NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 30th January 2014 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1	Apologies for Absence	Chair	
2	Declarations of Interest	Chair	
3	Minutes of the Meeting held on Thursday 28th November 2013	Chair	Approval
4	Matters Arising	Chair	
5	Patient's Story	Becky Parish	Information
6	Public Questions	Chair	
7	Chair's Update	Chair	Information
8	Accountable Officer Update	Mary Hutton	Information
9	Joining-up Your Care Update	Jonathan Jeanes	Information
10	West of England Academic Health Science Network Report (WEAHSN)	Mary Hutton	Information
11	System Leadership Programme Update	Alice Walsh/Hein Le Roux	Information
12	Performance Report	Cath Leech	Information
13	Assurance Framework	Cath Leech	Information
14	Our Journey for Quality 2014 to 2019 Summary	Marion Andrews-Evans	Information
15	Equality Information - Annual Report	Marion Andrews-Evans	Information
16	Integrated Governance Committee Minutes	Julie Clatworthy	Information
17	Audit Committee Minutes	Colin Greaves	Information

18	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 27th March 2014 at 2pm in the Board Room at Sanger House			

Gloucestershire Clinical Commissioning Group (CCG)
Governing Body

Minutes of the Meeting held on Thursday 28th November 2013
in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Dr Helen Miller	HM	Clinical Chair
Dr Steve Allder	SA	Secondary Care Specialist
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Caroline Bennett	CBe	GP Liaison Lead
Dr Charles Buckley	CBu	GP Liaison Lead
Julie Clatworthy	JC	Registered Nurse
Dr Malcolm Gerald	MGe	GP Liaison Lead
Colin Greaves	CG	Lay Member - Governance
Dr Will Haynes	WH	GP Liaison Lead
Mary Hutton	MH	Accountable Officer
Jonathan Jeanes	JJ	Interim Director of Transformation and Service Redesign
Cath Leech	CL	Chief Finance Officer
Dr Hein Le Roux	HLR	GP Liaison Lead
Dr Andy Seymour	AS	Deputy Clinical Chair
Mark Walkingshaw	MW	Deputy Accountable Officer
Alice Walsh	AW	Interim Director of Public Health
Valerie Webb	VW	Lay Member - Business
Dr Jeremy Welch	JW	GP Liaison Lead
Margaret Willcox	MWi	Director of Adult Social Care, GCC
In attendance:		
Becky Parish	BP	Associate Director Patient and Public Engagement
Marian Hoyle	MHo	Head of Patient Experience
Caitlin Lord	CLo	PALS Advisor
Alan Potter	AP	Associate Director Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 2 members of the public present.		

1 Patient's Story

1.1 The Chair welcomed the Patient and Public Engagement and Patient Experience Team.

1.2 CLo presented a patient case study to the meeting which concerned a patient who has had difficulties accessing the home dialysis service. The issue was that new referrals for home haemodialysis (HHD) had been suspended since earlier in the year due to difficulties with a provider's subcontractor who was providing the service. Although this was a specialist commissioning issue, the patient was helped by the PALS team.

1.3 <u>RESOLUTION:</u> The CCG Governing Body agreed that further discussion on these issues should be held at the next IGQC using this case to identify learning and action points for both commissioners and providers.

2 Apologies for Absence

2.1 Alan Elkin, Rob Rees and Dr Martin Gibbs.

3 Declarations of Interest

3.1 The following declaration was made:

- WH is married to Dr Sarah Vestey, Consultant Breast Surgeon at the Gloucestershire Hospitals Foundation Trust.

4 Minutes of the Meeting held on Thursday 26th September 2013 and Extraordinary Meeting held on 24th October 2013

4.1 The minutes of the meeting held on Thursday 26th September 2013 were approved subject to the following amendments:

- Section 7.4 to be amended read – *'Admissions – Decrease in 3.4% from previous year and work is underway in identifying the reason for this challenge.'*
- Section 15.4 to be amended to read – *'JC felt that the Strategy does not encompass some of the simple technologies which have been around for a while and queried the scope of the Strategy.'*

4.2 The minutes of the extraordinary meeting held on Thursday 24th October 2013 were approved.

4.3 JJ updated the Governing Body on the Call to Action process. Members heard that the process for developing the 5 year Commissioning Plan was discussed at the Governing Body on the 26th September 2013 where the process to be used to support the decision making was agreed. It was noted that the most crucial phase of the development of the 5 year Commissioning Plan is the engagement phase with partners, staff and the public and aligning this with the national Call to Action engagement process. JJ reported that the CCG has been engaging closely with partners to generate ideas and to help prioritise what will be included in the wider public engagement process. JJ reported that the 8 week engagement process will be launched on the 2nd January 2014 to give the opportunity to feedback on our ideas. JJ highlighted that there are three key tools for engagement. These are:

- a booklet with questionnaire for responses;
- 'Jack's' story (describes scale of the challenge, our vision for meeting the challenge, using 'Jack' as an example of how integration can improve care); and
- several shorter animated case studies.

5 Matters Arising

5.1 26.09.13 AI 5.5 – System Leadership Programme update is on the agenda. **Complete**

5.2 26.09.13 AI 8.8 – The Children and Families Bill 2013 potential risks are being considered as part of the current risk register review. **Complete**

6 Public Questions

6.1 There were no questions received from the public.

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

7.1 HM presented the Chair's report which was taken as read. The report provides a summary of key issues arising during October and early November 2013.

7.2 It was reported that HM and MH had attended a reception for health professionals at 10 Downing Street, where David Cameron and Jeremy Hunt were in attendance. HM met with Jeremy Hunt, Norman Lamb and David Cameron and had represented Gloucestershire CCG as being exceptional and invited them to visit.

7.3 HM advised that the Gloucestershire Practice Managers Event at Hatherley Manor was well attended. It was noted that 82 Practices had attended who were immensely engaged and who play a pivotal role in Primary Care. It was noted that these events would be an ongoing theme in supporting Primary Care.

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

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

8.1 The Accountable Officer introduced the report which was taken as read and provides a summary of key issues arising during October and November 2013. The key issues highlighted were:

8.2 Contracting round 2014/15 – MH advised that the draft commissioning intention is still outstanding and currently being developed with the final version to be issued in December 2013. MH updated members on a number of other emerging deadlines for the planning process.

1. The National Planning Allocation guidance is anticipated w/c 16th December.
2. The draft Year 1 and 2 Commissioning Plans need to be submitted by the 14th February 2014 and be formally signed off by the Governing Body by 31st March 2014.
3. Contracts needs to be signed off by 28th February 2014.
4. The two year plan for the Integration Transformation Fund will need to be developed and agreed by the Health and Wellbeing Board and be submitted in draft by the 15th February 2014. MH advised that an update on progress will be presented at the January Governing Body.
5. There will be an interim report from the engagement process at the end of January.

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

9 West of England Academic Health Science Network (WEAHSN) Report to Boards

9.1 MH presented the report from West of England Academic Health Science Network Board. MH felt it was important that the CCG is involved with the AHSN and this item is to be included on the Governing Body agenda going forward.

9.2 JJ reported that he was involved in the recruitment for the Service Improvements Managers for the AHSN and advised that they are anticipating recruiting in early January 2014. It was noted that each health community will benefit having a Senior Service Improvement Manager combined with a Support Manager.

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

10 System Leadership Programme Verbal Update

10.1 HLR provided a verbal update to the meeting. HLR strated that an offer was made to the Health and Wellbeing Board from the Leadership Centre in London to help facilitate project work to enable lessons to be learned and to improve and develop the systems leadership skills.

10.2 HLR reported that obesity was chosen as a workstream to understand the wider issues for underlying obesity. Members noted that three meetings had been held so far and that two System Facilitators had been recruited. HLR advised that three learning sites had been identified for development of a 'whole community approach' and these are Matson and Podsmead (Gloucester) and Oakdale (Lydney, Forest of Dean).

10.3 HLR reported that he had visited the Podsmead site yesterday which is recognised as an area of deprivation. HLR felt that visiting the local shops within this area gave him an indication of the overall picture. The local shops displayed limited stock of fresh fruit and vegetables. HLR emphasised that this work was about working with, not at, people and working closely with communities as a whole, including food suppliers.

10.4 Members felt it would be interesting to share the outputs and process of the programme and thought it would be a useful learning lesson to apply elsewhere. HLR advised that he is currently reading a background paper regarding this programme and it was agreed for HLR to circulate to members. It was also agreed that a written update will be presented at the January Governing Body meeting. **HLR**

10.5 <u>RESOLUTION:</u> The CCG Governing Body noted the verbal update.

11 Performance Report

11.1 CL presented the performance framework report which provided an overview of Gloucestershire CCG performance for the period to the end of October 2013.

11.2 The report is broken down into the five sections of the CCG performance framework and CL advised that a Lead Director has been assigned to each area for which they will update on key issues.

Clinical Excellence

11.3 MW advised that the ambulance service performance continues to be challenging and reported that an action plan has been provided by South West Ambulance Service Trust (SWAST) which included deploying additional ambulances and staff. MW reported that SWAST commissioned an independent review of all areas of operational performance. The review includes an assessment of all factors affecting Trust performance and is expected to support the Trust in developing additional actions in order to deliver sustained performance improvement. MW advised that an event is being held tomorrow to review the performance information with SWAST and that the result of the external review will be made available on the 9th December 2013.

11.4 The current position for the 62 day cancer performance demonstrates that there was an improvement in October although the final position is still being validated. MW advised that the Gloucestershire Hospitals Foundation Trust (GHFT) has completed a number of recommended actions which included the recruitment of two new consultants within Neurology. MW advised that there is a much improved coordination within the multidisciplinary team across the Trust. Members noted that action plans are more detailed and are on trajectory although it was recognised that there is further work to do.

11.5 MAE advised that although the MRSA target is zero, the more recent cases identified are not within GHFT but it was noted that the progress made is admirable, based on the historic position. MAE advised that the C.diff infections rate is still challenging as there are no emerging trends. It was noted that this is being considered with the NHS England Area Team and that there is learning being shared across the CCG patch. MAE reported that the Area Team recently held a summit on this topic and is monitoring this closely.

11.6 MAE advised that the Area Team are focusing attention on Never Events due to the number reported within GHFT. Members heard that GHFT will be under enhanced surveillance as discussed at the Area Team Quality Surveillance Group. MAE advised that any further Never Events would result in a Risk Summit being convened. The Area Team have arranged a meeting on Monday 2nd December with CQC, Monitor, GCCG and GHFT to discuss this further. MAE agreed to feedback the outcome of this meeting to members. MAE reassured the Governing Body that each reported case is reviewed and closely monitored.

Finance and Efficiency

11.7 CL advised on the financial position to the Governing Body members and it was noted that the overall rating for this perspective is 'Amber'.

11.8 CL reported that there is a risk to the underlying recurrent surplus although it is recoverable. The remainder of the key indicators shows 'green'. CL advised that the CCG is planning to achieve its planned surplus , although there are risks associated with this and pressures are emerging.

11.9 CL advised on the risks identified with the current financial plan:

- Capital Grant - the CCG is awaiting confirmation regarding allocations and the current plan assumes receipt of the allocations. There is a risk that a lower than planned level could be received. There is uncertainty regarding the adequacy of resources available nationally to fund all capital grants.
- Specialist Services – The exercise to establish the funding and transfers to specialist commissioning is still ongoing. CL advised it is likely that it will impact on our position and it was noted that we have an indicative estimate that the transfers will total around £1.5m.

11.10 Expenditure – CL reported that there is over-performance within GHFT and that work is progressing with referrals. This is being reviewed within the localities and plans are being developed to manage this position.

11.11 There is slippage against the planned QIPP schemes although alternative schemes are in development to help mitigate the full extent of the slippage being experienced. It was noted that Integrated Community Teams (ICT) is the biggest slippage area and that the teams are going live on the 8th January 2014.

Patient Experience

11.12 MAE advised that the 'Friends and Family' target indicates 'green', meaning that we met the national deadline. MAE advised that the Head of Patient Experience has put considerable effort into improving the system. It was noted that to achieve the required 15% rate is a challenge particularly around A&E and MIU.

11.13 MAE advised that a 'Staff and Comments box' has been installed in Sanger House. This is to enable the Patient Experience Team to hear feedback from CCG employees; whether a comment, concern, complaint or compliment. It was noted that the result of the annual survey within the provider trust will not be received until February/March 2014.

11.14 MAE advised that the Area Team is focusing on the mixed sex accommodation breaches. It was noted that breaches are still occurring within GHFT. It was acknowledged that when Emergency Departments are under pressure, this results in increased demand on beds. MAE advised that she is informed by the Nurse Director when these incidents occur.

11.15 MW updated members on the 'Getting Mrs Foster Home Week' and advised that this was about all health and social care organisations in Gloucestershire working together to improve patient discharge and transfer processes from acute and community hospitals in a programme called 'Getting Mrs Foster Home'. It was noted that a session has been arranged to capture the learning of that week and to inform the process for the next week planned at Cheltenham General Hospital.

11.16 Members noted that the emergency 4 hour performance for Quarter 3 is 95.45% to date, above the 95% target and is on trajectory to deliver in full for Quarter 3.

11.17 MW indicated that the winter pressures remain a challenge. It was noted that the urgent care system has been under pressure and that whilst the target had been sustainably delivered, the real test lies ahead once the winter commences fully.

11.18 MW advised there was an issue with temporary loss of capacity within cancer services and that the two week wait performance target was narrowly missed in September. MW reported that that target had been achieved in full in October and that there had been additional resources implemented, which included additional evening and weekend sessions to deliver this performance.

Partnership

11.19 MW advised that JJ, MH and KF are working through the Integration Transformation Plan and that the 5 year Commissioning Plan is being developed with key partners and progress has been made on this plan under tight deadlines.

Staff

11.20 MW advised that there is a key focus to ensure that all staff participate in the annual appraisal process. This process would review performance, set objectives and create a personal development plan. It was noted that this process will continue over the next few months.

11.21 CG noted that the sickness rates had improved which was encouraging. HM raised a query that had been forwarded to her by RR, regarding the numbers of staff who are on long term sick leave and if there was a measure for this. MW advised that a small number of long term staff are contributing to these figures and advised that this can be clarified separately. JC advised that the HR Governance is monitored through IGQC.

11.22 <u>RESOLUTION:</u> The CCG Governing Body

- **Noted the financial position as at 31st October 2013 and the inherent risks outlined within the attached report**
- **Noted the performance against local and national targets and the actions taken to ensure that performance is at a high standard.**

12 <u>Assurance Framework</u>

12.1 CL presented the Assurance Framework for 2013/14 which was presented to the IGQC on the 17th October 2013. The Assurance Framework identifies gaps in assurances and controls regarding the organisational objectives, along with details of the principal risks that have been identified by lead managers.

12.2 Members noted that the risks for the Patient Transport Service and NHS 111 had decreased. It was also noted that the patient information risk had decreased as this is being reviewed and worked through nationally.

12.3 The Governing Body members noted that the risk for AQP contract had increased as diagnostic activity had increased. MW responded that the contract has no set financial or activity value and that the contractor is registered to do this work. The challenge recognised is to ensure that access rights are manifested and monitored. It was noted that further work is being undertaken and that the impact on the wider system is being worked through which includes investment in additional diagnostic work on the basis that it will reduce the potential cost of hospital admissions.

12.4 <u>RESOLUTION:</u> The CCG Governing Body noted this paper which is provided for information.

13 <u>Amendments to the Constitution</u>

13.1 AP presented the paper which outlines the proposed changes to the Clinical Commissioning Group's Constitution resulting from a review of the Committee Structure. The principal proposed changes relate to the creation of a Priorities Committee, as discussed at the Extraordinary Governing Body meeting on the 24th October, and amendments to the Terms of Reference for the Audit and Integrated Governance Committees. In addition to the above changes, the existing Constitution had been revised to address minor inaccuracies and grammatical errors.

13.2 AP informed that a formal process needs to be undertaken to change the Constitution for the organisation. It was noted that the first stage of the process is to seek approval from the Governing Body.

13.3 Once approved by the Governing Body, changes to the Constitution will need to be agreed by member practices before approval can be sought from NHS England. AP informed that NHS England have strict deadlines and approval cannot now be sought until 1st June 2014.

13.4 CG highlighted that references to the 'Vice Chair' in the membership for the Priorities Committee on page 150, should read as 'Deputy Clinical Chair'. CG also suggested that the Priorities Committee should report to the IGQC until approval of the revised Constitution is obtained from NHS England. JJ commented that the Priorities Committee will be a smaller group going forward. AP

13.5 RESOLUTION: The CCG Governing Body:

- **Approved the amendments to the Constitution outlined in Section 4 of the report.**
- **Recommended approval of the changes by member practices and, subsequently, NHS England.**

14 Integrated Governance Committee Minutes

14.1 The Governing Body received the minutes of the meeting of the Integrated Governance Committee held on the 29th August 2013.

