Gloucestershire Clinical Commissioning Group Shadow Board

AGENDA

Meeting to be held at 2pm on Thursday 18th October 2012 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1	Apologies for Absence	Dr Helen Miller	
2	Declarations of Interest	Dr Helen Miller	
3	Minutes of the Meeting held on Thursday 13th September 2012	Dr Helen Miller	Approval
4	Matters Arising	Dr Helen Miller	
5	Chair's Update	Dr Helen Miller	Information
6	Presentation: The Learning Disability Partnership Board: Quality of Services in Gloucestershire	Margaret Willcox	Information
7	Carers' Commissioning Strategy	Jill Crook	Approval
8	Quality Assurance during the Transition	Jill Crook	Approval
9	Commissioning for Quality Report Quarter 1	Sarah Hughes	Information
10	Performance against Commissioning Report	Mary Hutton	Information
11	QIPP Programme Update	Mary Hutton	Information
12	Any Other Business (AOB)	Dr Helen Miller	
13	Public Questions	Dr Helen Miller	
Date and time of next meeting: Thursday 15th November 2012 at 2pm in Board Room at Sanger House			

Gloucestershire Clinical Commissioning Group (CCG)
Shadow Board

Minutes of the meeting held on Thursday 13th September 2012 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:

Dr Helen Miller	HM	Chair
Dr Andy Seymour	AS	Deputy Clinical Chair
Dr Caroline Bennett	CBe	GP - North Cotswolds Locality
Dr Charles Buckley	CBu	GP - Stroud & Berkeley Vale Locality
Jill Crook	JC	Director of Nursing
Alan Elkin	AE	Non Executive Director
Malcolm Gerald	MGe	GP
Dr William Haynes	WH	GP – Gloucester City Locality
Mary Hutton	MH	Director of Finance & Deputy Chief Executive
Richard Lewis	RL	Deputy Director of Human & Corporate Resources
Liz Mearns	LM	Medical Director
Jan Stubbings	JS	Chief Executive
Dr Jeremy Welch	JW	GP - Tewkesbury Locality
Dr Alice Walsh	AW	Deputy Director of Public Health

In attendance:

Mark Branton	MB	Deputising for the Commissioning Director Adults and Director of Adult Social Services
Simeon Foreman	SF	Company Secretary
Emma Simpson	ES	Board Administrator
Mark Walkingshaw	MW	Locality Commissioning Director

There was 1 member of the public present.

1 Apologies for Absence

1.1 Dr Hein le Roux, Rob Rees, Dr Martin Gibbs, Debra Elliott, Margaret Willcox, Sarah Hughes, Dr Shona Arora, Nuala Ring.

2 Declarations of Interest

2.1 There were no declarations of interest.

3 Minutes of the Meeting held on Thursday 19th July 2012

3.1 The minutes were approved as a true and correct record.

4 Matters Arising

Item	Description	Response	Action with
21.6.12 Agenda Item 7 7.2	Performance against Commissioning Report	Queries raised by Shadow Board members related to understanding the detail within the £1.1m offset at 5.11 and it was agreed that this information would be circulated. **To be re-circulated.**	**Deputy Director of Finance** **July 2012** **Completed**
19.7.12 Agenda Item 6 6.3	Dispensing Doctors	Missing map from Appendix 2 of the report to be circulated to the Shadow Board.	**August 2012** **Director of Commissioning Development** **Completed**
19.7.12 Agenda Item 8 8.5	NHS Dental Services in Gloucestershire	Information regarding out of hours capacity and demand to be circulated to the Shadow Board. Information received and circulated.	**August 2012** **Director of Commissioning Development** **Completed**

5 Gloucestershire Clinical Commissioning Group (CCG) Shadow Board Chair's Report

5.1 The report which outlines the key issues discussed by the CCG at its meetings in July and August was taken as read.

5.2 <u>Resolution</u> - The CCG noted the report plus verbal update.

6 Gloucestershire CCG Shadow Board GP Member Reports

6.1 The report provides the CCG Shadow Board with progress reports from locality representatives. It was agreed that reports should be standardised in future. Several additions were made to the written reports.

6.2 It was agreed that a working group comprising GPs and members of the Finance Team be established in order to ascertain which information needs to be reported. Dr Hein le Roux and Dr Jeremy Welch were volunteered to sit on this group. Action

6.3 It was noted that the Tewkesbury locality has undergone a name change to encompass Newent and Staunton and will now be known as TNS.

6.4 Highlights from the TNS locality included:

- Unscheduled Care (USC) – the whole locality is now signed up to Primary Care Foundation Work. A timetable has been set up to work through USC costs.
- Dermatology – work underway, starting to show promise.
- Living Well, Aspire, Return to Work ethos, work ongoing.
- Inaugural Patient Resource Group gaining momentum.

6.5 Key issues within the North Cotswolds:

- Opening of the North Cotswolds Hospital and the Jubilee Lodge Care Centre – pathways are working as efficiently as possible.
- Business case for inflammatory bowel disease.

6.6 South Cotswolds:

- Diabetes Programme – working on training and accreditation and waiting for funding.
- Anxiety regarding the cost of running the community hospital.
- Concern regarding the District Nursing Service.
- Multidisciplinary Team (MDT) Meetings
- Protected Learning Time meeting focusing on diabetes.

6.7 Gloucester City Locality –

- Improved financial position considered encouraging, practices working hard to achieve outcomes.
- Aspiration to improve community provision of care as much as possible, differences with rural areas.
- Key feature of locality = deprivation.

6.8 Stroud & Berkeley Vale –

- 2 practices require help to meet fair shares.
- Struggling with GP engagement.
- Concern regarding under-usage of Vale Hospital particularly regarding diagnostic waits where there is failure.
- Stroud locality are querying data from Bristol Trusts and it was confirmed a new information system had been implemented in both Bristol Trusts and this may have contributed to data issues.

6.9 Cheltenham –

- Problem filling vacancy in the Executive.

6.10 <u>Resolution</u> - The CCG Shadow Board noted the paper and verbal updates.

7 Future Commissioning of Services to Support Carers

7.1 JC introduced the paper which outlines proposals for the future commissioning of services to support carers in Gloucestershire for discussion.

7.2 It was noted that a CCG member needs to be nominated as Clinical Lead for the Carers Commissioning Project Group. The Chair informed the meeting that Dr Martin Gibbs has volunteered to do this.

7.3 A question was raised regarding the fact that the group was being asked to support funding for the proposal prior to the strategy being in place. It was explained that grants are committed and are ongoing until March 2013. It is necessary to determine the cost envelope prior to the strategy being in place in order to prevent the PCT committing to something it cannot deliver.

7.4 Clarity was sought in relation to the funding of adjoining areas. It was noted that discussions are already taking place on this. Action

7.5 <u>Resolution</u> - The CCG Shadow Board:

1. Agreed in principle to continue to fund carers' support services at current levels.

2. Agreed in principle the JCPB decision for carers' services to be jointly commissioned between NHSG [CCG from 1 April 2013] and GCC, and led by GCC.

3. Agreed in principle to support the JCPB decision that a joint NHSG and GCC carers' support budget should be established, managed by GCC.

4. Agreed in principle to extending the existing NHSG [CCG from 1 April 2013] carers' support contracts and grants for 6 months from 1st April to 30th September 2013.

5. Nominated Dr Martin Gibbs as Carers' Clinical Lead to join the Carers Commissioning Project Group and participate in the development of the new service specifications and the tendering process.

8 Gloucestershire Clinical Commissioning Group (Shadow Board) Draft Terms of Reference (TOR)

8.1 The Company Secretary informed the Committee that the updated draft TOR were circulated via email earlier in 2012 after first being brought to the Committee in August 2011.

8.2 It was agreed that the wording on page 11 section 13.2 would be replaced with the equivalent for the Cluster Board. Action: Comp Sec

8.3 It was noted that these TOR take the CCG as a sub-committee of the Board up to the end of March 2013.

8.4 **<u>Resolution</u> - The Shadow Board considered the TOR correct and agreed them, subject to the minor changes above, until 31st March 2013.**

9 Performance against Commissioning Report

9.1 The Director of Finance introduced the report which provides a strategic overview of the financial and service performance issues by exception.

9.2 The A&E performance target which was green for April/May/June has been sustained.

9.3 Areas of concern with regard to performance were outlined:

- Percentage of Trauma and Orthopaedic (T&O) admitted Pathways treated within 18 weeks – improvement in position to amber. Progress had been achieved through

demand management, commissioning additional non-recurrent activity and the Trust taking action at individual consultant level.

The recovery plan agreed with Gloucestershire Hospitals NHS Foundation Trust (GHT) targeted full compliance in Quarter 3.

- Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests – the commitment to deliver full compliance by August had not been delivered. Additional work had been carried out as planned but this had largelybeen consumed by 2 week wait patients.
-
- Additional capacity put in place, agreed recovery plan with GHFT involves additional weekend sessions in September and October. . Potential for additional activity is also being explored in Stroud and Cirencester. Full recovery plan due to Execs by close of play on 14.9.12.

- Percentage of patients seen within 2 weeks of an urgent referral for suspected cancer – . contributions to the failure to deliver this target in full included the problems experienced within the breast service and the impact of the diagnostics breaches. A significant proportion of breaches were also due to the fact that some patients are not making themselves available for appointment within 2 weeks. Recovery plan under development.
-
- 62 day cancer target. It was reported that this was largely due to urology capacity and that this was being addressed.

9.4 . It was discussed that patients choosing other providers includingthe independent sector treatment centres could help address endoscopy capacity issues. .

9.5 The Committee expressed dissatisfaction with GHFT performance in delivering against the diagnostics target. It was agreed that additional action should be taken, in view of the fact that the Trust had failed to deliver the target despite agreeing a number of recovery plans. It was agreed that in addition to the contract escalation process that had taken place that this should be picked up in the Clinical Priorities Forum (CPF).

9.6 C-Diff – a Root Cause Analysis is due regarding antibiotic prescribing.

9.7 It was noted that NHSG has planned to deliver a surplus of £8.9m for the year 2012/13 against an anticipated revenue resource limit of £962.7m.

9.8 Brief discussion took place in relation to Appendix 6.

9.9 <u>Resolution</u> - The Shadow Board noted the reported financial position for 2012/13 and the performance against the 2012/13 national targets and the actions taken to ensure that performance is at a high standard.

10 QIPP Programme Update

10.1 The CCG Shadow Board were provided with an update of progress against the QIPP themes and main programmes of work, identifying progress to date, key risks and proposed remedial actions.

10.2 It was noted that there is a savings gap (in cash terms) of -£688k.

10.3 It was noted that the Audit Committee is working through QIPP performance which seems to be more embedded this year.

10.4 Attention was drawn to section 5.3 which illustrates that there are currently 71 QIPP projects within the programme.

10.5 The Shadow Board heard that there is an issue regarding urology and this has been voiced to the CPF. Dr Sean Elyan is now acting on it.

10.4 <u>Resolution</u> - The Shadow Board noted the performance against planned QIPP programme and the proposed remedial actions.

11 Any Other Business

11.1 The Shadow Board voted in favour of a recommendation to adopt the PCTs current relevant policies, including the Medium Term Financial Plan (MTFP).

12 Public Questions

12.1 A member of the public asked the Committee:
"Can you confirm that the UKSH Contract was renewed without review as stated in the last Professional Executive Committee (PEC) minutes?

12.2 The response provided stated that the UKSH Contract is held by the Department of Health and still has 2 years left of a 5 year contract.

13 Date and time of next meeting

13.1 Thursday 18th October 2012 between 2pm and 5pm in the Board Room at Sanger House.

13.3 The meeting closed at 3pm.

Minutes Approved by the CCG Shadow Board. Signed (Chair):_____ Date:_____

Matters arising from previous Gloucestershire Clinical Commissioning Group (Shadow Board) Meetings July 2012

Item	Description	Response	Action with
13.9.12 Agenda Item 6	CCG Shadow Board GP Member Reports	It was agreed that a working group comprising GPs and members of the Finance Team be established in order to ascertain which information needs to be reported. Dr Hein le Roux and Dr Jeremy Welch were volunteered to sit on this group.	**Chair** **Completed**
13.9.12 Agenda Item 8	CCG Shadow Board Draft Terms of Reference (TOR)	It was agreed that the wording on page 11 section 13.2 would be replaced with the equivalent for the Cluster Board.	**Company Secretary**

Agenda Item 5

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	**18th October 2012**
Title	**Clinical Commissioning Gloucestershire (CCG) Shadow Board Chair's Report**
Executive Summary	The report highlights some of the activities of the Chair since the Committee last met. The Chair will give a further verbal update on her engagements at the meeting.
Key Issues	None.
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	None
Legal Issues(including NHS Constitution)	None
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable Development	None
Patient and Public Involvement	None
Recommendation	**This report is provided for information only**
Author	Dr Helen Miller
Designation	Chair, Clinical Commissioning Gloucestershire
Sponsoring Director (if not author)	

Agenda Item 5

Gloucestershire Clinical Commissioning Group (Shadow Board)

18th October 2012

Chair's Report

1 Introduction

1.1 This report sets out some of the key activities of the Chair since the Committee last met.

1.2

- National Female Leaders Action Learning Set, Centre for Voluntary Action, Birmingham.
- Leadership Gloucestershire – Presented a briefing on Health and Wellbeing.
- CCG Shadow Board Development Session - Preparation for CCG Assessment Day.
- Gloucestershire Strategic Health Authority (SHA) Mock Panel.
- Gloucestershire Voluntary and Community Sector Health and Community Wellbeing Strategy Group.
- CCG Assessment.
- NHS Commissioning Board Visit.
- Shadow Health and Wellbeing Board.
- Your Health, Your Care Strategy Board.

2 Recommendations

2.1 This report is provided for information only.

Learning Disability Governance Board Update

The Learning Disability Partnership Board: Quality of Services in Gloucestershire

2012 - 2013

Gloucestershire COUNTY COUNCIL

NHS Gloucestershire

Expectations around next steps on Winterbourne View

- Serious Case Review on Winterbourne has been published by South Gloucestershire Council.

- NHS Review of Commissioning and CQC Internal Review are expected to be published imminently (early September) as restrictions due to criminal proceedings relating to Winterbourne View being lifted. These will contain key recommendations.

- It is anticipated that this will be high-impact information with significant levels of media interest, FOI requests and public attention.

- Dept of Health Interim Review and CQC National Overview of Learning Disability Services published in June 2012.

Areas of exposure

Gloucestershire COUNTY COUNCIL

NHS Gloucestershire

Out of County Service Users

A lesson from Winterbourne View is that people placed in closed establishments at a distance from their placing authorities are exposed to increased risk & vulnerability

- We have **71** Service Users placed outside of Gloucestershire, **62** funded by GCC and **9** by the NHS.

- We have an unusually high number of Service Users placed in Gloucestershire from other counties.

  In the **104** Residential Care Homes Gloucestershire-funded placements constitute **457** of the **916** bed placements. This means **50%** of beds are either vacancies or are filled with placements funded by other authorities.

  This does not represent the whole of the out-of-county population residing in Gloucestershire as we are aware of significant numbers living in Supported Living too.

- Neither GCC nor NHS Gloucestershire are regularly informed of when placements are made by other Local Authorities or PCTs.

Service Users with Challenging Behaviour

A lesson from Winterbourne View was that Service Users with challenging behaviour are particularly vulnerable

- There is statistically unsubstantiated evidence that Gloucestershire has an above-average population of Service Users with challenging behaviour, originating both from Gloucestershire and placed here by other counties.

<u>This perception comes from:</u>

- The views of experienced clinicians
- 1/3 of referrals to 2gether trust are for individuals with challenging behaviour from their case load of 1,200.
- We are aware of large specialist provision such as Stepping Stones Resettlement Unit, which has 64 beds only 5 of which are funded by Gloucestershire.

- NHS Gloucestershire are decommissioning 5 in-patient beds. The Winterbourne View Interim report reports that secure in-patient services run by the NHS are twice as safe as those delivered by private providers so the quality of services given to individuals affected by this will require close monitoring to ensure it is a positive step.

Historic lack of quality system in Learning Disability and Mental Health services

The Winterbourne View Interim Review (Department of Health, July 2012) stresses the responsibility of commissioners for the quality of services provided to their Service Users.

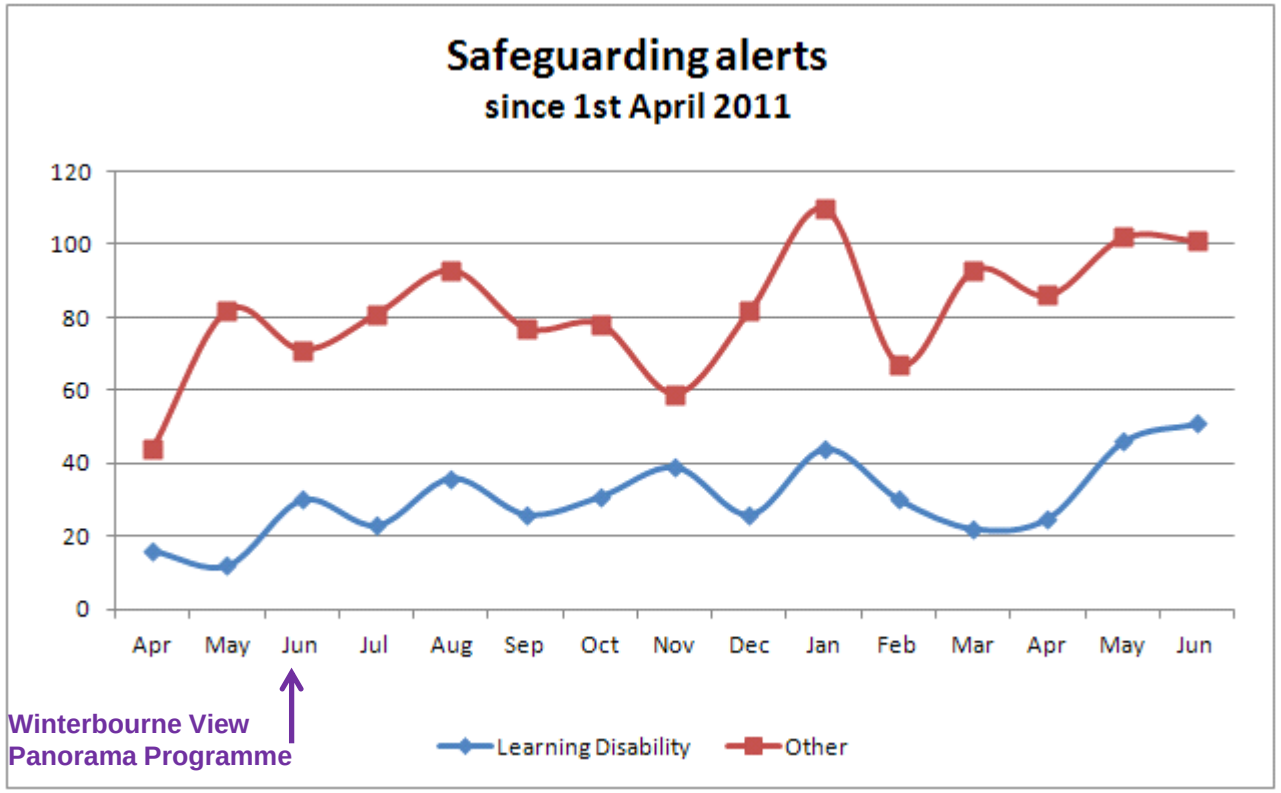
- The GCC Learning Disability Quality system until this financial year has been reactive rather than proactive. There has not been scope to undertake regular preventative action.

