	None	Budgets approved by the Governing Body. Monthly performance reporting to CCG Governing Body and quarterly reporting to the CCG's Audit Committee.	None				1. KPIs developed and uploaded to Verto performance management system. 2. Ongoing. 3. QIPP Portal developed to inform and report on QIPP schemes along with soft measures & intelligence. 4. Triangulation of information data and finance for year to date position and improved QIPP scheme

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating	Current risk rating	Trend	Progress with actions
Cath Leech **Lead Manager** Haydn Jones **Lead Committee** Audit & Risk Committee **Review date** 31.03.2019						**3x4=12**	**3x4=12**	⟺	forecasts. 5. Regular monthly meetings with service leads for scheme reviews. 6. Regular discussion regarding delivery with Core Team with a focus on escalation of risk and issues.
Date added 01.04.2018 **Directorate** **F16 Finance** **Executive Sponsor** Cath Leech **Lead Manager** Andrew Beard **Lead Committee** Audit & Risk Committee **Review date** 31.03.2019	Potential transfers of commissioning responsibilities between organisations from/to CCG may lead to cost pressures.	Assess all transfers and compare with current position to validate any proposed financial and workload impact.	None	Monthly performance dashboard for larger contracts with robust out of county contract monitoring reflected within performance reports. Monthly prescribing & CHC information including trends Internal audit reports and recommendations to be reported to Audit Committee.	None	**3x4=12**	**3x4=12**	⟺	All provider monitoring is being reviewed to spot anomalies within activity data that may have been potentially transacted on a different basis to which the funding was transferred from NHSE. Any material issues are being raised with the Specialist Commissioning Team which has resulted in some correction to the original allocation transfers. These transfers have been actioned recurrently in 2018/19 opening RL Transfers under the TCP programme being followed through and financial implications discussed with NHSE and guidance being worked through with joint GCC/CCG commissionerson an ongoing basis. These will have a significant financial impact on the CCG. Initial deep dive report to F & P development session in July with increased monitoring during the year. TCP impact being actively managed with LD commissioners to minimise financial risk Future likely impact of transfers being modelled using nationally available modelling tool.on CCG activity.
Date added 01.04.2018 **Directorate** **F24 Finance / K7 Maternity** **Executive Sponsor** Cath Leech **Lead Manager** Andrew Beard **Lead Committee** Audit & Risk Committee **Review date** 31.03.2019	Implementation of Electronic Patient Record system within our main acute provider There is also a risk that there is no reportable data for maternity services. This is due to the implementation of the electronic patient record system within GHNHSFT. Resulting in: reporting issues for clinical correspondence, national performance reporting and contractual management.	Development of a remedial action plan supported by CCG/CSU staff to mitigate risks of adverse clinical communication and incomplete reporting	None	Governing Body Business Session through performance and finance reports to the Governing Body discussion of risk at Quality and Governance Committee	None	**4x4=16**	**3x4=12**	↓	1. Comprehensive recovery programme in place. 2. Key work streams are focussed upon data quality, people and process, clinical safety and finance. 3. The Trust has put in place strengthened project infrastructure which includes support from the CCG. 4. The quality and comprehensiveness of activity and financial reporting continues to improve 5. Majority of the contract is block therefore mitigating some of the financial issue however elective performance monitoring and establishing a baseline for next financial year will be challenging 6. Deeper dive into identification of coding changes underway by Information Team
Date added 30.03.17 **Directorate** **F26 Finance** **Executive Sponsor** Cath Leech **Lead Manager** Fiona Robertson **Lead Committee** Audit & Risk Committee **Review date** on-going	Local Digital Roadmap - Resources (financial and workforce) may not be available to deliver the programme or projects within the STP which will **Resulting in** an impact on delivery and benefits.	County Wide IM&T Steering Group and associated sub groups in place reporting to Delivery Board and each organisation	None	ICS Delivery Board and each organisation's Board / Governing Body	None	**3x4=12**	**3x4=12**	⟺	On going dialogue within the Countywide IM&T Group on resourcing and potential risk to delivery. Bidding to national funds in progress. Risks regarding capital vs revenue funding model highlighted to NHSE. Strategy refresh commenced to review resourcing requirements over the next few years.
Date added 07.06.17 **Directorate** **F27 Finance** **Executive Sponsor** Cath Leech **Lead Manager** Fiona Robertson **Lead Committee** Audit & Risk Committee **Review date**	There is an increased risk of a cyber attack **Due to**: cyber threats continuing and become more sophisticated which, if successful, would **Result in:** the CCG's systems and information are at greater risk of being compromised.	The CCG has policies in place to reduce the probability and contracts with the CSU and CITs which include cyber security advice and services.	None	The CCG has policies in place to reduce the probability and contracts with the CSU and CITs which include cyber security advice and services. County Wide IM&T Steering Group and associated sub groups in place reporting to Delivery Board and each organisation	None	**3x4=12**	**3x4=12**	⟺	1. action plan following testing in progress, dependency on the implementation of new WAN/LAN timescale 2.response action plans reviewed and being updated 3. staff comms started, training plan to be developed 4.initial review of potential network improvements carried out, costed plans developed and being reviewed by the LDR Infrastructure Group. 5. business cases development and delivery programme started. Some countywide solutions will be progress once funding from NHSE is approved. 6. Follow up cyber exercise planned for December 18.
Date added 01.04.18 **Directorate** **F28 Finance** **Executive Sponsor** Cath Leech **Lead Manager** Andrew Beard **Lead Committee** Audit Committee **Review date** **31.03.2018**	Overall financial risk of the CCG not delivering the financial position resulting in the CCG not achieving it's statutory duty	Month End reviews of financial performance Deep dive of NHSE	None	Updates given to the Governing Body and Core on a monthly basis on the financial position Monthly returns to NHS England on our financial position	None	**3x4=12**	**3x4=12**	⟺	Reporting achievement of control total @ Month 2 Additional savings schemes being progressed
Date added 22.02.19 **Directorate** **Q23 Quality** **Executive Sponsor** Marion Evans Andrews **Lead Manager** Emergency Accountable Officer **Lead Committee** Audit Committee **Review date** **31.03.2019**	Due to the uncertainty surrounding EU-Exit arrangements there is a risk that some areas of healthcare delivery will be affected. These include: • supply of medicines and vaccines; • supply of medical devices and clinical consumables; • supply of non-clinical consumables, goods and services; • workforce; • reciprocal healthcare; • research and clinical trials; and • data sharing, processing and access. RECOMMENDATION TO INCLUDE THIS NEW RISK	LHRF Business group are co-ordinating the planing arranegements and liaising with the LRF SCG. If no-deal by last week of March then the Exec LHRP will meet to co-ordinate actions at a tactical level. NHSE and CCG are members of the LRF SCG.	None	All providers have been asked to undertake risk assessments and develop contingency planns. Also they ahev been asked to contact their suppliers to make sure they also have plans in place.	None	**3x4=12**	**3x4=12**	**NEW**	All Trusts have plans in place. GPs and hospices have been provided with check-lists and advice. Non-NHS providers have been asked for assurance. An exercise to test continhgency plans across the system has been arranged for 11th March. 2 meetings of the LRF SCG have taken place.
Objective 7 Develop plans for proactive care with partners that focs on early intervention									
Date added 06.01.17 **Directorate** **Q19 Quality** **Executive Sponsor** Marion Evans Andrews **Lead Manager** Julie Symonds **Lead Committee** Audit & Risk Committee **Review date**	There is a risk that children and young people in care do not get a review of their health needs, or that the healthcare plan is not implemented effectively. **Due to:** The number of CiC has grown significantly, meaning that the services providing RHAs are struggling to manage the increased demand. The CCG has a statutory duty to ensure that the health needs of Children in Care (CiC) are met and this includes the provision of RHAs whilst a child remains in care – every 12 months for those over 5 and every 6 months for those under 5. The main service that provides RHAs (public health nursing) is the responsibility of the county council, making the situation and its resolution more complicated. **Resulting in:** This is known to have a negative impact on subsequent longer term health and	Analysis of the impact of the increased numbers and the effectiveness of the current service arrangements has been undertaken, with proposals developed for a new model of provision. This is being overseen by the CiC Health Coordination Group, and decision making on next steps will be made by JCPE due to the multi-agency nature of the issue.	None	Performance reports to the Governing Body	None	**4x3=12**	**4x3=12**	⟺	The CCG and GCC have agreed to fund additional dedicated CIC nurses and additional nurses are in the process of being recruited to the team
Date added 15.01.2019 **Directorate** **Q22 Quality**	SWAST have identified a risk in the SW to patients due to call stacking. In Gloucestershire the risk is in category 2 patients where waits are longer than target times though Category 1 patients are responded to within the required	NHS E&I Quality Survalaince Group have oversight across the region of this risk. Locally the risk is monitored via the CCG Quality &	None	Performance reports to the Governing Body and Quality and Governance Committee. Update reports to Core Team meetings	None				1. SWASFT have reviewed rota's and opperating proceudres 2. SWAST have increased GP support in call handling hubs 3. System wide working between CCGs in SW and workshops to plan improvement actions. 4. Escaltion plans in place 5. Increase hold times for clinical valdiation in 111

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating	Current risk rating	Trend	Progress with actions
Executive Sponsor Marion Evans Andrews **Lead Manager** Rob Mauler **Lead Committee** Audit & Risk Committee **Review date** 31.03.2019	times. There are delays in responding to Category 4/5 health professional calls but this is not considered to pose a risk to the patients.	Governance Committee and by the CCG attendance at the SWAST contract quaity monitoring meetings led by Dorset CCG as lead for this contract.				**4x3=12**	**4x4=16**	**NEW**	6. New and additional resources invested in additional ambulances and crews due to commence in February 7. Reccurent additional investment to support staffing 8. Investment in NHS111 Category 2 'sense checks; 9. Use on non-urgent patient transport to transfer category 4/5 patients.

NHS
Gloucestershire
Clinical Commissioning Group

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

Minutes of the meeting held at 9.45am on 29 November 2018
Boardroom, Sanger House

Present:		
Alan Elkin (Chair)	AE	Lay Member Patient and Public Engagement
Mark Walkingshaw	MW	Deputy Accountable Officer & Director of Commissioning *(Deputising for Mary Hutton)*
Joanna Davies	JD	Lay Member Patient and Public Engagement
Colin Greaves	CG	Lay Member – Governance
Cath Leech	CL	Chief Finance Officer
Julie Clatworthy	JC	Registered Nurse
Teresa Middleton	TM	Deputy Director of Quality (*Deputising for Marion Andrews-Evans*)

In Attendance:		
Jeanette Giles	JG	Head of Primary Care Contracting
Becky Parish	BP	Associate Director Engagement and Experience
Helen Edwards	HE	Associate Director of Primary Care Locality Development
Alan Thomas	AT	Healthwatch Representative
Andrew Hughes	AH	Associate Director of Commissioning
Christina Gradowski	CGi	Associate Director of Corporate Governance
Cllr Roger Wilson	RW	Chair of Gloucestershire County Council Health and Wellbeing Board
Jo White	JW	Primary Care Programme Director
Sophie Atkins	SA	Governance Manager

1.	**<u>Apologies</u>**
1.1	Apologies were received from Marion Andrews-Evans (MAE), Helen Goodey (HG), Andrew Hopkins (AH) and Andy Shand (AS).