14.2 RESOLUTION: The CCG Governing Body noted these minutes.

15 Audit Committee Minutes

15.1 The Governing Body received the minutes of the meeting of the Audit Committee held on the 4th July 2013.

15.2 RESOLUTION: The CCG Governing Body noted these minutes.

16 Any Other Business

16.1 There were no items of any other business.

17 The meeting closed at 15:30.

18 Date and Time of next meeting: Thursday 30th January 2014 at 2pm in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair):_____ Date:_____

Matters arising from previous Governing Body Meetings - November 2013

Item	Description	Response	Action with
28.11.13 Agenda Item 10	System Leadership Programme	HLR advised that he is currently reading a background paper regarding this programme and it was agreed for HLR to circulate to members. It was also agreed that a written update will be presented at the January Governing Body meeting.	**HLR**
28.11.13 Agenda Item 13	Amendments to the Constitution	References to the 'Vice Chair' in the membership for the Priorities Committee on page 150, should read as 'Deputy Clinical Chair'.	**AP** **Completed**

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 7

Gloucestershire Clinical Commissioning Group

Governing Body Meeting Date	**Thursday 30th January 2014**
Title	**Gloucestershire Clinical Commissioning Group Chair's Report**
Executive Summary	This report provides a summary of key issues arising during December and early January 2014
Key Issues	The key issues arising include: • Gloucester Respiratory Team Operational • Homeless Patients and Discharges • Clinical Commissioning Event • Lay Member Update • Meetings attended
Risk Issues	None
Financial Impact	None
Legal Issues (including NHS Constitution issues)	None
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable Development	None
Patient and Public Involvement	
Recommendation	**This report is provided for information and the Board is requested to note the contents.**
Author	Helen Miller
Designation	Gloucestershire CCG Chair
Sponsoring Director (if not author)	

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire Clinical Commissioning (GCCG)
Clinical Chair's Report

1 Introduction

1.1 This report provides a summary of key issues arising during December and early January 2014.

2 Gloucester Respiratory Team Operational

2.1 The Community Respiratory Team and the hospital-based Respiratory Assisted Discharge Team have come together to form the Gloucestershire Respiratory Team (GRT) under the management of GCS.

2.2 The GRT will improve the quality of information and advice people receive, reduce lengths of stay in hospital and support GPs and surgery staff in managing complex patients. It provides urgent assessment within 48-72 hours of referral, with non-urgent referrals being seen within 14 days, supported discharge, home oxygen assessments, outpatient clinics and pulmonary rehabilitation.

3 Homeless Patients and Discharges

3.1 Following the decommissioning of the night shelter provision in Gloucester, our Acute Trust colleagues have been unsure where to send homeless patients following discharge, with many not being discharged to any type of temporary housing, despite the fact that they may be recovering from an episode of serious illness.

3.2 The new accommodation provider for chaotic homeless people, P3, has units in Gloucester, Cheltenham, and the Cotswolds which include wrap around services from Turning Point.

3.3 A meeting is being arranged for February between the CCG, P3, GCC, an ED consultant, the acute discharge team manager, Turning Point, and a senior manager at GHFT, to negotiate a discharge pathway for chaotic homeless patients.

3.4 P3 has had success in moving on the majority of their resident service users into new lifestyles since the start of the new programme and it would be positive for service users if ED could link with this provision.

3.5 To further join up services, the Gloucestershire Emergency Accommodation Resource (GEAR) organisation is running a 6 month pilot to provide housing advice (as well as 3 accommodation beds with weekly nursing care) for non-chaotic homeless patients who are discharged from the wards at GHFT. The pilot is funded by the Department of Health at a total of £27,000.

3.6 Additionally, the County Council funds a small homeless inreach and engagement service (to any type of organisation) from GEAR and have agreed to review this and look at the possibility of in reach into A&E, to specifically link with P3 and any other suitable services.

3.7 The work on homelessness is moving in the right direction with our priorities being to improve access to services, and joining up different partners to create clear options for the service users and prevent acute attendances and admissions.

3.8 GCS are also heavily involved in this work and there is an informal GHFT, GCS (homeless healthcare team), CCG, and GEAR working group who meet every 6 weeks. The CCG has asked that GCC join the group.

4 Clinical Commissioning Event

4.1 The CCG will be holding a clinical commissioning event for all GPs and other Practice staff to attend for a day in May/June this year (date currently being finalised). Partner organisations will also be invited from across the local NHS, Local Councils and third sector.

4.2 We want to ensure the day is used to support our local GPs in their roles as clinical commissioners, in addition to their roles as service

providers. We will take the opportunity to update colleagues on what the CCG has achieved, together with its partners, during its first year, as well as looking forward to describe our plans for the future.

4.3 As an event, to which we want to attract as many of our member practices as possible, we are planning an interesting and interactive day that will attract representation from all our member practices. A number of GPs locally have already been to events held by 'Hot Topics' – a group of Oxfordshire GPs who use an innovative approach to bring to life clinical evidence in a stimulating way.

4.4 We are delighted therefore that they have agreed to be a part of our day and think they will be a major attraction for our local GPs.

4.5 We will update the Governing Body nearer the time, when we have finalised the agenda. In the meantime, a small working group has been established, chaired by Dr Helen Miller, to lead the planning for the day.

5 Lay Member Update

5.1 Rob Rees, one of our Lay Members has advised the CCG that he has significant unexpected commitments and we have agreed that he will take a 6 month break from his CCG role, effective from the end of December 2013. This position will be reviewed in May and the Governing Body will be updated.

5 Meetings Attended

5.1 Opened for the Dementia Summit at Cheltenham Racecourse.

5.2 Visited the Cobalt Imaging Centre, Cheltenham.

5.3 Attended Kingfisher Treasure Seekers Church Christmas Show with invited guest Dr David Haslam (Chair of NICE) and Bill McCarthy (NHS England).

6 Recommendation

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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 8

Gloucestershire Clinical Commissioning Group

Board Meeting Date	**Thursday 30th January 2014**
Title	**Gloucestershire Clinical Commissioning Group Accountable Officer's Report**
Executive Summary	This report provides a summary of key issues arising during December 2013 and January 2014
Key Issues	The key issues arising include: • Integrated Community Teams • Winter Plan/Urgent Care update • PTS Update • Out of Hours (OOH) Procurement • 7-day Working • Military Covenant Workshop – Signing of Covenant
Risk Issues	None
Financial Impact	None
Legal Issues (including NHS Constitution issues)	None
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable	

Development	None
Patient and Public Involvement	
Recommendation	**This report is provided for information and the Board is requested to note the contents.**
Author	Mary Hutton
Designation	Gloucestershire CCG Accountable Officer
Sponsoring Director (if not author)	

Gloucestershire Clinical Commissioning (GCCG)
Accountable Officer's Report

1. Introduction

This report provides a summary of key issues arising during December 2013 and January 2014.

2. Integrated Community Teams

Strengthening adult health & social care integrated community teams (ICTs) update

As members know, in order to develop the capacity and capability of community services to help reduce the demand on secondary care services we are introducing a 24 hour single point of clinical access (SPCA), rapid response services and high intensity services in addition to the existing range of core ICT services provided by Gloucestershire Care Services (GCS). This will initially be in Gloucester City and then Cheltenham before wider roll out across the county during 2014.

Over the last few weeks, we have been working with GCS and practices in Gloucester City to put the extra services in place. Whilst GCS colleagues have a number of staff ready to provide the service and have worked hard in putting the elements in place, we have been finalising some practical details to ensure services get off to a smooth start. More specifically work has been focussed on the following:

- Assurance review of key commissioning requirements;
- Continuation of the review of financial requirements;
- Visits to individual practices in Gloucester to explain operation of services;
- Recommencement of recruitment campaign by GCS for additional staff;
- New weekly joint implementation meetings between GCS and GCC;

- Production and review of key clinical protocols;
- Additional ICT team sessions;
- GCS 'table top' simulation exercises;
- Finalisation of interim service specification and key outcome measures.

Subject to a final testing of operational readiness, we now expect extra services to go live in Gloucester City from Wednesday 22 January and will confirm the date for Cheltenham over the next few months.

3. Winter Plan/Urgent Care Update

➢ Additional Winter Funds:

In November 2013 NHS England announced additional non-recurrent funding to support health communities in the effective delivery of winter plans. Gloucestershire have identified a number of schemes including:

- Paediatric oxygen saturation monitoring
- An ambulance hotline for paediatric consultant advice.
- Ambulance clinical hub GP
- General Practitioner in an ambulance
- Enhanced bed management systems
- Increased 7 day working for diagnostics
- Enhanced integrated discharge team
- Development of 'hot clinics'
- Extended Emergency Department Nurse Practitioner service
- Additional Emergency Care Doctors
- Increased social care staffing to provide 7 day a week services

These schemes are currently being developed in order to actively influence the delivery of performance and high quality services during the current winter period.

➢ Enhancing patient discharge from hospital:

Weekly meetings of CEO's and Directors from health and social care providers continue, with significant work being undertaken to

help support effective and timely discharge from hospital. The key projects which are being delivered include:

- 7 day working across health and social care;
- Access to Domiciliary Care services;
- Review of patient assessment processes;
- Active reduction of length of stay;
- Review of Community Hospital discharge processes;
- Review of interim placements;
- Review of the Integrated Discharge Team.

These projects are being monitored closely with some evidence which suggests schemes are positively impacting upon the whole system. This includes Gloucestershire Hospitals NHS Foundation Trust successfully meeting quarter three four hour Emergency Department target.

- **Transforming urgent and emergency care services in England: Sir Bruce Keogh**

A comprehensive review has been undertaken into the way in which urgent and emergency care services are organised within England. The report sets out five key underpinning principles:

- We must provide better support for people with self- care.
- We must help people with urgent care needs to get the right advice in the right place, first time.
- We must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E.
- We must ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.
- We must connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

Within Gloucestershire CCG we are working to align current strategic thinking with the national proposals and the urgent care re-design schemes which are under active development across Gloucestershire are in line with the national direction.

- **‘Mrs Foster’ week**

‘Mrs Foster’ week was undertaken during November, which was a week long programme of work that looked at different ways of working across Gloucestershire Royal Hospital, with the aim of actively reducing the number of medically stable patients that remained within the acute trust. The programme evidenced improvements across critical performance targets, supported by positive staff and patient feedback/outcomes. The week was repeated during January 2014 across Gloucester Royal and Cheltenham General Hospitals with additional commitments to “work differently” across all key providers, with the primary focus being around reducing emergency admissions and increasing active discharge planning. The outcome of the January week is still to be formally evaluated but early feedback is positive. There is a planned roll out of the week within Community Hospitals during late January.

4. PTS Update

The new service went live at midnight on Sunday 1 December 2013. The new service Provider, Arriva Transport Solutions Limited (ATSL), have faced a number of challenges in the first weeks including call answering as the volume of calls to their centre has been extremely high. This was addressed within week one by the introduction of additional call lines and additional call handlers and planners. Online PTS trainers worked with the acute and community providers to train NHS staff in using the online system and overall bookings for December made online stands at 30 percent. Further work is required to increase this percentage.

Throughout December, ATSL undertook 11,065 Gloucestershire patient journeys. This activity was higher than anticipated and where demand was particularly high, experienced third party sub-contractors were used to supplement ATSL’s fleet of ambulances. There was some confusion identified across NHS staff relating to the key performance standards, booking processes and

particularly the concept of ‘booking a patient ready’ , without which an ambulance is not dispatched. This model is proven across other ATSL operations to enhance patient experience by reducing their wait and also reduces the number of aborted ambulance journeys. In order to support NHS staff with the changes a communications pack was developed and issued to all providers containing a summary of the contract standards.

Throughout December, ATSL managers have continued to meet with acute trust management teams to work together to address issues. This joint working and engagement will continue throughout January. Commissioning Leads will continue to meet weekly with senior ATSL managers throughout January and into February before business as usual contract management meetings are instated.

5. Out of Hours (OOH) Procurement

Work is progressing on development of the new OOH service specification as well as procurement Pre-Qualification Questionnaire and associated Memorandum of Information documentation. The specification will include reference to the new voluntary GP extended hours scheme from April 2014 and will also incorporate revised service activity data.

The project remains on course and we anticipate placing a contract advertisement via Supply2Health by Friday 28 March 2014. A new OOH service is anticipated to commence on 1 April 2015.

6. 7 Day Working

Following the recent national review of 7 day working in the NHS, we are leading a local implementation of the key recommendations in Gloucestershire in the short and medium term. Nationally it has been shown that if you are admitted to a hospital on a Sunday you have a 16% higher mortality rate than if admitted during the week, similarly the chance of readmission and increased length of stay are higher. This indicates the significant importance with which we must improve and standardise care at the weekends. Short term actions implemented already include: increased diagnostics at the

weekend at GHT, weekend social worker provision, and 24/7 expansion of the Single Point of Clinical Access as part of our Integrated Community Teams work. Alongside these actions already in place, in the next few weeks we will also outline a practical and far reaching project in the longer term to improve 7 day care across our community and an update on this approach will come to our next Governing Body.

7. Military Covenant Workshop – Signing of Covenant

Imjin Barracks in Innsworth hosted the signing of the agreement on 7th January 2014 by several military and civilian organisations which was attended by around 150 people.

The voluntary statement of mutual support between the Civilian and Armed Forces community is to encourage support for the Armed Forces in Gloucestershire.

The CCG is a signatory and presented at this event after the covenant was signed.

8. Recommendation

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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 9

Governing Body

Governing Body Meeting Date	30th January 2014
Title	Joining Up Your Care – Update
Executive Summary	As a key phase of the CCG's work to develop its Five Year Strategic Plan, an 8 week engagement exercise commenced on 2 January 2014, running to 28 February. A wide range of engagement activities are taking place, including stakeholder meetings in all seven of the CCG localities, 20+ public/staff drop-in sessions, distribution of engagement booklets and the use of animations and social media. The outcomes of this engagement exercise will be summarised into a report and inform the production of the final version of the Five Year Strategic Plan, for submission to NHS England in June 2014.
Key Issues	• Extensive engagement on the CCG's Five Year Plan proposals with patients, service users, the public, carers, staff and the CCG's partners • Nationally prescribed timescales to be met in relation to the production of the CCG's Five Year Strategic Plan and Two Year Operational Plan
Risk Issues: **Original Risk** **Residual Risk**	Assuming the national deadlines do not move, none.

Financial Impact	The Plans the CCG are required to produce will demonstrate how the CCG will deliver its savings targets.
Legal Issues (including NHS Constitution)	Not aware of any.
Impact on Health Inequalities	An Equality Impact Assessment has been completed and is on the CCG's website.
Impact on Equality and Diversity	An Equality Impact Assessment has been completed and is on the CCG's website.
Impact on Sustainable Development	The vision of the Five Year Strategic Plan describes how more care will be wrapped around people in their homes and communities, hence reducing the need for many people to travel greater distances to main hospital sites.
Patient and Public Involvement	This paper describes a significant process of patient and public involvement. The CCG's Clinical Programme Groups were also key to generating ideas for the Five Year Strategic Plan, on which there is patient representation.
Recommendation	i) Note the contents of this paper ii) Give delegated authority to the CCG's Accountable Officer and Clinical Chair for submission of first draft of the Five Year Strategic Plan, two year operational plan and the Better Care Plan on 14 February 2014.
Author	Jonathan Jeanes
Designation	Interim Director of Transformation and Service Redesign
Sponsoring Director (if not author)	N/A

Governing Body

30th January 2014

Joining Up Your Care

1 Introduction

1.1 The Governing Body will be aware that work is underway to develop the CCG's Five Year Strategic Plan by June 2014, working closely with health and care partners in Gloucestershire.

1.2 This paper will update the Governing Body on the progress to date with the development of the Strategic Plan, the timescales to its completion and the engagement work currently underway.

2 Developing the Plan and Engagement Work

2.1 The CCG has been developing its Five Year Strategic Plan since mid-2013, providing greater detail in the strategic context of Gloucestershire's existing 'Your Health, Your Care' Children and Young People's Plan and Health & Wellbeing strategies. A vital initial step was to work with partners to collect ideas and contributions to form the basis of generating a set of proposals that could be discussed more widely, i.e. with the public and staff.

2.2 The CCG therefore undertook a significant phase of engagement activity internally (including with its member practices) and externally (with service providers, Gloucestershire County Council and other partners) during the second half of 2013. The result of this engagement is 'Joining Up Your Care' (JUYC) and sets out the significant challenges faced by the local health and social care community, the proposed strategic direction, and proposals for things that can be done to meet these challenges. Using a set of open questions people are invited to give us their views

on what they think should be done to meet the challenges.

2.3 Additionally, an animation was produced - 'Jack's Story' – to capture the key elements of JUYC in a visual way, and in doing so illustrating what the positive effects would be for the people of Gloucestershire if the proposals within JUYC can be realised.

2.4 On 2 January, the CCG launched its 8 week engagement exercise with staff, service users, carers and the public (up to 28 February). As well as widely distributing copies of the engagement booklet, stakeholder events are being held in all seven localities (with representatives from our list of 1200+ stakeholders), along with 20+ public/staff drop-in sessions currently planned. Good use is being made of the CCG's Information Bus to help support these events. The most up-to-date list of events is below in Annex One. Along with Jack's story, a further seven animated patient stories are also being produced that will be released incrementally throughout the 8 week process.

2.5 Copies of the engagement booklet, 'Joining up your Care' and promotional postcards are available from a wide variety of public places, including GP surgeries, pharmacists, council buildings, hospitals, libraries and on-line at www.gloucestershireccg.nhs.uk.

2.6 Engagement opportunities are being promoted widely through direct invites, the local media (editorial and advertising), internal and community publications, social media and on the website above. Our partners are actively supporting the communication activity, particularly in relation to social media promotion, online activities and their own publications.

2.7 Work has also been commissioned by the CCG focused on discussion and ideas generation with 'seldom heard' communities.

3 Planning process

3.1 Just before Christmas, NHS England issued its Planning

Guidance ('Everyone Counts') for 2014/15 to 2018/19. A summary of the guidance is attached as Appendix One. Prior to the guidance being launched, the CCG had already developed its own timetable for completing the Five Year Strategic Plan, incorporating the wider engagement phase from 8 January to 28 February 2014.

3.2 The planning guidance states that all CCGs must have produced a Five Year Strategic Plan by 20 June 2014, with a first draft being submitted on 14 February; work is already underway by CCG managers and lead GPs to produce this first draft.

3.3 In order to align with these timescales, the CCG will be producing an interim report covering the outcomes from the first half of the engagement process at the end of January. This can then be used to inform the first draft of the Five Year Plan, with the final report on the outcomes from the engagement process produced in March, ready to inform the final version of the Plan for June 2014.