- We have very limited knowledge of some providers we use to purchase services

- The CQC has not inspected some of these residential homes and Supported Living placements regularly, in some instance for up to three years.

Safeguarding alerts and referrals are on the increase

- Safeguarding alerts for Service Users with Learning Disabilities have increased by **109%** since this time last year.
- Safeguarding referrals for Service Users with Learning Disabilities have increased by **212%** since this time last year.



	This year	Last year
Alerts	134	64
Referrals	53	17

Gloucestershire COUNTY COUNCIL

NHS Gloucestershire

Strategic initiatives in place in Gloucestershire to counter these exposure areas

Commissioning measures

- A specific challenging behaviour and complex needs procurement process is in place. This consists of a specific tender process and preferred provider list, reviewed and updated regularly and jointly between NHSG and GCC colleagues. Concerns identified by any party are immediately conveyed to partner organisations.

- Quality language is in place in spot-purchase contracts & can be used to support quality improvement as part of contract monitoring

- NHS Gloucestershire is a Pathfinder Clinical Commissioning Group. One of their focus areas is on tackling health inequalities to adults with Learning Disabilities, looking at challenging behaviour as a key focus area. (This is endorsed by the Department of Health Interim Review on Winterbourne.)

- Gloucestershire scored well on the SHA self-assessment for commissioners regarding quality of LD services.

Training

- NHS Gloucestershire are providing Positive Behavioural Support Training to:

- The staff at Westridge and Hollybrook.
- The providers supporting Service Users being discharged from these facilities.
- A 0.5 day general awareness course based on Positive Behaviour Support principles is being offered to all paid carers.
- There is a plan for further roll-out to parents.

- A plan for Positive Behavioural Support Training to be offered to providers is being developed by the GCC Workforce Development.

Safeguarding measures

- The Learning Disability Partnership is engaging with the Gloucestershire Safeguarding Board's annual plan.

- Safeguarding Event Chronology: Commissioners work with the safeguarding team to ensure patterns of safeguarding events are picked up on and responded to. This moves away from looking solely at single incidents and toward 'pattern recognition interventions'

- Embargo and Suspension: Commissioners regularly suspend or embargo resources from further placements where there are safeguarding issues or even where commissioners believe that an investigation warrants their full attention.

- Each person funded by NHS Gloucestershire has a named Clinical Case Manager (CCM), the primary element of their role relates to ensuring safeguarding of that individual whether placed in-county or out of county. The CCMs regularly liaise with the CQC and Safeguarding to provide quality assurance.

The CQC

- The CQC have visited the 3 assessment & treatment units in Gloucestershire as part of the 150 establishments similar in nature to Winterbourne View which they have recently visited.

- Actions Plans are being monitored where areas of concern have been identified (moderate concerns identified at Westridge , 2gether Trust [now fully compliant] and Stepping Stones Resettlement Unit).

- The Assessment & Treatment Unit in another county where there is 1 Gloucestershire Service User placed has also been visited.

Projects & Pilots in progress

- Out of County Initiative: GCC are currently reviewing **all** our out of county placements to ensure, in the first instance, the quality of service is appropriate, and secondly if possible to provide the placement back in County where appropriate quality monitoring will be regular and robust.

- Service Users are no longer being placed in other counties by Operations teams.

- Electronic monitoring pilot in place, evaluating the hours of care delivered by providers and comparing these against the funded hours and needs indicated by the Service User's Support Plan.

- An Intensive Support Team is being proposed by NHS Gloucestershire to deliver specialist community intensive support as advised by the Mansell Report, based on the model of the Birmingham Supported Living and Outreach Team (SLOT). The objective is to ensure people are sufficiently supported in the communities to avoid specialist placements or hospital admission and in the long-term to also create capable communities.

Quality Projects

The goal

- To ensure a robust implementation of quality measures in line with the learning from the Winterbourne Review (Department of Health).

The quality objectives

- To create an evidence based Quality Assessment Framework for services in Gloucestershire by the end of the year.

- To create a system which enables us to assess service user risk effectively and ensure their safety.

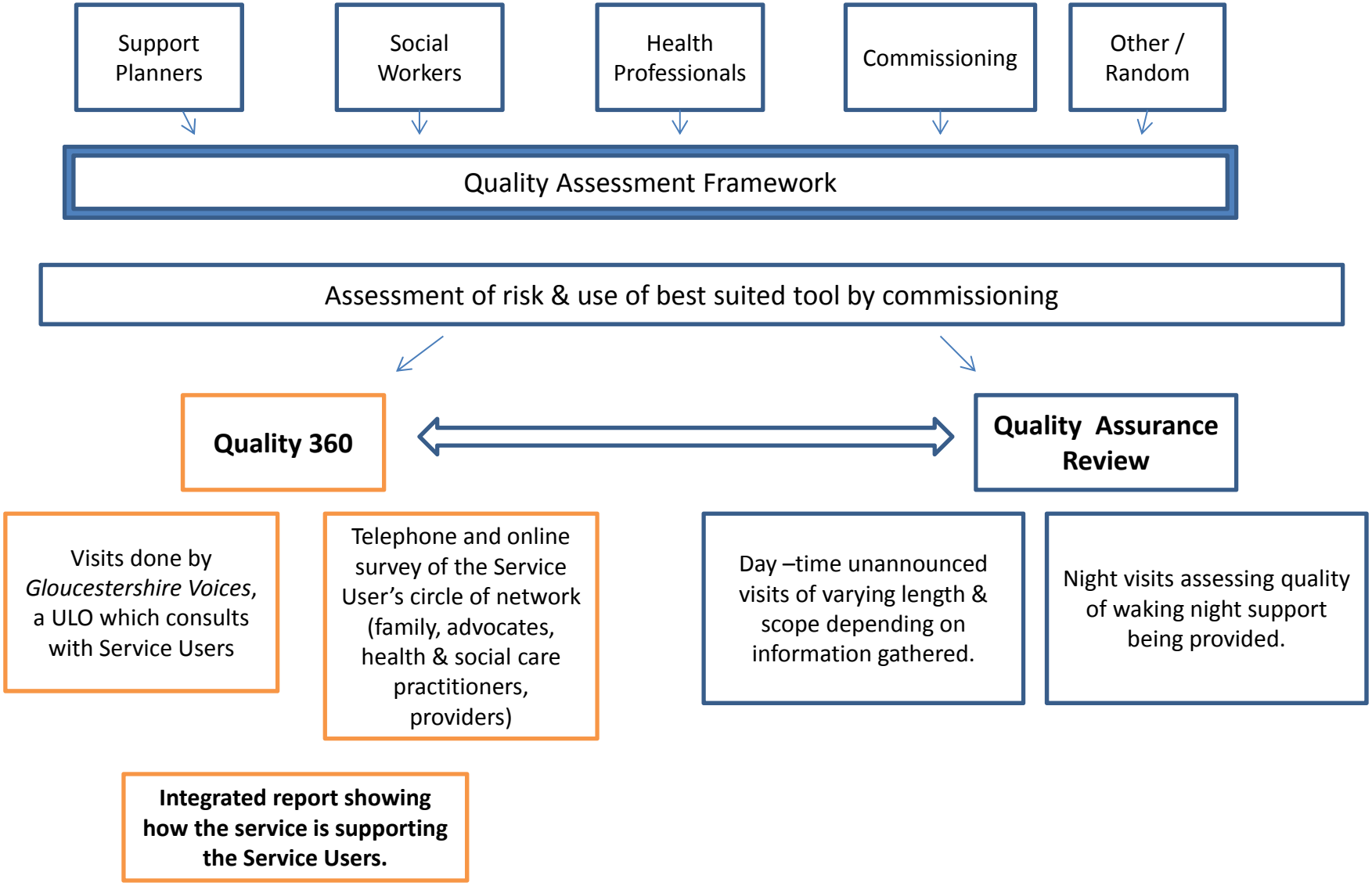
- To gradually extend the quality measures across the full spectrum of Learning Disability services, starting with closed settings: Assessment and Treatment Centres →Residential Homes → Supported Living → services purchased via SDS → community based support.

- To ensure we involve Service Users who are residing in Gloucestershire but funded by other authorities to the best of our ability.

- To create a high performance culture amongst providers in the county.

The components of the project (July 2012)

•The Quality Assessment Framework aims to reach as many providers as possible. Providers are chosen for a quality project both at random to find out more information and by referral following a concern.
•A range of information sources are used to ensure the quality project used is suitable for our perceived level of risk of the provider and to be the best form for capturing the kind of information we think we want to obtain.
•Quality projects can refer to one-another and be used to validate findings or verify performance improvement.
•Projects will change and develop with learning over the year.



Quality 360

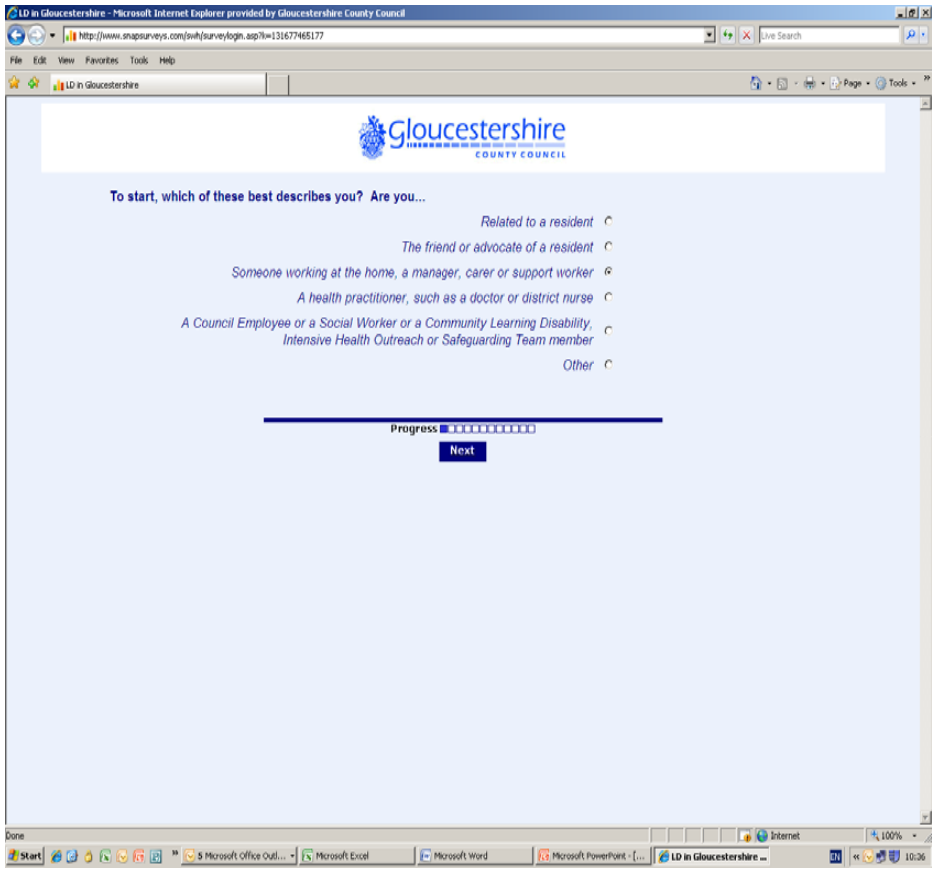
Social well being means being able to go out and about and meet friends

Can your friends visit you here at anytime?

Do you visit your friends?

Can your friends go to your room?

Do you have a boyfriend or girlfriend?



Consultation with Service Users by trained Quality Checkers employed by Gloucestershire Voices, a User-led organisation.

There is an alert mechanism built in that links straight to the commissioning team when concerns are raised.

Gloucestershire COUNTY COUNCIL

NHS Gloucestershire

Quality Assurance Reviews

Quality Assurance Reviews assess the quality of service delivered by the home against the following areas:

- The home is pleasant, comfortable, safe and well maintained place to live
- The people living in the home live meaningful and enjoyable lives and achieve outcomes which matter to them
- The home demonstrates a personalised approach to delivering care and support
- The home supports people to be independent, make choices and be in control
- The staff and managers working at the residential home carry out their jobs well
- People are treated with dignity and respect
- Records, processes and procedures are of a high standard
- People living in the home are safe and free from discrimination and harassment
- People living in the home are healthy

The tool can be used has flexibly and has:

•An initial checklist which can trigger further assessment
•A second part to gather more in-depth information
•A night visit checklist which can be incorporated in a Quality Assurance Review or carried out in isolation

For more information please contact:

Agy Pasek – agy.pasek@gloucestershire.gov.uk

07912 889146

Agenda Item 7

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	18th October 2012
Title	Carers Commissioning Strategy
Executive Summary	In September 2012 the Gloucestershire Clinical Commissioning Group received a report outlining proposals for the future commissioning of services to support carers in Gloucestershire. Based on that report the CCG: 1. Agreed 'in principle' to continue to fund carers' support services at current levels. 2. Agreed 'in principle' to support the JCPB decision for carers' services to be jointly commissioned between NHSG [CCG from 1 April 2013] and GCC, and led by GCC. 3. Agreed 'in principle' to support the JCPB decision that a joint NHSG and GCC carers' support budget should be established, managed by GCC. 4. Agreed 'in principle' to extending the existing NHSG [CCG from 1 April 2013] carers' support contracts and grants for 6 months from 1st April to 30th September 2013. 5. Nominated a CCG member as Carers' Clinical Lead to join the Carers Commissioning Project Group and participate in the development of the new service specifications and the tendering process. The September report explained that a

	Joint Carers Commissioning Strategy was being developed and that this would be presented to CCG and Gloucestershire County Council Cabinet in October 2012 for approval. This paper therefore presents the Joint Carers Commissioning Strategy for approval. The Strategy sets out the following: • Definition of a carer • Policy and Legislation • National research and evidence about caring • Local Context • Consultation with carers • Provision of services • Carers Assessments • The Way Forward • Proposed Service Remodelling o Carer advice and support service o Carers support planning o Carers breaks provision o Carers emotional support o Remodeling of existing in house services (GCC) • Future Funding Strategy
Key Issues	Agreeing 'in principle' the future approach to the Commissioning of Carers Support services as set out in the Joint Carers Commissioning Strategy. Agreeing to recommend to the NHS Gloucestershire and NHS Swindon Cluster Board that the strategy be formally adopted.
Risk Issues:	Failure to secure robust and sustainable

Original Risk **Residual Risk**	arrangements for commissioning of carers support services could lead to inadequate support for carers. This could result in increased break down of caring arrangements leading to increased pressures and escalating costs on statutory health and care services. Likelihood Severity Risk Score 3 4 12 1 4 4
Financial Impact	Continued funding for carers support funding at current levels (approximately £1.06 million per year) for the next 5 years (approximately £5.3 million in total). Significant cost avoidance for health and care due to caring roles being maintained for longer. It is calculated that in Gloucestershire, the estimated 61,500 carers, provide savings for the county's health and care services of approximately £997.2 million per year. Improved cost effectiveness through joint commissioning, resulting in reduced duplication in the commissioning of services and management of contracts.
Legal Issues(including NHS Constitution)	
Impact on Equality and Diversity	Equality Impact Assessment completed. All carers including adult carers, parents caring for children with disabilities and children and young people with caring responsibilities will be included in the carers commissioning strategy. All identified impacts on individual groups

	are considered to be either positive or neutral.
Impact on Health Inequalities	The carers support contract specifications will include requirements to focus support for those carers in the greatest need.
Impact on Sustainable Development	The carers support contract specifications will encourage collaborative working arrangements between voluntary and community sector providers in order to establish an infrastructure of support which is mutually beneficial and more resilient than current arrangements. The contracts awarded will be for a longer period than is currently the case, allowing for greater stability for providers and service users.
Patient and Public Involvement	Extensive engagement with local carers has been undertaken in relation to the types of services that are beneficial in supporting their caring role. Specific consultation with a broad range of carers during August 2012 in relation to how and where carers support should be delivered.
Recommendation	The Gloucestershire Clinical Commissioning Group is asked to: • Approve 'in principle' the Joint Carers Commissioning Strategy • Recommend to NHS Gloucestershire and NHS Swindon PCT Cluster Board that the Strategy be formally adopted.
Author	Becky Parish
Designation	Deputy Director Patient and Public Involvement
Sponsoring Director (if not author)	Jill Crook, Director of Nursing

Agenda Item 7

Gloucestershire Clinical Commissioning Group
(Shadow Board)

13 September 2012

Joint Carers Commissioning Strategy (2013-2016)

1 Introduction

1.1 This paper introduces the Joint Carers Commissioning Strategy (2013-2016) for Gloucestershire.

1.2 This paper seeks 'in principle' agreement from Clinical Commissioning Gloucestershire to a set of Recommendations set out below.

2. Background

2.1 This is the first Carers Commissioning Strategy for Gloucestershire and jointly been developed Gloucestershire County Council (GCC) and NHS Gloucestershire (NHSG).

2.2 The aim is to provide a strategic framework for the future commissioning of carers support to deliver agreed joint priorities. The Strategy takes into account the views of local carers in Gloucestershire. The Strategy relates to all carers to ensure a consistent and streamlined approach.

3. Joint GCC and NHSG Carers Commissioning Strategy (2013-2016)

The Strategy sets out the following:

- Definition of a carer
- Policy and Legislation
- National research and evidence about caring
- Local Context
- Consultation with carers
- Provision of services
- Carers Assessments

- The Way Forward
- Proposed Service Remodelling
    - Carer advice and support service
    - Carers support planning
    - Carers breaks provision
    - Carers emotional support
    - Remodeling of existing in house services (GCC)
- Future Funding Strategy

The Strategy can be found at Appendix 1.

4. Recommendations

The Clinical Commissioning Group is asked to:

- Approve ‘in principle’ the Joint Carers Commissioning Strategy
- Recommend to NHS Gloucestershire and NHS Swindon PCT Cluster Board that the Strategy be formally adopted.

Appendix 1

Joint GCC and NHSG Carers Commissioning Strategy 2013-2016 - Draft

Joint GCC and NHSG Carers Commissioning Strategy 2013-2016 - Draft

1. Introduction

Gloucestershire County Council and NHS Gloucestershire recognise the contribution unpaid carers make to society and the value, financial and otherwise, of the work they do in caring for those who could not manage without their help and support.

This is the first carers commissioning strategy for Gloucestershire and jointly been developed Gloucestershire County Council (GCC) and NHS Gloucestershire (NHSG). The aim is to provide a strategic framework for the future commissioning of carers support to deliver agreed joint priorities. The strategy takes into account the views of local carers in Gloucestershire. This strategy relates to all carers to ensure a consistent and streamlined approach.

2. Who is a carer?

Whilst there is no single definition of carers, the National Carers Strategy "Carers at the Heart of 21st Century Families and Communities" (2008) states that;

"A carer spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems".

and

"Carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen"

Recognised, Valued and Supported: Next Steps for the Carers Strategy (2010) acknowledged that carers are the largest support provision for disabled and vulnerable individuals and therefore contribute to the notion of the "Big Society". It identifies clear outcomes and sets out a vision for local authorities and NHS services to support carers in their caring role. These outcomes are;

- Carers are respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.
- Carers will be able to have a life outside their caring role,
- Carers will be supported so that they are not forced into financial hardship by their caring role
- Carers will be supported to stay mentally and physically well and treated with dignity
- Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods.