1.2	The Chair confirmed that the meeting was quorate.
2.	**Declarations of Interest**
2.1	The Chair asked members if they had any interests to declare in relation to any of the agenda items. No declarations of interest were made.
3.	**Minutes of the meeting held on 04 October 2018**
3.1	The minutes of the meeting held on Thursday 04 October 2018 were approved subject to the following amendments: • Section 1.1 'Marion Evans Andrews (MEA)' should have been 'Marion Andrews-Evans (MAE)' • Section 1.1 Cllr Roger Wilson sent apologies • Section 10.2, second sentence 'overspent' should have been 'overspend'
4.	**Matters Arising**
4.1	**26/7/2018, Item 4.5, Springbank Surgery – provision of general medical services from Hesters Way Living Centre.** AE requested that any useful additional information and learning from the Springbank Surgery Transition Plan be incorporated into the CCG framework. Update - transition plans have been combined. **The item was closed.**
4.2	**26/7/2018, Item 5.17, Merger Application from St Peter's Road and The Avenue Surgery.** HE suggested that the consultation across borders, where applicable, be added to the SOP. Update – this had been completed and included in the SOP. **The item was closed.**
4.3	**26/7/2018, Item 7.2, Premises Development Report.** Agreed that papers should be reviewed in respect of confidential material prior to being included on the public meeting agenda. Update – this had been actioned and completed. **The item was closed.**
4.4	**26/7/2018, Item 7.3, Premises Development Report.** AE requested an update on the overall progress of delivering the

	infrastructure plan. Update – this would be addressed in the confidential section. **The item was closed.**
4.5	**04/10/2018, Item 8.13, Quality Report HCAI.** AE asked TM for clarification on the term 'suppression therapy' for intravenous drug users. Update – TM emailed a definition to the Committee. **The item was closed.**
4.6	AE observed that all other actions had a future scheduled date of January or later in 2019.
5.0	**Application to merge from Phoenix Surgery and Romney House Surgery**
5.1	JG presented the paper and the supporting information from Phoenix Surgery and Romney House Surgery. JG summarised the position: • Both Surgeries held a GMS contract and were in the South Cotswolds Locality. • The practice boundaries overlapped. • Discussions around collaboration and closer working between the Practices started in December 2016. At that time Romney House Surgery was going through a period of transformation and experienced difficulty in GP recruitment. • In February 2017 the Partners from Phoenix Surgery became Partners at Romney House Surgery. Since then the Partners have been running Phoenix Surgery and Romney House Surgery as two separate GMS contracts. • On 3rd March 2018 the two Practices underwent a business merger, moving to one Partnership Agreement and one set of Accounts. The new entity was rebranded as Phoenix Health Group. • The partnership would like to merge GMS contracts to benefit from operating at a larger scale and the ability to pool resources across both sites. They also believe a merger would make it more attractive to prospective GP recruits. • Both practices would operate out of the existing premises and opening hours, 8am-6.30pm, would be maintained. • Both practices were on the same clinical system.

	Julie Clatworthy joined the meeting at 9.51am
5.2	JG confirmed that local neighbouring practices had been written to in South Cotswolds, North Cotswolds and Stroud & Berkley Vale as well as adjacent surgeries in South Gloucestershire and Wiltshire CCG areas.
5.3	JG explained that the practices had held meetings with their PPGs. BP fed back that the PPGs from both practices felt that the merger had already taken place due to their having worked together since December 2016 so there was no dissatisfaction regarding the merger going forward. PPGs would be maintained on both sites, they would not merge, however, there would be opportunities to come together to discuss some issues collaboratively.
5.4	JG added that no negative responses to the merger had been received from Healthwatch, the Local Medical Committee, Price's Mill Surgery or Wellington Road Family Practice. The merger would be from April 2019 giving time to finalise plans. There would be one IT system enabling patients to book appointments across both sites and the learning and development opportunities would also be across sites.
5.5	JD queried whether the two PPGs would have a strategic overview of the whole practice rather than focusing on each site. BP clarified that although there would be two PPGs, the chairs from each PPG would come together to discuss overarching strategic issues and learning from both sites. BP confirmed that there were different issues at each site that the PPGs would be able to get involved with and they were significantly different to warrant keeping separate PPGs. HE added that some areas had PPGs coming together as Locality PPGs so that could be adopted. HE confirmed that PCOG were highly supportive of the merger.
5.6	JC stated that she had previously raised concerns around due diligence regarding the minimum number of hours required to be worked by nurses to maintain their competence in accordance with the professional body, the Royal College of Nursing. JC noted that there had been no change to the very part time hours

	worked by the nursing staff since the issue had been raised. AE asked if the reports received so far provided reassurance; JC did not think so and suggested a due diligence be undertaken on the nursing model going forward. **ACTION HE to provide an update at the next meeting.** AE requested that this be considered at the start of all mergers going forward as well. **ACTION HE.**
5.18	**<u>RESOLUTION:</u> The committee:** • **Considered the recommendation from the Primary Care Operational Group meeting on 20 November 2018; and** • **Approved the request to merge contracts on 1st April 2019 from Phoenix Surgery and Romney House Surgery.**
6.0	**<u>Inter-Practice Minor Surgery Enhanced Service</u>**
6.1	AE queried what the doctors were actually doing that would be covered by this policy. TM explained that it would be operations or procedures that required a greater skill than what was covered by the GMS contract. HE added that the policy would allow GPs in individual practices to work on behalf of one another. AE stated that it was the scale of the services provided that was of interest and the actual procedures covered. HE responded that a list of procedures could be provided as an appendix to show the scale of minor operations being undertaken in practice. **ACTION HE.** One of the reasons this policy work was undertaken with Dr Allen Qwynn was due to the low number of minor operations being undertaken by practices which had had a knock on effect on the acute contract. The policy would prevent unnecessary referrals and support the direction of travel of cluster networks with practices working together and supporting each other.
6.2	JC raised the clinical governance gap around minor operations being undertaken in practices. The policy did support the Royal College view that it was better to maintain skills by doing a large number of procedures but did not include some basic requirements from a clinical governance perspective like allergies being recorded on the referral form. JC stated that this

	would put an extra onus on the CCG around ensuring that the practice clinical environments were appropriate, safe and that there were sufficient processes in place around record keeping and transferring care between practices following the procedure. JC understood that the policy was a contractual issue but would have liked to have seen a clinical governance plan to accompany this policy. HE responded that there were a set of guidelines that took account of the clinical governance issues raised as well as other issues around Medical Defence. The absence of allergy information on the referral form was noted by HE to review and change. **ACTION HE.** The patient follow up was covered within the guidelines and would be undertaken by the clinician who did the procedure. HE invited JC to review the guidelines with her to ensure all clinical governance issues were covered. **ACTION HE/JC.**
6.3	CG agreed with JC around the clinical governance issues and confirmed that they would be covered under the Quality & Governance Committee remit. With regards to the contractual change, CG requested a review of the impact of the revised policy on the acute referrals. **ACTION HE.** BP highlighted that some patients were eligible for free transportation to the hospital but not to a GP practice so this may need to be included in the impact assessment as it could potentially disadvantage some patients. **ACTION HE.**
6.4	AE queried if the move to more minor operations being undertaken in practices had been financially modelled. CL confirmed it had been modelled, based on estimates, and should be within the existing budget but there was always a risk that it would cost more.
6.4	AE asked who the Enhanced Services Review Group were and what they did. HE clarified that the group met monthly and reviewed all the enhanced services within the organisations, considered new proposals for the following year and worked on the Primary Care offer. The minutes from the Primary Care Operational group would mention the Enhanced Services Review Group work.
6.5	CG queried the response from PCOG. HE confirmed PCOG were supportive.

6.6	**<u>RESOLUTION</u>: The committee approved the use, in Gloucestershire, of the Inter Practice Minor Surgery Enhanced Service as recommended by PCOG at their meeting on 20 November 2018**.
7.0	**<u>Primary Care Quality Report</u>**
7.1	TM presented the Primary Care Quality Report providing the following key highlights: • Safeguarding o The focus was on ACES. The evidence showed that children who experienced up to 4 traumatic experiences in childhood were detrimentally affected in their adult life. A short video was available and would be circulated. **ACTION TM.** TM noted that positive feedback had been received following the GP Liaison Safeguarding Children's Forum and the CCG Locum event at which ACES was presented. o An audit had been undertaken on GP Safeguarding Practice. 72 out of 76 practices responded. The outcome had been that there was good practice regarding MDTs and Lead GP attendance at GP Safeguarding Forums which was high at 75% across a two year period. o The publication of the 'James' serious case review had been delayed until February 2019. o There were no new Safeguarding Adult Reviews but there were two ongoing reviews. o There were two ongoing Domestic Homicide Reviews. • Practice Prescribing Support – the number of pharmacist technicians in the team would be increasing from four to seven and the practice prescribing target and the premium were on target. • Measles – following the programme to encourage 16-25 year olds to complete the measles vaccination programme, 77.6% of children up to 18 years old had had 2 doses of MMR as at 31st August. • Seasonal Flu – there were two different vaccines this year and there were some challenges around delivery to practices. The uptake had been slightly lower than last

	year for the same period; at the end of October data shows 60.5% of over 65s, 37.4% of at risk patients, nearly 50% of 2-3 year olds and 39% of pregnant females had had the vaccine.
7.2	BP highlighted that the main area of PALS activity had been around patient transport and the application of the new eligibility criteria. It had been a very busy quarter and the team would be getting some additional support one day per week. The two practices that did not have a PPG had been contacted. One practice had invited interested patients to an event; however, no one went which was disappointing for the practice. That practice did have an active Friends Group that already does similar things to what a PPG would do. Therefore, the group's constitution was being reviewed to investigate if a hybrid could be achieved to meet the contractual requirements. Work was on going with the other practice without a PPG.
7.3	AE stated that the MRSA requirements had not been met and queried what was being done to tackle this. TM clarified that there had been five recent cases of MRSA and that a Public Health England multidisciplinary group had been formed to discuss this. A number of actions had been identified. All five cases were substance abusers with two of them already being known by Change Grow Live. There had been a lot of work undertaken to ensure antibacterial wipes were provided in the equipment kits.
7.4	RW explained that the Health & Wellbeing Board had set up a group a year ago that was led by Assistant Chief Constable Julian Moss. The group had organised a conference that took place earlier in the month that was attended by 220 people with a waiting list of 80 to introduce the concept of ACES. It was very well received and extremely good feedback given. Identifying children in need across the county not only hugely benefits the children but would provide cost savings going forward if psychological issues were dealt with at an earlier stage.
7.5	JC praised the next generation GP scheme and requested that the implementation of the next generation nurses scheme to support nurse training not be forgotten.