3.4 In parallel to the development of the Five Year Strategic Plan, three other key documents are also being produced and need to be submitted to NHS England on 14th February:

1) A two year operational plan, which will provide further detail about what is expected to be achieved in years one and two of the Five Year Plan. This will incorporate the CCG's QIPP work for 2014/15;
2) A financial plan;
3) The Better Care Plan, detailing how the Better Care Fund will be spent.

The CCG is required by NHS England to submit the final version of the two year operational plan and a further draft of the Five Year Strategic Plan by 4th April 2014.

3.5 In order to achieve the timescales detailed above, approval to submit the first draft Five Year Strategic Plan, the two year operational plan and the Better Care Plan on 14 February 2014 will need to be given by the Governing Body Board prior to its next meeting. It is therefore recommended that the Board give delegated authority to the CCGs Accountable

Officer and Clinical Chair to give this approval on its behalf.

3.6 A copy of the latest versions of the Five Year Strategic Plan and the Two Year Operational Plan will be provided to the Governing Body Board at its next meeting in March 2014. Discussion around these plans at that meeting will then provide an opportunity for the Board to be fully updated on the outcomes from the engagement exercise, as well as ensuring its full contribution to the final version of the Five Year Strategic Plan and the Two Year Operational Plan.

3.7 The above timetable can be summarised as follows:

14 February	First submission of Five Year Strategic Plan, Two Year Operational Plan, and Better Care Plan
13 March	Report to the Governing Body meeting on the output from the JUYC engagement exercise.
27 March	Discussion of all plans at Governing Body meeting in public session, informed by report on the outcomes from the 8 week Joining Up Your Care engagement exercise
4 April	Final submission of Two Year Operational Plan, submission of latest draft Five Year Strategic Plan and final version of the Better Care Plan

4 Recommendation(s)

4.1 The CCG Governing Body Board is asked to:

iii) Note the contents of this paper

iv) Give delegated authority to the CCG's Accountable Officer and Clinical Chair for submission of first draft of the Five Year Strategic Plan, two year operational plan and the Better Care Plan on 14 February 2014.

5 Appendices

Appendix One – Summary of the NHS Planning Guidance: Everyone Counts

ANNEX ONE – List of Public/Staff Drop-in sessions (as at 15 January 2014).

Day	Date	Venue	Time
Tue	14/01/2014	Foyer, Shire Hall, Westgate St, Gloucester	1pm - 3pm
Tue	14/01/2014	ASDA, Cheltenham (Information Bus)	9.30am - 4pm
Wed	15/01/2014	Stroud General Hospital, Stroud	1pm - 3.30pm
Thu	16/01/2014	ASDA, Gloucester	9.30am - 4pm
Mon	20/01/2014	Dilke Memorial Hospital, Cinderford	1pm - 3.30pm
Tue	21/01/2014	Morrison, Tewkesbury (Information Bus)	9.30am - 4pm
Tue	21/01/2014	Tewkesbury Community Hospital	12.30pm - 3pm
Thu	23/01/2014	Morrisons, Metz Way, Gloucester	9.30am - 4pm
Sat	25/01/2014	High Street, Cheltenham (Information Bus)	9.30am - 4pm
Mon	27/01/2014	Gloucestershire Royal Hospital	9am - 2pm
Wed	29/01/2014	Cheltenham General Hospital	9am - 2pm
Thur	30/01/2014	Tesco, Lydney (Information Bus)	10am - 3pm
Thur	30/01/2014	Lydney and District Hospital, Lydney	11am - 1.30pm

Day	Date	Venue	Time
Fri	31/01/2014	Market Place, Cirencester (Information Bus)	9am - 1pm
Fri	31/01/2014	Cirencester Hospital, Cirencester	11am - 1.30pm
Mon	03/02/2014	Vale Community Hospital, Dursley	10am - 12.30pm
Sat	08/02/2014	Farmers' Market, Cornhill Market Place, Stroud	9am - 2pm
Sun	09/02/2014	Hempsted Car Boot Sale, Gloucester (Information Bus)	8am - 1pm
Tue	13/02/2014	Market Square, Stow on the Wold (Information Bus)	10am -1pm
Tue	11/02/2014	North Cotwolds Hospital, Moreton in Marsh	10.30am - 1pm
Sun	23/02/2014	Cheltenham Racecourse Car Boot (Information Bus)	8am - 2pm

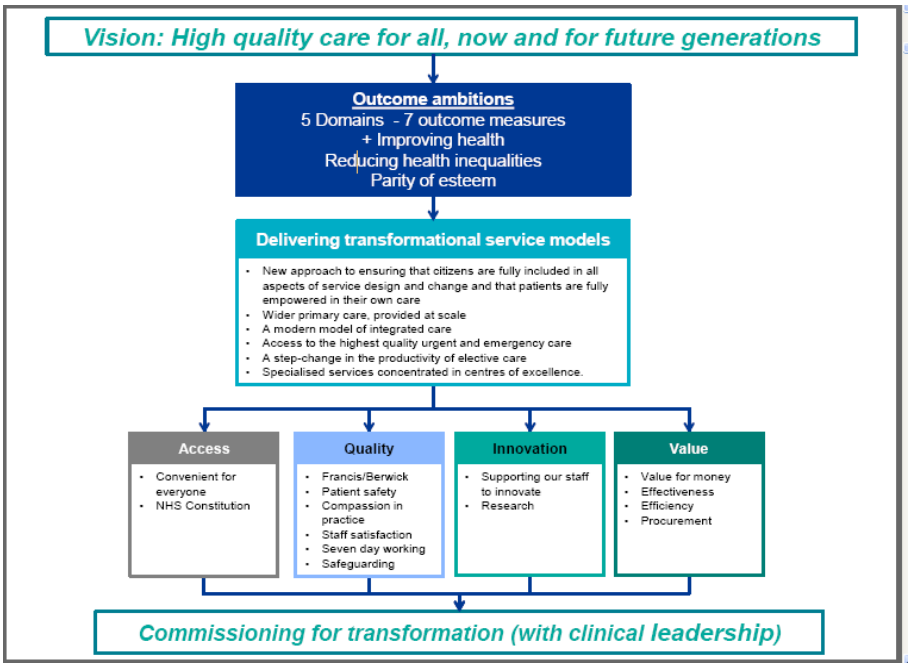
Based on the Draft Guidance, Issued by NHSE on 17th December

Vision

The vision set out in the NHSE guidance is that of ***'high quality care for all, now and for future generations'.*** In order to make this a reality the guidance sets out:

- **<u>High quality care.</u>** We will be driven by quality in all we do. No longer can we accept minimum standards as good enough – our patients rightly expect the best possible service.
- High quality care **<u>for all.</u>** We need to ensure that access to all services is on an equal footing whether the patient's need is for mental or physical help and support. We must put the greatest effort in providing care for the most vulnerable and excluded in society.
- High quality care for all, **<u>now.</u>** But high quality is not just an aspiration. The NHS provides high quality care, often to the highest standards of anywhere in the world, but we need to spread excellence more widely. We have to learn from the best and get better at sharing good practice rapidly across the NHS.
- High quality care for all, now **<u>and for future generations</u>.** We are investing not just for today but for the future. We have a responsibility to ensure that the NHS is on as strong a footing as possible, capable of remaining focused on quality through the significant economic challenges ahead. There is great urgency to plan strategically to start making the changes that are required to deliver models of care that will be sustainable in the longer term.

The focus is on the shift to doing a five and two year plan, in recognition of the long term change programme required to deliver the financial challenge across health and social care.



Commissioning Plans

- Plans must be firmly **tied into the vision**.
- Plans must be developed with an **outcomes approach**; focussing more on the results of what is done. Outcome ambitions are defined and must be clearly addressed within plans.

  These cover the 5 domains listed below:

  1. We want to prevent people from dying prematurely, with an increase in life expectancy for all sections of society.
  2. We want to make sure that those people with long-term conditions including those with mental illnesses get the best possible quality of life.
  3. We want to ensure patients are able to recover quickly and successfully from episodes of ill-health or following an injury.
  4. We want to ensure patients have a great experience of all their care.
  5. We want to ensure that patients in our care are kept safe and protected from all avoidable harm

  Plans also need to cover how we will deliver the 7 outcome measures listed below:

  1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
  2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
  3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
  4. Increasing the proportion of older people living independently at home following discharge from hospital.
  5. Increasing the number of people having a positive experience of hospital care.
  6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
  7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

  Additional plans are also expected to cover Improving health, reducing health inequalities and parity of esteem.
- Six characteristics of what care should look like in five years' time are defined within: '**Delivering transformational service models'** as:

  1. A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.

This area includes listening to patient's views, delivering better care through the digital revolution, transparency and sharing data.

2. Wider primary care, provided at scale.
3. A modern model of integrated care.
4. Access to the highest quality urgent and emergency care.
5. A step-change in the productivity of elective care.
6. Specialised services concentrated in centres of excellence.

- Plans should also maintain focus on the essentials, stated as:
  1. Quality
  2. Access
  3. Innovation
  4. Value for Money
- All plans should include the approach to the **Better Care Fund** (previous Integration Transformation Fund).

Planning Approach

- All CCG's must submit strategic plans (five year period covering 2014/15 to 2018/19) and operation plans in detail (2014/15 and 2015/16), a financial plan (all five years with more detail in first two) and a Better Care Fund (submitted from the H&WB board).
- The operational plans must demonstrate that the strategic plan is the driving force behind transformational change. The operational plans should contain outcomes and relevant local metrics which show the journey towards the tangible achievement of the overarching strategy.
- Plans must explicitly deal with the financial gap, containing appropriate risk and mitigation strategies.
- Five submissions will be required: Strategic, Operational, Financial, Direct Commissioning plan (NHSE responsibilities), and Better Care fund.
- A support programme has been put in place to help CCG's through the process.

Key Assumptions in Developing plans

- Plans are jointly agreed with the Health and Well Being Board.
- Plans are to be developed across the community (health and social care); with patient and public engagement (including Healthwatch)
- At a strategic level plans should be developed by 'Units of Planning'; within which Gloucestershire community = 1 UOP, but should work across with other CCG's regarding joint commissioning areas such as Ambulance and Specialist commissioning services.
-

Strategic Plan

- All plans need to have the ownership and buy in of the whole health economy, reflect a joint vision and a road map to get there.

- All organisations must be satisfied that the plan supports improvements for patients and service users.
- Plan should be short, focussed and describe what the system plans to achieve in an informative and engaging way.
- Strategic plans need to be at the forefront of the planning process.
- Plans should be clear on proposed future activity levels, referenced to historical trends and future service proposals; with a clear link between activity and finance.
- Submission with require: Plan on a page and Specific Key highlights (Appendix J guidance gives more specifics on content).

Operational Plan

The operational plan will include the key operational metrics needed to support the assurance of, and measure performance against, strategic plans. The plan will be structured around the four headings:

- Outcomes;
- NHS Constitution;
- Activity; and
- Better Care Fund.

Details regarding the content of the Operational Plan template can be found in Annex J.

Note: Whilst the guidance focuses on the performance indicators to be included, as part of producing a detailed plans this will include the detail for implementation of the year one and two components of the strategic plan.

Financial Plan: see finance briefing

Better Care Fund

The Better Care Fund plan requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled Better Care Fund budget will be implemented to facilitate closer working between health and social care services.

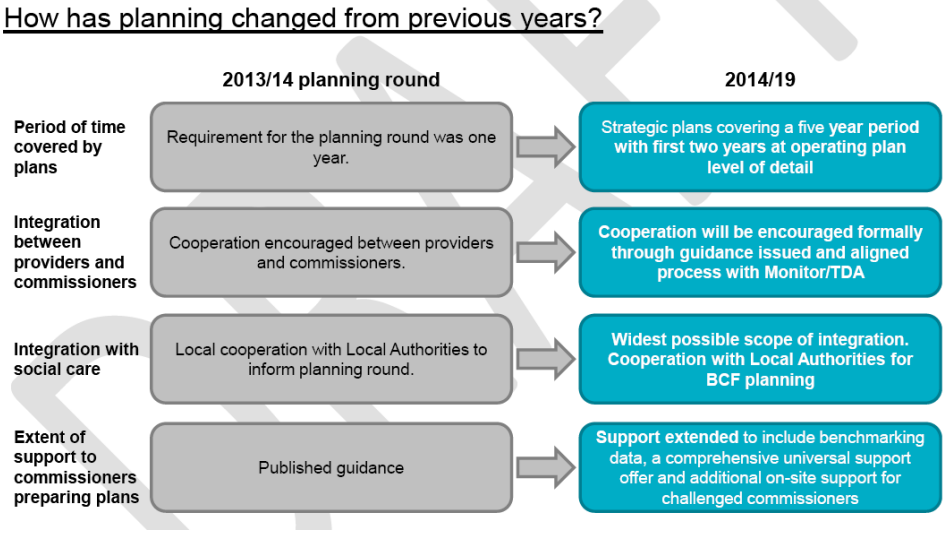
Joint plans should be approved through the relevant local Health and Wellbeing Board and be agreed between all local CCGs and the Upper Tier Local Authority. Health and social care providers should also be closely involved in plan development.

The plan should demonstrate clearly how it meets all of the national Better Care Fund conditions, include details of the expected outcomes and benefits of the schemes involved, and confirm how the associated risks to existing NHS services will be managed. The measures we expect CCGs to use in considering the quality of

the impact of the Better Care Fund are in Annex I, along with additional supporting information on developing BCF plans.

The allocation of funding will be through existing commitments and from core CCG allocation. Details regarding the allocation will be provided to the HWBB.

Changes from previous approach



Developing the plan

- Expectation that there is evidence of using the NHS Change Model in strategic and operational plans.
- Plans should be bold and ambitious, developed in partnership with providers and local authorities and locally led;
- The plans should not put another organisations plan at risk, or generate behaviours that work against the best interest of the patients.
- Local priorities should reflect those outlined in the health and wellbeing strategy.
- Participation and engagement should be central to the five year plan.

Commissioning Plan Structure

Elements to be included within any structure should include:

Fundamental			Key features to address in plans
1	Outcomes	Delivery across the five domains and seven outcome measures	TBC
2		Improving health	TBC
3		Reducing health inequalities	TBC
4		Parity of esteem	TBC
5	Patient Services	New approach to ensuring that citizens are fully included	TBC

		in all aspects of service design and change and that patients are fully empowered in their own care	
6		Wider primary care, provided at scale	TBC
7		A modern model of integrated	TBC
8		Access to the highest quality urgent and emergency care	TBC
9		A step-change in the productivity of elective care	TBC
10		Specialised services concentrated in centres of excellence	TBC
11	Access	Convenient access for everyone	TBC
12		Meeting the NHS Constitutional standards	TBC
13	Quality	Safety, effectiveness and patient experience	TBC
14		Response to Francis and Berwick	TBC
15		Patient safety	TBC
16		Compassion in practice	TBC

Note: The guidance already contains detail on specifics expected to be included, and we expect further guidance on areas to be included in each of these sections.

Submission and Assurance

The timetable for submission is shown below:

Activity	Deadline
First submission of plans	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Reconciliation process with NHS TDA and Monitor	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year operational plans and draft 5 year strategic plan	4 April 2014
Submission of final 5 year strategic plans • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Assurance of plans will be by the Regional and Local Area Teams; with further input from ministers, HWB and Local Government Association (LGA) into the Better Care Value plans.

The review and triangulation of plans will include:

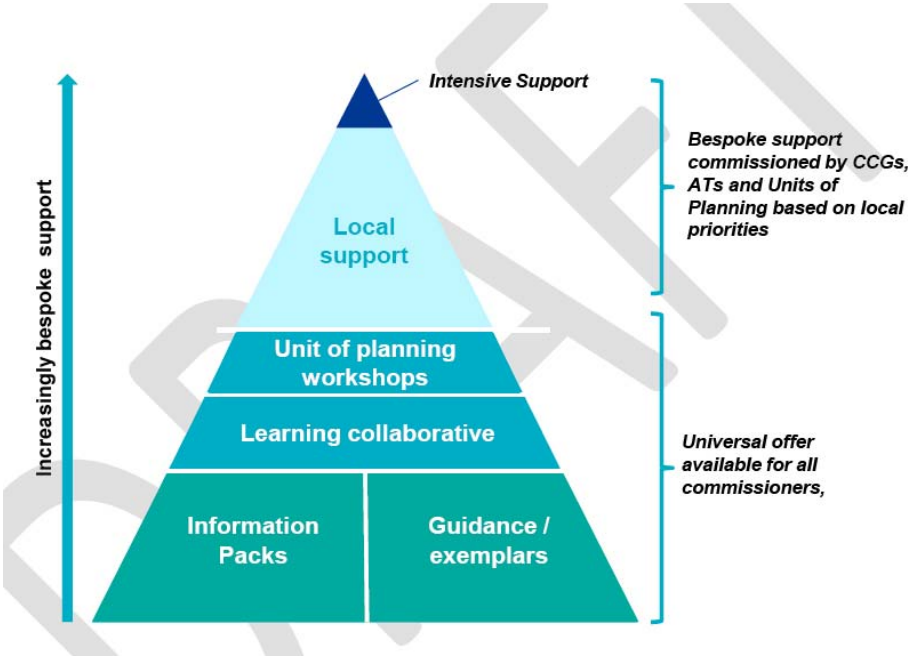
- the finances to secure delivery of the output objectives and adherence to the requirements outlined in the planning guidance;
- ensuring the finances and activity projections are supported by reasonable & deliverable planning assumptions including level of assumed QIPP delivery and underlying activity growth;
- triangulation of finance and activity;

- coherence with the other planning and output assumptions; and
- Testing the strength of local relationships, which are key to ensuring delivery.