3. Policy and Legislation

A key driver for transforming social care is 'personalisation' and providing greater opportunity for individuals to have more choice, independence and control over their support. The main themes around personalisation are prevention, stronger communities, and active citizenship. The relationships between carers and cared for are inter-linked meaning these themes are of equal importance. A personalised approach to supporting carers relies on:

- Carers being recognised as experts and genuine partners in all levels of service design and delivery.
- Carers being able to design and direct their own support, access direct payments and being involved in the assessment and support planning of the person they care for where appropriate.
- Integrated support planned around a whole family approach.
- Recognition of the emotional and social impact of caring.
- The development of a range of support for carers which reflects the diverse needs of carers and the outcomes they want to achieve.

(Carers and Personalisation: Improving Outcomes- DOH 2010)

Well developed personalisation promotes stronger communities and active citizenship. Commissioning is moving towards promoting positive hospitable communities for disabled and vulnerable people, this would also have a positive impact on the quality of life of carers. Organisations and communities are supported to develop these new ways of working through inclusion training, and moves towards community partnership commissioning.

The NHS Operating Framework 2012/13 states that: *"PCT clusters need to agree policies, plans and budgets with local authorities and voluntary groups to support carers"* and that plans should:

- Be explicitly agreed and signed off by both local authorities and PCT clusters;
- Identify the financial contribution made to support carers by both local authorities and PCT clusters and any transfer of funds from the NHS to local authorities.
- Identify how much of the total is being spent on carers' breaks.
- Identify an indicative number of breaks that should be available within that funding.

The Equality Act 2010 protects carers against direct discrimination or harassment because of their caring responsibilities. Carers are counted as being 'associated' with someone who is protected by the law because of their age or disability. Ensuring equality means ensuring opportunity for all carers to access suitable resources and support. The act means that carers will be recognised as individuals, respected and supported with regard to their caring role regardless of age, gender, disability, class, race, culture, diversity or sexual orientation. It also includes protection where carers are discouraged or prevented from using a service because they are caring for a disabled person.

4. National research and evidence about caring

Carers may not always identify themselves as carers and thus remain “hidden” from services that may advise, help and support them in their role. It is estimated that there are currently 6.4million carers in the UK, this equates to 1 in 8 adults. These individuals make a valuable contribution to their communities. Over 3 million are juggling paid employment and caring. By 2037 it is estimated that there will be over 9million carers in the UK. National research has indicated that there are almost 700,000 young carers aged under 18years. Nottingham University (2010) found that 1 in 12 secondary school children hold moderate or high levels of caring responsibilities.

According to The Princess Royal Trust (now The Carers Trust) and Carers UK the economic value of carers’ contribution to support and maintain the health and well being of the person they care for, equates to £119million per year. This is an average yearly contribution per carer of £18,473. The impact of carers not continuing to make this contribution would increase the demand on NHS and social care support. Carer breakdown can result in increased demand and cost on services such as hospital or residential admissions.

Nationally, the population is expected to reach 71.6 million by 2033, with 23% of people being 65 or older. The peak age for being a carer is 45-64 (Carers UK) which is the time when people tend to be at the height of their careers. Becoming a carer can impact negatively on their own economic security, as many carers have to adjust working hours, turn down promotion or give up work altogether to care for an elderly parent. Likewise the business community could be affected as the numbers of working age carers grow. This growth could mean difficulties in recruiting and retaining suitably qualified and experienced staff.

When people become carers, their opportunities for leisure and relaxation can be impacted leading to negative consequences for their health and well-being. Research has shown that carers are twice as likely as non-carers to develop ill-health (“In Poor Health” Carers UK 2004.) The increase in numbers of carers could mean an increase in health problems among the carer population.

5. Local Context

The number of adult carers in Gloucestershire is likely to be identified in the 2011 census is estimated at 61,500, providing savings for the county of about £997.2 million. In 2011 through the on-line pupil survey 1,843 young people identified themselves as young carers.

It is estimated that the county’s population will increase by an average of 3,100 people per year over the coming years reaching 674,000 by 2033. The demographic profile of the

county will also change. The number of older people (65 plus) will grow by two-thirds, reaching a total of 187,600 by 2033. In contrast, the number of children and young people (0-19) will decline by about 7,500. The number of working-age people (20-64) is projected to have only a marginal increase. It is likely that there will be

- A significant increase of older carers looking after a spouse or partner.
- A significant number of working age adults struggling to support parents while holding down a job.
- Carers of all ages in the caring role for longer periods of time.
- More parent carers looking after a child with very complex needs for years.
- More parents of an adult child with a disability, caring well into their 80s and 90s.

6. Consultation with carers

A range of information has been collected locally from carers about the type of services which support them, which services they most value, what improvements are needed and where the gaps in support are. In 2009/10 national and local consultation with carers indicated following as important supports:

Breaks from caring
Carers felt these need to be flexible and tailored to meet individual needs and provided in a variety of ways e.g. with or without the person being cared for and organised so that they benefit the carer and the person they care for. Quality time with the cared for was considered crucial (while someone picks up the caring role) to maintain the relationships. Breaks should be accessible to all carers and able to meet specific cultural needs.

Emotional support
Carers felt much emotional support can be gained from professionals increasing their understanding of carers. Carers who felt they were listened to and valued generally felt they were supported emotionally. However carers identified a need to have to access more specific emotional support at different stages of the caring role e.g. counselling, peer support, coping skills and carers groups.

Appropriate advice, information and advocacy.
Carers felt access to appropriate information and advice in a timely manner was vital. Carers often go back to organisations time and again. Carers have been involved in GCC led work examining experiences of adult social care assessment process. This has highlighted the need for support planning through all stages of assessments including those for carers.

Services to maintain carers' health and well being.
Support which enables carers to balance their caring role with other aspects of their life (work, relationships, leisure and their own health) is essential, promotes life chances and is

valued by carers. Carers Emergency Support, flexible services and GP awareness are particularly highlighted by carers as important. Recent feedback from carers who have accessed flexible carers' budgets demonstrates that this is well received and achieves the outcomes identified by carers as needing themselves.

Practical caring skills and looking after yourself
Dealing with the practical and emotional aspects of caring and looking after oneself can often be overlooked, carers report these can often be important elements to the sustainability of a caring role. Evidence from the Caring with Confidence and Positive Caring Programmes show that carers benefit greatly from support with this, enhancing their lives and those of the person they care for.

Support for young people with caring responsibilities
Young carers stated that they find specialist services more appropriate as there is an understanding of their situations and issues. Group activities, forums and training and information within the context of the whole family approach were considered important.

BME Carers
A specific BME carers event in October 2011 highlighted that carers felt services should be sensitive, appropriate and innovative to meet their needs. They felt organisations have not been consistently proactive and approaches have been ad-hoc. Carers felt more could be done to establish a strong effective BME network. Many carers who attended were not aware of personalisation and personal budgets, those who did expressed concern about the assessment process and the lack of culturally appropriate services.

Recent workshops in August 2012 focused on key areas: Individual Budgets, accesses to information and advice, support in GP practices, emotional support, training and having a voice.

Individual Budgets
Carers had limited knowledge of what these were but carers did feel that it would be useful to be more in control of how their needs could be met and would use it to improve their health and well being and reduce stress. Carers did feel that the process would need to be straightforward and thought that having the option of some support being available if they need guidance or advice would be helpful.

Support in GP surgeries
Carers were keen to see opportunities such as the carers' register in GP surgeries developed further and extended. They highlighted the key role primary care staff have in identifying and responding to carers at an early stage. Practical suggestions included health checks, carer clinics with an advice worker, flexible appointments, double appointments, a carers card and fast track referrals from GP to social care if required.

Emotional Support and resilience
Carers felt that 'going for counselling' could be stigmatising so this should be called something else and be provided at a neutral venue. It was agreed that emotional support was important and could be through a group, a one to one in a more relaxed environment and formal counselling if required.

Access to information and advice
Many carers felt there was too much information at one time but generally the view was that information was needed as early on as possible. This information should be given from the most appropriate person at that time and be someone that they can go back to later on.

Additional training to be included in the Positive Caring Programme
Suggestions included first aid, hygiene and nutrition, moving and handling, dealing with emergencies, legal matters, employment and benefits.

Having a voice
The majority of carer agreed that meetings should be local rather than countywide. A small number also felt this should have a link to HealthWatch. It was suggested that each local area can nominate a carer to attend a countywide meeting with relevant commissioners and other stakeholders.

Young carers
Following 2 specific young carers workshops the support for the person they care for again was highlighted as important in their overall support, also being recognised by professionals, and activities which enable them to meet other young carers.

The on line pupil survey 2012 had responses from 1,843 young people who identified themselves as young carers. Overall their responses were positive about their life and experiences, 41.9% were overall satisfied with their life, 65% stated that caring for someone makes them feel good about themselves. However 59.4% said that they worry about the person they care for, 22% stated that because of their caring role they miss out on friends, 32% said they feel tired and 13.4% stated that they feel lonely.

Consultation with carers from BME and condition specific carers groups has been included as part of the most recent consultation. However it is evident that this is an area which will require more development, as whilst some BME groups are fully engaged others are less so.

7. Provision of services

Currently carers can access services in 3 ways:

- By paying for them themselves
- By using GCC funded services
- By using a flexible budget.

There are a number of providers who are commissioned to provide services through a block contract or small granted funded by GCC or the NHS. There are also a number of organisations funded through other GCC and NHS sources which benefit carers, for example the range of short breaks provision for disabled children and their families.

The types of service and relevance to carers vary. Some services provide more flexibility than others,

- 5 organisations provide breaks for carers by offering support in the home.
- 5 provide more traditional provision such as day centres in order that carers get a break.
- 3 provide person centered support/activities to the cared for person and the carer.
- Carers Gloucestershire and Gloucestershire Young Carers provide a range of countywide provision advice, support and activities other than breaks..

Services are not necessarily aligned to carers aspirations and expressed support needs, for example maintain education or employment. Likewise emotional or behaviour support such as counselling/ one to one emotional support is not currently widely available. The move towards delivering outcomes in the National Carers Strategy would ensure these are addressed. There are about 52 carer support groups which are facilitated to some degree through Carers Gloucestershire. This group facilitation forms part of a larger contract. The purpose, effectiveness, consistency and popularity with carers of these groups varies.

The extent to which current service provision meets the needs of under-represented carers eg BME and those that care for people with a learning disability is not fully known at this stage.

Carers value the reassurance that should something happen to them in an emergency, which means that they are unable to care, someone will help. Currently GCC commissions Worcestershire Telecare in partnership with Carers Gloucestershire and GCC to provide emergency cover should this be necessary. Detailed emergency plans enable the cared for persons needs to be met quickly in the home, reducing unnecessary hospital admissions or emergency residential placements. Emergency plans have also been developed with Young Carers through Gloucestershire Young Carers. However the long term cost effectiveness of these arrangements as they are currently arranged is questionable.

The use of flexible budgets (currently up to £500 per person per year) has increased and is popular with carers. Access is through a carers assessment and can be used for support defined by the carers as helping to sustain their caring role and/ or promote their health and well being. This has been used creatively and there is potential to expand this provision. The use of individual or personal budgets is developing within the parent carers groups and through the use of BHLP (Budget Holding Lead Professionals). More fundamental work to develop personal budgets for all carers is yet to be developed. A carer's resource allocation system is not yet available.

8. Carers Assessments

The level of assessment of carers in Gloucestershire is variable. Carers' assessments are completed by GCC and NHS staff. The current pathway for carers needs to be redefined to ensure it is clear and consistent. Good practice is evident in some areas. However it is evident that certain carer groups are under-represented:

- Learning disabilities
- Mental Health
- Palliative carers
- Young carers.

There is some anecdotal evidence through feedback from providers and carers themselves that the level of assessment of BME carers is too low. Which BME groups are underrepresented and whether they go on to access services is not known.

Families who care for children with disabilities are assessed by children's services. They can, if they feel this is not sufficient, have a separate carers assessment in their own right. Young carers are usually assessed using a CAF,(Common Assessment Framework) however young carers who are aged over 16 are entitled to a carers assessment. Good practice would suggest that this is completed jointly between adults and children's services, with adult services taking the lead. Very few have been completed to date. Monitoring systems to assess the quality and numbers of assessments for carers of adults are well developed, less so for those who care for children or for children who care.

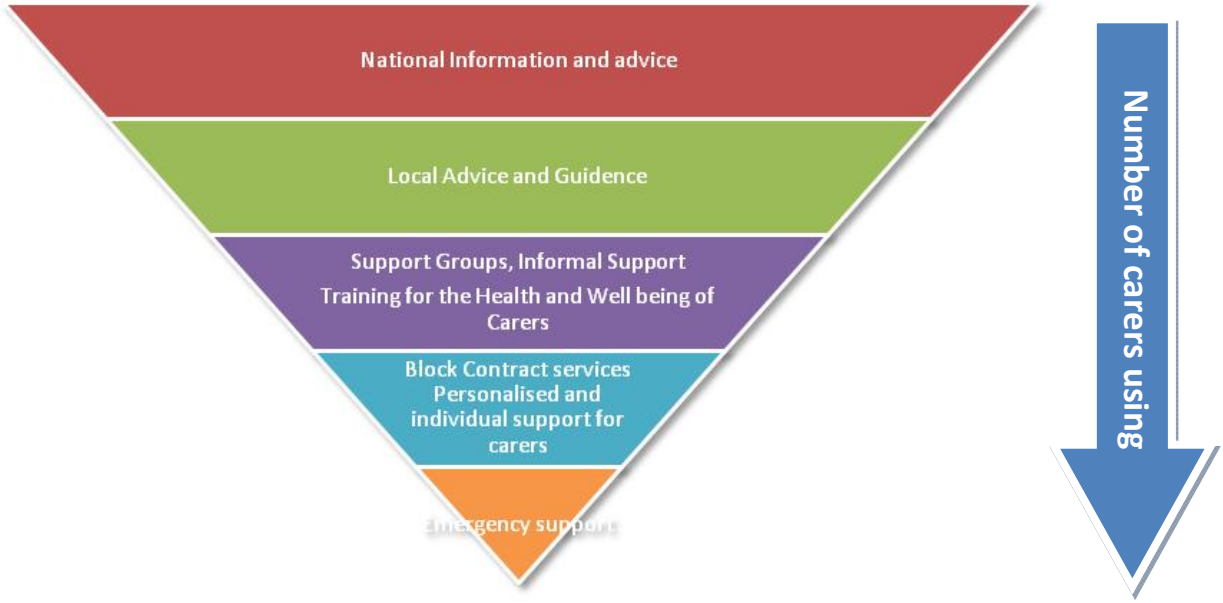
Previous consultation with carers about carers assessments has indicated the process is not always seen as a positive experiences, eg issues around consistency, forms not being followed up if left with carer, and lack of clarity from the worker about the purpose of an assessment.

9. The Way Forward

The joint GCC/ NHSG aspiration for carers is that they are supported in their caring role by accessible advice and guidance and good quality, services that offer value for money.

Service provision for carers has evolved over a long period of time, since the ring fenced carers grant was established following the National Carers Strategy in 1999. Previous funding routes and the way in which services have developed have resulted in a pattern of provision which is patchy and does not respond to the views of carers or changing national policy. Separate GCC and NHS Gloucestershire funding streams have resulted in a lack of coherence with duplication and inconsistency in support. While there are examples of good practice, support needs to be more accessible locally, more flexible and personalised. In

particular GP practices need to be able to access support for carers more effectively given their role as a crucial point of contact. There is a need to establish a clear carer's pathway to assessments and support.



National information and advice

There are many ways individuals can access information relating to carers. Many national organisations will provide carer specific information as such as Carers UK helpline, The Carers Trust and Young Carers Net and Carers Direct. It will be important that carers are informed of organisations that can provide information.

Local Advice and Guidance

Locally, there are a number of providers who are contracted to provide individuals with information and advice and it is important to ensure that this is not duplicated. Carers identify that information and advice is important to them but getting this at the right time is what makes the difference. Carers do need specific advice and advocacy at times and this will continue to be part of the overall support for carers, however it is crucial that this has is reshaped in order to reduce duplication and address identified gaps. These services should be accessible to all carers at point of need.

Support group, informal support, training for health and well being for carers

Emotional support is currently provided on an ad-hoc basis and is often a by-product of the service rather than the service itself. To provide carers in the future with support to sustain them in their caring role, it is vital that emotional support and support for carers' health and well being is included within the remodelling of carers support. This can be provided through

existing carer groups or short term counselling provision for those carers who are assessed as needing this.

GCC delivers the Positive Caring Programme which is available to all carers. It is a 6 session course that helps carers to obtain support, receive information about local services and develop coping skills/problem solving tools, remain healthy and consider planning for future. Courses are arranged according to locality, condition of the person being cared for or cultural/language needs. Young carer specific sessions have been developed with Gloucestershire young carers. There is good take up 740 carers have completed the course since April 2010 and feedback has been positive. Carers are encouraged to establish ongoing support networks following completion of the programme, support to establish their own carers' group is available. It sits well in the prevention agenda and case examples demonstrate the programme has reduced the need for high level, complex support. The course costs £200 per carer. This programme will be developed in order to enable carers to access further more mainstream education and leisure opportunities through signposting onto other relevant organisations.

GP surgeries could also play a pivotal role in this area, currently there is limited support for carers other than surgery link (volunteer service where individuals ensure carers' information in GP surgeries waiting rooms is kept up to date) and there is a strong argument for this being a main area for development.

Individual, personalised and culturally specific support

Breaks continue to be a crucial way for carers to access support; however the type of support and how this is shaped by individual carers will need to be developed. Developing Individual Budgets will provide flexibility and increasingly the types of breaks and support will be shaped by carers themselves. The Carers flexible budgets service has provided a good template to develop individual budgets for carers. Carers who have accessed this have been able to decide themselves how their needs can best be met. Feedback from staff and carers has been positive and demonstrates the flexibility this approach offers. The next step will be to maintain block contracts whilst enabling more carers to have individual budgets.

Emergency or Crisis Help

Nationally and locally emergency support for carers must be an integral part of support to carers. Currently the Carers Emergency Scheme has been successful in delivering this support across the county. It is a partnership between GCC, Carers Gloucestershire and Worcestershire telecare. Feedback from carers indicates the assessments and emergency plans completed are good quality and that the service gives carers peace of mind and reduces their stress. However the high cost of this provision means that it is important to look at how this can be provided differently. One approach is to provide it as part of in house provision with detailed contingency plans completed at the same time as the initial carers

assessments. This would mean existing providers identified on these plans would provide any emergency support should it be required by the carer.

10. Proposed Service Remodelling

Joint GCC and NHSG offer to carers

This proposed model is encapsulated within the offer for carers below stating that GCC and NHSG will;

- Ensure carers have appropriate and timely advice and support
- Ensure carers have access to take an Individual budget
- Ensure carers have appropriate support to access the services they need
- Ensure that flexible breaks provision is in place to meet the needs of carers and their families
- Ensure that support is available to carers to help maintain their health and well being
- Ensure the carers are supported in their caring role.
- Ensure that carers have opportunities to maintain a good quality of life

Contracts to be tendered

The following are the proposed contacts which would be tendered. All of these services will include Young carers and Parent Carers.