7.6	CG noted that there were actions to reduce CDiff in Gloucestershire and requested further data evidence showing whether or not the work undertaken had had an impact. TM confirmed that there was a lot of data which could be provided in the next report. JC added that what was missing, particularly with regards to the data received by Q&GC, was Primary Care issues. PCCC requires clarity regarding the outcomes of actions to understand if further work could be carried out to support the reduction of cases. CG to liaise with TM regarding report content. **ACTION CG/TM.**
7.7	CG queried whether the practice that 'required improvement' in the CQC report had had a similar report previously to indicate an underlying issue. TM would check this. HE added that further detail would be provided in the confidential section of the meeting.
7.8	**RESOLUTION: the committee noted the Quality Report**
8.0	**Primary Care Premises Report**
8.1	AH presented the report highlighting the following: • 2018/2019 plan – by the end of the financial year four schemes were expected to be fully completed and opened. • Cleevelands medical centre, Bishops Cleeve – expected to be completed by 18th December and open to patients from 14th January 2019. The Seven Posts and Greyholme surgeries would then close. • Stow Surgery – the building was expected to be open before the end February or early March 2019. • Kingsway – there would be a soft opening on 3rd December and the formal opening on 15th December to which the CCG had been invited. • Cinderford Health Centre – had received unanimous planning approval since writing the report.
8.2	AE requested further information regarding the impact of opening one surgery whilst closing two. BP confirmed that it had been a contentious issue particularly regarding the closure of the Seven Posts surgery. There had been regular contact with the elected representatives, especially those from the

	Prestbury area and a review of public transport completed. Contact would be continued to be able to respond to any reactions at the time of closing.
8.3	RW explained that there had been an appeal against the pharmaceutical licence refusal at Cleevelands that was unsuccessful. The original refusal was upheld which caused quite a bit of opposition and difficulty in the Bishops Cleeve area. AH added that there had been a number of issues that created local campaigns like the practice wanting to sell the land after the surgery closes and the buyer submitting an application for housing development. The new surgery had raised concerns that a pharmacy was starting up close by regardless of whether or not they could prescribe. AH clarified that there was no risk to CCG investment or to the completion of the build. AE queried the basis for the licence refusal. RW confirmed that it was government policy following the pharmaceutical needs assessment last March.
8.4	CG noted an error in dates in point 18 on page 11; it should state 2021-2026 not 2016.
8.5	**RESOLUTION: the committee noted the Primary Care Premises Report.**
9.	**Premises Development Group Minutes – September and October**
9.1	The group reviewed the Premises Development Group Minutes from September and October.
9.2	**RESOLUTION: the committee noted the Premises Development Group meeting notes.**
10.	**Delegated Primary Care Financial Report**
	CL presented the financial report and highlighted that: • The year to date forecast for the delegated primary care budget was breakeven. • The areas of overspend were: ○ Maternity and sickness – there was a significant amount committed to be paid.

	○ Enhanced Services – extended hours and Learning Disabilities Enhanced Services. ○ GP pay award – unexpected additional pay award. Discussions were ongoing with NHS England regarding potential funding for this. • The areas of underspend were: ○ Continuation of savings from business rates. • The population growth had been slightly higher than anticipated so the forecast for next year would be re assessed.
10.1	AE expressed concern that there would be increased pressure on the budget next year due to the target for Learning Disabilities Enhanced Services health checks increasing from 65% to 75%. CL clarified that as well as taking into account the existing targets and roll over into next year, the increase in targets would also be calculated and taken into account through the budget setting process. If the delegated budget were to need to be increased, this would be taken to the Governing Body for review.
10.2	**RESOLUTION: the committee noted the report on Delegated Primary Care Budget**
11.	**Any Other Business**
11.1	AH highlighted the 2018/19 Premises Improvement Grant (IG) Proposals. AH noted that the CCG had been successful in obtaining funding from NHS England. The practices have been written to and the schemes need to be started before the end of the financial year. Details were provided in Appendix 1.
11.2	AH reported that Appendix 2 detailed the ongoing smaller schemes funded through the delated budget. AH explained that applications were being made to Councils around section 106 for smaller grants to support a number of these schemes.
11.3	AE requested further clarification around the paragraph on page two that read 'Although, the PCC should note that all 6 projects were eligible for funding under the criteria set out in the current 2013 GMS Premises Costs Directions.' AH explained that the

	premises improvement grants operated within national regulation. Premises Cost Direction 13 stated that all practices were eligible to apply for improvement grants and the CCG needed to consider requests but did not have to approve them.
11.4	AE asked if CL had reviewed the recommendations and supported them. CL requested the recommendations be amended to state 'support the proposals subject to the financial position being reviewed'.
11.5	CG thanked AH and DM for the report as, although these were small amounts of funding, they make a difference to the practices.
11.6	**RESOLUTION: the committee approved the proposal that the CCG provides financial support to the proposals listed in Appendix 3, to a maximum of £35.6k, subject to finances being available.**
11.7	There was no other business.
	The meeting closed at 10.53am
	Date and time of next meeting: **The next meeting will be held at 9.45am on Thursday 31st January 2019, Boardroom, Sanger House.**

Quality and Governance Committee (Q&GC)

Minutes of the meeting held on Thursday 13th December 2018 at 9.00am, in the Boardroom, Sanger House

Present:		
Julie Clatworthy (Chair)	JC	Registered Nurse
Alan Elkin	AE	Lay Member Patient and Public Engagement
Mary Hutton *(from item 4.2)*	MH	Accountable Officer
Peter Marriner	PM	Lay Member – Business
Mark Walkingshaw *(until item 4.2)*	MW	Director of Commissioning / Deputy Accountable Officer
Dr Will Miles	WM	GP Quality Lead - GCS
Dave McConalogue	DM	Consultant in Public Health, GCC
Dr Lawrence Fielder	LF	GP Quality Lead – 2G
Dr Caroline Bennett	CB	GP Quality Lead – GHFT
Marion Andrews-Evans	MAE	Executive Nurse & Quality Lead

In Attendance:		
Christina Gradowski	CGi	Associate Director of Corporate Governance
Julie Symonds	JS	Deputy Director of Nursing
Robert Mauler	RM	Senior Quality and Safety Manager
Teresa Middleton	TM	Deputy Director of Quality
Imelda Bennett *(item 6)*	IB	Designated Doctor Safeguarding Children
Jo Bridgemen *(item 6)*		Specialist Nurse Safeguarding
Annette Blackstock *(item 6)*		Designated Nurse Safeguarding Children and Safeguarding Adult Manager
Dr Christian Hamilton	CH	Head of Planned Care
Beth Bennett-Britton *(item 7)*	BB	PH Consultant with a lead for PH Nursing for Children
Andrew Mitchell *(item 13)*	AM	HR Business Partner, ConsultHR
Lisa Netherton	LN	Governance Officer
Sophie Atkins	SA	Governance Manager

1.	**Apologies**
1.1	Apologies were received from Cath Leach, Dr Lesley Jordan and Jo Davies.
1.2	The meeting was confirmed as quorate.
2.	**Declarations of Interest**
2.1	JC requested declarations of interest in relation to any agenda item.
2.2	WM, LF and CB declared a professional interest to the relevant clinical agenda items. JC noted the professional interests but there were no grounds for them not to take part in discussions and decision making.
3.	**Minutes of the Meeting held on Thursday 18 October 2018**
3.1	The minutes of the meeting held on Thursday 18 October 2018 were reviewed and approved as an accurate record.
3.2	JC introduced the Implement a New Treatment Pathway for Wet Age-Related Macular Degeneration report that was going to HOSC that day. The Governing Body had had a chance to review it as had JC. JC had made a few amendments and requested that the committee sign off the revised commissioning policy for Wet Age-Related Muscular Degeneration.
3.3	**RESOLUTION: the Committee:** • **Approved the minutes of the meeting held on Thursday 18 October 2018.** • **Agreed and supported the Commissioning Policy for Wet Age-Related Macular Degeneration for use in Gloucestershire.**
4.	**Matters Arising and Actions**
4.1	**Matters Arising**
4.1.1	**IGQC 274 Item 5.25.3, Primary Care Quality Report - GP Dashboard** It was noted that dashboard was presented to the Primary Care Commissioning Committee in the first instance in July and it would then

	be reported to the October IGQC. *Update 18/10/18* - JS provided an update, on behalf of TM, that seasonal flu and vaccines had taken priority and requested this to be carried forward to December's meeting. *Update 13/12/18* - TM confirmed that the only change since it was last seen was to the report format, not content. MAE added that the report was seen by PCCC so if agreed how often the report should go to PCCC then provides the assurance required by C&GC. JC agreed 6 monthly was appropriate. CGi to record on PCCC planner. **ACTION CGi. Item closed.**
4.1.2	**IGQC 275 Item 7.8, Mortality Briefing - Policy** KH reported that a policy for the Multi-agency Mortality Review Process Group was being written and this was to be presented to a future IGQC meeting. *Update 19.04.18* - As the Deputy Director of Nursing post was vacant, this item was carried forward until the new person was in post. *Update 23.08.18* - Update provided in the Quality Report. Full update would be reported to the October IGQC. *Update 13.12.18* - JS reported that a working group had been formed to revitalise the main Mortality Review Process group. The 2019 meetings would be based around reviewing the Dr Foster data. Themes would be pulled out and case reviews completed that would be sent to the Mortality Review Process Group in advance to be discussed at the meetings for better learning outcomes. JC queried if the Terms of Reference would be updated accordingly; JS confirmed they would be brought to the April meeting. **ACTION JS. Item open until April 2019 meeting.**
4.1.3	**IGQC 278 Item 10.2, Policies** CGi advised that HR legacy policies would be brought to a future IGQC meeting. *Update 13.12.18* - CGi reported that a number of policies had been reviewed and were available through the HR portal leaving the legacy policies to be reviewed. This would be ready for the April meeting. **Item open until April 2019 meeting.**
4.1.4	**IGQC 293 Item 5.3, Quality Report - Boost** TM to share BOOST project results at a future IGQC meeting. *Update 13.12.18* – JC requested a short project briefing to be circulated by TM following the meeting. **ACTION TM.** Once received JC would decide if the item was relevant and to remain open or not. **ACTION JC. Item remained open.**

4.1.5	**IGQC 299 Item 5.32.2, Quality Report – Safety Thermometer** An update on the safety Thermometer would be given to an IGQC meeting. *Update 13.12.18* – agenda item. **Item closed.**
4.1.6	**IGQC 307 Item 5.1.16, Appendix 2 GHFT Quality report – TrakCare for safeguarding reporting** The link had now been made but the system was not being utilised. It had been raised at GHFT's safeguarding meeting and they had had a formal letter from MAE regarding this but no response had yet been received. MAE to escalate this to MH. *Update 18/10/18* - MAE confirmed that issue was still ongoing. GHFT had been formally written to and they had raised it at their internal Safeguarding meeting. Some data was being collected but not fully utilising the electronic system. Further update to be provided at December meeting. *Update 13/12/18* – MAE and MW confirmed TrakCare was now being used by GHFT. Update on the agenda. **Item closed.**
4.1.7	**IGQC 308 Item 5.1.16, Appendix 2 GHFT Quality report – TrakCare** The link had now been made but the system was not being utilised. JC requested that CL raise with the county wide group as well. *Update 18/10/18* – CL reported that the IM&T group meeting had not met yet. *Update 13/12/18* – JC reported that CL had raised it with the group but was unaware of their response. **Item remained open.**
4.1.8	**IGQC 309 Item 9.2, Annual Health Report for Children in Care – admin support** MAE stated that a business case for administrative support within the CCG could be completed. *Update 18/10/18* – MAE confirmed that the business case had not progressed as a review of staffing was being undertaken. Pauline Edwards would be transferred into CCG from GCS. The administration support had been depleted due to sick leave. Update to be provided at February's meeting. *Update 13/12/18* – MAE stated that the designated nurse in Children's Care was now employed by CCG. Additional funding had been given to provide additional administration support. **Item remained open until February 2019 meeting.**