The Framework of Excellence in Clinical Commissioning: For CCGs (Draft from Nov 13) will be integral to the approach for assurance of plans; with discussions expected on the basis of the 6 domains.

Planning Support

A support package will be available from NHSE, in line with the diagram below:



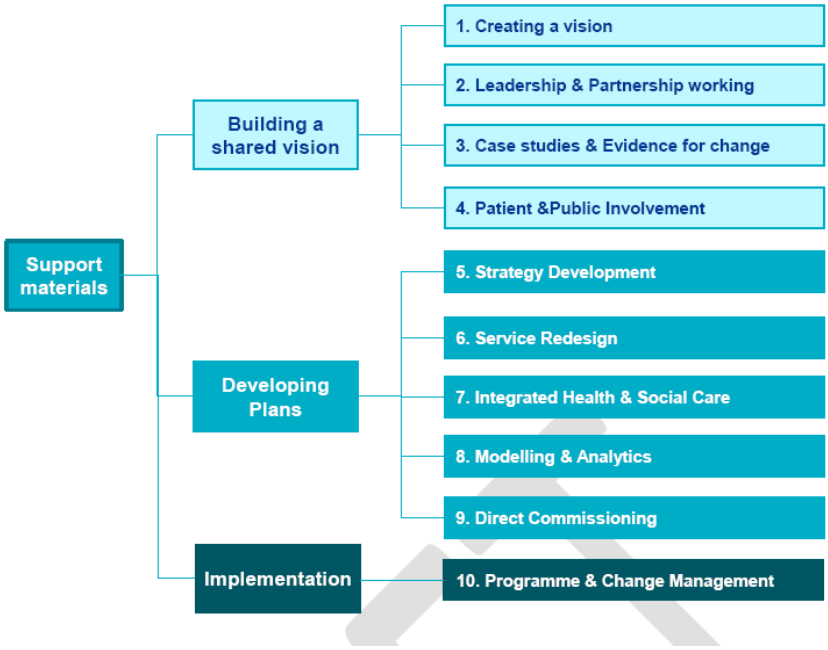
The universal offer will include:

- Practical support on participation - Our interactive web based Transforming Participation in Health and Care tool already provides advice, good practice, evidence and case studies on approaches to good public participation. The expectation is that local and regional voluntary sector organisations will work to make certain that public participation reaches all parts of local communities. There should be particular focus on seeking and achieving input from communities which have traditionally not provided sufficient input into NHS decision-making.
- Any town health system and Better Care Fund models - To support CCGs in preparing plans, the Any town health system will be published in January. The Better Care Fund modelling tool enables HWBs to model high level integration interventions.
- Data packages - data and analysis packs showing the local opportunities for improvement and relative performance e.g. commissioning for Value packs released in October.
- Strategic planning workshops - Local workshops designed to kick-start the planning process and build local relationships to create a joint vision and

prepare for planning submissions. They will provide practical and technical advice about translating a strategy into a financial and operating plan and will support joint ways of working through advice on creating local governance arrangements aimed at galvanising action and initiating stakeholder discussions.

- Learning collaborative - This will support the spread and adoption of learning, best practice and technical expertise. We are planning to create a programme of webinars and learning events on key topics across three broad areas of: best practice sharing; strategic planning by injecting thought leadership and support for the technical aspects of planning and delivery.

The local support has been built around three core areas, and ten specifications, as shown below:



Further detail on how to access the support will be available by the end December.

NHS
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Clinical Commissioning Group

Agenda Item 10

Governing Body

Governing Body Meeting Date	**Thursday 30th January 2014**
Title	**West of England Academic Health Science Network Report**
Executive Summary	The attached document is the second quarterly report produced by the West of England Academic Health Science Network.
Key Issues	The following key issues are referred to in the report: • Governance • Research Evidence into Practice • Commissioning Evidence-based Care • AHSN Informatics Strategy • Enterprise and Translation
Risk Issues: Original Risk Residual Risk	None.
Financial Impact	None.
Legal Issues (including NHS Constitution)	None.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note this report which is provided for information.
Author	Mary Hutton/Deborah Evans
Designation	Gloucestershire CCG Accountable Officer
Sponsoring Director (if not author)	Mary Hutton

Report from West of England Health Science Network Board, 10 December 2013

1. Purpose

This is the second quarterly report for the Boards of the member organisations of the West of England Academic Health Science network which includes the three health research active Universities, NHS Trusts and Foundation Trusts, Community Interest Companies who provide community health and social care and the seven Clinical Commissioning Groups.

A similar briefing will be circulated to a wider range of partners and stakeholders following each quarterly meeting of the Academic Health Science Network Board.

Board papers will be posted on our website - http://www.weahsn.net

2. Report from the Senior Leaders Meeting

The AHSN is holding a seminar prior to each Board meeting for Chairs and Chief Executives, University representatives and Accountable Officers/Chairs of our seven CCGs. The first one of these was in Chippenham on 9 December and attracted good representation from both Chairs and Chief Executives. The meeting heard a progress report on the AHSN plus three short presentations on:

- Patient Safety – where support for the existing programme, for strengthening community health services participation and developing a primary care branch, was expressed
- Informatics – where the AHSN was encouraged to add value by supporting interoperability – or join up – of data systems at individual patient level
- Evidence into Practice – where people felt there was real benefit in learning together how to improve adoption and spread across the West of England.

Chairs and Chief Executives welcomed the opportunity to meet as a group.

3. Key Items for Decision and Discussion

The Board approved the following items:

3.1 Governance

The final steps in becoming a "Company Limited by Guarantee" were made which strengthens financial flexibility and is a better basis for working with industry. The Board also approved the Contract with NHS England.

3.2 Evidence into Practice

The Board approved six local proposals for research evidence into practice for immediate implementation or further work up. These included cemented hip replacements, two around intra partum maternity care and telehealth for chronic kidney disease.

A national priority recommended by NICE and adopted as a priority for the South West Cardio-vascular Strategic Clinical Network which is about anti-coagulants for stroke prevention in people with atrial fibrillation was also supported and will be an early focus. The Board was keen to receive future proposals from mental health and community services.

The Board sponsor for Evidence into Practice is Frank Harsent, Chief Executive of Gloucestershire Hospitals Foundation Trust.
Anna Burhouse, currently Director of Strategic Modernisation at 2Gether Mental Health Foundation Trust is joining the AHSN in January as Director of Change, Innovation and Service Improvement and will lead this work.

3.3 Commissioning Evidence Based Care

Dr Peter Brindle has been appointed as Clinical Leader to lead on this work.

We have secured a skills development programme for Commissioners on "Seeking, Understanding and Presenting Evidence" which has been tailored to local needs and is running on 29 January 2014. It will be open to Clinical Commissioning Groups, NHS England and Public Health colleagues.

The Board sponsor is Ian Orpen, Chair of Bath and North East Somerset Clinical Commissioning Group.

3.4 AHSN Informatics Strategy

The Board approved a high level informatics strategy the aim of which is to add value to local health communities' efforts. The approach is to Connect, Use, Aggregate and Share data at patient, pathway and population level.

The initial focus will be on interoperability of data – which is about joining together all the data systems from different health providers at individual patient level. Some compelling examples of better patient safety, improved risk management and greater efficiency are arising from early work in the West of England. Gloucestershire and B&NES will now undertake option appraisals with AHSN support on what is best for their areas.

Richard Tarring, Finance Director of Sirona, is the Sponsor for this programme.

3.5 Enterprise and Translation

The Board approved the Operational Plan for this which includes mapping the health related companies in all three Local Area Partnerships with a focus on Small and Medium sized Enterprises.

4. Items to Report

The Board received a number of items for information and report including:

- **Small Business Research Initiative** following our brief to Small and Medium Sized enterprises around the deteriorating patient, we received sixty proposals and these have now been shortlisted by clinical faculty members of the Patient Safety Programme down to ten. Interviews will result in three or four chosen proposals whose proposals will be funded for development to proof of concept stage and ultimately for use in the service.

- **Patient Safety** - we expect national guidance shortly about establishing Patient Safety Collaboratives which seem to be based on a very similar model to the Safer Care South West programme. We are working with the AHSN member organisations and our colleagues in South West AHSN, Wessex and Kent Surrey and Sussex to develop proposals to NHS England by the end of this financial year.

- **CLAHRCwest Chair** - Dr Mark Pietroni, the Director of Public Health for South Gloucestershire, has become the Chair of the CLAHRC Board and will represent the CLAHRC on the AHSN Board
  .
- The **NHS Leadership Academy** is holding a TEDMED conference on leadership at the Watershed, Bristol on 11 April 2014 with AHSN support. Watch out for advance publicity through your organisations.

- **NICE** – the AHSN has signed a collaboration agreement with NICE which includes specific partnership work on anticoagulants for atrial fibrillation.

- **Evaluation** - the AHSN Board has approved an evaluation framework for the AHSN and the CLAHRC which involves a team from the Universities of Bristol, Bath and the West of England. It is led by Professor Christine Harland, now of Cardiff University.

- We held a **Patient and Public Involvement** Event on 4 November 2013 as the next stage in developing our Patient and Public Involvement work. This is to be a joint development with CLAHRCwest and the new Comprehensive Research Network.

Deborah Evans – Managing Director
December 2013

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Agenda Item 11

Governing Body

Governing Body Meeting Date	30th January 2014
Title	Systems Leadership Programme Update
Executive Summary	The purpose of this paper is to update the Governing Body on the local implementation of the national Systems Leadership Programme (SLP). It explains the rationale behind the SLP and gives a progress report on key activity and learning to date.
Key Issues	Gloucestershire Health and Wellbeing Board are participating in the national SLP. The local SLP challenge is around addressing intergenerational obesity. Systems leadership approaches can be applied to other complex, intractable problems and a key objective of this project is to build leadership capacity across local systems for the benefit of local residents. A multi-agency SLP Project Board are progressing this work and each organisation within the system shares the responsibility for, and ownership of, the programme.
Risk Issues: **Original Risk** **Residual Risk**	Not applicable

Financial Impact	Places receive a grant of £27,000, and have contributed £10,000 to pay for expert facilitation The intention is to build on existing activity and assets where possible. It is therefore anticipated that the activities of this project will be met from existing resources.
Legal Issues (including NHS Constitution)	Not applicable.
Impact on Health Inequalities	Obesity is an inequalities issue. A key focus of this project is to reduce obesity-related health inequalities and specific work streams are underway in support of this outcome. A due regard statement is to be completed.
Impact on Equality and Diversity	**Yes/No** If yes describe
Impact on Sustainable Development	Systems leadership approaches encourage sustainable development through building leadership capacity, and taking collective responsibility, across the system and at all levels, including within communities.
Patient and Public Involvement	Community engagement is a key work stream for the SLP.
Recommendation	Paper for information only
Author	Sue Weaver
Designation	Public Health Manager, Gloucestershire County Council
Sponsoring Director (if not author)	Alice Walsh, Interim Director of Public Health, Gloucestershire County Council

Governing Body

30th January 2014

Systems Leadership Programme Update

1 Introduction

1.1 What is the systems leadership programme?

In 2012 representatives from the Department of Health (DH), Public Health England (PHE), the Local Government Association (LGA) and associated leadership development organisations, identified the need for a paradigm shift in public sector leadership. The DH subsequently provided funding for external facilitation for around 30 Health and Wellbeing Boards to develop their leadership capacity, and Gloucestershire was successful in securing a place on this programme.

The underlying thesis is that organisations, communities, and indeed society as a whole, function as complex adaptive systems. Leadership in such systems requires attitudes, behaviours and skills which go beyond traditional mechanistic ideas about leadership, management and change. Developing such leadership capacity is best approached by focusing on 'real work', drawing on the multiple perspectives of the participants. The systems leadership programme is designed around these principles.

The programme aims to:

- Help to develop solutions to a local 'wicked issue'* through leadership development
- Ensure that the leadership learning is left in place to allow it to be used for other wicked issues.

*Wicked issues are 'complex, messy and often intractable challenges that can probably rarely be totally eliminated. There are no known solutions to wicked issues, partly because there are no simple, linear causes – the causes

themselves are often complex, ambiguous and often interconnected'. Tackling wicked problems requires 'clumsy solutions' that is, multiple partial solutions that take bite-sized chunks out of the problem to gradually reduce its severity. This involves a different way of working together (Informal Networks, 2009).

Participation in the SLP includes the time of experienced leadership development 'enablers' to help local areas develop their project, whilst advancing leadership in their area. David Bolger and Holly Wheeler have been recruited to work with GHWBB on the initial stages of this project until March 31st 2014.

The programme encourages the use of these five guiding principles:

- Keep it grounded in 'real work'
- Get the people who do that work involved
- People own what they create
- Keep making the connections between the pilot and the rest of your work
- Follow wherever it takes you.

Systems approaches involve:

- **Developing an understanding of the system** – particularly the way different parts relate. One way of doing this is by creating 'systems diagrams' to identify pivotal points for intervention
- **Appreciation of different perspectives** – any perspective not taken into account becomes a source of potential difficulty or opposition – the first step in appreciating different perspectives is to recognise your own (this is harder than it sounds) and a good systems leader can recognise that your own perspective as one of many possible perspectives. There are some key techniques available for doing this.
- **Making new connections between different parts of the system** – it is the quality of the connections, not just the different parts of the system that contribute to transformational change**.**

1.2 **Gloucestershire Systems Leadership Challenge**

Gloucestershire Health and Wellbeing Board (GHWBB) chose to focus on reducing intergenerational obesity as the 'real work' through which to develop its systems leadership capacity.

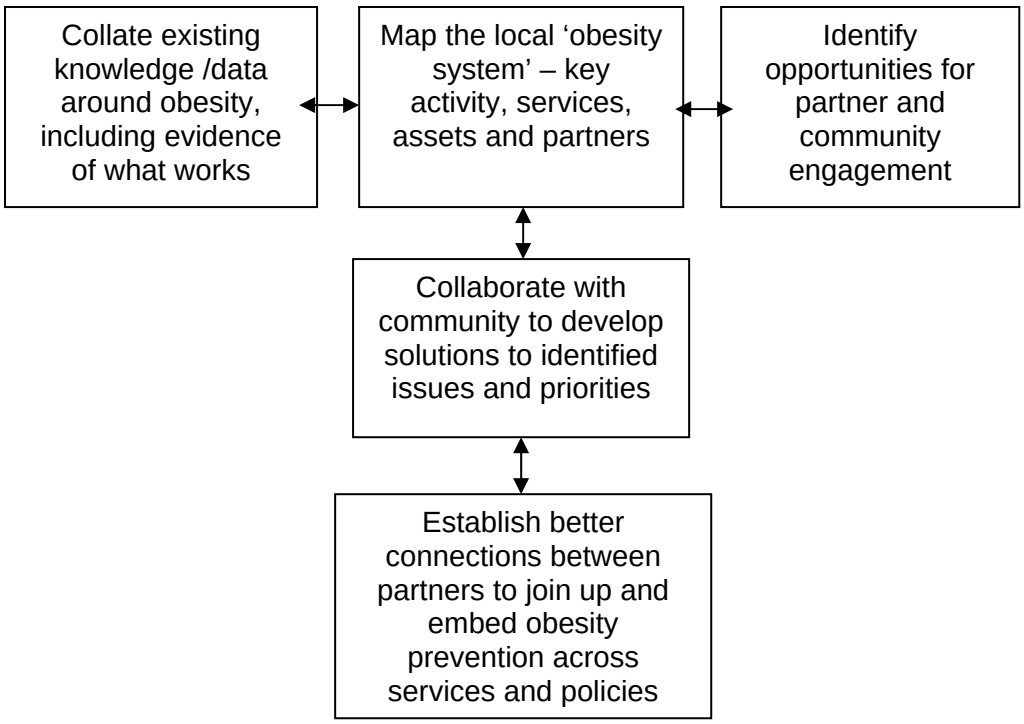
Reducing obesity is one of the five priorities identified by GHWBB in its strategy 'Fit for the Future'. It was chosen because of its significant impact on the health and wellbeing of local people – in fact the Department of Health (DH) have described it as 'probably the most widespread threat to health and wellbeing in the country' (DH, 2011). Obesity is also a significant cause of health inequalities because it affects our poorest, and more vulnerable, individuals and families the most. Levels of child obesity are almost twice as high among those children living within our most deprived communities, compared to those living in our least deprived communities. People with physical or learning disabilities, or mental health problems, are also more likely to be obese, which confounds their already worse health and wellbeing outcomes. Although there is some evidence that the overall rise in obesity levels is starting to flatten, the data suggests that these inequalities are continuing to widen.

2.3 **Progress to date**

A small Project Board, chaired by Cllr Dorcas Binns (Lead Member for Public Health and Communities) has been formed to take this work forward (Appendix 1 for membership). This Board reports to the Gloucestershire Health and Wellbeing Board (GHWB).

The planned process is given in Figure 1 below. In the spirit of 'following where the work takes you' the group has not yet developed a timed action plan. The Board is first undertaking enquiries as to *what* is needed before we can move on to *how* we can better coordinate approaches and interventions.

Figure 1: Planned process



This group has undertaken preliminary stakeholder and asset mapping to understand more about the local obesity system.

Three neighbourhoods have been identified to work with to explore and test community-based solutions for obesity. They are Matson and Podsmead in Gloucester, and Oakdale in Lydney in the Forest of Dean. These communities have high levels of child obesity and an active interest in health and wellbeing.

A review of the evidence for what works in addressing obesity, including different perspectives on what could help locally is underway. A key element of this is ongoing engagement with our 'test' communities to develop an understanding of what they are already doing that could contribute to reducing obesity, what else they would like to do, and what support they need from us to make this happen.