Carer advice and support service

This service will provide advice and support as an outreach service in localities. Individual workers to work directly with carers providing information and advice through venues in the community, such as GP practices, community centres and other bases will be a feature of this contract. Specific support and activities for young carers and parent carers will be part of this tender. There will be a focus on enabling young carers to plan and promote their life opportunities and linking them to other organisations and services for example, youth support service, education and further higher education. This service would improve the support around important transitions throughout a carers life.

Carers support planning and assessments

This service will work with the full range of carers and Multi Disciplinary Teams to complete some carers assessments and work with carers following assessment. This service will work with carers to complete their contingency plans for emergencies, and help carers decide how they want to use their individual budgets. They would advocate on carer specific issues where required.

REPLACEMENT PAGE – Amendment made following dispatch to printers.

Carers breaks provision

Breaks will need to be flexible to meet the requirements of carers and those they cared for. It will include all carers, and so specialist dementia provision could be provided as well as support for parent carers. It will provide a more whole family focused approach to support. This could be co-ordinated through each locality or provided on a countywide basis. This could be a framework agreement incorporating a cost and volume element. To incentivise providers engagement with personalisation the contract could also operate as an umbrella arrangement such that any provision that has moved to direct payment during the year will offset the staged reduction in contract size at year end. It will need to include provision for condition specific support for marginalised carers and emergency care to deliver to carers emergency plans.

Carers emotional support

This service will provide a range of emotional support to carers from short term counselling to peer befriending services and carers support groups. Ensuring carers have access to the emotional support they need at the right time. Work will need to be undertaken to make sure that groups across the county are supported to run effectively.

It is anticipated that the small grants programme for BME groups will remain in place to enable more targeted engagement with carers from different communities.

Carers Voice

There is a need to ensure that carers across the spectrum have a strong voice and are able to influence commissioning and provision. We want to see carers views shaping services and contributing to reviews and monitoring of services. There are currently different mechanisms for carers views and consultation, these should be brought together to work towards a carer led organisation or forum. Any such arrangements need to reflect the needs of different localities and interests e.g. young carers. This would ensure a strong carer representation is developed. This new approach needs to be separated from direct services and support. It could be developed initially by the GCC carers team or commissioned as a separate contract**.**

Remodeling of existing in house services

It is proposed that the Carers Emergency Service is moved into mainstream provision addressed initially at the point of the carers' assessment and that the emergency plans are completed by the carer support planners. The service response would be coordinated

though out of hours teams who would action the contingency plans as required. The carers' team would continue to promote this service with staff.

GCC carers team has been successful in ensuring that the joint GCC and NHS carers actions plans have been delivered to demonstrate that Gloucestershire was working to deliver the National Strategy Outcomes. The role of the team in the future should focus on development and change management to ensure the whole system is working to meet the needs of carers. The work of the team will focus on:

- **Increase individual budgets.** The need to increase individual budgets is evident, however this will need to be a gradual staggered approach, with careful oversight, administration and governance of spend. The team will work with staff to ensure that the carer pathway is developed and to audit the performance and quality of carers' assessments throughout the county to ensure good practice is promoted. They will also work with staff to ensure carers are recgonised as equal partners in care who have the skills, knowledge and experience to contribute to the process.

- **Training for carers.** The current positive caring programme is a successful service and is currently relatively inexpensive. It will be offered to all carers at the identification stage. It will be expanded to reflect carers' views about the knowledge and skills they feel are important and will continue to reflect wider service user training such managing memory and the expert patient programme.

- **GP Practice support service.** Putting in place developing pathways between GP, primary care and GCC staff. Systems to maintain carers' registers, access to carers' assessments and individual budgets will form part of the team remit. The team will also need to ensure new pathways link into the wide range of support available across all sections including VCS.

11. Future Funding Strategy

GCC and NHS Gloucestershire currently commit around £3 million in total to support carers, NHSG commit £1.061million and GCC £1.998 million. Taking into account the changing needs of carers and national drivers it is important that this money targets carers in most need and ensures that support is robust to meet these needs.

Given the anticipated rises in the number of carers, the changing demographic profiles and issues such as increasing inter-generational and mutual caring, future cost pressures are anticipated. This strategy seeks increased cost effectiveness of current services, better targeting of spend and efficiencies in delivery and infrastructure of carers support. This is addressed in the following ways:

- Move towards personalisation and individual budgets, offering defined predictable amounts of spend per carer, whist increasing choice. National and some local evidence indicates better value for money being achieved.
- Improved more efficient identification and streamlined processes through, for example, primary care will offer some process efficiencies.
- Investment in developing robust infrastructure and processes, for example, through improvement in rates and quality of carers' assessments, leading to better, more informed targeting and more family and community focused solutions to carers' needs.
- Joint more structured approach to commissioning services offering more clarity to providers of the services required, reducing duplication of services and offering the opportunity for more reshaping directly by carers through their individual choices.

The following table is the proposed allocation of funding for carers support services for 3 years with an optional 2 year extension. This would enable the development and gradual transition to Individual budgets. The table highlights which services will be tendered, budgets managed by carers themselves and which will be provided in house

Support	**Contract/ In-House**	**Approx Allocated Budget £**
Local Advice and Guidance		
Carers Support Planning and assessment	Contract	400,000-700,000
Carer advice and support service- including young carers provision	Contract	400,000-700,000
Support Groups/informal support/ carers training/ health and well being for carers		
Positive Caring Programme	In-house GCC	60,000- 70,000
Emotional Support	Contract	200,000-300,000
Carers Voice	TBD	40,000-50,000
GP Practice/carer pathway support including assessment	In-House GCC	170,000-190,000
Block contract services, personalised and individual support for carers		

Countywide Breaks provision for all carers	Contract	800,000-1.000,000
Individual Budgets- for the first year.	Direct to carers	255,000
Culturally specific support and condition specific support	Small grants	£109,000
Emergency and Crisis Help		
Emergency Budget- service to be absorbed into mainstream provision and carer specific support	In- House GCC	£30,000
	Total range	**2.464,000-3.404,000**

It is anticipated that services would be in place by September 2013. The existing joint Carers Commissioning Steering Group will monitor progress of the strategy and resulting services provided.

References

Commissioning for carers: An action guide for decision makers – ADASS and PRT et al 2009

Commissioning better outcomes for carers- and knowing you have – ADASS and PRT 2010

National Carers Strategy Refresh-recognised, valued and supported -DoH 2010

Gloucestershire Carers Strategy -Revised 2011

Gloucestershire Carers Survey Report- Gloucestershire County Council 2009/2010

NHS Operating Framework - DoH- 2011

National Carers Survey Report – DoH 2009/2010

BME Carers Exclusion before Inclusion Report- Gloucestershire County Council 2011

Carers and Personalisation – Improving Outcomes DoH 2010

In Poor Health - Carers UK, 2004

Valuing Carers: Calculating the value of carers support -Carers UK 2011

The Equalities Act 2010- What do I need to know as a carer –Govt Equalities Office 2010

Agenda Item 8

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	**18th October 2012**
Title	**Quality assurance during the transition**
Executive Summary	This paper has arisen from discussions in the Commissioning for Quality Group about the need to maintain a robust quality assurance process during the transition and also to develop new systems that meet the statutory responsibilities of the new organisation (the Clinical Commissioning Group).
Key Issues	Future governance arrangements Roles and responsibilities Lines of reporting and accountability
Risk Issues: **Original Risk** **Residual Risk**	Uncertainty and lack of assurance
Financial Impact	None
Legal Issues(including NHS Constitution)	Range of compliance issues with statutory duties.
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable Development	None
Patient and Public Involvement	Patient experience is one of the three domains of quality referred to in this report – *quality care is care which looks to give*

	the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what an individual wants or needs and with compassion, dignity and respect.
Recommendation	It is recommended that Clinical Commissioning Group (CCG) endorse the proposed approach as a broad direction of travel. Subject to the agreement of CCG more detailed proposals will be brought forward, including: • Roles and responsibilities of the Quality sub committee • Quality assurance strategy • Reporting structures • Governance frameworks
Author	Heather Beer Dr Charles Buckley
Designation	Senior Clinical Development Manger CCG Member
Sponsoring Director (if not author)	CCG Member

Agenda Item 8

Gloucestershire Clinical Commissioning Group
(Shadow Board)

18th October 2012

Quality assurance during the transition

1 Introduction

1.1 This paper has arisen from discussions at the Commissioning for Quality Group about the need to maintain a robust quality assurance process during the transition and the need to develop new systems that meet the statutory responsibilities of the new organisation (the CCG).

1.2 So, what are we trying to achieve? In simple terms, the role of the CCG board is to address two questions related to quality assurance:

- Quality monitoring: *are we happy that our patients are receiving the best affordable healthcare?*
- Governance: *are we happy that we have the right systems in place to ensure the best affordable healthcare for our patients?*

1.3 To address these two questions this paper proposes governance arrangements, outlines frameworks and identifies unresolved issues and areas for development.

2 Background and context

2.1 Improving quality and healthcare outcomes remains the primary purpose of all NHS funded care.

2.2 Under the Health and Social Care Act 2012 CCGs have a statutory duty to:

- Promote continuous improvements in the quality of the health services that they are responsible for commissioning; care that is effective, safe and provides as positive an experience as possible; and

- Assist and support the NHS Commissioning Board in making continuous improvements in the quality of primary medical services.

2.3 Previous papers to the CCG have provided information on the existing processes of governance and quality assurance and performance monitoring.

2.4 Darzi (2008) set out three dimensions to quality, all of which must be present to provide a high quality service:

- *Clinical effectiveness* – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individuals health outcomes
- *Patient safety* – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individuals safety
- *Patient experience* – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, inc being treated according to what an individual wants or needs and with compassion, dignity and respect.

This definition of quality is now enshrined through the Health and Social Care Act 2012.

2.5 The Act has also defined success in terms of the outcomes that are actually achieved for patients and users. The evolving NHS Outcomes Framework sets out national quality outcomes, which all NHS organisations, including CCGs, should be contributing towards.

2.6 This framework builds upon the Darzi's definition of quality through setting out five overarching outcomes or domains, which aim to capture the breadth of what the NHS is striving to achieve. There are a number of specific indicators within each of the domains, with more indicators due to be added from 2013/14.

3 Current quality assurance process, issues and gaps

3.1 Governance structure

The Integrated Governance Committee (IGC) has overall responsibility for quality ensuring that key performance indicators for quality are developed and monitored for all commissioned services.

In order to assist the IGC in fulfilling this role, the Commissioning for Quality Group (CfQG) was established as a sub group of the IGC. The original intent was for this group to act as a mechanism for review and evaluation of quality issues prior to consideration by the IGC. In principle, the terms of reference for the Group have been adequate, but in practice the output from the Group has not delivered sufficient action. We now have an opportunity to revise the role for such a group within a new governance structure for the CCG.

3.2 Reporting

Reporting on quality issues has evolved over time in response to IGC requests. The current style of reporting is largely qualitative in nature, as can be seen in the Quarter 1 Commissioning for Quality Report [Agenda Item 9].

What these reports do well is to provide a summary of the key quality issues, highlight good practice, significant risks and where there are concerns about quality of commissioned services and list relevant actions taken to address poor performance. However, in future it is recommended that we develop a quantitative dashboard approach, supported by a commentary highlighting exceptions. This approach will enable more effective monitoring of trends and progress.

3.3 Providers

An internal review of the current governance and quality monitoring arrangements within NHSG was carried out mid 2012 and concluded that whilst there were robust processes in place for the main local providers of healthcare services,

there were a number of areas where the quality assurance process could be strengthened in order to have parity in level of scrutiny across healthcare providers, notably:

- Minor providers including independent hospitals, AQP;
- Primary care medical services;
- Care homes (NHS funded)
- Care homes (social care funded)

3.4 Other issues

There are some unresolved issues relating to quality assurance frameworks:

- There is no quality assurance strategy and framework for the organisation;
- We lack some provider-specific quality assurance frameworks, which would triangulate key quality measures to provide an overall view of quality of services. This is currently *in situ* for Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) but not for the other providers.

We also recognise that quality is systemic – the patients journey cuts across primary and secondary care, health and social care and involves multiple professionals. Therefore, in future quality reporting should align to the planned approach by the CCG of clinical programme groups. This is an area for development. NICE Quality Standards and QOF metrics will dovetail well with this approach.

4 Future quality assurance

4.1 So, what does good look like?

We can check this with reference to our two opening questions:

- Quality monitoring*: are we happy that our patients are receiving the best affordable healthcare?*
- Governance: *are we happy that we have the right systems in place to ensure the best affordable healthcare for our patients?*

4.2 The NHS South of England "Tools for Commissioning for Quality" published in July 2012 sets out some guiding principles that can help us. We should aim to have:

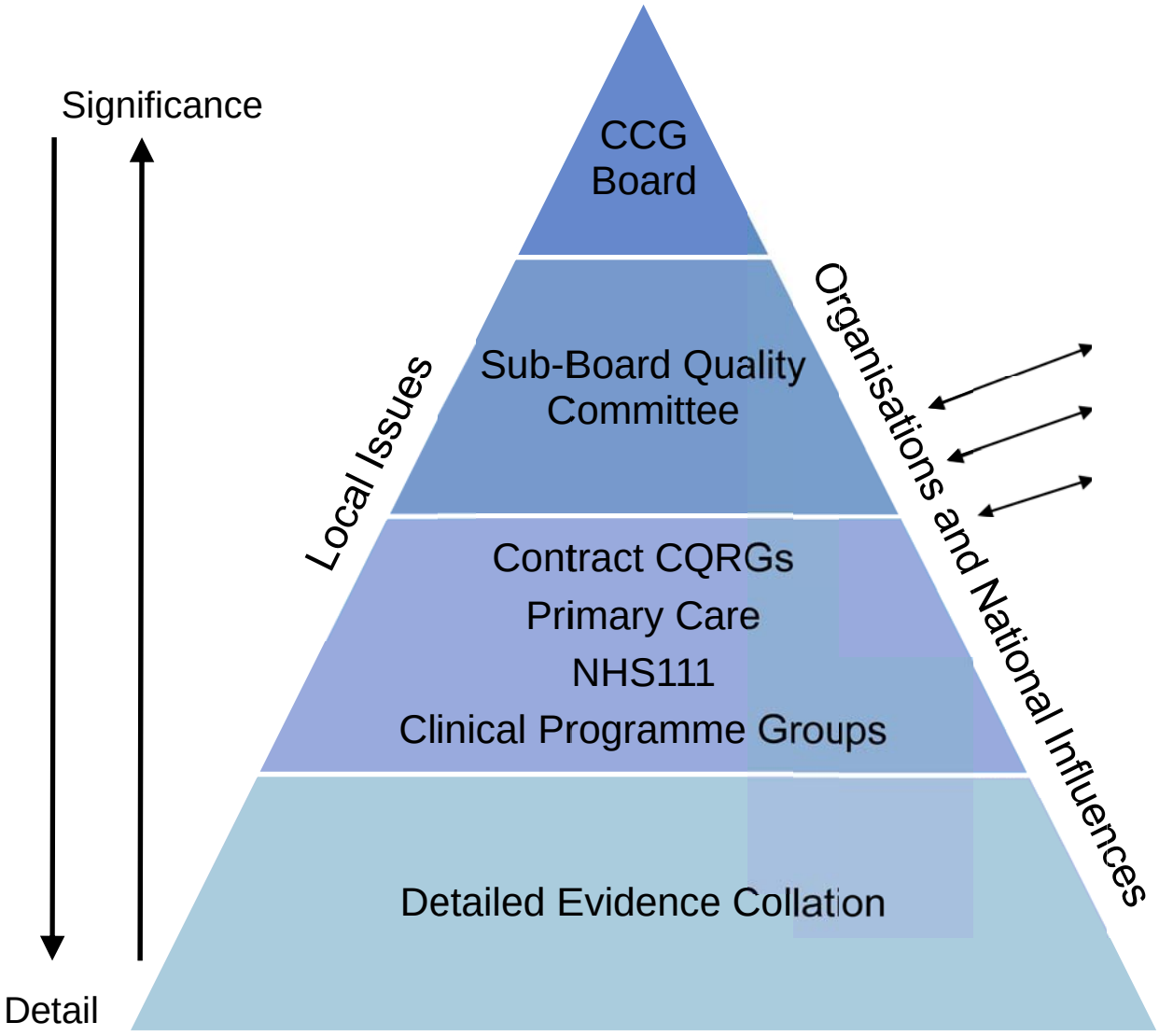
- Internal governance systems specifically to manage the quality agenda and to hold providers to account ;
- A clear organisational structure that cascades responsibility for reviewing quality performance;
- Quality monitoring as a standing agenda item and embedded in the working practices of the CCG Board;
- A process for escalating quality performance issues to the CCG Board via an effective and well represented Quality sub-Committee;
- Agreed protocols determining which issues should be escalated;
- Clear mechanisms to ensure that robust action plans are put in place to address quality performance issues;
- An explicit review process to follow up action plans;
- A clinical effectiveness strategy for adopting and implementing best practice; and
- A clinical audit programme to enable the identification of unwarranted variation and promotion of improvement initiatives.

4.3 <u>Future governance and reporting</u>

The future governance process should support a strengthened, consistent approach to scrutiny and assurance. This should allow the CCG to review and respond to high level issues with confidence that effective supporting processes are in operation to assemble detailed information and conduct reviews. This information should be easily available to the CCG as required.

4.4 The following diagram sets out the proposed levels of scrutiny and assurance.

Levels of Quality Assurance



4.5 Reporting and Quality assurance frameworks

In future, it is recommended that QA frameworks should be developed in conjunction with providers and commissioners to enable the triangulation of information against the three domains of quality.

This, more quantitative, "dashboard" approach will draw on evidence from a variety of sources, including:

- CQC – assessment against core standards and Quality and Risk profiles
- Outcome Framework indicators
- Other national performance indicators e.g. ambulance quality indicators
- Patient safety indicators – SI, Incidents, CAS Alerts
- Patient experience data - 4Cs, patient survey results.
- Locally agreed quality indicators e.g. CQUINs, patient experience reports
- Evidence from national public health and quality observatories eg the Acute Trust Dashboard which is produced by the East Midlands Quality Observatory.

In addition to the dashboard, the QA report should also contain a short narrative element that will allow qualitative assessments and provide a route for the input of "soft" data.

5 Recommendations

It is recommended that CCG endorse this proposed approach as a broad direction of travel.

Subject to the agreement of CCG more detailed proposals will be brought forward, including:

- Roles and responsibilities of the Quality sub committee
- Quality assurance strategy
- Reporting structures
- Governance frameworks

6 Appendices

- Appendix 1 - Supporting information for reference

Appendix 1

Supporting information for reference

How to: Maintain Quality during the transition: Preparing for handover, National Quality Board, May 2012.

Quality in the new health system – Maintaining and improving quality from April 2013, A draft report from the National Quality Board, August 2012.

Our NHS Care Objectives: A draft mandate to the NHS Commissioning Board, July 2012.

Tools for Commissioning for Quality, NHS South of England, July 2012.

Preparing for the Francis Report: how to assure quality in the NHS, Kings Fund, July 2012.

The Functions of Clinical Commissioning Groups, DH June 2012.