4.1.9	**IGQC 311 Item 5.1.20.1, Appendix 7 Primary Care Quality Report** There was a slide pack available so the link would be circulated. *Update 13/12/18* – the committee had not received the slides. CGi to ask BP to circulate. **ACTION CGi. Item remained open.**
4.1.10	**IGQC 322 Item 11.1, Update on Effective Clinical Commissioning Policies** JC to share the report (ventral mesh rectopexy) with MW. *Update 18/10/18* – AE noted that the report had been circulated. **Item closed.**
4.1.11	**IGQC 326 Item 13.2, Data Security and Information Governance Update** MAE confirmed that there was already a log kept and agreed that an analysis of incidents, trends and learning from the last 12 months could be brought to a future meeting. CGi would liaise with Tony. *Update 13/12/18* – agenda item. **Item closed.**
4.1.12	**IGQC 329 Item 4.2, Research – Glos** MAE informed group of changes around research costs with funding lost from One Glos. Group didn't want to lose the local intelligence of what was happening in research even though Bristol focused. AS queried who represents NHS England ACTION MAE to find out. *Update 13/12/18* – agenda item. **Item closed.**
4.1.13	**IGQC 330 Item 5.1, Quality Report** The Committee discussed changes around GCC Children's Social Services and MAE updated that the team was moving to the CCG in due course. LF said that the referral forms were very onerous and difficult to complete. There was a plan to review it to speed up process. AS requested assurance that the form was amended to make it easier for GPs to complete. ACTION MAE report back. *Update 13/12/18* – MAE reported that there had been another visit from OFSTED. The letter received following the visit had been more positive acknowledging improvements but that there was still a long way to go. The Director of Children Services thought it would take another 18 months to make the changes required for improvement. The major issue was recruitment of social workers. There was a high agency staff usage with agency staff only staying for short periods creating instability and lack of consistency for the children. They had recruited a lot of newly qualified social workers, however, they need a lot of support and further training. **Item remained open.**

4.1.14	**IGQC 331 Item 5.1, Quality Report** There was an issue around access to patient records in relation to Safeguarding cases discussed. It was not always possible to access them or not complete records as parent's decision. AS requested that representation made to NHS England regarding this issue. ACTION MAE would ask Helen Goodey. Update at next meeting *Update 13/12/18* – MAE clarified that a parent could legally opt out of sharing their child's records and there was nothing that could be done to overturn their decision under normal circumstances. If, however, there was a genuine safeguarding concern then the parent's wishes could be over ridden legally. **Item closed.**
4.1.15	**IGQC 332 Item 5.1, Quality Report** Mortality group being reinvigorated. Emily Benter had left so Katy Hopgood suggested as replacement. ACTION JS to contact Katy and invite her to join. *Update 13/12/18* – JC requested this item be added to IGQC 275 Item 7.8. **Item closed.**
4.1.16	**IGQC 333 Item 5.1, Quality Report** AS queried why vitamin B12 specifically mentioned. MAE clarified that patients on those particular diets had associated risks. AS requested a note explaining this ACTION MAE *Update 13/12/18* – agenda item. MAE added that the Vitamin B12 guidance had been updated and was moving away from injections to high dose oral medication which would increase the workload of practice nurses as longer process. **Item closed.**
4.1.17	**IGQC 334 Item 5.2, Quality Report** AS raised concerns that pink slips seem to have worsened and requested an update around this. ACTION: ask Teresa Middleton to provide an update next meeting. *Update 13/12/18* – TM highlighted that pink slips were provided in two instances: • in response to published national audits – assurance requested that outcomes of national audits known about and reviewed. In order to support this a National Audit Review group was set up to review them. Recent national audits had not contained any local data, therefore, pink slips had not been raised, reducing the number received. • in response to NICE quality standards or clinical guidance. The pink slips were raised through the Clinical Effectiveness Group on

	behalf of the chair to CPGs, Clinical Quality Group or provider organisation and the response awaited for. Responses were chased by the team. ACTION TM to circulate briefing. **Item closed.**
4.1.18	**IGQC 337 Item 5.2, Quality Report** RM updated the group on CQC visits. Although not official expect GHFT to be 'requires improvement'. SWAST CQC should be 'good'. ACTION RM to provide update next meeting. *Update 13/12/18* – to be added as an agenda item at February's committee. **Item remained open until February.**
	MH joined the meeting at 9.32am and MW left.
4.2	**Matters Arising from 18 October 2018 Meeting**
4.2.1	DC gave a presentation of a qualitative study on the experience, practices and perceptions of homeless people and health. The aim of the study was to explore the experiences and perceptions of health and access to healthcare services by homeless people and the themes covered were: • Reasons for homelessness (recent and long term) • Perceptions and understanding of health (childhood trauma, substance misuse and mental health issues contributory factors) • Managing health • Social networks and health • The relationship between health and living environment • Accessing health services (barrier to GPs as no address) • Homeless health care team based in Glos mission (Glos and Cheltenham had better provision than for rural homelessness)
4.2.2	CGi queried how rough sleeping affected life expectancy. DC explained that the life expectancy was 47 years of age for someone who was rough sleeping in the UK as opposed to 73 for someone who was not.
4.2.3	MH reported that an update had been requested from the SWEP initiative that guaranteed all rough sleepers somewhere to sleep during the winter period. AB added that Dr Ian Jarvis had given a brilliant presentation on homelessness at a recent GP Forum for Adults and he had been asked to present at the Adult Safeguarding Board.
	JC moved to item 6 as the Safeguarding team joined the meeting.

6.	**Safeguarding**
6.1	**Safeguarding Annual Report**
6.1.1	AB introduced the Safeguarding team and explained that the team was moving to all be located in the CCG. AB presented the Safeguarding Annual Report and highlighted the key points: • Engagement with Primary Care had been really good with up to 80 GPs attending the GP Children Safeguarding Forum that was run three times a year. • An Adult Safeguarding Forum had been set up that 40 GPs attended regularly. • On average, there were normally two domestic homicide reviews running at one time as well as two serious case reviews with children and two adult cases. • Fundamental changes to the structure of accountabilities of Safeguarding led to reviewing the ways of working with the police and other partner organisations; this was ongoing. • Primary Care audits had been improved and highlight what Safeguarding knowledge already exists and what the gaps were. • Child protection information sharing was progressing and had been a challenge due to the work having to be completed by the providers. • Alerting providers regarding the changes to the Liberty Protection Safeguards would continue. • Assessing effectiveness and seeking assurance around Safeguarding remains a priority. • An Adult and Children Safeguarding Strategy was being drafted.
6.1.2	IB raised concerns that although the providers were using the child protection information sharing system when children with a Safeguarding plan were admitted, notifications were not being received in Social Care. This had been raised and NHS digital were investigating this nationwide issue. AB added that the Safeguarding team had their own systems and processes in place to address the issue until it had been resolved including asking all children who attended the Emergency Department if they had a social worker. It was agreed that AB would keep the committee updated to NHS Digital's progress and ensure that CL was aware of the issue as the Board's IT lead. **ACTION AB.**

6.1.3	JC queried if the information was shared with the Health Visitors. IB explained that Health Visitors were not part of the sharing system but they were informed via the paediatric liaison health visitor forms. The committee discussed the risks, mitigations that were in place and whether the risk should be added to a corporate risk register. The Safeguarding team were asked to undertake a risk assessment to establish this. **ACTION Safeguarding team**. MAE or CL were asked to write to NHS Digital to raise as a serious concern for the CCG. **ACTION MAE/CL**.
6.1.4	MAE praised the team for the work undertaken last year and noted that Working Together (2018) involved a lot of work that would continue next year.
6.1.5	**RESOLUTION: the Committee noted the Safeguarding Annual Report.**
6.2	**Safeguarding Policy**
6.2.1	JB summarised the position regarding the Safeguarding policies highlighting the need for a separate Adult Safeguarding Policy. AB added that the Children's and Adult's Safeguarding policies would co-link, reference each other and would need to be amended to incorporate the Liberty Protection Safeguard in future. JC requested that where roles were mentioned, like the Caldicott Guardian, links were included with contact details to make it easy for people to make contact. JC added that there was no mention of the Police and requested that was amended to ensure that inclusiveness was reflected. **ACTION JB.**
6.2.2	**RESOLUTION: the Committee approved the Adult Safeguarding Policy with the following amendments:** • **Include the contact details for any roles mentioned** • **Include the role of the Police in the process**
6.3	**Safeguarding Priorities**
6.3.1	JC queried if the outcomes from the internal Safeguarding audit had been incorporated within the priorities for next year. AB confirmed they were and reported that there was an action log monitoring progress. AB added that a training needs analysis was being undertaken and any

	gaps, particularly regarding level 3 Children's Safeguarding and adult Safeguarding would be addressed. CGi confirmed that the NCA policy was scheduled to come to the next committee which would clarify the issues raised at the Audit & Risk Committee. AE stated that measuring the outcomes of the training was important; it was not just the number of people who had completed it. IB agreed and reported that there were plans to audit this.
6.3.2	Responding to queries raised in other committees, AB reported that GCC Liquid Logic software was in place for children in care and, following complaints from GPs regarding the on-line referral portal, agreement had been given for the multi-agency referral forms to be e-mailed to the secure local authority address. The issue had been escalated to the GCC for them to review.
6.3.3	JC requested that the impact of the changes to the Public Health nurses was monitored and any issues fed back to the committee. **ACTION AB.**
	IB, JB and AB left the meeting. *JC returned to the Matters Arising 4.1.19*
4.1.19	**Update on IG Incidents** CGi fed back that TW had produced the report summarising that there had been 11 incidents between 1 December 2017 to 30 November including: • 4 emails or letters were sent from the CCG with the wrong address; • 2 emails were sent with unnecessary patient information; • 2 issues of data quality regarding records containing inaccurate or incomplete information; • 2 stolen or lost IT devices; and • 1 incidence of the website being defaced None of the incidents reached the threshold for Serious Incident reporting and learning from the incidents had been incorporated into staff training sessions.
	Break taken at 10:25 – 10:35 *LF and CH joined the meeting*