A number of key connections, between different transformational agendas, and different parts of the 'obesity system' have been made, with some tangible benefits for service users and communities.

Key learning

The following points provide some examples of key discoveries to date:

- Enormous energy and potential within some of our communities and many examples of innovative health improvement activity – often delivered at little or no cost
- A feeling of powerlessness some communities, too much power seeming to reside in distant agencies, that fail to take into account local views
- High aspirations around health and wellbeing, including improving nutrition and living more active lifestyles – but communities do not want our 'solutions', they want support to do things 'their way'. The support we've been asked for is rarely financial, and where it has involved some initial funding, it has been nominal amounts. The support needed includes listening and assisting, advocacy, help to make the right connections or help to 'unblock' specific barriers within the system

Systems approaches are already 'leaking' into other areas of our work, for example the Domestic Abuse and Sexual Violence Board are applying systems leadership principles and techniques to achieving its outcomes.

Communication

- Members of the SLP Project Board are taking collective responsibility to update their own organisations and networks on the development of this agenda
- The SLP work is standing item on the HWBB agenda
- A series of quarterly bulletins will be produced by the SLP Project Board to inform stakeholders interested in learning more about systems leadership in general, and or the progress of the local project. These will shortly be published on the Gloucestershire County Council website, along with other key references.

2.4 **Next steps**

Continue community and stakeholder engagement with a view to co-developing obesity prevention interventions – aiming to develop recommendations for future work and some

action on the ground in early 2014.

A joint workshop between the GHWB and Project Board is scheduled for January 21st 2014. This aims to share the systems leadership learning and contribute to the development of systems leadership capacity within the Board.

2 Recommendation(s)

2.1 This paper is for information only.

3 Appendices

- Appendix 1 – SLP Board Membership

Appendix 1: Systems Leadership Project Board Membership

Name	Role	Organisation	Email
Councillor Dorcas Binns	Cabinet Lead for Public Health and Communities	GCC	Dorcas.Binns@gloucestershire.gov.uk
Councillor Jennie Dallimore	Deputy Leader of Gloucester City Council & Cabinet Member for Communities and Neighbourhoods	Gloucester City Council	Jennie.Dallimore@gloucester.gov.uk
Alice Walsh	Interim Director of Public Health	GCC	Alice.Walsh@gloucestershire.gov.uk
Mark Patterson	Acting Head of Health and Wellbeing	Public Health England	Mark.Patterson@phe.gov.uk
Dr Hein Le Roux	GP and CCG Board Member	Gloucestershire CCG	Hein.LeRoux@glos.nhs.uk
Diana Billingham	Public Health Manager	GCC	Diana.Billingham@gloucestershire.gov.uk
Sue Thompson	Commissioning Officer	GCC	Susan.THOMPSON@gloucestershire.gov.uk
Louise Matthews	Commissioning Officer	GCC	Louise.Matthews@gloucestershire.gov.uk
Justine Rawlings	Associate Director Clinical Programmes	Gloucestershire CCG	Justine.Rawlings@nhs.net
Tess Tremlett	Community Engagement Manager	Forest of Dean District Council	Tess.Tremlett@fdean.gov.uk
Philip Williams	Lead Commissioner Community Infrastructure	GCC	Philip.Williams@gloucestershire.gov.uk
Sue Pangbourne	Head of Paid Service	Forest of Dean District Council	Sue.Pangbourne@fdean.gov.uk
Peter Hibberd	Strategic Director	Forest of Dean District Council	Peter.Hibberd@fdean.gov.uk
Sue Weaver	Public Health	GCC	Sue.Weaver@gloucestershire.gov.uk

	Manager		
Helen Flitton	Project Officer	GCC	Helen.Flitton@gloucestershire.gov.uk

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Agenda Item 12

Gloucestershire Clinical Commissioning Group

Governing Body Meeting Date	30th January 2014
Title	Performance report
Executive Summary	The enclosed performance framework report provides an overview of Gloucestershire CCG performance for the period to the end of December 2013.
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 sections of this report.
Financial Impact	Not meeting key financial targets
Legal Issues (including NHS Constitution)	These are set out in the main body of the report
Impact on Health Inequalities	Not Applicable.
Impact on Equality and Diversity	There are no direct health and equality implications contained within this report
Impact on Sustainable Development	There are no direct sustainability implications contained within this report
Patient and Public Involvement	These are set out in the main body of the report

Recommendation	The Board is asked to: • Note the financial position as at 31st December 2013 and the inherent risks outlined within the attached report • Note the performance against local and national targets and the actions taken to ensure that performance is at a high standard.
Author & Designation	Sarah Hammond, Head of Information & Performance Andrew Beard, Deputy CFO Kelly Matthews, Associate Director of Strategic Planning
Sponsoring Director (if not author)	Cath Leech, Chief Finance Officer

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Agenda Item 12

Gloucestershire CCG

Performance report

1.1 Executive summary

1.1.1 The enclosed performance framework report provides an overview of Gloucestershire CCG performance against the in-year organisational objectives for the period up to the end of December 2013. Finance and Commissioned Service performance reports including the latest QIPP position are also incorporated. The report is broken down into the five sections of the GCCG performance framework:

- Clinical Excellence
- Finance and Efficiency - A combined Finance and Efficiency report including QIPP delivery and the CCGs financial position.
- Patient Experience
- Partnerships
- Staff

This months' paper also includes an update on the annual operating plan. This section updates the Board on the delivery of key components of the integrated annual operating plan within the service transformation and commissioning priorities for 2013/14.

1.1.2 A full summary of performance against all national and local standards is included within the relevant scorecard for that section of the report. An overarching GCCG performance dashboard is included as a supporting appendix; providing an overview of all key national and local targets.

1.1.3 Further supporting appendices provide a full analysis of the CCG's Finance position and progress against individual QIPP programmes.

1.1.4 The 2013/14 commissioning performance dashboard (appendix 1) covers the 2013/14 Everyone counts targets, NHS Constitution commitments and key 'local offer' commitments. All sections of the scorecard have been updated with the latest available information.

1.2 Balanced scorecard 2013/14 – up to 31st December 2013

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

1.2.1 Clinical Excellence – Amber, due to red rating of 1 success criteria.

Finance and efficiency – Amber rating with all success criteria rated as amber.

Patient experience – Amber, due to amber rating of 2 success criteria.

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

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

1.2.2 The sections below provide an overview of each domain and a more complete position statement for each of the Amber and Red rated indicators.

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

2.1 Perspective 1. Clinical Excellence

2.1.1 Clinical Excellence – Period to 31st December 2013

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

It should be noted that current success criteria and associated key performance indicators are related to setting up quality assurance within the organisation. These indicators are currently under review by the CCG Clinical Quality Team and any amendments will be reflected within future reports.

PERSPECTIVE 1	Clinical Excellence	Amber
Success criteria: *Support the work of the clinical programme groups and the localities ensuring that quality and patient safety is at the heart of their work*		G
Key performance indicators		
Development of qualitative measures based on the six dimensions of quality, for each of the CPGs, to enable assurance of clinical excellence attainment.		G
Adoption of Quality Impact Assessment tool for all new proposed initiatives, to be reviewed by senior quality team prior to QIPP assurance board. This will provide assurance that clinical quality has been actively considered in all QIPP initiatives.		G
Success criteria: *2. Provision of regular, robust information to provide assurance that our service providers are delivering quality, safe & clinically effective services.*		G
Key performance indicators		
Develop a robust process to timely monitor compliance with NICE, to provide assurance that all NICE publications are considered and Technology Appraisals are implemented within the required time frame.		G
On-going assurance from the commissioner/provider clinical quality review groups, that clinical quality is assured.		G
Success criteria: 3*. Key local and National standards relating to Clinical Excellence*		R
Key performance indicators		
Achievement of key local and National standards relating to Clinical Excellence – see section 2.2.1		R

2.1.2 **Success criteria 1: Support the work of the clinical programme groups and the localities ensuring that quality and patient safety is at the heart of their work (Green).**

This is progressing, in collaboration with the Clinical Programme Group (CPG) development team. There is a draft musculo skeletal (MSK) outcomes framework, including quality measures, currently being reviewed by the CPG for MSK.

The Quality impact assessment tool is now part of the PMO (Project management Office) toolkit and is routinely completed prior to submission to the QIPP assurance group. Work is now progressing to ensure provider organisations routinely complete, with new service /contract variation proposals.

2.1.3 **Success criteria 2: Provision of regular, robust information to provide assurance that our service providers are delivering quality, safe & clinically effective services (Green).**

NICE process, - Since April 2013 there have been 25 NICE technology appraisals (TAs) published, 14 of which are applicable to Gloucestershire CCG, in terms of commissioned services from GHNHSFT and 2gether NHSFT. The new agreed NICE TA process is working, with more timely response to queries of progress of implementation plans. There is significant work being undertaken in implementing the TAs relating to ophthalmology.

Quality report – this report is routinely produced for the Integrated Governance and Quality committee (IGQC).

Clinical effectiveness – scheduled bi-monthly meetings. Terms of reference have been submitted to the IGQC, and agreed. Work of the group is integrally linked to work of the CPGs and localities. Exact linkages are developing. Further work is being undertaken on how the work schedule of the groups link.

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

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

Issues identified in the following areas:

- Cancer waiting times – first definitive treatment within 62 days GP referral
- Cat A RED 1 Ambulance incidents
- Cat A RED 2 Ambulance incidents
- Cat A 19 minute response incidents
- Number of Health care acquired infections

- Number of Never events

Areas of good performance include:

- Overall reduction in the number of over 30 minute handover delays
- Achievement of all cancer 31 day targets

The dashboard below provides a more complete position statement for the domain. Each of the Amber and Red rated indicators are reported on by exception in section 2.3. This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance. TIA and dementia diagnosis information is due to be reported quarterly; at the point of writing this report information on these indicators is not available yet.

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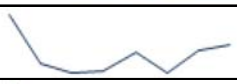
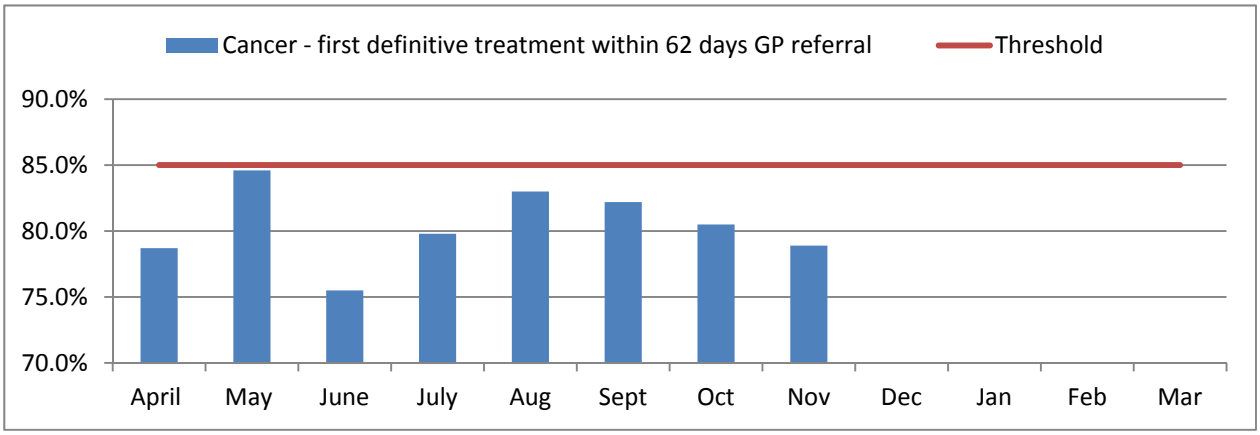
Local and National standards relating to Clinical Excellence					Red rated
Patients Access to planned care services	Threshold	Month	Performance	YTD performance	Trend
Cancer - first definitive treatment within 31 days of a cancer diagnosis	96%	Nov	100.0%	99.4%	
Cancer - subsequent treatment for cancer within 31 days - surgery	94%	Nov	97.5%	98.7%	
Cancer - subsequent treatment for cancer within 31 days - Drug Regime	98%	Nov	100.0%	99.5%	
Cancer - subsequent treatment for cancer within 31 days - Radiotherapy	94	Nov	100.0%	100%	
Cancer - first definitive treatment within 62 days GP referral	85%	Nov	78.9%	80.5%	
Cancer - first definitive treatment within 62 days screening service	90%	Nov	100.0%	98.3%	
Cancer - first definitive treatment within 62 days upgrade	90%	Nov	100.0%	91.2%	
Patients Access to unscheduled care					
Cat A RED 1 Ambulance incidents	75%	Dec	66.3%	69.9%	
Cat A RED 2 Ambulance incidents	75%	Dec	68.8%	72.2%	
Cat A 19 min response Ambulance	95%	Dec	94.2%	94.9%	
Over 30 minute ambulance handover delays (GHNHSFT)	<2012/13	Nov	104	755	
Over 1 hour ambulance handover delays (GHNHSFT)	<2012/13	Nov	9	163	
Crew clear up delays of over 30 minutes	<2012/13	Nov	19	125	
Crew clear up delays of over 1 hour	<2012/13	Nov	2	25	
Enhancing quality of life for people with long-term conditions					
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	80%	Nov	87.8%	81.4%	
Treating and caring for people in a safe environment & protecting them from avoidable harm					
Number of MRSA infections (Health Community)	0	Nov	0	5	
Number of MRSA infections (GHNHSFT)	0	Nov	0	0	
Number of C.diff infections (Health Community)	162	Nov	12	133	
Number of C.diff infections (GHNHSFT)	52	Nov	4	42	
Number of Never Events	0	Nov	0	3	

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

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



Year to date performance is Amber rated. 80.5% against a threshold of 85%. Threshold – at least 85% of patients should receive their first definitive treatment for cancer within 62 days of GP referral.

November's performance was below the levels set as part of the recovery trajectory. GHNHSFT performance for GCCG patients was 80.4% (21 of the 23 breaches occurred at GHNHSFT). Five of the 9 specialties failed to meet the required standard. November specialty performance by exception is detailed below:

Head & Neck 71.4%
Lower GI 75.0%
Lung 28.6%
Upper GI 77.8%
Urology 65.2%

Improvements were seen in Gynaecology and Haematology.

GCCG have requested and received an updated action plan which is being working through with providers to determine the likelihood of year-end achievement.

The actions put in place to improve performance from December onwards are being reviewed during weekly performance meetings.

December performance is due to be reported in the second week of February.

Cat A RED 1 Ambulance incidents (SWAST north division)

Cat A 8 min response - The percentage of Category A RED 1 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.

Red 1 calls are the most time critical and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions.

Current year to date performance is Red rated. 69.9% against a threshold of 75%.
Threshold – at least 75% of incidents requiring an emergency response should be arrived at within 8 minutes.

South Western Ambulance Service Trust (SWAST) North division performance has now been below the 75% threshold for all 3 quarters of the year. Quarter 3 performance was lower than the level achieved in quarter 1 and 2.

Overall activity has increased during the first 8 months of 2013/14 (6.0% increase compared to the same period in 2012/13); as of the end of November 2013 SWAST North division activity was 3.9% above contracted levels.

Year to date Gloucestershire activity has decreased slightly to 5.2% above contract (previous report 5.5%). Activity in November was 2.8% above contract.

SWASFT commissioned an independent review of Red Category performance in order to establish the risk of delivery going forward. The initial outcomes of the independent review have put forward recommendations on how to deliver sustained performance against this target. GCCG are currently working through the findings of this report and working with SWAST to identify potential productivity opportunities.

SWAST have provided trajectories for recovery based on the activity volumes seen between April and October.

Cat A RED 2 & A19 Ambulance incidents (SWAST north division)

Cat A 8 min response - The percentage of Category A RED 2 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.

Red 2 calls, which are defined as serious but less immediately time critical
and cover conditions such as stroke and fits,

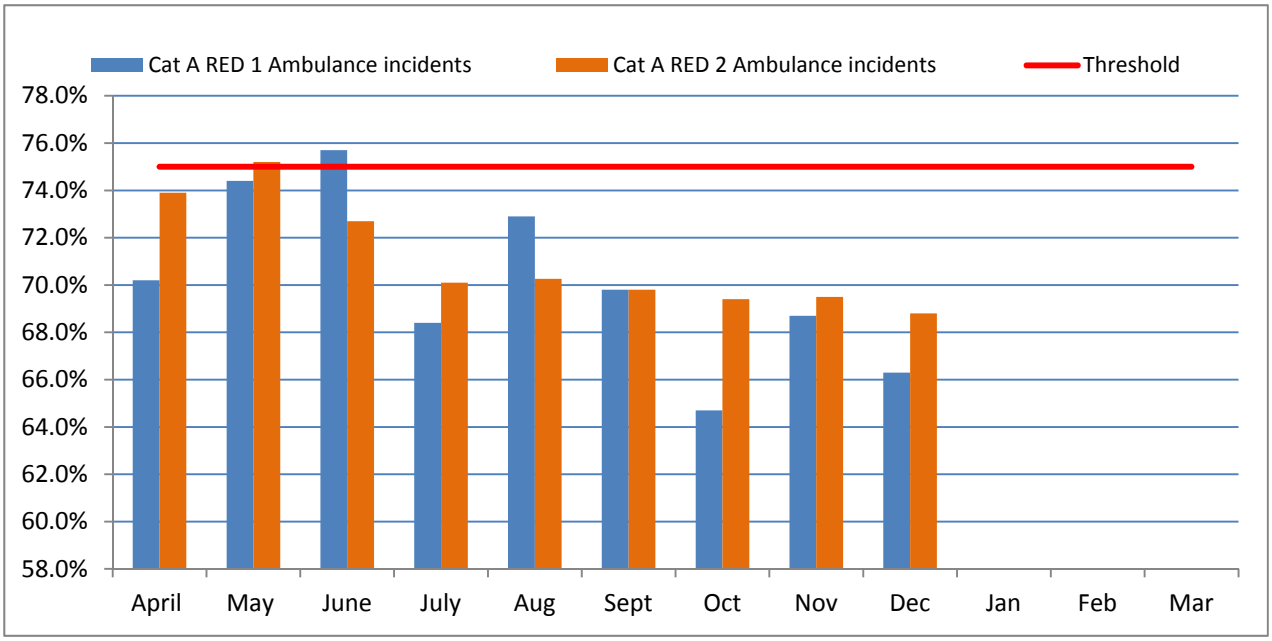
Current year to date performance is Red rated. 72.2% against a threshold of 75%.