Agenda Item 9

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	**18th October 2012**
Title	**Commissioning for Quality Report – Quarter 1**
Executive Summary	This Quarter 1 report provides Clinical Commissioning Gloucestershire (CCG) with a summary of the three aspects of quality: • Patient and Carer Experience • Patient Safety and Risk • Clinical Effectiveness The Commissioning for Quality Group (now a sub-group of the CCG) assesses, scrutinises, and triangulates data from a wide range of sources in order to seek assurance in relation to the quality of commissioned services. This report summarises the outcomes from the Commissioning for Quality Group, highlight areas of best practice and high quality, as well as any areas of concern or risk along with evidence of remedial action or plans that are in place.
Key Issues	As the new CCG structures and ways of working emerge, such as the development of Clinical Programme Groups, we will need to review and refine the way we assure ourselves of the quality of commissioned services. The authorisation requirements for CCG have quality at its core and as a thread through all the authorisation domains.

	There is also a plethora of new guidance and consultation documents that have emerged in recent months and the CfQG and CCG need to agree how we respond to these and ensure that we have good governance arrangements in place and that we truly understand the quality – safety, effectiveness and experience – of care we commission. A paper setting out proposals regarding quality assurance during the transition can be found elsewhere on the agenda [Item 8].
Risk Issues: **Original Risk** **Residual Risk**	
Financial Impact	The quality indicators included in the Provider contracts include the following financial implications: Commissioning for Quality and Innovation (CQUIN) scheme. Financial penalties for non-achievement of quality and performance indicators.
Legal Issues(including NHS Constitution)	None
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable Development	None
Patient and Public Involvement	Includes information collected on Patient and Carer experiences.

Recommendation	The Clinical Commissioning Gloucestershire Shadow Board are invited to note this Report.
Author	Sarah Hughes
Designation	Deputy Director of Nursing
Sponsoring Director (if not author)	Jill Crook, Director of Nursing Charles Buckley, CCG Lead

Agenda Item 9

Gloucestershire Clinical Commissioning Group
(Shadow Board)

18th October 2012

Commissioning for Quality Report – Quarter 1

1 Introduction

1.1 This Quarter 1 report provides Clinical Commissioning Gloucestershire (CCG) with a summary of the three aspects of quality:

- Patient and Carer Experience
- Patient Safety and Risk
- Clinical Effectiveness

1.2 The Commissioning for Quality Group (now a sub-group of the CCG) assesses, scrutinises, and triangulates data from a wide range of sources in order to seek assurance in relation to the quality of commissioned services. This report summarises the outcomes from the Commissioning for Quality Group, highlight areas of best practice and high quality, as well as any areas of concern or risk along with evidence of remedial action or plans that are in place.

2 Patient and Carer Experience

2.1 Mixed Sex Accommodation

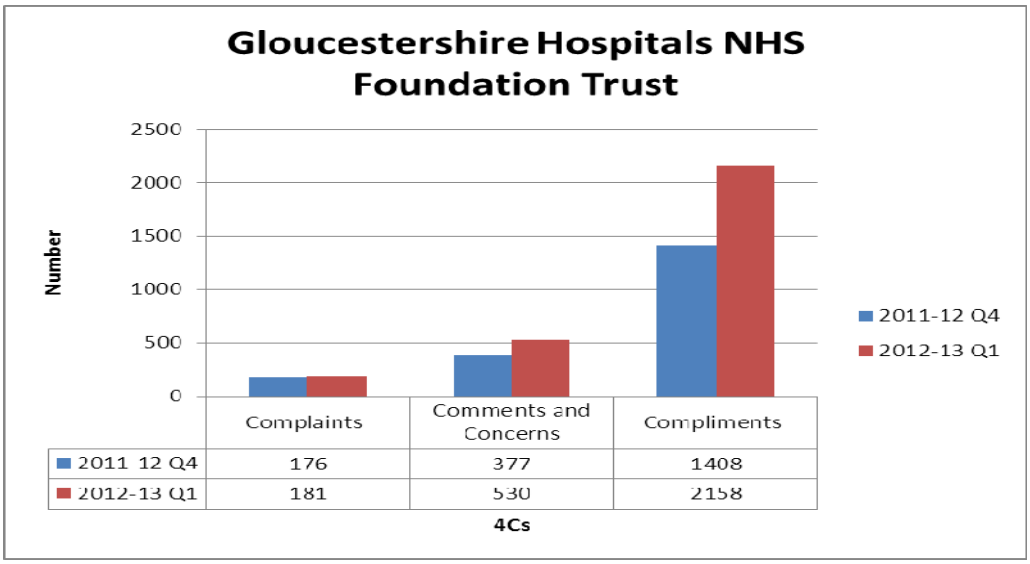
The requirement to eliminate mixed sex accommodation breaches at all provider sites (GHNHSFT, Care Services, and 2gether FT) remains a key priority. In 2011/12 there were zero breaches at Care Services and 2gether sites, but breaches continued at GHNHSFT (a total of 393 breaches across the year). The record of zero breaches has continued at Care Services and 2gether sites in the first Quarter of 2012/13. A total of 33 breaches were recorded at GHNHSFT in April 2012, but since then the situation has improved with zero breaches being recorded on May and June.

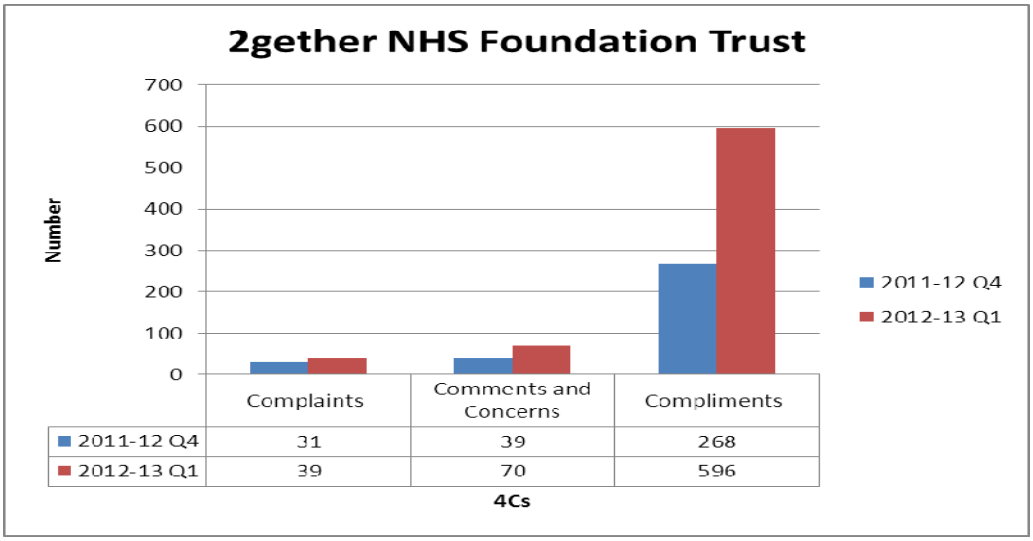
2.2 Friends and Family Test

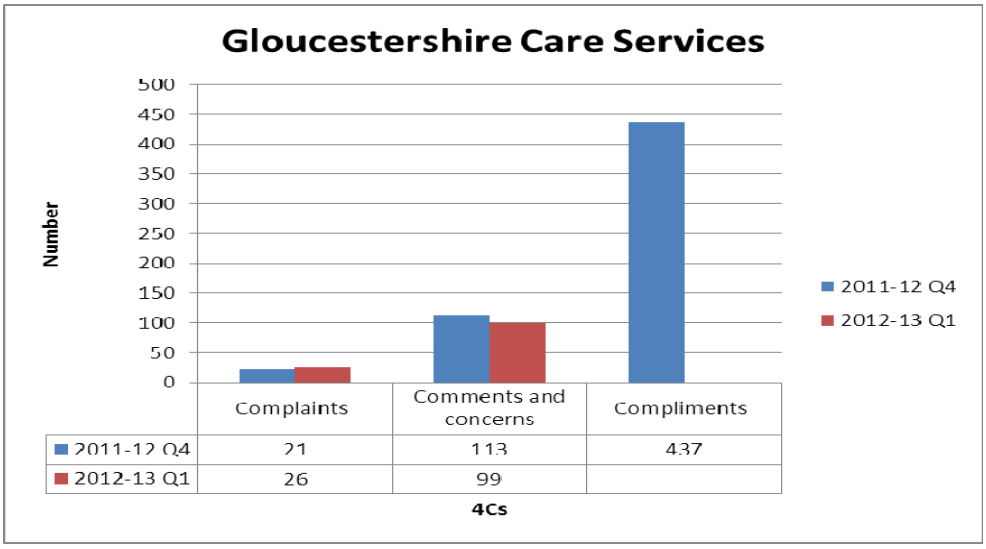
The Prime Ministers Friends and Family test is expected to be introduced as part of the 2013-14 contract round, with results expected to be available from April 2013 onwards for each acute inpatient ward and Accident and Emergency department. The ambition for the South is that, not only will all acute providers meet the national requirement for acute inpatient wards and A&E departments, but also that all community wards and minor injury units are using the Friends and Family Test from April 2013. A state of readiness survey is currently being undertaken in Gloucestershire in preparation for implementation.

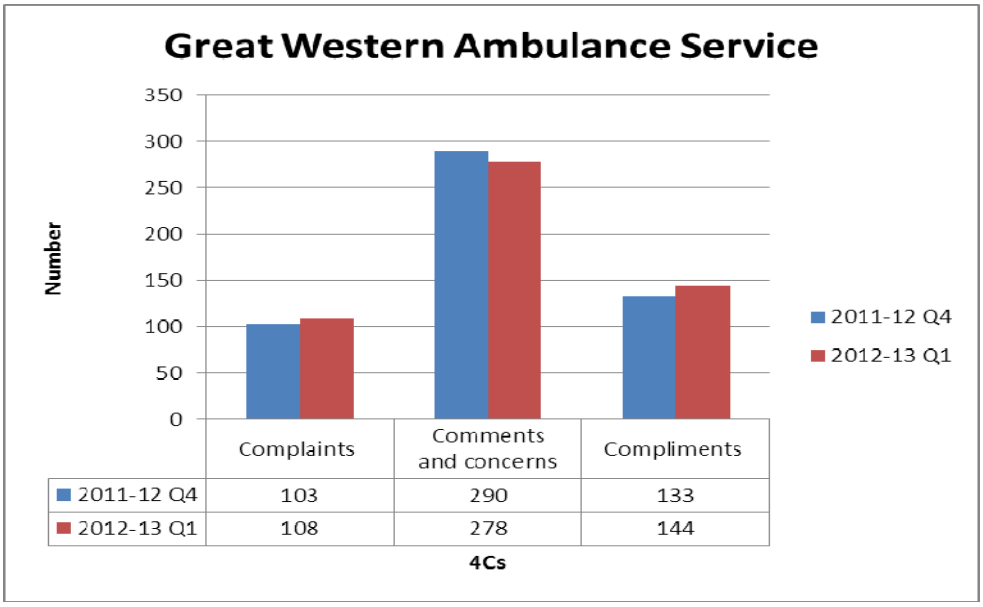
2.3.2 Compliments, Comments, Concerns, and Complaints (4Cs)

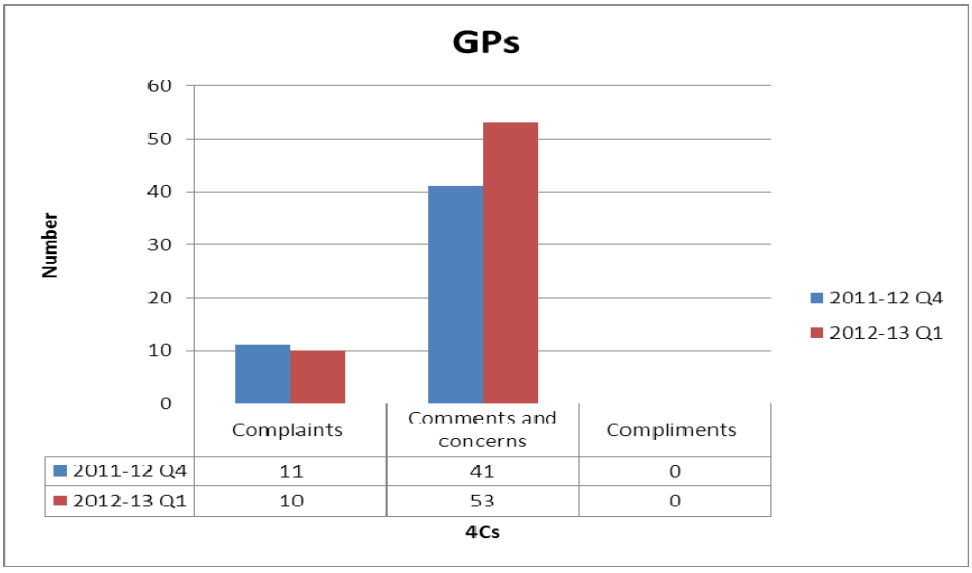
The graphs below show the number of Compliments, Comments, Concerns, and Complaints (4Cs) received by the principle providers during Quarter 4 of 2011/12 and Quarter 1 of 2012/13.

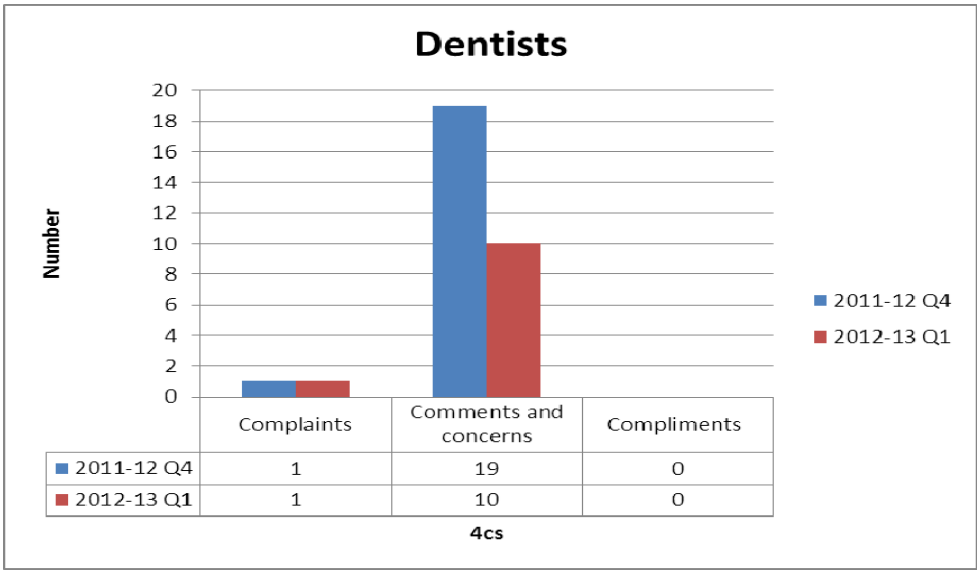


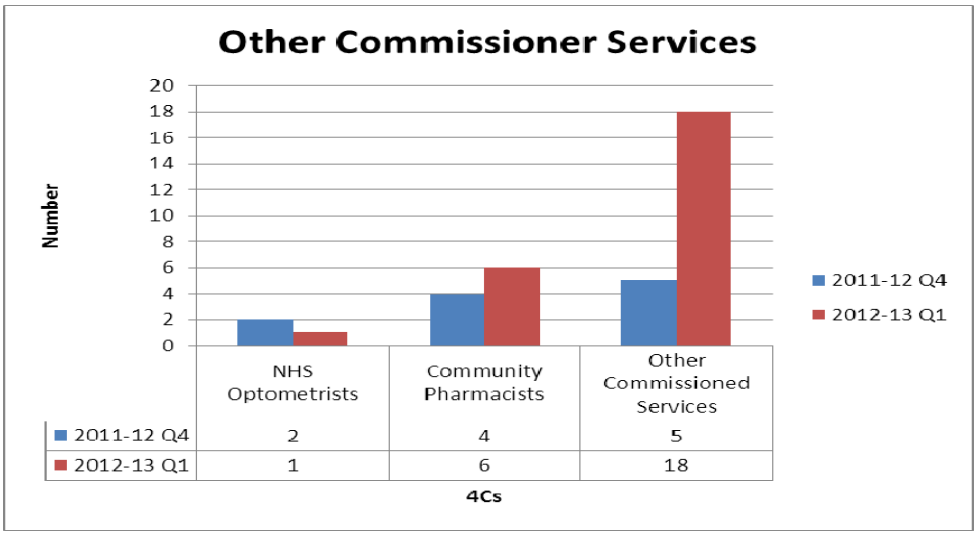



Gloucestershire Care Services
Number
500
450
400
350
300
250
200
150
100
50
0
2011-12 Q4
2012-13 Q1
Complaints
Comments and concerns
Compliments
2011-12 Q4 21 113 437
2012-13 Q1 26 99
4Cs


Great Western Ambulance Service
Number
350
300
250
200
150
100
50
0
2011-12 Q4
2012-13 Q1
Complaints
Comments and concerns
Compliments
2011-12 Q4 103 290 133
2012-13 Q1 108 278 144
4Cs


GPs
Number
60
50
40
30
20
10
0
2011-12 Q4
2012-13 Q1
Complaints
Comments and concerns
Compliments
2011-12 Q4 11 41 0
2012-13 Q1 10 53 0
4Cs





2.3.3 Carers Commissioning Strategy

NHS Gloucestershire and Gloucestershire County Council are currently working on the development of a joint Carers Commissioning Strategy which will deliver the requirements in relation to carers support set out in the National Carers Strategy and the NHS Operating Framework. The joint aspiration for carers as set out in the strategy is that carers are supported in their caring role through accessible advice and guidance amd good quality services that offer value for money. This is covered in more detail in a separate report to the CCG [Agenda Item 7].

3 Patient Safety

3.1 Infection Control

Year to date performance in relation to C. Diff was above trajectory at the end of Quarter 1 (53 cases against a target of 48). This has continued into Quarter 2, with performance at the end of July at 77 cases compared to a target of 64. C. Diff rates within GHNHSFT remain within target at the end of July (26 cases against a target of 27). NHS Gloucestershire are currently trying to ascertain the reasons for the increase in community C. Diff rates, including looking again at the the prescribing of antibiotics by GPs (although a 6 month study last year showed that GPs were following this fairly consistently). The GHNHSFT microbiologist has suggested that the increase might be due to the development of new strains that are resistant to antibiotics.

3.2 Medicines Management

The focus for the medicines management team is to be assured that patient safety is a top priority. This is achieved through a number of ways, ranging from following up all medicines management incidents reported on Datix, all controlled drug reported incidents, any potential controlled drug soft intelligence issues and reviewing clinical evidence for use of new and existing medicines. Investigations that result in concern are escalated directly to the Director of Nursing. Medicines Management is overseen by the NHS Gloucestershire Drugs and therapeutics group, that concentrates on primary care, and The Medicines Management Interface Group that concentrates on the medicines management issues at the interface of primary care and secondary care. Controlled drugs is overseen by the Gloucestershire Local Intelligence network. All these groups report into the NHS Gloucestershire Commissioning for Quality Group.

3.2.3 Incidents

NHS Gloucestershire encourages all staff and independent contractors to report incidents. Staff and all GP practices are able to report electronically via the ‘Datixweb’ system. Other independent contractors are able to report via a paper based system.