5.	**County Wide Quality Report** *The agenda was incorrectly numbered in this section. The minutes were re numbered accordingly with reference made to the agenda numbering.*
5.1	**County Wide Quality Report (item 5 on agenda)**
5.1.1	MAE presented the Quality Report which provided assurance that quality and patient safety issues were given the appropriate priority. The report included County-wide updates on: • National Institute for Health and Care Excellence (NICE); • Clinical Effectiveness; • Research and Development; • Safeguarding; • Mortality Review Group; • Patient Experience and Engagement; • Infection Control; • Prescribing update; • Immunisation and Vaccination; and • Appendices to County-wide report The report was taken as read and MAE presented the highlights.
5.1.2	MAE noted that the number of calls received by the GCCG Patient Advice and Liaison Service (PALS) for advice or information in Q2 18/19 of the call breakdown table should state 99 not 1. PALS had seen a rise in the number of contacts which had impacted on resources. Additional support had been organised to help clear the backlog. There had been a significant number of calls, some of which had been from distressed patients, in response to the implementation of changes to the prescribing of Liothyronine (T3) medication. BP had undertaken a review of the change process for future learning.
5.1.3	MAE reported that a new Lay Chair had been appointed for the Maternity Voices Partnership (MVP) that replaced the Maternity Services Liaison Committee.
5.1.4	MAE stated that there had been nine instances of MRSA of which five

	had been acquired in the Trust which was a concern. Many of these cases were linked to IV drug misuse so a working group had been formed to review the processes and implement county wide solutions regarding this group of patients. DM added that Bristol had undertaken a review two years ago following a similar rise in their MRSA cases and their evidence and learning was used to support the Gloucestershire review. The outcome from the work had been to include wipes in the packs provided to needle exchange patients and to raise awareness of the risks and precautions that could be taken to help avoid infection.
5.1.5	MAE described an increased priority around infection control in the Trust. LF requested assurance that the CDI case numbers include all the CDI cases including those from the Community. TM confirmed they were and explained the difficulty in differentiating exactly where the infection had been picked up. The committee discussed the issues and agreed that the review processes was about learning and prevention so, although it was not critical to know exactly where the infection started, questioning was required to ensure prevention measures focused where needed.
5.1.6	MAE explained that there had been some issues regarding the delivery of the seasonal flu vaccines within the county to GP practices, however, due to an over delivery error to one particular practice, vaccines had been re distributed across the county. The issues around GP practices not receiving what they ordered and the difference between chemists and GP ordering processes were discussed along with potential changes to how the vaccines could be ordered next year to prevent stock issues. DC explained Public Health's experience of the process this year. MH requested a summary of the issues experienced across Gloucestershire and the learning from the experiences be brought to March's committee. **ACTION TM.** TM reported that the healthcare worker uptake in GHT, 2G and GCS were all over 70%.
5.1.7	AE noted the positive news around the increase in MMR uptake in children and young adults across Gloucestershire. The group discussed the percentage uptake needed for herd immunity. DC explained that it depending on the disease and how easily it was spread. Over 90% was a good uptake rate. AE-importance of social media really affected uptake.
5.1.8	**RESOLUTION: the Committee noted the County Wide Quality Report.**

5.2	**Appendix 1.1 CEG Minutes 18.09.18 (item 5.1 on agenda)**
5.2.1	Not everyone had received the CEG Minutes from 18 September 2018. JC requested that they be circulated. **ACTION CGi.** Any issues from the minutes should be fed back to CGi. **ACTION All.**
5.3	**Appendix 1.2 ECCP Minutes 18.10.18 (item 5.2 on agenda)**
5.3.1	The committee reviewed the ECCP Minutes from 18 October 18.
5.3.2	**RESOLUTION: the Committee noted the ECCP Minutes 18.10.18.**
5.4	**Appendix 1.3 ETC Feedback (item 5.3 on agenda)**
5.4.1	JC noted the ETC feedback report, stated that it had been useful additional information for the committee and requested that it continue to be included in the report.
5.4.2	**RESOLUTION: the Committee noted the ETC Feedback.**
5.5	**Appendix 1.4 Gloucestershire Mortality Review Group (item 5.4 on agenda)**
5.5.1	JS reported that the group had not met since the last committee meeting. The Coroner's Office provided a comprehensive update to the Gloucestershire Mortality Review Group which led to the discussions around amending the structure of the group to include case reviews to be discussed in depth. The Chair of the group, Dr Sean Elian, was stepping down as Medical Director at GHFT; the new Medical Director would be invited to join the group.
5.5.2	JC understood that the group should be more strategic and identify themes but requested assurance that the actual deaths would be reviewed to ensure learning would not be missed. JS confirmed that the death would be reviewed and discussed as part of the review process. LF explained that the Gloucestershire Coroner's Office was very helpful and provided information and supported the group.
5.5.3	Regarding 5.0.3 of the minutes, JC queried whether the group had reviewed the 2018 LeDeR annual report and incorporated into the review process. MAE explained that this would be incorporated into the update report Cheryl would be bringing to February's meeting.

5.5.4	**RESOLUTION: the Committee noted the Gloucestershire Mortality Group Minutes 02.10.18.**
5.6	**Appendix 2.0 GHFT Report (item 5.5 on agenda)**
5.6.1	The report was taken as read and JS presented the highlights: • There had been no further never events since the last report. • The Trust were finalising an investigation into a near miss never event involving a 14 year old female due to have ear surgery. The hair on the side of the head to be operated on had been shaved and just before the surgery the girl's mother shaved the rest of her head so it was not lopsided. When the girl was moved on to the operating table, her head tilted the wrong way so the block was nearly applied to the wrong ear. • A risk of delayed care due to outpatient capacity in a number of specialities had been identified. CH explained that the implementation of TrakCare resulted in a loss of capacity and back log. Cancer always took priority so other groups of patients waited longer. Follow up pending lists were the worst affected and had been reviewed with 'to be seen' dates added in order to monitor subsequent delays. Three patients had been harmed due to the delays. JC queried if the measures in place were acceptable. JS confirmed that a working group had been formed to scrutinise the issues and it had been on the agenda at all the meetings JC and CH attended. • Vacancies remain high, however, there had been a successful healthcare assistant recruitment programme and the benefits were starting to take effect. Good assurance had been received regarding staffing for the winter pressure period. • NEWS2 had been implemented Trust wide and regular audits were being carried out. It had been identified that areas with a higher percentage of bank and agency staff were scoring the lowest; revised training for these groups of staff had been implemented. • The four hour ED performance continues to do well. • The winter plan appeared robust and considered patient flow. • The Surgical Assessment Unit (SAU) had been up and running and had a positive impact for the patients. JC queried whether the SAU was mixed sex. JS confirmed they were not mixed bays but the facilities were shared.

	• The CQC report was expected early next year. MAE added that one of the areas of concern raised at the pre meeting with CQC was staffing levels, clinical leadership at ward department level and mental health was a focus in the review.
5.6.2	CB raised that the GHFT CQRG minutes had not been included in the report and queried if there had been a change in reporting structure. JC confirmed that they should still come to the committee for review and asked CGi to check if the latest minutes had been to a previous meeting or ensure they would be included in February's papers. **ACTION CGi.**
5.6.3	MH reported the first winter significant pressure had occurred. MAE added that the number of high risk respiratory patients were higher than last year but it was not flu, it was respiratory viruses. CH expressed concern that elective theatre list cancellations could be avoided by better planning. This could lead reduce on the day cancellations. MH asked for this to be monitored. **ACTION CH**.
5.7	**Appendix 3.0 2G Report (item 5.6 on agenda)**
5.7.1	LF summarised the main points: • There were staffing issues at all levels including nine WTE medical vacancies so there had been a high dependency on agency staff. There were vigorous vetting processes in place for agency staff and the contracts held with agencies had been rationalised to reduce the cost whilst maintaining quality. • There were high staff sickness levels in the most high stress environments. • There were no serious incidents in September, however, there were three in October. • An out of county patient who had been placed in St Andrews hospital, Northampton died in April 18. This highlighted an issue regarding monitoring our out of county placements as we were not informed of the death for a number of months afterwards. An enquiry into the death had been requested and would be brought here once received. MAE had asked 2G to review their out of county patients following a previous death. MAE added that CQC had raised issues regarding St Andrews so no further placements would be made with them at present. • There was a twenty week wait for IAPT services. The reporting of county numbers had been amended in line with other CCGs so

	the figures had improved slightly but this remained an issue. • Their inpatient and outpatient services were scored in the top 20% of mental health services in England and 79% of staff responded that they would recommend the Trust to their friends and family in the FFT. • All 'must dos' from the recent CQC report were being actioned.
5.7.2	JC queried what was being done to address the poor performance in DTOCs as it stated that it was an issue with social services. MH clarified that this was a new problem and it was being investigated.
5.7.3	JC requested an update from the visit to Wootton Lawn. MAE confirmed that Jenny had visited and had been very impressed. LF declared that a family member was a patient in Wootton Lawn. JC acknowledged the declared interest but as no decisions were being made, LF did not have to leave the meeting.
	BB and AB joined the meeting at 11:35 *JC moved to item 7*
7.	**Equality Analysis of service changes to school nursing/health visiting in relation to safeguarding**
7.1	JC welcomed BB to the committee and explained the background that led to BB being asked to present to the committee. BB explained that the service had been re modelled prior to starting in the role following budget reductions. The changes in service and reduction in staff have been as a result of the changes in service structure. During the transition period vacancy control practices were adopted. When the new model staffing numbers had been reached the model was re organised into the new structure. This had been completed by April 2018 so the issues should have been resolved through the introduction of new efficiency schemes like baby hubs and telephone contact with families. Each Public Health Nursing team was up to full complement apart from a number of vacancies within the school nurse team.
7.2	MH explained that Locality Plans were being drawn up and asked what the breakdown of these teams were by Locality. BB did not have that breakdown but would be able to provide it. **ACTION BB.**

7.3	JC stated that the committee understood the new universal offer but needed to understand the impact of the changes on the system. AB described that the main issue had been the inability of school nurses to attend child protection conferences where there was a school child who had been seeing a school nurse. That led to the school nurses having to prioritise the Safeguarding meetings and then they could not undertake school nursing activities leading to school nurses leaving. AB requested assurance that there would now be enough school nurses to be able to attend the required meetings. BB confirmed that they were up to the planned compliment following the re modelling of the service in 2016 to deliver the service in a new way. The burden of Safeguarding demand was a relatively recent development in relation to the re structure process. JC clarified that the CCG had been raising the issue for the last two years.
7.4	CB described a noticeable difference in the Public Health offer following the re structure and queried if any review of the impact of the change had been undertaken. WM added that with regards to school nurses not being as visible at the schools, if the child did not see the school nurse then for that child and the family there was no school nurse for them to contact. BB confirmed that GPs had raised that they did not have Public Health nurses in the practices any more. Comparing directly with the previous structure had been difficult due to a lack of previous base line data, however, with regards to the mandated service performance indicators huge improvements had been seen. JC queried if 360 feedback was being requested. Gaining feedback from the GPs would be a useful source of information.
7.5	BB reported that the increase in demand around Safeguarding had been an issue and had been detracting from the Public Health Services. The increase occurred following the OFSTED report of GCC Children's Services with more emphasis being put on identifying children at risk. JC described that there had been a steady increase in cases over the last few years as well as an increase in the number of children going into care so the increasing trend was clearly identifiable. The trend had been mirrored across the country so PH should not have been surprised by the increase in service involvement. MAE added that there were a high number of children in care from out of county which had also increased the pressure on services.
7.6	BB reported that Dawn Chapel who heads up the Safeguarding team in GCS undertook an audit to inform the strategy discussions and identified that health and social workers had been included but often a

	health representative had not attended. To address this, a Band 7 Safeguarding nurse joined MASH to undertake the health research and link with all the other agencies. MAE requested clarification as a nurse had been in MASH from its fruition. AB clarified that an additional nurse attended to support the additional work being undertaken and create resilience. BB reported that a specific inbox for GCS Safeguarding had also been created for social workers to access.
7.7	JC queried whether any additional funding would be allocated to the team to support the Safeguarding demand. BB responded that it had been recognised that additional resource was required in the PH nursing team to support Safeguarding and work was ongoing to address this. A paper had been drafted for a proposed pathway for health into those Safeguarding Strategy discussions. JC thanked BB for the update and invited BB to return to update the committee on progress. **ACTION BB.**
	BB and AB left the meeting at 12:15 *JC returned to the Quality report*
5.8	**Appendix 4.0 GCS Report (item 5.7 on agenda)**
5.8.1	The report was taken as read. MAE highlighted the main issues: • There had been four serious cases of urosepsis which was a cause of concern. Hannah Williams met with the Trust to get assurance around the actions that had been taken. One factor that had been identified was a breakdown in communication between nursing staff. An action plan was in place that had been reviewed and provided assurance. • The VTE assessment target had not been met. An action plan had been put in place and was being progressed. JC queried if the assessments had been done but not entered onto the system. MAE thought this was the case. • The vacancies within District Nursing in Cheltenham remained a hot spot. The committee discussed the potential reasons behind the vacancies. MAE added that an audit had been undertaken to see if there were alternative ways to deliver the service.
5.8.2	LF noted that governance issues could lose priority during the merger process between 2G and GCS. The new Board would be in place by March 19 and ensuring they were up to date with the issues should be a priority.