Cat A 19 minute response - The percentage of Category A 19minute incidents, which resulted in an emergency response arriving at the scene of the incident within 19 minutes.

Current year to date performance is Amber rated. 94.9% against a threshold of 95%.

See RED 1 for related actions.

The graph below shows RED 1 & 2 ambulance incidents for 2013/14 compared to target levels.



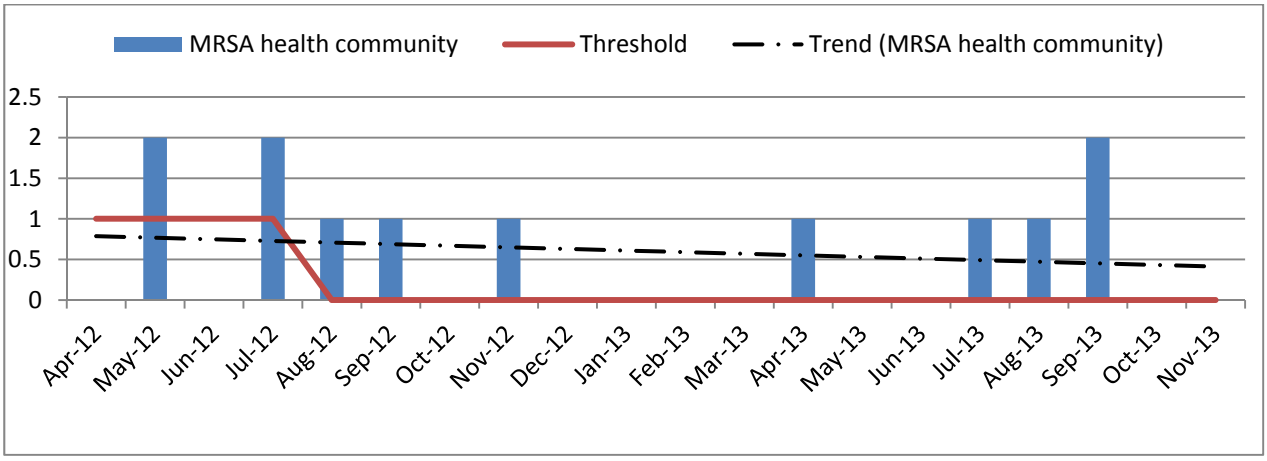
Number of MRSA infections (Health Community)

Number of MRSA infections (Health Community) – Current year to date performance is Red rated. 5 cases against a target of zero.

There have been 3 cases at GHNHSFT so far this year; all were pre-48 hour and therefore only count against the Health Community target. GHNHSFT have completed a root cause analysis (RCA) and have reviewed with the GCCG quality team and taken forward the findings from this analysis.

A further 2 cases have been reported in September. The first was an Endocrinology patient at Great Western Hospital and the second was a Plastic Surgery patient at North Bristol Trust.

No further incidences occurred during November 2013. For CCG actions please see GCCG Quality report to the Integrated Governance Quality committee (IGQC).

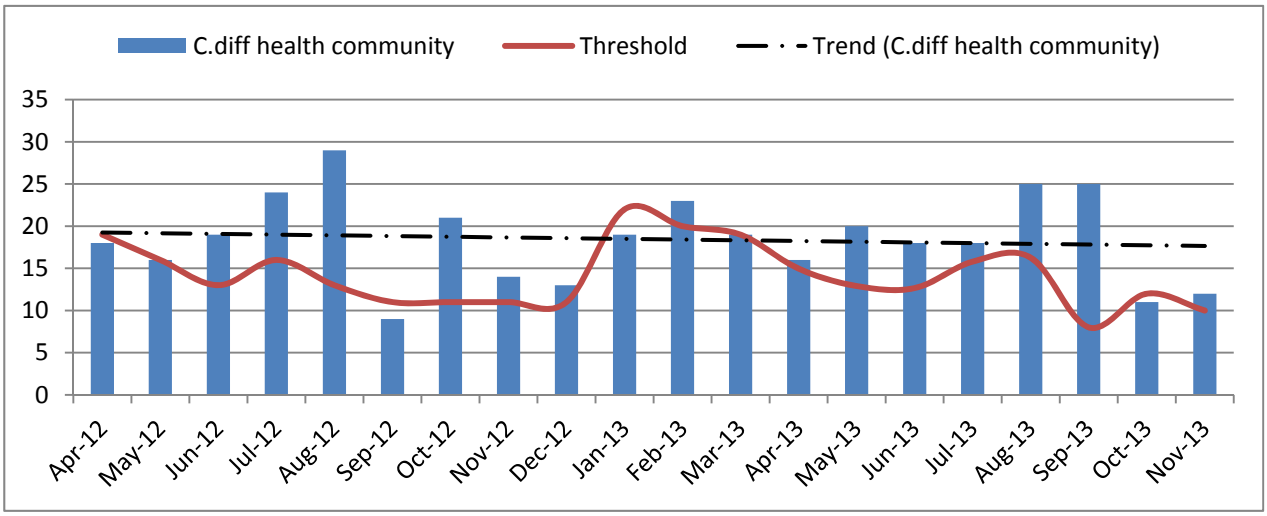


Number of total C. diff infections (Health Community)

Number of C. diff infections (Health Community) – Current year to date performance is Red rated. 145 cases against a target year to date target of 103. Threshold for the year is 162 cases.

In Q2 there were a cumulative total of 68 episodes of Clostridium Difficile infection against a cumulative target of 41 cases. Of these 50 were identified in patients in the community and 18 were identified in patients whilst a hospital inpatient.

In Q3 a further 11 episodes were reported in October 2013 and 12 cases reported in November. For CCG actions please see GCCG Quality report to the IGQC.



Number of Never Events

Red rated due to 3 never events reported in 2013/14.

April never event at GHNHSFT relates to the retention of an organ retrieval bag, the error was discovered prior to the patient leaving the theatre however, the patient did require additional surgery and further anaesthetic.

August Never event at GHNHSFT relates to an orthopaedic hip joint where an incorrectly sized implant was used during a hip revision. On discovery the implant needed to be changed so the patient was operated on for a second time.

October Never event at GHNHSFT relates to a retained pack following Gynaecology surgery. The incident will be subject to a full root cause analysis investigation and reported to the GCCG quality team.

No further incidents have been reported in November.

3.1 Perspective 2. Finance and Efficiency

Perspective 2	Finance & Efficiency	Amber

Success critieria: To ensure a financially viable commissioning organisation with an underlying recurrent surplus			A
	Threshold	Lower threshold	RAG
Underlying recurrent surplus (%age)	2%	1%	A
Surplus - year to date variance to planned performance (%age)	0.10%	0.25%	G
Surplus - full year variance to planned performance (%age)	0.10%	0.25%	G
Running costs year to date (variance to running costs allocation)	Within RCA		G
Running costs forecast outturn (variance to running costs allocation)	Within RCA		G
BPPC performance on non-NHS invoices by value (year to date)	95%	80%	G
Cash drawdown in line with planned profiles (%age variance)	2%	5%	G
Success critieria: QIPP Full year Forecast			**A**
	Threshold	Lower threshold	RAG
QIPP - full year forecast delivery to planned performance (%)	95%	80%	A

3.1.1 Finance and efficiency – Period to 31st December 2013

Summary:

- The CCG is forecasting to deliver its planned surplus of £6.757m.
- Pressures are inherent within the contract monitoring of some providers, particularly GHFT, and the current level of non-contracted activity highlights a further financial risk. Discussions are ongoing with lead providers to agree the extent of the year end position.
- Under-performance continues to be reported against QIPP targets and, it is acknowledged that the impact of any new mitigating actions will be limited in the remainder of the financial year.
- Financial risks are monitored through a continuous review of budgets and proposed investments and the use of the CCG's contingency and activity reserves.
- The better payment practice code performance for the year to date (for non-NHS invoices by volume) is 91.8% which is below the targeted figure.
- Key risks:
  - QIPP slippage may increase causing an additional cost pressure to the CCG
  - Provider contracts are showing over performance in elective and non-elective areas
  - Capital grants – the CCG has yet to receive the planned capital grant (£2.95m) and there is a small risk that a lower than planned level could be received.

The overall assessment for the finance and efficiency perspective is amber for which more detail is provided in the following sections. However, this assessment should be read in conjunction with those risks outlined within paragraph 3.8.

3.2 Resources

The CCG's current anticipated resource limit (see Appendix 2) is £677.512m; reflecting an increase of £422k in the month. This movement relates to funds received for the Ambulance Service for winter pressures and covers the northern area covered by the Trust (i.e. the allocation is not solely for Gloucestershire).

GHNHSFT have clarified that the entirety of a QIPP scheme of £500k relates to specialised activity and, therefore, this scheme should be allocated to NHSE. However, the specialised commissioners are disputing this view and are seeking a resolution to this issue.

The CCG has anticipated capital grant funding within its allocations to fund integrated care equipment of £2.95m. This funding has yet to be received but the CCG has received advice from NHS England (NHSE) that it should continue to assume its receipt.

3.3 Expenditure

The financial summary as at 31st December 2013 shows a year to date surplus of £5.068m in line with the plan and further detail is shown at Appendix 3. Key budget areas with either a financial risk or forecast outturn variance are highlighted below:

Key Indicates a favourable movement in the month Indicates an adverse movement in the month	**Trend**	**Forecast Over/ (Under) Spend £'000**
Gloucestershire Hospitals NHS FT		
As in previous months, analysis work undertaken continues to support the view that the SLA is under extreme pressure. Recent indications are that elective referrals from GPs have increased and this should be viewed together with upward trends in non-elective activity and a richer case mix, combined with a longer length of stay, in emergency treatments. Over the last two months, monitoring information has highlighted an increased throughput in both non-elective and outpatient activity. There are also indications that the provider will be increasing activity in a number of specialties in the last three months of the year in addition to the increases above plan	↓	£0.0

seen in the year to date. Discussions are currently underway with the provider on this issue to understand the demand and impact on waiting times. The Trust and CCG are currently working through in detail the significant areas of variance to agree the forecast position and from this the recurrent position on the contract which will inform the planning for 2014/15.		
Winfield Hospital		
Orthopaedic activity treated by the provider is higher than in previous years on a casemix that is richer than other local Trusts. However, a review of the costs of such activity across other in-county providers has not highlighted a reduction in similar procedures in GHFT. An overall review of orthopaedic activity is currently underway across all providers to understand the overall position and feed this into the work being carried out by the clinical programme group for this area.	⬇	£753.9
South West Ambulance Service		
The contract overperformance has stabilised from the position recorded earlier in the financial year. It is not anticipated that the increase in emergency activity recorded above plan will be rectified in the remainder of this financial year.	⬆	£572.0
Any Qualified Provider (AQP)		
Initial analysis undertaken in this area has highlighted increases which are not supported by reduced activity in GHFT or other acute providers. Work continues to assess the implications of these referrals.	⬇	£427.2
Non Contractual Activity (NCA)		
Further analysis has been undertaken in this area to inform the calculation of a more robust outturn forecast. This exercise has highlighted, in particular, those providers, predominantly in London, that were paid in previous years by the Specialist Commissioning Consortium. It is anticipated that some of these providers may need to be subject to a formal contract in 2014/15 due to the levels of activity treated.	⬇	£501.2
Patient Transport Services		
As anticipated, the commencement of the new PTS contract from 1st December has led to a reduction in the costs of taxis and other private providers. It is, however, important not to assume that the first month represents a trend and this position will be monitored closely on a monthly basis.	⬆	(£10.2)
Continuing Health Care		

The current underspend primarily relates to Free Nursing Care, Enteral Feeds and Continence Products.		(£443.7)
Community Services		
As in previous months, the majority of the forecast overspend relates to the equipment pool operated by Gloucestershire County Council. The number of items used has increased above the plan reflecting the focus on improving discharge processes.		£143.6
Oxygen		
The home oxygen assessment service commenced in October and the initial impact that this service has made will not be reported within national data until January 2014. The forecast overspend is based on year to date trend information.		£328.5
GP Prescribing		
The prescribing data received to October 2013 highlighted an adverse movement which relates to the correction of a previous national overestimate of the impact of cost reductions on selected drug tariffs effective from 1st October. The forecast underspend in this area has, therefore, reduced from last month. Although growth in the volume of prescriptions in 2013/14 has increased, the average cost per item has reduced by more than the national average.		(£791.6)
Local Enhanced Services		
Following a detailed review of this budget, the outturn forecast has been reassessed, with the underspend significantly reducing. Primarily, this movement follows analysis of payments made for the new Care Home LES but has, also, been impacted by recharges from NHS England for items paid in error on the CCG's behalf during the earlier part of the financial year.		(£80.0)
Running Costs		
The forecast includes an estimate of PropCo recharges (in advance of confirmation of extent of the recharge) which highlights a potential pressure. Contradictory guidance has been received by the CCG and it is anticipated that the charging mechanism will be clarified on a national basis by the end of January.		(£324.0)

The recurrent impact of the 2013/14 forecast outturn, including QIPP delivery, is being built into the 2014/15 financial plan.

3.4 **QIPP**

The current programme continues to show slippage against plan and requires careful monitoring over the coming months. Appendix 4 shows the forecast slippage against programme areas, Appendix 5 shows each scheme and its RAG rating in terms of implementation, in year savings and also its forecast impact in 2014/15. Additional schemes have been and are continuing to be identified to compensate for the forecast under delivery. Where known, the forecast for these additional schemes has been included in the forecast. The slippage and associated financial risk is reflected in each budget line within the forecast outturn.

3.5 **Cash (Appendix 6)**

The CCG has received a revised maximum cash drawdown (MCD) figure for 2013/14 which has been based on a recent national submission (in December) and highlights a significant increase from the position shown last month (although not to the value requested). This exercise will be repeated in February to inform the year end position. The current predicted cash limit is shown in the appendix and highlights that the CCG has drawn down cash in line with anticipated profiles for the year to date.

3.6 **Better Payment Practice Code (Appendix 7)**

It is a national target to pay all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice. The year to date position shows a deterioration in the volume of invoices paid to 91.8% (from 95.0%) with all other measures being consistent with last month.

3.7 **Statement of Financial Position (Appendix 8)**

The position shown excludes the impact of transfers of legacy balances from Gloucestershire PCT as at 31/3/13. Following receipt of further national guidance, the CCG will have to provide for potential fertility and CHC costs arising after 1 April 2013, this is line with internal financial planning assumptions. In 2013/14, costs incurred prior to this date will be charged to NHS England.

3.8 **Financial Risk**

The following risks may be material to the current financial position:

- <u>Capital Grants</u>
  Access to capital grants has been assumed within the current plan. As is the position nationally, the CCG is awaiting confirmation from the NCB regarding such allocations and the current plan assumes receipt of the allocations

- <u>Contract Performance</u>
  A large number of the CCG's contracts are variable and there is a risk of over performance against the contracted value. Monitoring is showing significant over performance against the plan, an estimated value of the validated overperformance has been included in the financial plan.

- <u>QIPP slippage</u>

Due to the nature and scale of system changes within the QIPP programme along with the number of live schemes for the organisation there is a high risk of slippage to the programme.

- Properties
  Under the charging regime for NHS Property Services the CCG will be charged for any void space in properties owned or managed by NHS Property Service. The CCG will be meeting with Prop Co to discuss ways to reduce this risk.

- LD Joint Funded Placements
  Although such packages have been reviewed regarding the extent of health and social need identified, the CCG disputes that it should bear the cost of delays in implementing the new care plans.

- Financial Ledger
  The CCG has to use the national finance system and the associated Integrated Single Financial Environment reporting structure. This has led to very limited flexibility in reporting the position and the CCG is working with other organisations to enable greater flexibility in the reporting structure to enable effective local reporting.

Recommendations

The Governing Body is asked to

- Note the financial position and the inherent risks outlined within the attached report

4.1 Perspective 3. Patient experience

4.1.1 Patient Experience – Period to 31st December 2013

PERSPECTIVE 3	Patient Experience	Amber
Success criteria 1: Reporting: *Improve reporting of patient experience and the use of feedback to influence commissioning intentions*		A
Key performance indicators		
Friends & family test - Roll out of FFT as per agreed national timetable		**G**
Friends & family test - improvement in the average FFT score for acute inpatient care & A&E services between Q1 2013/14 & Q1 2014/15		G
Results of Maternity, Emergency & elective inpatient surveys		A
Results of Community mental health survey		To be included when available
Review appropriateness and quality of feedback from providers		A
Qualitative feedback including that from surveys, FFT, 4Cs and Healthwatch		A
Results from the provider assurance framework through monitoring in the Provider Quality Review meetings		To be included when available
Success criteria 2: Staff Involvement: *Improve staff reporting of the three domains of quality - safety, effectiveness and experience*		**G**
Key performance indicators		
Review the systems for the management of Serious Incidents and Never Events and develop mechanisms to identify themes, ensure lessons are learnt and feedback is provided to member practices and service providers		To be included when available
Establish a system for CCG staff to share their experiences and make suggestions so that the CCG and providers can learn from staff's Friends and Family experiences		G
Success criteria 3: Effecting change based on patient experience feedback : *Staff recognise the value of patient experience in their commissioning role*		**G**
Key performance indicators		
Use patient stories to monitor the quality of commissioned services		A
Use individual patient experience to inform the wider decision making in improving services		G
Constructively respond to requests for specific engagement on themes identified through feedback		G
Success criteria: 4*. Key local and National standards relating to Patient Experience*		A
Key performance indicators		
Achievement of key local and National standards relating to Patient Experience – see section 4.2.1		A

4.1.2 **Success Criteria 1: Reporting – Improve reporting of patient experience and the use of feedback to influence commissioning intentions (Amber).**

Currently reporting overall recorded as 'Amber' for this element.