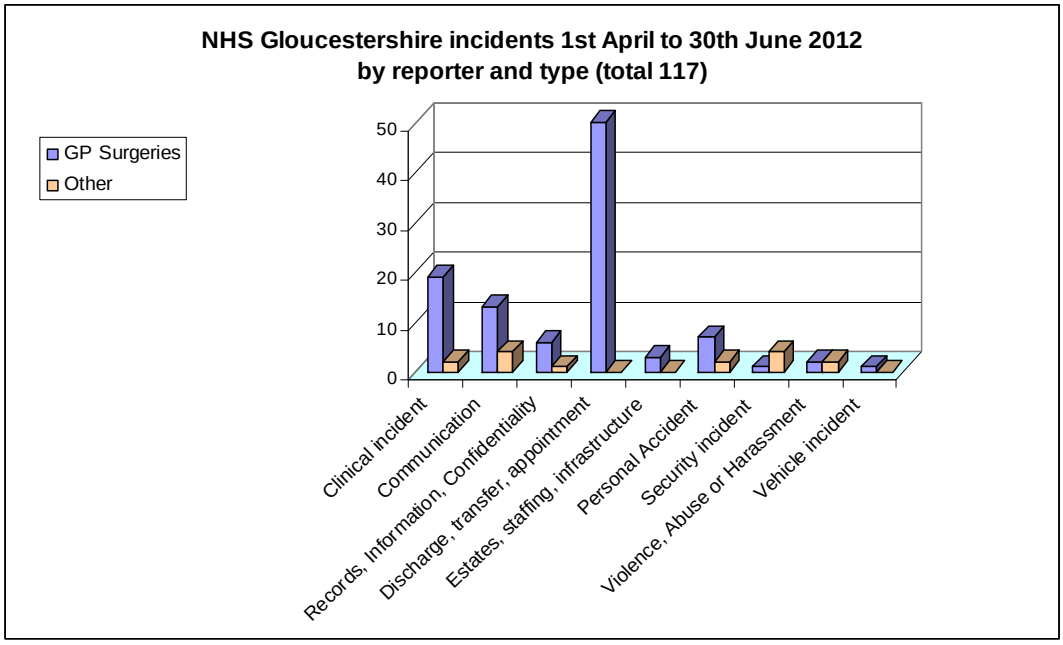
Details of incidents are entered onto the ‘Datix’ database which is used

to provide reports for groups and managers throughout the organisation in order to ensure that any relevant trends are properly considered and that lessons learned are appropriately shared. Regular reports are sent to the relevant leads and managers on a monthly basis. However, serious issues are flagged to the appropriate managers and providers immediately on submission.

Information regarding common themes and trends arising from the incident reports are shared with the GP community via the e.bulletin.

Many of the incidents reported by GPs relate to problems encountered with services provided by local NHS organisations. Details of these incidents are provided to the relevant organisations by the Governance Team by way of monthly reports either for investigation (where the incident is considered significant) or information on more minor incidents. This ensures that the issues can be investigated and action taken to prevent re-occurrence.

The graph below provides an analysis of the 117 incidents reported to NHS Gloucestershire during the quarter ended 30th June. Of these, 102 were reported by GP practices and 15 were reported by NHS Gloucestershire employees and other third party contractors.



3.2.4 **Serious Incidents**

NHS Gloucestershire is responsible for monitoring the quality and

progress of investigations into SIs reported by those providers for whom the organisation acts as lead commissioner. The processes and timescales for managing SIs are included within the contracts that NHS Gloucestershire has with the providers.

Details of all SIs are recorded on the national STEIS database. Under the arrangements for monitoring SIs agreed between NHS Gloucestershire and the provider organisations, incidents are generally closed on the database by NHS Gloucestershire once final reports and detailed action plans have been received. The implementation of actions is monitored by NHS Gloucestershire in liaison with the providers.

The tables below show the numbers and types of Serious Incidents reported by each of the principal providers for the last four quarters.

GWAS	**11/12 Q2**	**11/12 Q3**	**11/12 Q4**	**12/13 Q1**
Response Delay	0	3	2	4
Admin/IT Issue	1	0	1	0
Misdiagnosis	2	0	2	1
Call Classification/ Records	0	0	0	1
Inappropriate Advice	0	0	0	1
Suspected Theft	1	2	0	0
Clinical Incident	1	1	1	1
Road Traffic Accident	1	0	0	0
Possible staff contamination	0	1	0	0
Total	**6**	**7**	**6**	**8**

2gether	**11/12 Q2**	**11/12 Q3**	**11/12 Q4**	**12/13 Q1**
Suspected Suicide	10	5	2	3
Attempted Suicide	4	1	3	2
Unexpected death	0	1	1	0
Assault/ Threatened	1	2	1	0

Assault				
Patient Fall	0	0	0	1
Fractured hip	1	1	0	0
Admin/IT issue	0	0	1	0
Illegal act by patient	0	0	0	1
Total	**16**	**10**	**8**	**7**

GHT	**11/12 Q2**	**11/12 Q3**	**11/12 Q4**	**12/13 Q1**
C.Diff/Norovirus	3	1	1	1
MRSA	0	0	0	0
Admin/IT Issue	0	1	1	1
Unexpected Death	1	1	2	1
Clinical Incident	0	2	4	2
Pressure Ulcer	2	2	1	1
Legionella	0	0	0	1
Never Event	0	1	0	**0**
Total	**6**	**8**	**9**	**7**

Care Services	**11/12 Q2**	**11/12 Q3**	**11/12 Q4**	**12/13 Q1**
C.Diff	1	0	0	0
Pressure Ulcer	3	9	9	7
Misappropriation of drugs	0	0	0	0
Attempted Suicide	1	0	0	0
Admin/IT Issue	0	0	0	2
Unexpected Death	0	1	3	0
Total	**5**	**10**	**12**	**9**

The table below provides an analysis of the status of the actions relating to the SIs reported by the principal providers during 2011/12 and 2012/13.

Org.	No. of Reports	No. of Actions	Actions Completed	Actions Not due	Actions Over-due
GWAS	29	81	63 (78%)	4 (5%)	14 (17%)
2gether	49	157	111 (70%)	23 (15%)	23 (15%)
GHT	33	226	129 (57%)	28 (12%)	69 (31%)
Care Services	36	210	153 (73%)	41 (20%)	16 (7%)
Total	**147**	**674**	**456** (68%)	**96** (14%)	**122** (18%)

As can be seen from the table above, there has been considerable progress in implementing action plans, although assurances are awaited in respect of a number of 'over-due' actions. NHS Gloucestershire managers are continuing to work with the provider trusts to improve the timeliness of assurances that actions have been implemented.

4 Clinical Effectiveness

4.1 2012/13 Commissioning for Quality and Innovation (CQUIN) Schemes – Quarter 1 Attainment

CQUIN goals for 2012/13 have been agreed with each provider as listed below. Where quarter 1 reporting was due, providers have confirmed attainment of the targets expected.

- Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT):
  - Reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE)
  - Patient experience – personal needs
  - NHS safety thermometer
  - Dementia

- Sepsis six implementation
- Acute kidney injury (AKI)
- Patient experience escalator
- Supporting clinical change programmes
- Oesophageal doppler/cardiac flow monitoring

- Great Western Ambulance Service NHS Trust (GWAS):
  - Patient experience
  - Appropriate conveyance
  - Implementation of the Major Trauma Networks
  - NHS number

- NHS Gloucestershire Care Services (GCS):
  - VTE prevention
  - Responsiveness to personal needs of patients
  - NHS safety thermometer
  - Dementia
  - Patient experience escalator
  - Falls prevention & reduction
  - Maternal mental health (MMH) pathway
  - End of life

- ^{2}gether NHS Foundation Trust (2GFT):
  - VTE prevention
  - Patient experience
  - NHS safety thermometer
  - Telecare and Telehealth support for people with dementia
  - Improving services and the outcomes for women with mental ill health during pregnancy and up to one year post birth
  - Care co-ordination
  - Medicines management
  - Falls prevention
  - Outcome measurement tool for learning disability services

4.2 Map of Medicine

A Project Lead and Programme Administrator are now in post to work closely with the Clinical Programme Groups (CPGs) to support the localisation, publication and sharing of pathway developments using Map of Medicine.

At a recent Project Board meeting, localised pathways for both Vertigo

and Dizziness were ratified by members and will be published in due course to join the existing Gloucestershire pathways on The Map i.e. Dementia, Chronic Obstructive Pulmonary Disease (COPD) and Smoking Cessation. Care maps currently known to be in development for publication include Cataract, Wet Age-related Macular Degeneration (AMD), Hip Osteoarthritis, Knee Osteoarthritis, Low Back Pain and Brain Tumour. Publication of Gloucestershire's Joint Formulary is also being explored.

Map of Medicine have recently launched a software update which incorporates improved content navigation, the ability for clincians to produce professional development certificates, and a sidebar tool which links the Map of Medicine directly to the clinical workflow and allows instant access to care pathways and referral forms either during or shortly after patient consultation. The Map of Medicine computer desktop icon has now been rolled out to every GP practice within the county, allowing quicker access to the system.

A Gloucestershire Map of Medicine launch will be organised in the near future, following an increase in the number of published localised pathways.

5 Recommendation(s)

5.1 The Clinical Commissioning Gloucestershire Shadow Board are invited to note this Report.

NHS Gloucestershire 2012/13 Integrated Performance Scorecard

Target	Principal Delivery Targets		2011-12 Outturn	Apr 2012	May 2012	Jun 2012 Q1	Jul 2012	Aug 2012	Sept 2012 Q2	Oct 2012	Nov 2012	Dec 2012 Q3	Jan 2013	Feb 2013	Mar 2013 Q4	Year to date	Year end forecast	Perf. Measured
Unscheduled Care																		
Accident & Emergency																		
PHQ23	**4-hour A&E target** - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		GRH	94.5%	94.5%	98.0%	97.6%	95.8%	95.9%								96.6%	> 95%	
		CGH	90.5%	92.1%	97.5%	96.3%	96.8%	98.1%								95.5%	> 95%	C
		GHNHSFT total	92.8%	93.5%	97.8%	97.0%	96.2%	96.9%								96.1%	> 95%	
		GCS - MIU	99.9%	99.9%	99.9%	100.0%	99.9%	100.0%								99.9%	> 95%	C
Ambulance																		
PHQ01	**Cat A 8 min response** - The percentage of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	
		GWAS	75.6%	76.2%	77.3%	79.7%	77.4%	78.1%								77.7%	> 75%	**C**
		Glos only	76.5%	77.7%	78.6%	79.1%	78.5%	79.5%								78.7%	> 75%	
PHQ02	**Cat A 19 min response** - The percentage of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
		GWAS	95.6%	96.6%	96.4%	96.2%	95.6%	96.1%								96.2%	>95%	**C**
		Glos only	95.5%	95.9%	95.9%	96.0%	95.6%	95.9%								95.8%	>95%	
Planned Care																		
Acute Care Referral to Treatment																		
PHQ19	Percentage of admitted pathways treated with in 18 Weeks	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C
		Actual	90.9%	91.4%	91.2%	87.8%	94.0%									91.2%	>90%	
PHQ20	Percentage of non - admitted pathways treated within 18 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	98.3%	97.9%	98.4%	98.3%	98.3%									98.3%	>95%	
PHQ19	Percentage of Trauma & Orthopaedic admitted Pathways treated within 18 Weeks	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C
		Actual	80.3%	81.3%	80.9%	76.8%	87.0%									81.4%	>90%	
PHQ21	Percentage of incomplete Pathways that have waited less than 18 Weeks	Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	C
		Actual	94.1%	94.9%	95.3%	94.7%	94.2%									94.8%	<92%	
Diagnostics																		
PHQ22	Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests	Target	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	C
		breaches	1,608	150	361	443	363									1,317		
		Performance	2.3%	2.3%	5.4%	6.3%	5.3%									4.9%	<1% in Q4	
Cancer Waits																		
PHQ024	Percentage of patients seen within 2 weeks of an urgent referral for suspected cancer	Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C
		breaches	932	150	136	89	103									478		
		Performance	92.2%	85.6%	89.1%	91.0%	90.7%									89.1%	>93%	
PHQ25	Percentage of patients seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C
		breaches	165	45	3	0	0									48		
		Performance	88.5%	64.3%	97.8%	100.0%	100.0%									90.8%	>93%	
PHQ06	Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis	Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	C
		breaches	25	0	2	2	1									5		
		Performance	99.1%	100.0%	99.3%	99.1%	99.6%									99.5%	>96%	
PHQ07	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C
		breaches	3	0	0	0	1									1		
		Performance	99.4%	100.0%	100.0%	100.0%	98.3%									99.5%	>94%	
PHQ08	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regime	Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	C
		breaches	0	0	0	0	0									0		
		Performance	100.0%	100.0%	100.0%	100.0%	100.0%									100.0%	>98%	
PHQ09	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C
		breaches	0%	0%	0%	0%	100%									100%		
		Performance	100.0%	100.0%	100.0%	100.0%	98.9%									99.8%	>94%	
PHQ03	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	C
		breaches	180	16	19	19	18									72		
		Performance	86.0%	84.8%	86.3%	79.6%	82.0%									83.5%	>85%	
PHQ04	Percentage of patients receiving first definitive treatment for cancer within 62 days from an NHS Cancer screening service	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C
		breaches	8	1	1	0	1									3		
		Performance	96.9%	95.5%	96.3%	100.0%	95.0%									96.6%	>90%	

NHS Gloucestershire 2012/13 Integrated Performance Scorecard

Target	Principal Delivery Targets		2011-12 Outturn	Apr 2012	May 2012	Jun 2012 Q1	Jul 2012	Aug 2012	Sept 2012 Q2	Oct 2012	Nov 2012	Dec 2012 Q3	Jan 2013	Feb 2013	Mar 2013 Q4	Year to date	Year end forecast	Perf. Measured
Primary and Community Care																		
Primary care																		
PHQ31_04	Percentage of people eligible for the NHS Health Check programme who have been offered an NHS Health Check	Target	18.0%			5.0%			5.0%			5.0%			5.0%	5.0%	20.0%	C
		Actual	23.6%			5.6%										5.6%	>20%	
PHQ31_05	Percentage of people eligible for the NHS Health Check programme that have received an NHS Health Check	Target	6.1%			1.7%			1.7%			1.7%			1.7%	1.7%	6.7%	C
		Actual	9.1%			2.2%										2.2%	>6.7%	
Community care																		
Local 2 Week Offers																		
LO1	Average wait to be seen by the Adult Physiotherapy Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2	2		M
		Ave wait (weeks)	2.6	2.7	2.3	2.7	2.3	2.2								2.2		
		Max wait (weeks)	7	11	10	12	9	13								13		
LO2	Average wait to be assessed for a wheelchair by the Specialist and Non-Specialist wheelchair Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2	2		M
		Ave wait (weeks)	0.9	1.3	0.6	0.5	0.8	0.6								0.6		
		Max wait (weeks)	6	7	5	5	7	5								5		
LO3	Average wait to be seen by the Podiatry Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2	2		M
		Ave wait (weeks)	2.4	2.8	2.5	2.9	3.1	3.5								3.5		
		Max wait (weeks)	7	9	12	10	14	14								14		
LO4	Average wait to be seen by the Children's Occupational Therapy Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2	2		M
		Ave wait (weeks)	1.5	1.2	1.0	1.0	1.2	1.0								1.0		
		Max wait (weeks)	3	5	3	3	3	3								3		
LO5	Average wait to be seen by the Children's Physiotherapy Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2	2		M
		Ave wait (weeks)	1.1	1.3	1.1	1.3	1.4	0.7								0.7		
		Max wait (weeks)	6	6	6	6	6	4								4		
LO6	Average wait to be seen by the Children's Speech and Language Therapy Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2	2		M
		Ave wait (weeks)	1.9	2.0	1.9	1.8	1.8	1.9								1.9		
		Max wait (weeks)	9	7	8	6	6	3								3		
Community Care Referral to Treatment																		
Paediatric																		
AMB 01	Percentage of patients referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	97.0%	98.0%	99.0%	98.0%	99.0%	100.0%								98.8%	>95%	
AMB 02	Percentage of patients referred to the Paediatric OccupationalTherapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	97.0%	95.0%	97.0%	96.0%	100.0%	100.0%								97.6%	>95%	
AMB 03	Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%	>95%	
Adult																		
AMB 04	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	96.0%	100.0%	99.0%	97.0%	99.0%	100.0%								99.0%	>95%	
AMB 05	Percentage of patients referred to the Podiatry Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	97.0%	98.0%	97.0%	96.0%	96.0%	95.0%								96.4%	>95%	
AMB 06	Percentage of patients referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	96.0%	98.0%	96.0%	99.0%	99.0%	100.0%								98.0%	>95%	
AMB 07	Percentage of patients referred to the Adult Physiotherapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	99.0%	98.0%	95.0%	92.0%	96.0%	97.0%								95.0%	>95%	
Specialist Nurses																		
AMB 08	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%	>95%	
AMB 09	Percentage of patients referred to the Diabetic Nursing Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	100.0%	98.0%	100.0%	100.0%	100.0%	98.0%								99.0%	>95%	
Public Health																		
PHQ30	Number of clients to the NHS Stop Smoking Service who report that they are not smoking 4 week after setting a quit date	Target	3,950			766			1,506			2,272			3,505	766	3,505	C
		Actual	4,003			893										893	>3505	

NHS Gloucestershire 2012/13 Integrated Performance Scorecard

Target	Principal Delivery Targets		2011-12 Outturn	Apr 2012	May 2012	Jun 2012 Q1	Jul 2012	Aug 2012	Sept 2012 Q2	Oct 2012	Nov 2012	Dec 2012 Q3	Jan 2013	Feb 2013	Mar 2013 Q4	Year to date	Year end forecast	Perf. Measured
Mental Health and Learning Disabilities																		
Adults of Working Age																		
PHQ12	Proportion of those patients on a Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	Target	95%			95%			95%			95%			95%	95%	95%	C
		Actual	100.0%			100.0%										100.0%	>95%	
PHQ11	Number of home treatment packages delivered by Crisis Team	Target	939			255			483			711			939	255	939	C
		Actual	1,844			401										401	>939	
PHQ10	The number of new cases of psychosis served by the Early Intervention Team	Target	70			18			36			53			70	18	70	C
		Actual	85			23										23	>70	
Improving Access to Psychological Therapies (IAPT)																		
PHQ13_5	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Target	3.9%			2.2%			2.3%			2.5%			2.6%	2.2%	9.6%	C
		Actual	4.8%			1.7%										1.7%	>9.6%	
PHQ13_6	The proportion of people who complete therapy who are moving towards recovery	Target	N/A			50.0%			53.8%			53.6%			53.3%	50.0%	52.8%	C
		Actual	50.2%			43.8%										43.8%	>52.8%	
Quality																		
Quality Indicators																		
PHQ26	Eliminate mixed-sexed accommodation breaches at all providers sites	GHT	393	33	0	0	6	0								39	39	C
		GCS	0	0	0	0	0	0								0	0	C
		2gether	0	0	0	0	0	0								0	0	C
PHQ29	Percentage of all adult inpatients who have had a VTE risk assessment	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C
		GHNHSFT	92.9%	94.5%	94.0%	92.9%	93.3%									93.7%	>90%	
		GCS	95.8%	98.1%	97.8%	94.9%	97.9%									97.2%	>90%	
Cleanliness and HCAIs																		
Methicillin Resistant Staphylococcus Aureus (MRSA)																		
PHQ27	Number of MRSA infections (Health Community)	Glos HC target	14	1	1	1	1	0	0	0	0	0	0	0	0	4	4	C
		Glos HC actual	10	0	2	0	2	1								5	4	
PHQ27	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target	5	1	0	0	0	0	0	0	0	0	0	0	0	1	1	C
		GHNHSFT actual	3	0	0	0	0	1								1	1	
Clostridium Difficile (C.Diff)																		
PHQ28	Number of total C Diff infections (Health Community)	Glos HC target	182	19	16	13	16	13	11	11	11	11	22	20	19	77	182	C
		Acute Hosp	97	6	4	5	10	13								38		
		Comm Hosp	24	1	2	1	2	2								8		
		Community	158	11	10	13	12	14								60		
		Glos HC actual	279	18	16	19	24	29								106	>182	
PHQ28	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target	73	9	8	5	5	5	5	5	6	6	6	6	7	32	73	C
		GHNHSFT actual	92	6	6	6	8	10								36	73	