5.8.3	JC stated that it was good to review the additional information provided on SALT and queried if there was a timescale for the decision on the service focus and funding. MAE was not aware of the timescale but would provide an update at the next meeting. **ACTION MAE.**
5.8.4	JC asked if the impact of the x-ray service issues on patients had been assessed. MAE confirmed that concerns had been raised.
5.8.5	JC requested an update on the Stroud theatre staff availability at the next committee and suggested it be added to the list of visits. **ACTION MAE.**
5.9	**Appendix 5.0 Arriva Report (item 5.8 on agenda)**
5.9.1	RM explained that the performance KPIs had almost been reached, complaints had reduced, the procurement stand still was due to end at midnight and would then be in transition.
5.10	**Appendix 6.0 Primary Care Report (item 5.9 on agenda)**
5.10.1	JC requested additional information on the practice nurses in future. MAE explained that there would be a new practice nurse support structure being introduced. JC requested an update at February's meeting. **ACTION MAE.**
5.11	**Appendix 7.0 Care Homes Report (item 5.10 on agenda)**
5.11.1	MAE reported that the last CH CQRG had been very positive. Lots of work had been undertaken within care homes including some interesting initiatives like immunising staff and point of care testing. DM agreed that the point of care testing could be a very positive change. The current process produced the test results within 6-8 days and the proposed new process would provide the results within 15 minutes. This was due to be piloted and would be evaluated.
5.11.2	MAE explained that the care home support team were undertaking work with the care home staff around deteriorating patients and early identification to call help in when required.
5.11.3	MAE reported that the International Dysphagia Standards had been introduced which affected the care homes as lots of their patients were

	on soft diets. A dietician would be joining the team in January and the first job would be to raise awareness in care homes as well as in Primary Care to ensure correct prescribing.
5.12	**Update on Never Events (item 5.11 on agenda)**
5.12.1	JS provided an update on the GHFT theatre never event action plan. JC expressed disappointment that the theatre visit had not occurred.
5.13	**Gosport Independent Panel Report – Briefing Paper**
5.13.1	TM reported that GCS had undertaken a full review but no response had been received from GHT. MAE added that the care home support team were reviewing the report from GCS. JC asked TM to provide an update in February. **ACTION TM.**
5.14	**RESOLUTION: the Committee noted the Quality Report.**
8.	**Risk Management**
8.1	**Risk Management report**
8.1.1	CGi highlighted that risk managers had been provided with feedback from the A&RC on the quality of risk articulation and had been asked for a thorough explanation of how the risk had been mitigated. 4risk would be implemented in February so training on the system and risk management would be provided.
8.2	**Corporate Risk Register**
8.2.1	CGi reported that two risks had been reduced: • L9 There was a risk that clinical tasks were missed in Improved Access pilots where pilots were using Information systems to send clinical tasks. The risk had been reduced from 12 (Amber) to 8 (Amber) as all practices had been visited and system configurations had been checked. The internal governance meetings would continue and there had been no serious incidents reported. • EXT 1 One Place Project a risk of judicial review of the project plans, which involved changes to urgent care. The original risk was 12 (Amber) but this had been reduced to 4 (Yellow) as the

	project was being phased and the consultation was planned for autumn 2019. The project risks would be continually reviewed through its implementation.
8.2.2	CGi explained that the Transformation and Service Redesign Directorate had requested that the following be closed: • T12 Insufficient clinical and operational capacity and leadership across the system. Leading to lack of delivery within the Clinical Programme Groups. This risk has been reduced from 12 (Amber) to 4 (Yellow) as the actions had been completed.
8.2.3	CGi stated that there had been two requests for risks to be included on the register: • K9 Risk that the CCG was unable to meet the national target for CHC. Due to: Currently there are 42 CHC funded individuals with a Learning Disability a review conducted showed that there are 28 individuals who had not had a review. Resulting in missed target and poor patient experience for the actual patient and their family. This was currently rated as an Amber risk 12 (3x4). • T18 Lack of a detailed plan for specialist services transfer. CCG commissioners monitoring the situation. NHSE recommissioned diabetic eye screening for April 2019 onwards. This was currently rated as 12 (Amber).
	MH left the meeting at 12:38
8.2.4	CGi highlighted that further detail regarding the SWAST risk had been provided and confirmed that the A&RC had approved all recommendations.
9	**Update on Effective Clinical Commissioning Policies**
9.1	**Assisted Conception**
9.1.1	*RM left the meeting at 12:49*
9.1.2	CH provided an update on the changes to the Assisted Conception Policy: • The number of cycles changed from three to two; • Takes the CCG from being in the top 12% to the top 30%; and

	• Any frozen embryos would be kept after the second attempt to be used privately;
9.1.3	JC noted that the amended policy did not incorporate the updated NICE guidance and requested it be brought back to a future meeting. **ACTION CH.**
9.1.4	**RESOLUTION: the Committee ratified the updated Assisted Conception Policy which reduces the number of commissioned IVF/ICSI attempts from 3 down to 2 (using a frozen embryo transfer where available for second attempt in preference to a second fresh cycle).**
	DC left the meeting at 12:53 *JC moved to item 11*
11	**Evidence Based Interventions' consultation from NHS England presentation**
11.1	CH gave a presentation on the evidence-based interventions programme. *JS left and DC returned to the meeting at 12:55*
11.2	CB stated that it was mainly aimed at secondary care but some practices were not being applied the same way across Primary Care so it would be good to be aimed at Primary Care as well. CH agreed and confirmed the patient would remain under a Consultant. DES received very little information regarding surgery in Primary Care and this needed to be addressed. LF added that HG was keen for minor surgery in Primary Care to increase so consistency across the GP practices was needed. JC agreed and stated that it would be good to include patient aftercare in the development work as well. CB suggested that prostrate procedures could be reviewed as lots of people were asking for it. **ACTION CH.**
11.3	**RESOLUTION: The Committee noted the presentation.**
	CH left the meeting at 13:07

10.	**Minor Ailment Scheme (MAS)**
10.1	TM explained that following the implementation of the NHS England guidance, the Community Pharmacy Enhanced Service for Minor Ailments (MAS) had been reviewed and amended. These required ratification.
10.2	**RESOLUTION: the Committee approved the final revised specification of MAS service.**
12.	**Data Security & Information Governance**
12.1	**Information Governance & Data Security Update**
12.1.1	MAE informed the committee that there was due to be a cyber security exercise carried out in February for IT staff regarding how to manage if there were to be a cyber-attack. This would be followed in May by a cyber resilience exercise with partners.
12.1.2	**RESOLUTION: the Committee noted the contents of the report.**
12.2	**Data Security & Assurance Working Group meeting notes 14.11.18**
12.2.1	**RESOLUTION: the Committee noted the notes from the Data Security & Assurance Working Group 14.11.18.**
12.3	**Gloucestershire Information Governance Group Meeting Minutes 18.07.18**
12.3.1	**RESOLUTION: the Committee noted the minutes from the GIGG meeting 18.07.18**
12.4	**Joining Up Your Information (JUYI)**
12.4.1	JC explained that there was a query around the clarity of advice provided when children were at risk but their parents refused permission to share their records between organisations. MAE clarified that the legal position was that parents can opt their children out and that can only be challenged where there was a genuine Safeguarding risk. The family court could override parental opt out. WM requested that the clarification be included in What's New This Week. **ACTION MAE.** MAE suggested that the matter be discussed with the JUYI team

	so that clear guidance was available to GPs using the system. **ACTION Una Rice.**
13.	**HR six monthly report**
13.1	**HR six monthly report**
13.1.1	AE highlighted that there continued to be a growth in head count which would impact on next year's budget. CGi agreed and stated that CL could explain the potential impacts next year around management costs. MAE explained that the clinical pharmacists and POL were employed by CCG but they were programme costs rather than management costs. CGi reported that awareness would be raised through team briefings.
13.1.2	CB noted that there were quite a lot of CCG staff on secondments and queried where they would show. CGi confirmed that they would remain on their employer's records. It was agreed that due to the time constraints, HR would be included on the next meeting agenda. **ACTION CGi.**
14.	**Health & Safety Report**
14.1	**RESOLUTION: the Committee noted the Health & Safety Report.**
15.	**Any Other Business**
15.1	CB suggested that in order to cover everything in the agenda the calendar meeting times should be amended to four hours. **ACTION LN.**
	The meeting closed at 13.19pm.
	Date of Next Meeting: Thursday 14 February 2019, 9am in the Boardroom, Sanger House.

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire Clinical Commissioning
Audit & Risk Committee

Minutes of the meeting held at 9:00am,11 December 2018, Board Room, Sanger House

Members Present:		
Colin Greaves	CG	Chair Audit & Risk Committee
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Alan Elkin	AE	Lay Member, Patient and Public Experience
Jo Davies	JD	Lay Member, Patient and Public Experience
Peter Marriner	PM	Lay Member, Business
In Attendance:		
Cath Leech *(Agenda Item 15)*	CL	Chief Finance Officer
Gerald Nyamhondoro *(Agenda Item 10)*	GN	Corporate Governance Administrator (taking minutes)
Andrew Beard *(Agenda Item 13)*	AB	Deputy Chief Finance Officer
Christina Gradowski *(Agenda Item 8)*	CGi	Associate Director of Corporate Governance
David Porter *(Agenda Item 9)*	DP	Head of Procurement
Adam Spires *(Agenda Item 5)*	AS	Internal Audit Manager, BDO
Justine Turner *(Agenda Item 5)*	JT	Internal Audit Manager, BDO
Paul Kerrod *(Agenda Item 7)*	PK	Local Counter Fraud Specialist
Alex Walling *(Agenda Item 6)*	AW	Engagement Lead – Grant Thornton
Debbie Sanders *(Agenda Item 4)*	DS	Clinical Manager, CHC, Integration Directorate
Kim Forey *(Agenda Item 4)*	KF	Director of Integration
Haydn Jones *(Agenda Item 11)*	HJ	Associate Director, Business Intelligence

1. Apologies

1.1 There were no apologies given.

1.2 The meeting was confirmed as quorate.

2. Declarations of Interests

2.1 No declarations were made.

3. Minutes of the Audit & Risk Committee meeting held on 11 September 2018

3.1 The minutes of the meeting held on Tuesday 11 September 2018 were approved as an accurate record, subject to the following amendments:

3.2 The last two sentences of paragraph 10.3 should read "DP responded that the Assisted Conception procurement plan was drafted but a date had not yet been agreed". **ACTION DP/CGi to agree meeting date**.