We are awaiting quarter 3 data for Friends and Family test (FFT) and therefore have no update on the information previously provided to the Governing Body (see below in italics).

FFT target for the end of quarter 2 was to improve the Acute trust response rate from Q1 baseline to 5% (with a 15% target for the end of quarter 4). This was achieved and exceeded for both Inpatients and the Emergency department (ED). October 2013 data (the latest collated at the time of writing) shows an increase in response rate for GHNHSFT, exceeding the target set for end of Q4. Response rates for A&E are still below the 15% threshold which affords the figures validity, but with the new token system in place now established, it is hoped that the response rate will continue to rise. A comment box has been placed alongside the token boxes to encourage more qualitative feedback.

4.1.3 **Success Criteria 2: Staff involvement – Improve staff reporting if three domains of quality: safety, effectiveness and experience (Green).**

GCCG Patient and Public Engagement (PPE) objective for 2013/14 is to establish a system for GCCG staff to share their experiences and make suggestions so that the CCG and providers can learn from staff's Friends and Family experiences.

In November 2013 a pilot FFT was launched for GCCG, Central Southern Commissioning Support Unit (CSCSU) and NHS England Area Team staff based at Sanger House. To date there have been 3 responses, which have been fed back to the appropriate provider.

The Commissioning for Quality and Innovation (CQUIN) 2014/15 Guidance states that Commissioners will need to be assured that their providers are on track to have fully implemented the staff Friends and Family Test from 1 April 2014. GCCG is currently agreeing CQUIN schedules with all providers.

4.1.4 **Success Criteria 3: Effecting change based on patient experience feedback – staff recognise the value if patient experience in their commissioning role (Green).**

Linked to success criteria 1 regarding improved reporting, GCCG will work with providers to agree processes for more comprehensive data sharing to ensure a greater evidence base of local patient experience is collected and used to inform future commissioning decisions, service changes and service redesign and

service reconfiguration.

- GCCG is currently developing a comprehensive Patient Experience CQUIN which will cover shared decision making, patient experiences informing service improvement and staff training.

4.2 Reporting of key local and national standards – Patient experience

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

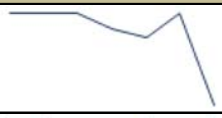
Issues identified in the following areas:

- Emergency department 4 hour waiting times
- Mixed sex accommodation breaches
- Cancelled operations – not rebooked within 28 day
- RTT pathways in excess of 52 weeks
- Number of patients seen within 2 weeks of urgent referral for breast symptoms.

Areas of good performance include:

- Referral to treatment targets have been achieved
- Significant improvement in 6 week diagnostic performance due to improvements with initial diagnostic and planned Endoscopy waiting times

The dashboard below provides a more complete position statement for the domain. Each of the Amber and Red rated indicators are reported on by exception in section 4.3. This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Local and National standards relating to Patient Experience					Amber rated
Patients Access to planned care services	Threshold	Month	Performance	YTD performance	Trend
% of admitted pathways treated within 18 Weeks	90%	Nov	90.9%	92.6%	
% of non - admitted pathways treated within 18 Weeks	95%	Nov	97.3%	97.5%	
% of incomplete Pathways that have waited less than 18 Weeks	92%	Nov	94.7%	95.4%	
Zero RTT pathways greater than 52 weeks	0	Nov	0	2	
% of patients seen within 2 weeks of GP referral for suspected cancer	93%	Nov	94.1%	93.8%	
% of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected	93%	Nov	92.5%	86.2%	
% of patients waiting more than 6 weeks diagnostic test	1%	Nov	1.3%	0.87%	
% of patients waiting more than 6 weeks for a Planned/ Surveillance diagnostic test from their to be seen date – Endoscopy procedures only	1%	Nov	8.9%	8.9%	
Patients access to community care					
% referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	95%	Nov	95.0%	98.0%	
% referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	95%	Nov	100.0%	98.0%	
% referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	95%	Nov	99.0%	99.0%	
% referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	95%	Nov	100.0%	99.0%	
% referred to the Podiatry Service who are treated within 8 Weeks	95%	Nov	98.0%	98.0%	
% referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	95%	Nov	100.0%	99.0%	
% referred to the Adult Physiotherapy Service who are treated within 8 Weeks	95%	Nov	97.0%	97.0%	
% referred to the Parkinson Nursing Service who are treated within 8 Weeks	95%	Nov	100.0%	100.0%	
% referred to the Diabetic Nursing Service who are treated within 8 Weeks	95%	Nov	100.0%	100.0%	

Patients Access to unscheduled care	Threshold	Month	Performance	YTD performance	Trend
4-hour A&E target GHNHSFT	95%	Dec	95.1%	94.3%	
4-hour A&E target GCS MIU	95%	Dec	99.9%	99.9%	
12 hour trolley waits	0	Dec	0	0	
Positive patient experience of secondary care					
Mixed-sexed accommodation breaches	0	Nov	21	48	
Cancelled operations - 28 day breaches	0	Nov	3	39	
Urgent operations cancelled for a second	0	Nov	0	0	
Positive patient experience of mental health services					
Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	95%	Q2	99.5%	99.8%	
The proportion of people who have depression and or anxiety discorders who receive psychological therapies	13%	Q2	6.6%	6.6%	
The proportion of people who complete therapy who are moving towards recovery	50%	Q1	50.6%	50.5%	

4.3 **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.**

Year to date performance is 94.3% compared to a target of 95%. Threshold – at least 95% of patients should be transferred, admitted or discharged within 4 hours.

GHNHSFT achieved the 95% target in December having narrowly missed in November. The final Q3 position at the end of December was 95.2%. The year to date position has improved to 94.3%.

A comprehensive action plan has been put in place, which considers, pre hospital, in hospital and post hospital sections of pathways. There are identified senior leads and a governance process to oversee delivery.

Performance continues to be monitored weekly by the GCCG. The allocation of winter monies has now been completed with a number of schemes put in place for the winter period.

Recruitment of additional Emergency department nurses and doctors has been completed. Additional resource has also been allocated to improve access to diagnostic tests 7 days per week.

In late November Mrs Foster's week saw the health community focus on discharge and made inroads into increasing discharges and learning areas for further

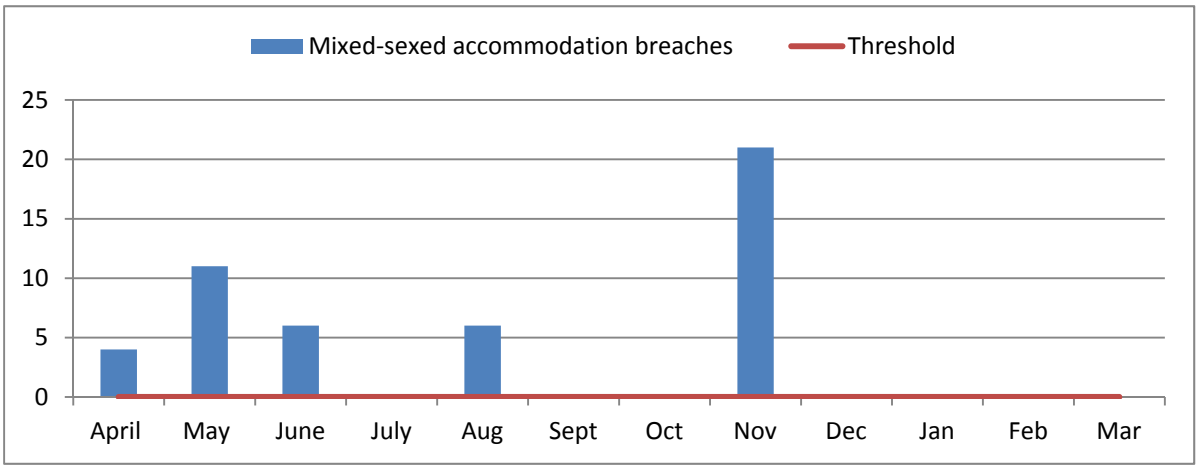
improvement. This has been repeated in January at both Gloucestershire Royal and Cheltenham General Hospitals.

Eliminate mixed-sexed accommodation breaches at all providers sites

To date 48 patients have been involved in mixed sex accommodation breaches against a target of 0.

GHNHSFT complete a route cause analysis for all mixed sex breaches and the outcomes are discussed with GCCG. GCCGs Senior Quality and Development Manager have regular meetings with the GHNHSFT lead for patient experience to review progress and identified actions.

There were 4 breaches in November at Cheltenham General Hospital; affecting 21 patients. GCCG quality team have reviewed incidents with provider, a detailed action plan has been put in place following review.

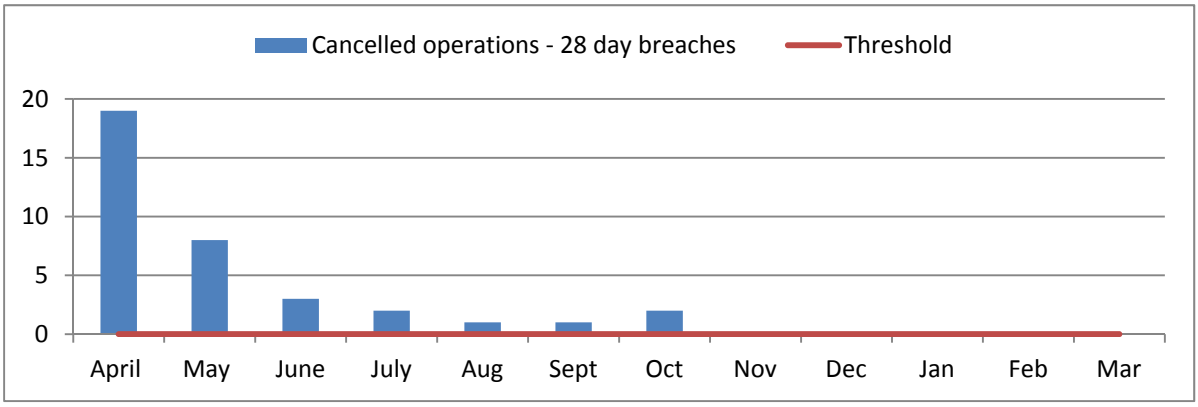


Cancelled operations - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days.

The year to date position (at the end of September) for GHNHSFT shows a total of 39 patients have been cancelled on the day of admission for non-medical reasons and patients have not been provided with another date within 28 days; the threshold is zero.

Bed pressures in quarter 1 resulted in a high number of cancellations on the day for a non-clinical reason.

Of the 39 breaches 27 occurred in April and May where significant pressure was experienced within the unscheduled care system. In November 3 patients at GHNHSFT were cancelled and not provided another date within 28 days.



Number of completed admitted pathways greater than 52 weeks

1 patient in April 2013 had a completed admitted pathway with a wait longer than 52 weeks. The patient at Plymouth Hospitals NHS Trust waited over 52 weeks for treatment.

GCCG were not made aware of any issues and Plymouth were unable to provide sufficient evidence of mitigating actions. GCCG withheld payment for patient's treatment in line with national guidance.

A second patient pathway in excess of 52 weeks at GHNHSFT occurred in September. The patient was waiting for a Urological procedure; GCCG are reviewing the root cause analysis with GHNHSFT and will take appropriate actions to minimise the potential for future breaches.

No breaches occurred in November.

Cancer waiting times – patients seen within 2 weeks of an urgent referral for breast symptoms

Relates to the percentage of patients seen within 2 weeks of an urgent referral for breast symptoms, where cancer is not initially suspected.

It is a requirement for all Breast referrals to be seen within 14 days in line with the national Cancer 2 week wait (2ww) performance target.

Year to date performance is Red rated at 86.2% against a threshold of 93%

Performance in August was significantly below the 93% threshold at 46.6%; all 117 breaches occurred at GHNHSFT. Following the implementation of an action plan September performance was 73.0% and has improved to 97.7% in October. November's performance was slightly below the national target at 92.5% with 14 of the 15 breaches occurring at GHNHSFT.

As per the agreed action plan a trajectory for sustainable delivery has been agreed. Weekly updates are provided by GHNHSFT.

While capacity within the breast service has acutely affected the the 14 day target specifically relating to breast; the overall two week wait target for suspected cancer referrals was Amber rated in August and September. Performance has been delivered and sustained for October and November in line with GHNHSFT action plan.

Percentage of patients waiting more than 6 weeks for diagnostics test.

Overall performance for the year has been good and has demonstrated a significant improvement from previous years. November's performance was above the 1% threshold at 1.3%, due to a specific issue with Echocardiography at GHNHFST. Of the 88 breaches at GHNHSFT 79 were related to Echocardiography.

GCCG has received assurance that this was an isolated incident and that performance will improve in December.

5.1 Perspective 4. Partnerships

5.1.1 Partnerships – Period to 30th November 2013:

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PERSPECTIVE 4	Partnerships	Green
Success criteria 1: *Building effective partnership working by putting in place a joint planning and governance framework to improve outcome for the Gloucestershire population*		**Green**
Key performance indicators		
Signed off Better care fund (BCF) plan		In line with National timetable
Develop a 5 year commissioning plan agreed with key providers		In line with National timetable
Development and maintenance of system wide forum encompassing all providers across heath & social care, independent and voluntary sector		G
Success criteria 2: *Delivery of the Health & Well Being plan*		**Under development**
Key performance indicators		
Increase the range and volume of services commissioned jointly with both GCC and District Councils.		
Increase the range and volumes of services commissioned jointly with the third sector on a locality basis within which the agenda of early intervention and prevention are woven into a range of local statutory health and social care services.		
Success criteria 3: *Effective urgent care pathway to enable more patients to stay in their own home*		**Green**
Key performance indicators		
Increase in the number of people who remain in their normal place of residence		To be incorporated into BCF
Partnership working group established to review dashboard and set targets.		**G**

5.1.2 **Success criteria 1: Building effective partnership working by putting in place a joint planning and governance framework to improve outcome for the Gloucestershire population (Not rated)**

The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round, the national total is £3.8bn. It provides an opportunity to transform local services so that people are provided with better integrated care and support.

The draft plans for the BCF must be submitted on the 14th February, with final plans due on the 4th April 2014. Plans must have the agreement of providers and sign off by the Health and Well Being Board

The CCG and Local Authority are working together with partners to agree principles and priorities for joint working. A paper outlining some draft principles is being taken to the Health and Well Being Board in January. Work is currently being undertaken on what is included in the BCF, the governance around the development and operation of the BCF for Gloucestershire and the role of providers and the third sector within the operation of the BCF.

There are a number of fora within the health and social care community which include providers and commissioners which support a joint planning approach and these are being fully utilised to develop the two year operational and five year strategic plan.

5.1.3 Success criteria 2: Delivery of the Health & Well Being plan (under development)

Further clarity around further commissioning and contract management strategies will form part of the BCF plan.

5.1.4 Success criteria 3: Partnership working group established to review dashboard and set targets.

Health and social care working group established, part of its remit is to review the discharge dashboard including key targets and deliverables across the unscheduled care system.

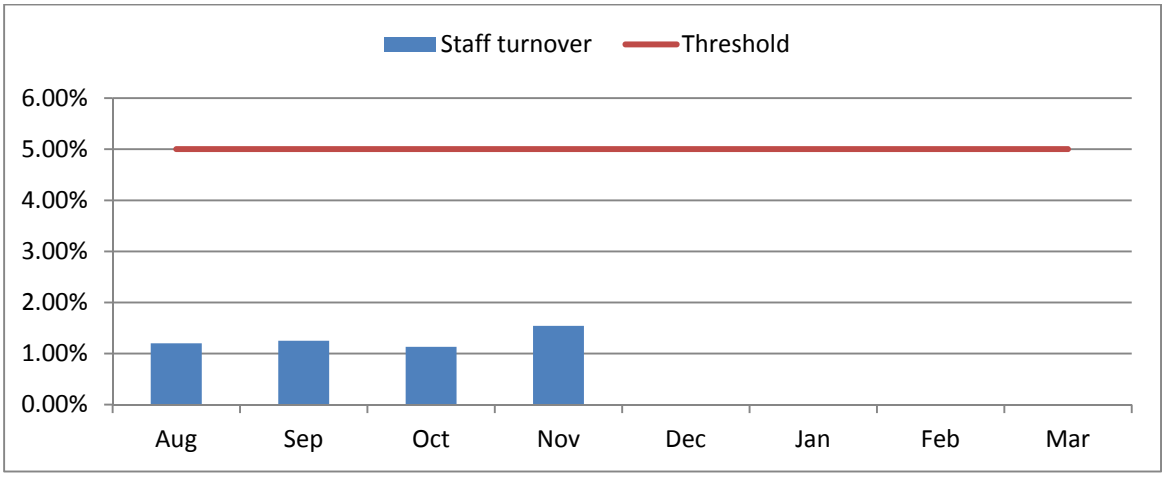
6.1 Perspective 5. Staff

6.1.1 Staff – Period to 31st December 2013:

PERSPECTIVE 5	Staff	Green
Success criteria 1: *Attracting and retaining high quality staff aligned to the CCGs vision and values*		**G**
Key performance indicators		
Turnover - % of employees leaving the organisation		**1.45%**
Number of current Vacancies in structure		**14**
Success criteria 2: *Personal development processes that are linked to the strategic plan*		**Due October onwards**
Key performance indicators		
All staff should have a personal development plan		**Collating results from October**
Proportion of staff with appraisal meeting within the last 6 months		**Collating results from October**
Success criteria 3: *Staff are Happy and Motivated*		**G**
Key performance indicators		
Staff sickness levels		**2.39%**
Staff Survey		**Annual only**

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

Monthly turnover has decreased from 1.54% to 1.45% per month. The number of leavers since April 2013 is 23 (1 in December).