Notes

PHQ 2012/13 NHS Operating Framework commitments
EC Existing commitment
AMB Strategic Health authourity Ambition objective
Local Local target
LO Local offer to Gloucestershire Health Community to reduce waiting times

Key to RAG status

Green On or above plan
Amber Below plan
Red Significantly below plan

Key to 'performance measured'

C = assessed on cumulative performance against plan
M = Figure as at end of month

Key to abbreviations

GNHSFT - Gloucestershire Hospitals NHSFT
GCS - Gloucestershire Care Services
GWAS - Great Western Ambulance Service

Gloucestershire Clinical Commissioning Group
(Shadow Board)

Meeting Date	**18th October 2012**
Title	**Performance against Commissioning Report**
Executive Summary	This integrated performance report provides Gloucestershire Clinical Commissioning Group (GCCG) with a strategic overview of the financial and service performance issues by exception. This report sets out the Financial position is as at the end of August 2012. The Commissioned Service Performance position is dependent upon the availability of the data.
Key Issues	These are set out in the main body of the report
Risk Issues: Original Risk Residual Risk	All risks are identified within the relevant section of the report.
Financial Impact	Not meeting key financial targets
Legal Issues (including NHS Constitution)	Compliance with the NHS Constitution as part of the 18 week referral to treatment commitment
Impact on Equality and Diversity	Not Applicable.
Impact on Health Inequalities	The are no direct health and equality implications contained within this report
Impact on Sustainable Development	The are no direct sustainability implications contained within this report
Patient and Public Involvement	The Health, Community & Care Overview and Scrutiny Committee receive a report of performance against key targets.
Recommendation	The GCCG is asked to: • Take note of the reported financial position for 2012/13

	• Take note of the performance against the 2012/13 national targets and the actions taken to ensure that performance is at a high standard.
Author & Designation	Roy Hewlett , Assistant Director Performance & Planning Steve Perkins, Head of Financial Planning
Sponsoring Director (if not author)	Mary Hutton, Director of Finance

Agenda Item 10

Gloucestershire Clinical Commissioning Group (Shadow Board)

October 2012

Performance against Commissioning Report

1 Introduction

1.1 This report sets out NHS Gloucestershire (NHSG) 2012/13 Financial position as at the 31st August 2012 and Commissioned Service performance dependent upon the availability of the data. It is broken down into two sections covering performance relating to the key commissioning service targets and financial positions of NHSG.

1.2 Only those areas of performance assessed as being at significant risk of failure at year end, or other issues that engendered concerns throughout the year, for which the Board need to be made aware of, are included in the report. The full summary of performance is included in Appendix 3.

1.3 The supporting appendices provide a full analysis of the PCT's Finance position and performance against our Commissioning performance targets. The 2012/13 commissioning performance scorecard (appendix 3) provides an integrated report describing the performance of NHSG. The scorecard covers the 2012/13 Operating Framework targets, NHS Constitution commitments and key 'local offer' commitments.

2 Performance

2.1 A full overview of current performance of the NHSG against the national and key local targets is given in appendix 3 and is ordered in the following overarching themes;

- Unscheduled Care
- Planned care
- Primary and Community Care

- Public Health
- Mental Health and Learning Disabilities
- Quality

All indicators are RAG rated based on the *2012/13 NHS Performance Framework* thresholds. In addition to this, Year To Date and Year End Forecast positions are given to aid quantifying the level of risk.

2.2 The overall level of performance is very good and a summary of the YTD position is given in the table below. This shows that of the total of 50 indicators reported on; 37 were rated Green (74%), 10 Amber (20%) and just 3 Red (6%).

Breakdown of current year to date performance by RAG status of indicator			
	Green	Amber	Red
NHS Gloucestershire	37	10	3

Percentage	74%	20%	6%

2.3 Areas where performance has been particularly good include:

- The 4 hour A&E target has been achieved in every month this year apart from April. There has been a significant improvement in 4 hour A&E performance at GHNHSFT where the target was achieved in May, June, July and August.
- Both Cat A8 and A19 performance targets have been achieved throughout the year in the GWAS region and within Gloucestershire.
- Patients are able to receive treatment for Community Services in Gloucestershire within 8 weeks of referral. These are some of the best access times in the country.
- VTE risk assessment target has been consistently met within GHNHSFT.

2.4 The table below provides a fuller position statement for all the Red and significant Amber rated indicators. This table outlines current performance, identifies the issues leading to that performance and mitigating actions being taken to recover performance. The table may also include an update on other areas that may currently be performing well but have historically been the cause of concern, an example of this would be the 4 hour A&E target performance.

Ref	PCT	Indicator	Status	Issue	Mitigating Action
Planned Care					
PHQ19	NHS Glos	At least 90% of Trauma & Orthopaedic admitted RTT pathways should be treated within 18 Weeks	**RED YTD** There was a significant improvement in performance in July to 87.0% for NHSG. GHNHSFT performance in July was 84.9% this represents their best ever performance for this standard.	Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) has had a persistent backlog of between 200-300 T&O patients that have already waited more than 18 weeks. The bulk of this backlog needs to be cleared, and the average waiting time reduced, to enable the target to be achieved sustainably.	At a performance meeting with GHNHSFT, held on the 29th August, the improvement in performance was recognised and GHNHSFT restated their commitment to achieve the target by the end of Q3 2012/13. Four consultants currently not achieving the standard are changing their working patterns to reduce the number of outpatient sessions and increase theatre sessions thus enabling the longer wait patients to be treated GHNHSFT have appointed an admissions supervisor and will be providing RTT training for OP nursing staff

Ref	PCT	Indicator	Status	Issue	Mitigating Action
					from Mid-September. Both of these actions will improve waiting list management. Patients suitable for transfer are to be offered alternative providers for their surgery. New Referrals into Orthopaedics have reduced by 15% at month 4 which will help with GHT capacity pressures.
PHQ22	NHS Glos	Not more than 1% of patients should have waited more than 6 weeks for one of the 15 key diagnostic tests	**AMBER YTD** 5.3% in July (363 breaches of which 348 were at GHNHSFT and all for endoscopy procedures).	GHNHSFT have not had sufficient capacity to meet demand and clear the waiting list backlog (currently estimated at 350 cases behind trajectory in August).	A formal Performance Management Meeting with GHNHSFT took place on the 10th September. GHNHSFT have submitted a revised recovery action plan and trajectory stating that the backlog will be eradicated by November

Ref	PCT	Indicator	Status	Issue	Mitigating Action
			GHNHSFT have also confirmed that they will be reporting over 300 breaches at the end of August against an agreed recovery trajectory of nil.	GHNHSFT had provided the additional activity agreed in their recovery action plan. However urgent endoscopy 2 week cancer referrals have increased significantly in that period (by 27%) and much of the additional capacity has been directed at meeting the 2 week cancer target. This has meant that they will fail to achieve their target of nil breaches by August.	2012. GHNHSFT will extend the contract of the two locums and increase weekend lists ensuring that the additional activity is ring fenced for over 6 week waiters. NHSG will be meeting with the GHNHSFT Service lead fortnightly to monitor progress against their revised recovery plan.
PHQ24	NHS Glos	At least 93% of patients should be seen within 2 weeks of an	**AMBER YTD** 90.7% in July	Performance has been impacted by an increase of 11% in 2 week referrals in the	NHSG held a Performance Management Meeting with GHNHSFT on the 7th September.

Ref	PCT	Indicator	Status	Issue	Mitigating Action
		urgent referral for suspected cancer		first 4 months of 2012/13 compared to the same period the previous year. Additionally many of the breaches are due to patients choosing to wait longer than 2 weeks. An audit by GHNHSFT of their 93 breaches in June found that 75 (81%) were due to patients being unable or unwilling to attend within 2 weeks. Lack of endoscopy capacity has also led to patients having to wait longer than 2 weeks.	GHNHSFT will be proposing measures to reduce the number of patient choice breaches which are the largest component of all breaches. The increased endoscopy capacity has reduced the number of lower GI breaches significantly.

Ref	PCT	Indicator	Status	Issue	Mitigating Action
PHQ03	NHS Glos	At least 85% of patients receiving first definitive treatment for cancer should be seen within 62 days from an Urgent GP referral	**AMBER YTD** 82% in July, 83.5% YTD	Urology has been the specialty which has seen the majority of breaches in Q1. There have been breaches associated with the lung pathway and patients accessing endoscopy diagnostic, however these issues have been addressed.	NHSG has issued a Performance Notice to GHNHSFT and held a Performance Management Meeting with the trust on the 7th September to understand the actions being taken to deliver the performance standards. GHNHSFT has submitted an action plan primarily around Urology patients with the following actions: - Increase theatre capacity (inc. evening & weekend sessions) - Review of clinical staffing rota's - Employment of a Consultant and Clinical Fellow Performance is expected to remain below target in August but recover in

Ref	PCT	Indicator	Status	Issue	Mitigating Action
					September.
Primary and Community Care					
LO1	NHS Glos	The average wait to be seen by the Adult Physiotherapy Service should be within 2 weeks	**AMBER YTD** 2.3 in July	Gloucestershire Care Services (GCS) believe that the main problem is long waits in the Stroud & Gloucester Localities.	A Performance Management Meeting was held on 30th August 2012 to agree and review the GCS action plan which includes: - Recruitment of a total of 5 locums (2 physios , 3 podiatrists) all now in post - Increasing permanent staffing capacity to manage the increased levels of activity - Permanent staff expected to be in place by November (2.0WTE for Podiatry and 1.4WTE for Physiotherapy) - GCS expect performance to be attained in both specialities from the end of September 2012
LO3	NHS Glos	The average wait to be seen by the Podiatry Service should be within 2 weeks	**RED YTD** 3.1 in July	Through a combination of an increase in activity and staff shortages a backlog has built up that has led to increased average waits.	

Ref	PCT	Indicator	Status	Issue	Mitigating Action
					Progress is being monitored weekly and the latest information indicates that performance is back on plan.
Improving Access to Psychological Therapies (IAPT)					
PHQ13_5	NHS Glos	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	**AMBER YTD** 1.7% in Q1 against a plan of 2.2%	This target was achieved in 2011/12. 2gether NHS Foundation Trust has stated that the dip in performance is due to not all patients being asked to complete a baseline questionnaire. This is imperative if patients are to be counted for both aspects of these targets.	NHSG held a Formal Contract Performance Meeting on the 25th September with 2gether who presented a recovery action plan and trajectory. This is based on increasing referrals into the service and shows that the target will be achieved at year end. It has be agreed that progress of this recovery plan will monitored monthly to ensure that any slippage can be identified as soon as possible and remedial actions instigated in-year.
PHQ13_6	NHS Glos	The proportion of people who complete therapy who are moving towards recovery	**AMBER YTD** 43.8% in Q1 against a plan of 50%		
Quality					

Ref	PCT	Indicator	Status	Issue	Mitigating Action
PHQ28	NHS Glos	Number of C.Diff infections (Health Community)	**RED YTD** 29 against target of 13 in August, YTD 29 over Plan	Despite improved performance in recent months the August figure was above the agreed ceiling level. No specific themes can be identified to account for the increase; however similar levels of increases have been experienced in other health communities.	NHSG is working with Primary Care and all health care providers to ensure that anti-biotic prescribing are within guidelines and that RCAs (Root Cause Analysis) are carried out where clinical concerns exist. NHSG will be part of a South West review group of community infections, to further understand the increases seen across the South West in July. NHSG has also set up an infection control group with the Dir. of Nursing chairing this group to take a more detailed view of the infections within the county.

3 NHSG Revenue Financial Position 2012/13 – Overview

3.1 NHS Gloucestershire (NHSG) has planned to deliver a surplus of £8.9m for the year 2012/13 against an anticipated revenue resource limit of £962.7m. Appendix 1 shows the income and expenditure position for the year. Appendix 2 illustrates the position for expenditure and outturn variance.

3.2 The income and expenditure year to date position at 31st August 2012 is a surplus of £3.7m. This is in line with the planned year end position of £8.9m surplus. Table 1 below identifies the key variances at Month 05:

3.3

Programme area	Forecast Outturn Variance £'m
Healthcare Providers	(2.8)
Primary Care & Prescribing	0.8
Admin & Provisions	0.0
Reserves	10.9
Total	8.9

3.4 Gloucestershire Hospitals NHSFT – Contract overview

3.5 The Month 4 overall year to date position is £2.0m overspent (£1.1m at month 4). GHFT data available at month 5 reporting is complete up to month 4. The following report is based on extrapolation of the month 4 data.

3.6 At this stage in the contract year there are significant variables with assumptions included that will affect the eventual full year contract outturn position. The biggest variable is the £12.3m of planned QIPP (quality, innovation, productivity, prevention) savings within the contract to be achieved.

3.7 A contract forecast outturn overspend of £6.7m (£5.4m at month 4) is reported. Key issues generating the overspend increase are Emergency admissions and Excluded drugs (Lucentis).

3.8 This reported position currently assumes the majority of QIPP is achieved. Assessment of 'actual' scheme delivery will be taking place as we progress through the year.

3.9 A summary of the significant variances along with an explanation of the issues and mitigating actions are given in the table below.

Finance Section - exceptions based on significant overspend variances in the NHSG outturn variance

(Sign convention – a positive value indicates an underspend, negative (-) value indicates an overspend)

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
Secondary Health Care Provision				
Planned Care				
GHFT contract – Excluded Drugs	-£0.4m	-£1.1m	Lucentis Drugs activity is 7% year to date above activity plan at Month 4.	Discussions are currently taking place around a supplier discount rate on Lucentis. On-going assessment of activity trend increase to validate if this growth rate continues or levels.
Unscheduled Care				
GHFT contract – Emergency admissions	-£2.4m	-£6.3m	The current forecast overspend is based on a review of previous year trends that suggests that the variance will stabilise after the first half of 11/12.	Work is continuing to understand the root causes of the variance and identify any issues that can be addressed.

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			If it continues to escalate through the second half year there is another £2m risk.	
GHFT contract – Maternity/other Non-Elective admissions	-£0.44m	-£0.8m	Increased Obstetric admissions trend above planned levels.	This variance is being reviewed. Indication is that the numbers of births have not significantly increased but complexity of births (e.g. increased C-sections) and levels of non-delivery admissions have increased resulting in this variance.
Other Contractual				
GHFT contract – QIPP delivery	-£2.0m	-£3.6m	The reported forecast position currently includes £7.3m of the £12.3m QIPP requirement as 'assumed' contract benefit. However, in addition to the assumed QIPP benefit, £1.4m of Emergency threshold	Planned Care and Unscheduled Care programme leads will be reviewing each scheme delivery assumption and potential for additional schemes on an on-going basis.

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			adjustment has also been accounted for within the reported contract position. As a result £3.6m lower delivery than the contract plan is reported. The original planned benefit was profiled as being delivered later in the financial year. Overall scheme delivery will be reviewed each month.	
Out Of County Contracts			At month 5, North Bristol Trust (NBT) and University Hospitals Bristol Trust (UHBT) continue to face some system based information problems. Month 4 monitoring forecasts a £0.1m overspends on the NBT contract in non-electives	We are in contact with UHBT and NBT to understand the impact of the information problems and changes to their cumulative position. NBT have greater issues, and are planning to have worked these through by the end of November.

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			(plastic surgery, general medicine and urology); whilst UHBT forecasts a small underspend at Month 3. Elsewhere, Great Western forecasts an overspend of £0.4m on elective T&O and PBR excluded devices. UH Oxford forecasts an overspend of £0.4m in non-elective T&O and cardiology.	
Specialist Commissioning				
South West Specialised Commissioning Group (SWSCG)			Forecast underspend of £1.7m, based on month 3 data. Underspend of £1.3m on Mental Health- largely due to forecast on low secure, and £0.4m on acute- with GHT forecasting the largest underspend within this. Best case based on SWSCG's	We will work through SWSCG information to unpick straight-line variances as they arise and keep in close contact with them in relation to their QIPP delivery. NCA budget assumptions, particularly around Heart of

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			estimate. Worst case takes SWSCG's position then adjusts for NCA budget transfer assumptions made in SWSCG.	England need resolution.
Non Acute				
Continuing Healthcare (CHC)	£1.2m	£2.9m	As at month 5, low placement numbers and associated costs have resulted in a significant forecast under spend. Month 5 has seen a slight increase in numbers of CHC funded Older People placements, thus reducing the forecast under spend by approximately £0.1m from month 4. CHC budgets were reduced by £2.2m for 12/13 due to significant QIPP achievement in 11/12. The £2.9m forecast under spend is against this rebased	Continual close monitoring in conjunction with Funded Nursing Care placement numbers and costs, which are likely to rise as CHC costs fall. At present however, there is only a small YTD overspend reported against FNC.

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			budget.	
Funded Nursing Care (FNC)	-£0.22m	-£0.52m	Reduction in CHC eligibility has led to increased pressure on FNC budget. Particular increase around Self-funders from m4 to m5	See above (CHC)
Mental Health	-£0.27m	-£0.65m	There are currently a large number of Eating Disorder (ED) placements in out of county placements, if this number continues the financial pressure on the ED budgets could rise.	On-going placement reviews in ED.
Learning Disabilities	-£0.21m	-£0.5m	Delivery of QIPP savings plans has left a potential financial pressure around Joint Funded placements in particular.	Discussions around additional Social Transfer related funding is taking place in hope of mitigating risk of pressure in this area.
Acquired Brain Injury	£0.20m	£0.5m	Placement numbers have reduced from 4 to 1 since the beginning of the year.	

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
Primary care				
Community Pharmacy	£-0.32	£-0.9	Part of the overspend relates to higher than planned prior year costs. The pattern of spend from previous years indicates claims will be higher as the year progresses.	On-going monitoring and liaising with medicines management team
Dental	0.49	1.0	Dental Budget continues to under spend against available resources. Higher dental income in month 4 contributing to higher under spend in month.	On-going monitoring and liaising with Primary care team.