3.3 The first sentence of paragraph 17.3 should read "Audit & Risk Committee informed the committee that normally there would be a meeting with both the internal and external auditors before the end of the year; however, as BDO were new auditors, CG suggested delaying the meeting with them until 2019.

4. Matters Arising

4.1 **13/03/18, Item 12.9** Threshold of Waivers was reviewed (see agenda item 12). Proposals were recommended for approval by the Governing Body. **Item to remain open**.

4.2 **10/07/18, Item 3.4.3** The confidentiality of provisions of the ICS MoU was considered. **Item closed**.

4.3 **10/07/18 Item 10.1.10** Kim Forey and Debbie Sanders were invited to the December Audit committee meeting (see agenda item 4) to provide an update on the improvements made to PHB following on from the recommendations from the SR case. Further updates received and included in the follow-up report suggesting the recommendation be closed pending Audit Committee's approval. **Item closed**.

4.4 **11.09.18, Item. 514** Internal Audit Progress Report (IAPR). CG requested that the evaluation of the Medicines Management data be completed before it was closed. Further update received and included in the follow-up report suggested the recommendation be closed pending the Audit Committee's approval. **Item closed**.

4.5 **11/09/18, Item 5.2.3** Internal Audit Safeguarding Report (IASR). CGi queried who the mental capacity lead was? HLR confirmed he was the GP clinical lead with Simon Thomason the jointly appointed lawyer for GCC. CGi was not aware of this appointment and did not think the Continuing Healthcare Team were aware either. CGi suggested including an intranet page with main Safeguarding leads and suggested Simon Thomason be invited to meet the team. CGi met with Simon Thomason, and discussed training to be provided to the CHC, Integration and Quality teams. Simon Thomason produced a draft MCA policy. **Item closed**.

4.6 **11/09/18, Item 5.2.4** (IASR). PM commended the report as it highlighted areas for improvement and requested that CGi ensure the report was included on the Quality & Governance Committee agenda. CG concurred emphasising that recommendations be actioned. JT confirmed that as action dates became due the lead would be contacted for an update and evidence of completion requested. Follow up reports on action plans would be brought to Audit & Risk Committee to flag any overdue actions. **Item closed.**

4.7 **11/09/18, Item 6.1.1** External Audit Progress Report (EAPR). Due to a change in the audit software being used for 2018-19 with requirements to ensure the issues facing the CCG were

fully addressed, external auditors would not be able to provide the audit plan until the next committee meeting in March. This would be in line with the timeline of last year. **Item to remain open.**

4.8 **11/09/18, Item 6.1.3** EAPR. The data and coding supporting GHFT reported activity was reviewed on a monthly basis. GHFT colleagues were requested to respond to these challenges highlighting when and how coding amendments would be made. **Item closed.**

4.9 **11/09/18, Item 8.1.3** Registers of Gifts and Hospitality (RGH). CG requested that historical records be kept in an archive; with the last two years recorded in the report going forward. Noted and actioned. **Item closed.**

4.10 **11/09/18, Item 8.1.4** RGH. Declarations of interest. **Item closed.**

4.11 **11/09/18, Item 9.2.4** Corporate Risk Register (CRR). AE stated the normal process was that a risk was put on the register, reviewed, dealt with and monitored. CGi agreed that the risk could be articulated in a clearer way and would feed that back. The risk was rearticulated. **Item closed.**

4.12 **11/09/18, Item 9.2.5** CRR. CG requested the narrative of the Primary Care risks be reduced further. CGi was asked to liaise with Primary Care to review the risks in accordance with comments. CGi sent all risk leads feedback and the primary care risk was reviewed and feedback given. **Item closed.**

4.13 **11/09/18, Item 9.2.6** CRR. The committee discussed well written risks, training already undertaken and what more could be done to continue making improvements. PM asked the external auditors to provide an example of a best practice risk register. Many issues were raised about risk articulation and risk mitigation would be addressed with the roll-out of 4Risk. **Item closed.**

4.14 **11/09/18, Item 9.4.1 Corporate Risk Discussion on Risk Appetite.** CGi explained the CCG had a Risk Management

Policy rather than a Strategy and it would be good to have a Governing Body discussion about risk appetite in order to formulate a Risk Management Strategy. This would go to the Governing Body followed up with a discussion around risk appetite and developing a Risk Management Strategy.

CG requested a short paper detailing risk management going forward including a potential procurement of a risk management tool. CGi presented the papers detailing risk management and procurement of a risk management tool. These were Agenda Items 8.1 & 8.2 of the Audit & Risk committee meeting held on 11 December 2018. It was suggested to the Chair of the A&R Committee the Committee is delegated responsibility for developing a risk appetite statement for inclusion in the Risk Strategy Policy. **Item to remain open.**

4.15 **11/09/18, Item 10.3 Summaries of Procurement Decisions**. CG stated the Governing Body would need to approve the Assisted Conception service (ACS) procurement and queried when it was going to come to the meeting? DP responded that the procurement plan was drafted but a date had not yet been agreed. DP/CGi to agree a meeting date. **Item to remain open.**

4.16 **11/09/18, Item 11.5 Register of Waivers of Standing Orders – Waivers.** CG noted that an external consultancy had been sourced for the ICS One Place work but the cost was not split with GHFT. The CCG was incurring all One Place project costs in 2018/19, although he acknowledged that some of this had been funded through ICS Transformation monies. **Item closed.**

4.17 **11/09/18, Item 12.3 STP/ICS Solutions Report**. AE stated there was further learning relating to schemes that were thought to be effective and running well but not reaching optimum activity like OPAL. AB agreed and added that regular reporting would support improved forecasting. **Item closed.**

4.18 **11/09/18, Item 16.1 Audit Committee Checklist (Self-Assessment).** CGi explained that all committees complete an

annual review process. **Item closed.**

4.19 **11/09/18, Item 17.1 Any Other Business.** AB reported that the CCG Financial Control Plan governance templates needed to be completed for NHS England. The Committee agreed. **Item closed.**

4.20 **11/09/18, Item 17.2 Any Other Business.** PM stated that one of the checklist questions queried if the Committee reviewed its effectiveness and suggested this be added as an agenda item to facilitate this discussion. **Item closed.**

4.21 **11/09/1, Item 17.3 Any Other Business.** CG informed the committee that normally he and other lay members would be meeting with both the internal and external auditors before the end of the year; however, as BDO were new auditors, CG suggested delaying the meeting with them until 2019. The Committee agreed. CG would meet with Grant Thornton. **Item closed**.

4.22 **ICS Update – MOU and Planning**

4.22.1 An ICS MoU update was considered by the committee The ICS had a long-term strategic plan broken down into short-term operational plans. 2019/20 is the first year of a required 5-year system response to the Long Term NHS plan (LTP). Planning for implementation was progressing. CG commented that the diagram constituted an important tool for elaborating the MoU and planning activities.

4.22.2 HLR probed the level of cooperation and cohesiveness to develop an Integrated Care System (ICS) operating plan. CL stated that the exercise faced structural challenges. In terms of integrated care, partners facing a collective goal, but as entities, they were accountable to their own separate governance bodies, constitutions and statutory obligations. CL added there was a requirement for a cultural shift pursuant to promoting integrated care.

4.22.3 The ICS MoU and plan pointed toward the need to make

significant progress in the development of integrated health management capabilities and a system-wide plan setting out locally determined population health priorities. JD emphasised the need to effectively engage partners in promoting the CCG perspective of the ICS framework. PM enquired as to the efficiency of managing ICS resources. CL explained that in terms of managing required resources, there was proactive interaction between chief finance officers and deputies within the system.

4.22.4 CG stated that it was not the committee's role to judge the ICS, but it had an obligation to monitor its resources. CG requested CGi appraise the committee on progress. **Action: CGi to report back on progress.**

Kim Forey and Debbie Sanders joined the meeting at 09:20am.

4.23 <u>Verbal Update on Personal Health Budget (PHB) and Continuing Health Care (CHC)</u>

4.23.1 KF and DS delivered the verbal update on PHB and CHC. KF addressed the strategic aspects of PHB and CHC risk mitigation. KF explained relevant risk mitigation tools had been in place and operational for some time and the CCG had the competency to apply such tools.

4.23.2 KF added that the CCG and the County Council (CC) jointly held controlled packages of care, which were designed to limit the risk of fraudulently accessing packages that share common elements with PHBs.

4.23.3 KF stated that their team was developing a structured operating environment providing a platform which promoted transparency in application and monitoring of PHBs and CHCs. KF explained one of the tools being developed was a prepayment card which would provide a real time data of how the PHBs were being used by patients and create an audit history.

4.23.4 KF stated that the prepayments cards promoted efficient use of

funds by restricting card use to purchasing health services, rather than other items. Any monies that were not spent were kept as a contingency fund by patients. Such funds could be recovered by the CCG from patients, if not spent on health services.

4.23.5 DS addressed the strategic aspects of the PHB and CHC. DS explained the CCG worked with the County Council to tighten control of funds by closing gaps leading to fraudulent inflating of services from service providers. DS gave an example of the rules relating to signing of timesheets had been tightened. DS added that the team tightened the monitoring of day to day use of PHB by each individual patient.

4.23.6 CG acknowledged the effort of KF and DS's teams but expressed concern that the budget provision for CHC showed financial risk arising from material underestimates.

4.23.7 KF warned the CCG was not facing only CHC financial risk, but also performance risks. The CCG was performing below both the national and regional targets. KF added that there was also a need to build comprehensive social work capacity which would contribute towards establishing multi-disciplinary teams.

4.23.8 CG requested that KF and DS should return at a future date and provide information on how such material risks occurred and how the risks were being addressed. **Action: KF and DS.**

4.24 RESOLUTION: The committee noted the ICS, PHB and CHC verbal updates.

Kim Forey and Debbie Sanders left the meeting at 09:50am

5. Internal Audit

5.1 **Progress Report**

5.2 AS stated that the internal audit team had experienced good cooperation from the CCG staff in completing the audits. AS updated the committee of progress made against the 2018/19

internal audit plan (IAP). AS also stated that BDO had either reviewed or will review: Key Financial Systems, Primary Care Commissioning, Conflict of Interests, Data Security & Protection Toolkit, Human Resources, CHC, QIPP Management, Adult Safeguarding and GDPR Implementation Processing to ensure the processes and operating tools were effectively embedded across the CCG.

5.3 AS presented the Risk Maturity, Primary Care Commissioning and HR Internal Audit reports. AS stated, that they were completing the fieldwork on Key Financial Systems and General Data Protection Regulation and they anticipated presenting these reports at the next Audit & Risk Committee.

5.4 **Assessment of Risk Maturity**

5.4.1 AS clarified the purpose of the risk maturity assessment was advisory and to help ensure that an effective risk management culture became embedded across the CCG by highlighting areas where processes could be improved.

5.4.2 AS stated, the CCG's Governing Body Assurance Framework (GBAF) was put in place to provide assurance, and that controls were in place to mitigate the key risks that could impact on the CCG's delivery of its corporate objectives.

5.4.3 AS explained that the fieldwork had been undertaken. Internal Audit established the risk appetite of the CCG should be agreed, clearly documented and communicated. This was because it was found that members of staff interviewed during the review were unable to say what the CCG's risk appetite was. AS added that the CCG risk management tools required an upgrade and replacement of the current use of spreadsheets to record directorate risks, corporate risks and the governing body assurance framework.