4 Recommendations

4.1 The Board is asked to:

- **Take note of the reported financial position for 2012/13**
- **Take note of the performance against national targets and the actions taken to ensure that performance is at a high standard.**

5 Appendices

5.1 Appendix 1: NHSG Income and expenditure position for 2012/13 as at month 5
Appendix 2: NHSG Year to date expenditure and Outturn variance at month 5
Appendix 3: NHSG Performance Scorecard
Appendix 4: NHSG Capital programme 2012/13 at month 5
Appendix 5: NHSG Better Payment Practice Code
Appendix 6: NHSG Cash Reconciliation
Appendix 7: NHSG Balance Sheet

Agenda Item 11

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	**Thursday 11th October 2012**
Title	**QIPP Programme Update**
Executive Summary	This paper provides the GCCG with an update of progress against the QIPP themes and main programmes of work, identifying progress to date, key risks and proposed remedial actions.
Key Issues	• NHSG has planned to deliver a surplus of £8.9m for the year 2012/13.
Risk Issues: **Original Risk** **Residual Risk**	**Risk:** Non delivery of saving and service redesign plans. **Addressed by:** Close working with the Project Management Office. Identification of additional saving schemes and slippage within other service area budgets. **Current rating:** 15 **Risk:** QIPP programme benefits realisation shifts. **Addressed By**: Project management and performance data utilised to predict benefits realisation, reduce level of risk within assumption. Work programmes continue to drive harder on savings delivery in year. **Current Rating**: 8
Financial Impact	Not meeting key financial targets
Legal Issues(including NHS Constitution)	Not applicable.
Impact on Equality	Not applicable.

and Diversity	
Impact on Health Inequalities	Not applicable.
Impact on Sustainable Development	No sustainable development issues are highlighted by the report.
Patient and Public Involvement	Not applicable.
Recommendation	The GCCG are asked to: • Take note of the performance against planned QIPP programme and the proposed remedial actions.
Author	Kelly Matthews
Designation	PMO Lead
Sponsoring Director (if not author)	Mary Hutton

Agenda Item 11

Gloucestershire Clinical Commissioning Group
(Shadow Board)

Thursday 11th October 2012

QIPP Programme Update

1 Introduction

1.1 NHS Gloucestershire has a requirement to deliver £29.8m recurrently from its QIPP programme, to ensure financial stability moving into 2012/13. NHS Gloucestershire are currently developing QIPP plans to support the planned delivery of a surplus £8.9m in 2012-13. To achieve this position commissioner QIPP schemes are being delivered in conjunction with local providers to ensure whole system reform. To support this change NHSG has identified a source of invest to save funding and maintains uncommitted headroom to pump prime service change.

This paper and supporting appendices sets out the key progress to date, key risks and proposed remedial actions and provides an overview of the 2012/13 QIPP programme currently being developed.

2 QIPP Programme Overview

2.1 QIPP Themes

The QIPP programme covers the breadth of the commissioning agenda and all themes are underpinned by a core principle of care closer to home, in line with the organisational strategy.

The rolling QIPP programme continues to build on 2011-12 and has been split into the following themes and programmes.

QIPP Theme	Programme
Unscheduled Care & Long Term Conditions (Including Community Care)	• System wide change • Pathway Development (Assessment, Diagnostics and Ambulatory Care) • Self-Care Management and

	Prevention. • Community Provision
Planned Care	• Contract Strategy • Service Strategy (including use of clinical programme approach) • Demand Management
Reducing variability in Primary Care	• General Medical Services • Optometry • Dental
Prescribing	• Best Practice • Waste Medication • Medicine Optimisation • GP Dispensing • Joint Formulary
Mental Health and Learning Disabilities Services	• Improve services for clients with challenging behaviour • Improving Health Inequalities • OOC Placements • Eating Disorders • Access to Psychological Therapies
Continuing Healthcare	• EoL Domiciliary Care Procurement • Testing Eligibility • Reducing Referrals
Non Clinical	• Estates • Back Office

The supporting appendices provide a detailed overview of the programme and individual projects.

3 Finance

Savings Plan 2012/13

Against a requirement to deliver £29.8m worth of savings in 2012/13, across the QIPP programme plans are in place to deliver £30.5m of cashable savings, as shown in table below.

Theme	Target Savings	Planned Savings (Rec)	Planned Savings (Non Rec)	Grand Total	Savings Gap (In Cash Terms)
Unscheduled Care / Long Term Conditions	£5,043	£4,252	£791	£5,043	£0
Planned Care	£5,691	£5,547	£50	£5,597	-£94
Prescribing	£7,526	£7,526	£0	£7,526	£0
Primary Care	£1,500	£0	£1,500	£1,500	£0
Community Care	£3,000	£3,109	£0	£3,109	£109
Mental Health	£1,200	£850	£0	£850	-£350
Learning Disabilities	£2,500	£2,500	£0	£2,500	£0
Continuing Health Care	£2,200	£2,200	£0	£2,200	£0
Non Clinical	£1,150	£0	£650	£650	-£500
Contract Contributions	£0	£1,523	£0	£1,523	£1,523
Grand Total	**£29,810**	**£27,507**	**£2,991**	**£30,498**	**£688**

The over planning of savings allows for risk mitigation in relation to shifts in the potential realisation. Alongside the savings shown above further benefits in relation to avoiding growth equates to an additional £1.8m of benefit.

Based on the application of assumed timescales for delivery of individual QIPP schemes, the table below demonstrates expected phasing of savings delivery by quarter throughout 2012/13. As can be noted from the quarterly profiles above significant delivery is required from quarter 2 onwards.

(Note: all figures are shown in £000's in all tables)

Theme	Q1	Q2	Q3	Q4
Unscheduled Care / Long Term Conditions	£556	£1,449	£1,589	£1,448
Planned Care	£220	£1,382	£1,973	£2,023
Prescribing	£4,132	£1,132	£1,132	£1,132
Primary Care	£0	£0	£750	£750
Community Care	£750	£786	£786	£786
Mental Health	£0	£0	£175	£675
Learning Disabilities	£0	£833	£833	£833
Continuing Health Care	£1,750	£150	£150	£150
Non Clinical	£0	£0	£0	£650
Contract Contributions	£381	£381	£381	£381
Grand Total	**£7,788**	**£6,113**	**£7,769**	**£8,828**
	26%	*20%*	*25%*	*29%*

Savings Position as at end August 2012.

At month 5 the projected savings delivery within 2012/13 is £27.2m of cashable savings, as shown in the table below.

Theme	Target Savings	Assumed Savings (Rec)	Assumed Savings (Non Rec)	Assumed Grand Total	Savings Gap (In Cash Terms)
Unscheduled Care / Long Term Conditions	£5,043	£2,309	£1,396	£3,705	-£1,338
Planned Care	£5,691	£4,139	£25	£4,164	-£1,528
Prescribing	£7,526	£7,526	£0	£7,526	£0
Primary Care	£1,500	£0	£1,426	£1,426	-£75
Community Care	£3,000	£2,487	£0	£2,487	-£513
Mental Health	£1,200	£675	£0	£675	-£525
Learning Disabilities	£2,500	£2,000	£0	£2,000	-£500
Continuing Health Care	£2,200	£3,080	£0	£3,080	£880
Non Clinical	£1,150	£0	£590	£590	-£560
Contract Contributions	£0	£1,500	£0	£1,500	£1,500
Grand Total	**£29,810**	**£23,716**	**£3,436**	**£27,152**	**-£2,658**

The gap from financial requirement can be addressed with non recurrent contingent resources.

The mitigating actions to address the projected £2.7m shortfall on a recurrent basis can be noted as:

1) Continue to increase the planned savings position to over plan beyond requirement; building in contingency for slippage in scheme delivery.
2) Review of in year delivery to assess if the benefits realisation from existing projects can be increased.
3) There is a focus on understanding the increased unscheduled care acute admissions; to ensure QIPP programmes are in place to effectively impact upon the increased spend and ensure services are developed to care for people at right time, in right place.
4) The Your Health, Your Care strategic implementation plan is modelling the impact from the priority areas for change, including key components of the QIPP programme, over the next 5 years to ensure recurrent change into 2013/14 and beyond.

4 Current Key Risks and Proposed Remedial Actions

The key risks from across the QIPP programme can be noted within the table below, alongside their remedial actions:

Key Risks	(L) (1-5)	(C) (1-5)	Total	Remedial Actions
Insufficient plans for reassurance regarding financial stability moving into 2012/13.	3	5	15	Director leadership at theme level, further projects in development for additional saving. Contingency and non-recurrent slippage identified to support delivery of control total. Further ideas under development.
Insufficient engagement across the health community with regards to savings plans.	2	4	8	Theme directors responsible for ensuring contractual engagement, QIPP health community groups in place to ensure senior clinical, management and financial sign up. Joint approach to inclusion in contracts for 2012/13. Alignment to Gloucestershire Strategy for Care.
Insufficient detail to map impact in relation to workforce and provider capacity.	3	4	12	Business case process requires that all projects are fully scoped for service outcomes including workforce and bed impact. Routine performance management of both business case preparation and project implementation ensures consistent and targeted focus on these areas. The Resources Steering Group routinely review system workforce and capacity impacts as part of the strategic review for the health community operating framework and plan.
Signification proportion of 2012-13 business cases still under development with no planned go live date.	2	4	18	Focus pieces of work across Gloucestershire Health Community to progress development of business case.

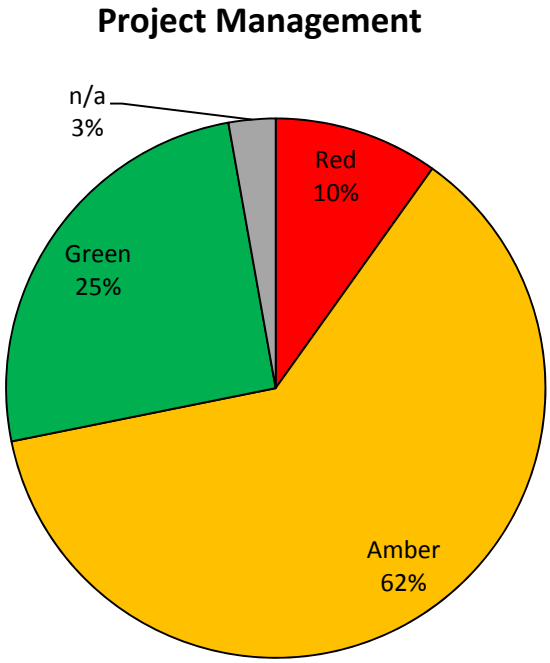
5. QIPP Programme Updates

A robust programme management process has been developed to ensure governance mechanisms are in place to performance manage delivery.

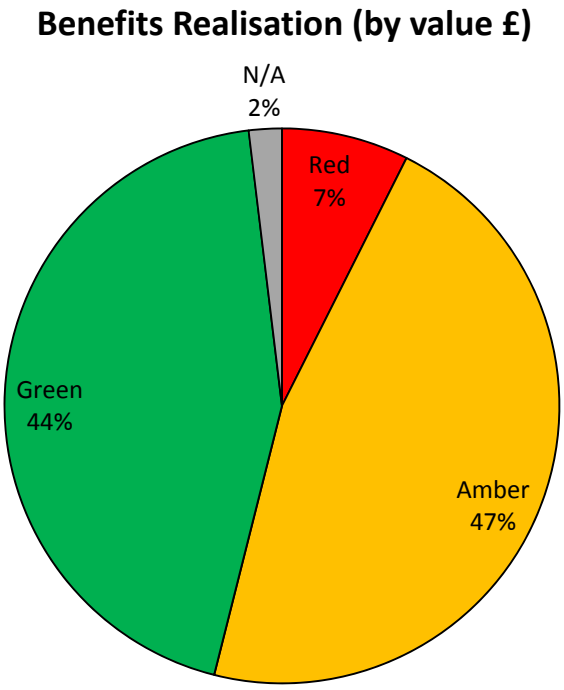
Programmes and projects are assessed in relation to the following 2 perspectives:

- Project Management. Robustness of project plan and ability to deliver against key milestones for implementation.
- Benefits realisation. Ability to deliver financial outcome as proposed within the original project plan assumptions.

Currently there are 71 QIPP projects included within the programme, assigned as Raised, Open (Implementation) and Open (Performance Management) of which the % assessed as red, amber of green rating for project management are shown in the chart below.



Since the previous report the projects assessed as green have increased to 31% (from 25%), amber risk rating has decreased to 53% (from 62%) and a subsequent slight increase in red schemes to 13% (from 10%).



Since the previous report the projects assessed as green have increased to 44% (from 30%), amber risk rating has decreased to 47% (from 63%) and a subsequent slight increase in red schemes to 7% (from 5%). There is a noted shift in benefits realisation; at this point in the year we are able to assess the ledger position more accurately to note whether major schemes are on track, most significantly CHC and Prescribing.

The current highlight programme report is attached within appendix A, detailing:

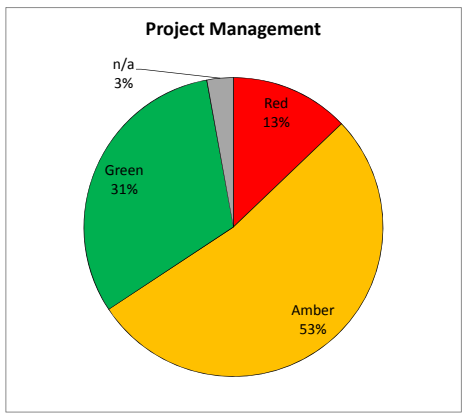
- Key Achievements
- Red or significant amber risk programme areas and mitigating actions.

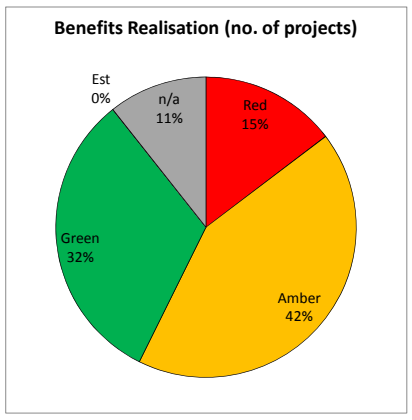
5 Supporting Documents

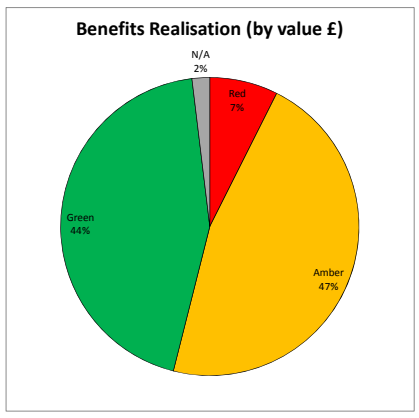
Appendix 1: QIPP Highlight Performance Report (September 2012)

Programme Management Office

QIPP Highlight Performance Report September 2012
Overview







Key		
Project Status:	**Green**	Project documentation well developed programme of work on track.
	Amber	Further work required within project documentation, some slippage in milestones.
	Red	Limited project documentation completed or project implementation delayed.
Benefits Realisation:	**Green**	KPIs on track, high level of confidence in ability to deliver outcome, contract mechanisms are in place.
	Amber	The scheme is on track but concerns around benefits to be realised.
	Red	Limited or no confidence in delivery of outcome.

Red Programme	**Reasons and Actions**
Planned Care	(Red rating based on both project management and benefits realisation assessment, dependent on size, priority and complexity of workstream)
Consultant to Consultant Referrals	Consultant to Consultant Referral Policy was not agreed with GHNHSFT in 2011-12 and therefore benefits were not realised. Project has been rolled forward for 2012-13, 100% risk share to NHSG, £250k saving. Assurance will be required as to approach to agreeing policy with GHNHSFT and timescale. NHS Gloucestershire programme lead is currently exploring opportunity across all 'other' referrals i.e. midwifery.
Community IV Service (Planned Procedures)	Operational pathway issues still flagged by GHNHSFT and require further provider to provider (GCS to GHNHSFT) conversation to resolve clinical issues. Scheme implementation delay and secondary care pathway issues will have significant impact upon activity as the service and benefits realisation commenced in November 2011. Ongoing performance management of scheme monitored by NHSG & GCS QIPP Performance Operational Group. Performance data at year end of 2011/12 showed limited impact.
Significant Amber Risks	
Telehealth (LTC Theme)	As at 1st October 2012, 512 patients have been referred to telehealth within the county - the deployment of units across Gloucestershire remains challenging. A robust communication and engagement plan is in place and will be need to be further developed throughout 2012-13 in order to reach 2000 unit deployment trajectory. Additional resource has been agreed to support clinical engagement.
T&O Programme	A 90% risk share (GHNHSFT) has been agreed for the 2012-13 T&O Pathways Programme, which has resulted in the programme moving from red to amber risk rating. However NHSG are committed to developing a joint programme with GHNHSFT to deliver the £1.8m savings target. Pathways implemented in 2011-12 saw little impact upon activity and were not assessed alongside substantial backlog. The 2012-13 programme with align 18wk RTT to pathway development. Generic MSK pathway mapping events took place in July and a draft pathway was developed; further details of each step are currently being worked up and feedback gathered from GPs and Consultants. A spinal pathway workshop was held on 25th July 2012 and where gaps in the current pathway were identified and seperate workstreams developed to analyse and work up potential future options.
Dermatology	As part of the clinically led programme strucuture in place by CCG, a Dermatology programme is under development. The component projects include Demand Management, work on Primary Care DES, Advice & Guidance, Interface Services (both equity of provision and alignment) and clinical guidelines (including specific pathway re design). A programme team has been established led by Dr Andy Seymour. Key programme outcomes to date include Dermatology Advice & Guidance and an Interface Service for Tewkesbury went live in June 2012. A Gloucester City GPSI Dermatology Service trial has been to market an a preferred provider appointed - aiming for service go live in October 2012. The Clinical Programme Board continue to develop a health community approach to thedesign and implementation of a future intermediate tier model, with an aim to implement during 2013/14.
Enhanced Community Provision	The Enhanced Community Provision Programme equates to £2.4m of the USC programme in 2012-13, with a two thirds risk share to NHSG. Projects within the programme include Living Well and Use Of Community Hospital Beds. Project documentation and timescales are required for the PMO to assess impact and provide assurance against an anticipated impact from the start of Q2. A Community Hospital Group has also been established by GCS.

	Significant Progress to Date
GP Peer Review	GP Peer Review (3 specialty min.) went live countywide in November 2011, with all practices in the county signed up to a form of peer review (in house design or NHSG QoF QP Scheme). Performance data (Nov -11 to September -12) indicates a 7.7% reduction in GP referrals for those specialties selected and a 0.2% reduction in referrals for those specialties not selected. The 12-13 scheme will aim to expand to all practices peer reviewing all specialty referrals by September 2012 - currently 86% of practices have signed up to the LES scheme.
Advice & Guidance	Advice and Guidance commenced with Dermatology in June 2012. Initial uptake and feed back has been positive in both primary and secondary care. At the end of September 2012 100 referrals for Dermatology Advice & Guidance had been received, 57% were returned to primary care and 29% onwardly referred to secondary care. The joint working group (NHSG & GHNHSFT) have idenitifed Haematology and Renal as the next specialties to go live in November 2012.
Respiratory - Pulmonary Rehab	Service commenced 1st November 2011 and Pulmonary Rehabilitation courses are available to patients across the county.
CHC	In terms of benefits realisation this QIPP Programme is forecast to over deliver against the initial target set.
Joint Funding & CHC Reviews (Learning Disabilities Theme)	GCC and NHSG Joint Funding Policy and Criteria was agreed at the Joint Commissioning Partnership Executive on 24th July 2012. Reviews of the current 230 joint funded individuals have began with an aim to ensuring that correct care and funding is in place.
Prescribing	Prescribing growth rate currently -0.77%, 4th best in South West region.