5.4.4 CGi reiterated that dedicated risk management software would effectively support the identification and reporting of risk as well as produce a suite of risk. AS further emphasised risk management software would help create an audit trail and enable the study of risk trends. AS added Key Performance

Indicators (KPIs) were needed to drive risk management activity and added the Risk Management Policy needed to be updated.

5.4.5 AS identified the following as areas of good practice in the CCG:

- The CCG had clear themed strategic objectives
- The Governing Body provided leadership for the risk management process.
- All directorate risks were recorded in the corporate risk register
- Risks identified were assessed using the risk matrix
- Training was offered to all directorates by the Associate Director of Corporate Governance.
- Governing Body and Senior Managers received Risk Appetite training.

5.4.6 JD commended the overall positive effort and development in risk management in the CCG.

5.5 **Primary Care Commissioning**

5.5.1 JT presented the Primary Care Commissioning report and explained that NHSE had issued an internal audit framework based around primary care commissioning; this formed the basis of the audit.

5.5.2 JT stated that the internal audit found evidence of good practice by the CCG teams in a number of areas, including estates management and GP resilience funding showing some good processes. Progress had been made across Adult Safeguarding Risk Maturity assessment. Actions and performance targets were met.

5.5.3 JT stated that she hoped to see progress on the medicine management recommendation on the Prescription Ordering Line (POL).

5.6 **HR Starters and Leavers Report**

5.6.1 JT presented the starters and leavers report. She reported that internal audit did not find any evidence of any staff overpayment or that people were being improperly employed.

5.6.2 JT stated that internal audit discovered duplication of some staff email accounts and missing email addresses. There was a process for removing staff having left the IT system. However, there was no systematic process to check that staff had been removed from the system once the request had been made. JT acknowledged that the problems and were being addressed.

5.6.3 JT explained that staff statutory and mandatory training was also covered in the corporate induction. It was constantly promoted and monitored by the Governance Team with monthly reports on uptake and compliance.

5.6.4 AE expressed concern regarding what appeared to be a lack of adequate transparency in vetting and monitoring work permit documentation and added that there were risks that the CCG was breaching its duties. CGi stated that the problem was of a structural nature, as it was exacerbated by the outsourced structure of HR.

5.6.5 CGi acknowledged the cited problems and the need for improvement of processes. She reassured committee members that actions had been taken to improve the starters and leavers processes. CGi had met with Andrew Mitchell and Victoria Nangreave from the CSU to work through the processes and had uploaded new forms to the intranet and disseminated updated guidance to CCG staff.

5.7 RESOLUTION: The committee noted the Internal Audit reports.

6. External Audit Report

6.1 AW read out the External Audit report (EAR). AW explained that they had started planning for the 2018/19 financial

statements audit and were due to commence an interim audit in early 2019.

6.2 AW advised they were rolling out a new audit methodology and they would subsequently discuss the new approach with officers of the CCG. The external audit team expected to issue an audit plan summarising its approach to the key risks related to the audit in March 2019.

6.3 AW stated that the external auditors planned to report their interim findings in March, and these would be incorporated into the Progress Report. AW added that the Audit Findings Report would be brought before the committee in May and the Annual Audit Letter would be produced in June.

6.4 RESOLUTION: The committee noted the External Audit Report.

7. Counter Fraud Report

7.1 PK presented the Counter Fraud report to the committee. Before this he announced that Lee Sheridan was leaving the Counter Fraud team. He also announced that Tom Taylor (TT) was the new chair for the Counter Fraud Authority (CFA) and TT was introducing structural changes aimed to flatten the organisation, introducing counter fraud champions with more involvement at local level.

7.2 KP stated that CFA aimed to strategically position itself to increase provision of support to Audit Committees. Through enabling greater exchange of data and information with increased use of new technologies and innovations. KP announced two Counter Fraud newsletters had been issued and the newsletters were accessible via the organisation's intranet.

7.3 KP stated the Counter Fraud team (CFT) had developed an e-learning training package which was planned to be incorporated into the existing mandatory training programme.

CG commended the progress on the introduction of the new e-learning tool.

7.4 PK stated that the Counter Fraud Survey was launched in November 2018 in order to measure fraud awareness levels across the organisations. The results of the survey would be benchmarked against other Gloucestershire organisations and members of the National Counter Fraud Managers Group. PK advised that further updates would be brought before the next committee.

7.5 RESOLUTION: The committee noted the Counter Fraud report

8. Risk Report

8.1 CGi presented the Risk Management Paper, Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF). The committee discussed high level risks registering 12 or above which were included in the Governing Body Assurance Framework (GBAF). The CCR brought together all the directorate risks. CGi stated that some of the old risks were closed or required closure whilst some new risks were emerging and required attention.

8.2 CGi requested the T12 risk be closed. This risk had been reduced from 12 (Amber) to 4 (Yellow) as the actions had been completed.

8.3 CGi requested that risk K9 be included in the CRR and GBAF. The risk involved the CCG's inability to meet the national target for Continuing Health Care (CHC). Risk T18 was recommended for inclusion in the CRR and GBAF as it identified a lack of a detailed plan for specialist services transfer.

8.4 CGi referred to the Internal Audit review of risk management,

which focused on risk maturity. The purpose of this was to ensure that an effective risk management culture became embedded across the CCG, by highlighting areas where processes could be improved.

8.5 CGi discussed the acquisition and implementation of new risk management software called 4Risk. CGi explained 4Risk was cloud based and had a provision for 500 users with an annual fee of £5000. CGi also explained that although RSM suppliers required a standard 3-year contract, they had agreed a 2year contract with the CCG.

8.6 CGi added that the advantage of 4Risk was that RSM provided on-site training and support to the users. In addition, 4Risk software was user friendly and would be able to support the specific requirements of each directorate.

8.7 CGi stated that the software had risk appetite supporting features and allowed the user to develop and use their own Key Performance Indicators (KPIs) on the 4Risk platform. The Corporate Governance team planned to conduct 2day training for 4Risk risk leads in April 2019.

8.8 CG stated that 4Risk was a step in the right direction in terms of bringing improvement to the scope and management of risks because it makes it easier to understand a broader area of risk exposure and establish better monitoring and control.

8.9 RESOLUTION: The committee recommended the inclusion of risk K9, the inclusion of risk T18 and the closure of risk T12.

David Porter joined the meeting at 10:45am

9. Procurement Waiver of Standing Orders

9.1 DP presented the 17 waivers of standing orders, and said most

of the waivers were associated with primary care and were of low value. DP added the waiver with the most significant value was the Beezee Bodies waiver with a value of £332,000. DP emphasised such a waiver could at face value appear significant but in reality, this was a high intrinsic value scheme aimed at reducing child obesity.

9.2 RESOLUTION: The committee noted the Procurement Waiver of Standing Orders.

David Porter left the meeting at 10:55am and Haydn Jones joined the meeting.

10. Declarations of Interest Report

10.1 GN presented the Declarations of Interest Report (DOIR). GN highlighted that the level of compliance in the CCG was lower than expected. GN explained that only 87.5% of members complied with the statutory requirement to declare interests and the overall level of compliance in the CCG was 66.2%.

10.2 CG stated that the level of non-compliance was worrying and there was a need to improve compliance to a satisfactory level. CG emphasised the executive team should further investigate the problem. **Action: Executive team.**

10.3 CGi also added that the Corporate Governance team could develop a programme to train and appraise staff, during team briefings, on managing conflicts of interest. **Action: GN and LN (Lisa Netherton).**

10.4 RESOLUTION: The committee noted the Declarations of Interest Report.

11. STP Solutions Report

11.1 HJ provided an overview of the STP (ICS) Solutions. HJ added overall risk adjusted delivery at Month 7 was £17.509m out of a total savings target of £18.602m (94.1%). HJ explained the savings plan of £18.602m was included in the financial plan for 2018/19.

11.2 HJ stated the financial risk for 2018/19 was mitigated by a risk share agreement with GHFT. HJ further commentated GHFT had agreed a block contract for all activity except elective inpatients and day cases. There was a further risk share with GCS for specific schemes where GCS provided services to support delivery of schemes such as MSK.

11.3 HJ stated the Finance team had developed methodologies and models to map the links between savings plans and contract performance. HJ added the team had focused on refining best practice by also studying the approach and models employed by other CCGs. Members discussed the report.

11.4 RESOLUTION: The committee noted the STP Solutions Report.

Paul Kerrod and Dr Hein Le Roux left the meeting at 11:00am

12. Scheme of Delegation Report

12.1 AB presented the Scheme of Delegation (SD) to the committee. The committee considered SD and the proposed changes. AB explained that the review had focused on procurement limits.

12.2 Other proposed changes included an explicit inclusion of primary care payments, the reporting of waivers to the committee; the signing of Personal Health Budget contracts and an increase of petty cash from £25 to £50.

12.3 RESOLUTION: The committee noted and recommended changes for approval by the Governing Body.

13. Aged Debt Report

13.1 AB presented the Aged Debt report. The report provided a summary of the aged debt as at 27th November 2018. AB added the Aged Debt report showed escalating figures. However, at the time of presenting the report some payments had been made to the CCG.

13.2 AB gave an outline of outstanding debts which included an NHS England debt, which stood at £849,000. Members considered the report.

13.3 RESOLUTION: The committee noted the Aged Debt report.

14. Audit & Risk Committee Self-Assessment & Checklist

14.1 CG presented the Audit & Risk Committee Self-Assessment & Checklist which provided an overview of responses from Audit & Risk Committee members and attendees, to the self-assessment survey and exercise, undertaken regarding the committee's effectiveness.

14.2 The committee considered the outcome of the self-assessment exercise and agreed that the committee should agree to a set of strategic objectives at the beginning of the financial year. To be clearly followed by supporting and guiding operational objectives for the committee.

14.3 RESOLUTION: The committee noted the Audit & Risk Committee Self-Assessment & Checklist.

Jo Davis left the meeting at 12:28pm

15. ISAE3402 Service Auditor Report in Respect of Primary Care Support Services

15.1 CL presented the ISAE3402 Service Auditor Report to the committee. The report explained that NHS England had commissioned reporting accountants to review controls over systems that impacted on CCG accounts and related to primary care support services.

15.2 The CCG developed its controls to ensure it had confidence in the numbers within the accounts and payments being made. External Audit would carry out substantive testing of the CCG's own controls and sampled transactions to give assurance.

15.3 CG stated that the ISAE3402 Service Auditor Report was an

important report. However, the committee and the CCG could also gain assurance on this matter from the work of External Audit.

15.4 RESOLUTION: The committee noted the ISAE3402 Service Auditor Report

16. Any Other Business

16.1 CG mentioned it was necessary for the Committee and its members to commit themselves to the benchmarks derived from themes in the Audit & Risk Committee Self-Assessment & Checklist to drive committee effectiveness. CG added the committee appeared to be operating effectively.

16.2 PM suggested attendees should feel free to contribute to discussions relating to the committee's effectiveness.

The meeting was closed at 11.35am

Date and time of the next meeting

The next meeting would be held at 9:00am on Tuesday 12 March 2019, in the Board Room, Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Audit Committee:

Signed (Chair):_____ Date:_____