There are 14 vacancies within GCCG structure; 0 jobs live on NHS Jobs.

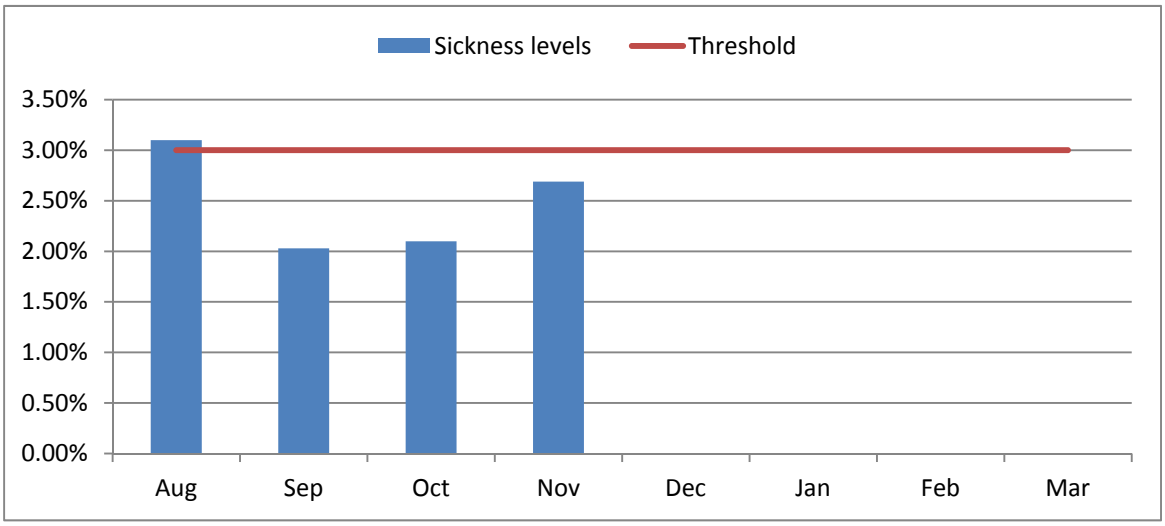
6.1.3 Personal development processes that are linked to the strategic plan

The CCG has commenced the roll-out of their PDP process to ensure that objective setting is in place. This is a rolling programme which is anticipated to be completed by the end of March.

6.1.4 Staff are Happy and Motivated

Staff survey results to be reviewed annually when survey takes place.

Staff sickness levels up to the 31st December have been 2.39% which is below the GCCG target of less than 3%, and lower than that reported in November. 2.39% equates to 1157 full time equivalent (FTE) working days. The sickness absence rate is calculated by the total number of FTE days lost divided by the total number of working days.



7.1 Annual Operating Plan: 2013/14

7.1.1 The Clinical Commissioning Group produced an Annual Operating Plan (AOP) for 2013/14, which outlined its key programmes of work, how national standards will be met and the financial impact of plans. This is in the context of the national guidance 'Everyone Counts: Planning for patients 2013/14' published by NHS England.

7.1.2 This section updates the Board on the delivery of key components of the integrated annual operating plan within the service transformation and commissioning priorities for 2013/14. This is supported by the strategic vision, basis for change, ensuring national standards are met and the financial impact.

7.1.3 There are a total of 47 projects across the CCG which support the delivery required as part of NHS Gloucestershire CCG AOP. Thirty six (76.5%) of the project areas are expected to be delivered by the end of financial year in line with their plans, of which a number of projects have completed all actions by the end of Q2 (11 - 23.4%).

7.1.4 This section below outlines the key areas completed by theme.

7.1.5 The Board is asked to note the update on performance to date; a full report will be presented in March 2014.

7.2 AOP Update Report – Q2

7.2.1 Integration

The integration agenda is fundamental to the delivery of Joined Up Care with its key ambition of developing an Integrated Community Team model.

The Integrated Community Teams model and Service Specification has been agreed. Rapid Response and High Intensity services are due to 'go-live' in Gloucester Locality in January 2014.

7.2.2 Clinical Programme Groups (CPG)

The aim of the clinical programmes is to provide a transparent framework for defining the best health outcomes possible for the population within the resource available and commissioning services which deliver these outcomes; involving colleagues across the health and social care community. The approach should drive clinical changes to commissioning informed by best practice, opportunity for change and innovative thinking.

Completed developments from the CPGs include:

- The Frail Elderly CPG has launched the Dementia Toolkit, along with training resources made available for the evaluation of the enhanced model.

- The Care Homes Enhanced Service, based on sign up from GP practices will ensure 78% of all care homes have a lead GP practice assessing patients within their homes on a periodic basis.

- The Quality Premium scheme which supported delivery of weight management has been implemented and is forecast to achieve.

- The Mental Health Integrated Care Teams Service Specification has been completed, agreed and placed into the 2gether NHS FT contract to ensure ongoing management of this service.

- The development of the LDISS (Learning Disability Intensive Support Service) has been agreed, Case Support planners have been reviewing cases ahead of this service being introduced and work is currently underway to map the map the work programme for 2014/15.

- The OPAL service has commenced at GRH in October 2013. Assessment of future commissioning will be part of the ongoing evaluation of the service; including focus on the relationships with ICTs.

- The Community Diabetes Service in primary care was re-launched in July 2013. The Enhanced Service has covered 84 out of the 85 practices.

- The Home Oxygen and Assessment service commenced in October, assessing new patients from November 2014.

In addition to the delivery of the expectations within the Annual Operating Plan a number of other key achievements have been made in 2014/15 including the following:

- Gloucestershire CCG has successfully integrated the GCS Community Respiratory Team with the acute Assisted Discharge Team, supporting the continued development of integrated / 'joined up' care within Gloucestershire.

- Established the Cardiovascular Disease (CVD) CPG in October 2013. The group has defined its key work areas for 2014/15 and will look to identify ways to improve upon the utilisation of services.

7.2.3 Urgent Care

The Unscheduled Care work plan aims to focus on ensuring patients "receive care at the right time and in the right place," as close as possible to the patient's home which will reduce demand within the Urgent Care system. The outcome will be to reduce the reliance upon bed based services and support service providers to deliver according to agreed performance and quality standards.

The NHS '111' service saw a concerted effort from CCG and providers in working through the rectification plan has ensured this service is available to the public prior to the busy winter period, helping to support the typical high demand anticipated.

The Ambulatory Day Unit / AEC model has been trialled at GRH, with implementation of the recommendations ongoing, the model will be evaluated and the outcome of this will inform further development of the service in 2014/15.

Positive evaluation of usage and deflection of admissions via the SPCA (Single Point of Clinical Access) will support further development of SPCA to align with Integrated Community Teams going into 2014/15. In addition, development of joint protocols with SWAST regarding the use of SPCA to avoid admissions, has improved the provision of care, supporting the CCG approach to 'joined up' Care.

The Risk Stratification Enhanced Service has seen positive sign up with all 85 practices having completed the initial data extractions. Audit of the successful completion of this project is underway to identify 'Lessons Learned'. Plans in place to support the DES for Unplanned Admissions for 2014/15 along with supporting the developments within the ICT workstream.

7.2.4 Planned Care

The Planned Care work schedule aims to develop countywide services, and to commission system-wide developments, developed by CPGs and localities.

The Advice and Guidance Service is now in place in 8 specialities reducing the requirement for patients to receive secondary care referrals by providing consultant advice to GPs quickly within specific clinical pathways.

In order to support the increased demand and ensure timely access to diagnostic tests, the CCG identified a number of alternative providers of diagnostic services. A total of 8 contracts have been signed to provide diagnostic services through the Any Qualified Provider route, with engagement and locality visits completed across Gloucestershire.

7.2.5 Supporting Strategies

In order to support delivery of the priorities as laid out in the operating plan a number of enabling work streams were identified including such as joint commissioning, governance of Contracts and performance monitoring.

A new purpose built 20- single bedded unit Hospital in Tewkesbury has opened, offering a wide range of services such as a minor injuries unit, outpatient's clinic, and an Assessment & Rehabilitation Unit.

Performance monitoring is in place along with the QIPP and CQUIN schedules within contracts in order to assure delivery of key components of the CCGs Annual Operating plan continues to be delivered.

7.3 Recommendations

The CCG are asked to take note of the update to the Annual Operating Plan 2013/14.

Appendices:

Ref	Description
1	GCCG Dashboard 2013/14
2	Resource Limits
3	Summary Financial Position
4	QIPP financial summary against 2013/14 plan
5	QIPP assessment by scheme
6	Cash
7	Better Payment Practice
8	Statement of Financial Position
9	Briefing on performance framework

Gloucestershire CCG 2013/14 Integrated Performance Scorecard

Target	Principal Delivery Targets		2012-13 Outturn	Apr 2013	May 2013	Jun 2013/ Q1	Jul 2013	Aug 2013	Sept 2013/ Q2	Oct 2013	Nov 2013	Dec 2013/ Q3	Jan 2014	Feb 2014	Mar 2014/ Q4	Year / Quarter to date	Year end forecast	Perf. Measured
Unscheduled Care																		
Accident & Emergency																		
CB_B5	**4-hour A&E target** - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		GRH	94.5%	91.4%	91.9%	93.7%	95.5%	93.7%	94.4%	94.4%	93.3%	93.8%				93.6%		
		CGH	95.0%	89.9%	93.1%	95.4%	93.4%	97.2%	97.9%	98.2%	97.3%	97.5%				95.4%		
		GHNHSFT total	94.7%	90.8%	92.4%	94.4%	94.7%	95.0%	95.7%	95.8%	94.7%	95.1%				94.3%		
		GCS - MIU	99.9%	99.95%	99.88%	99.91%	99.9%	99.9%	99.95%	99.96%	99.87%	99.9%				99.92%		
CB_S9	**12 hour trolley waits** (no A&E attender should wait more than 12 hours from the decicision to admit to admission)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative
		GRH	0	0	0	0	0	0	0	0	0	0						
		CGH	0	0	0	0	0	0	0	0	0	0						
		GHNHSFT total	0	0	0	0	0	0	0	0	0	0						
		GCS - MIU	0	0	0	0	0	0	0	0	0	0						
Ambulance																		
CB_B15_01	**Cat A 8 min response** - The percentage of Category A RED 1 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	Cumulative
		SWASFT	n/a	70.2%	74.4%	75.7%	68.4%	72.9%	69.8%	64.7%	68.7%	66.3%				69.9%		
		Glos only	n/a	69.9%	70.1%	73.6%	67.3%	78.7%	76.4%	63.8%	66.9%	62.2%				69.9%		
CB_B15_02	**Cat A 8 min response** - The percentage of Category A RED 2 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	
		SWASFT	n/a	73.9%	75.2%	72.7%	70.1%	70.3%	69.8%	69.4%	69.5%	68.8%				72.2%		
		Glos only	n/a	74.7%	74.8%	72.7%	72.8%	70.2%	69.2%	70.2%	68.1%	67.1%				72.3%		
CB_B16	**Cat A 19 min response** - The percentage of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
		SWASFT	95.5%	95.2%	95.9%	95.2%	94.6%	95.0%	94.1%	94.6%	94.3%	94.2%				94.9%		
		Glos only	95.0%	95.7%	95.2%	94.1%	95.1%	94.8%	93.6%	95.0%	94.4%	92.9%				94.6%		
CB_S7	Over 30 minute ambulance handover delays (GHNHSFT)	Actual	2,473	136	86	77	78	98	76	100	104					755		Cumulative
CB_S7	Over 1 hour ambulance handover delays (GHNHSFT)	Actual	731	71	10	18	19	10	13	13	9					163		
CB_S8	Clear up delays of over 30 minutes	Actual	n/a	12	14	6	16	19	24	15	19					125		Cumulative
CB_S8	Clear up delays of over 1 hour	Actual	n/a	5	3	7	4	0	2	2	2					25		
Delayed Transfers of Care (DTOC)																		
Local	Average number of Delayed Transfers of Care for acute patients in the month	GHNHSFT target		14	14	14	14	14	14	14	14	14	14	14	14	14	14	Cumulative
		GHNHSFT actual		14.8	16.6	9.8	10.5	9.8	8	11.2	13	6				11.1		
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	GHNHSFT		0	0	0	0	0	0	0	0	0						
Local	Average number of Delayed Transfers of Care for non-acute patients in the month	GCS target		10	10	10	10	10	10	10	10	10	10	10	10	10	10	Monthly
		GCS actual		5.5	8	5.5	5.3	4.6	5	7.8	10					6.4		
Harmoni 111																		
Local	Calls answered within 60 seconds	Target	N/A	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Monthly
		Actual		73.9%	89.5%	95.7%	96.6%	97.9%	96.1%	98.7%	97.9%	96.8%				93.7%		
Local	Calls abandoned after 30 seconds	Target	N/A	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	
		Actual		4.4%	3.1%	1.3%	2.4%	0.4%	0.7%	0.4%	0.3%	0.5%				1.5%		
Local	Calls triaged	Target	N/A	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	
		Actual		77.3%	75.6%	74.8%	74.0%	74.7%	79.3%	79.8%	80.3%	82.9%				77.6%		
Local	Calls warm transferred	Target	N/A	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	
		Actual		-	49.3%	44.4%	55.7%	76.4%	77.2%	82.7%	74.8%	66.4%				65.9%		
Local	Longest wait for an answer	Target	N/A	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	
		Actual		00:27:35	00:15:48	00:18:17	00:12:00	00:07:09	00:08:00	00:05:45	00:06:05	00:05:31						
Local	Longest wait for a call back	Target	N/A	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	
		Actual		03:07:38	00:08:53	00:25:45	00:11:53	00:12:24	00:09:57	00:06:28	00:25:21	00:09:55						
Planned Care																		
Acute Care Referral to Treatment																		
CB_B1	Percentage of admitted pathways treated with in 18 Weeks	Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	Cumulative
		Actual		93.6%	92.8%	93.2%	94.2%	93.7%	91.3%	91.2%	90.9%							
CB_S6	Number of completed admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual		1	0	0	0	0	1	0	0							
Local	Number of specialties where admitted standard was not delivered	Actual		2	7	5	3	4	6	6	2							
CB_B2	Percentage of non - admitted pathways treated within 18 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		98.0%	97.9%	97.9%	97.6%	97.1%	97.2%	97.1%	97.3%							
CB_S6	Number of completed non-admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual		1	0	0	0	0	0	0	0							
Local	Number of specialties where non-admitted standard was not delivered	Actual		1	2	2	5	5	5	7	4							
CB_B3	Percentage of incomplete Pathways that have waited less than 18 Weeks	Target		92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	
		Actual		95.6%	95.7%	95.9%	95.8%	95.2%	95.3%	94.9%	94.7%							

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CB_S6	Number of incomplete pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative
		Actual		0	0	0	0	0	0	0	0							
Local	Number of specialties where incomplete standard was not delivered	Actual		4	4	4	4	4	5	4	2							
Cancelled Operations																		
CB_B18	**Cancelled operations** - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative
		Actual		19	8	3	2	1	1	2	3							
CB_S10	**Urgent operations cancelled for a second time** - number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual		0	0	0	0	0	0	0	0							
Diagnostics																		
CB4	Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests	Target		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	Cumulative
		Actual breaches		68	68	41	60	57	44	62	88					488		
		Actual Perf		0.98%	0.94%	0.60%	0.84%	0.83%	0.62%	0.84%	1.3%					0.87%		
Local	Percentage of patients who have waited 6 weeks longer than their due date for a planned diagnostic surveilance test (GHNHSFT only)	Target		N/A	N/A	N/A	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	
		Actual		74.6%	66.7%	67.8%	23.5%	13.3%	2.4%	10.5%	8.9%							
Cancer Waits																		
CB_B6	Percentage of patients seen within 2 weeks of an urgent GP or GDP referral for suspected cancer	Target		93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	Cumulative
		Actual breaches		67	38	48	51	121	89	50	60					524		
		Actual Perf		93.8%	96.1%	95.2%	95.2%	88.8%	92.0%	95.7%	94.1%					93.8%		
CB_B7	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%	Cumulative
		Actual breaches		4	5	2	15	117	63	4	15					225		
		Actual Perf		97.7%	97.7%	99.0%	92.8%	46.6%	73.0%	97.7%	92.5%					86.2%		
CB_B8	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%	Cumulative
		Actual breaches		4	0	0	3	2	3	0	0					12		
		Actual Perf		98.2%	100.0%	100.0%	98.7%	99.1%	98.9%	100.0%	100.0%					99.4%		
CB_B9	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%	Cumulative
		Actual breaches		1	1	0	1	0	0	0	1					4		
		Actual Perf		97.7%	97.9%	100.0%	97.8%	100.0%	100.0%	100.0%	97.5%					98.7%		
CB_B10	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%	Cumulative
		Actual breaches		0	0	0	0	0	0	1	0					1		
		Actual Perf		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	100.0%					99.5%		
CB_B11	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%	Cumulative
		Actual breaches		0	0	0	0	0	0	0	0					0		
		Actual Perf		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%		
CB_B12	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%	Cumulative
		Actual breaches		20	18	25	22	17	23	24	23					172		
		Actual Perf		78.7%	84.6%	75.5%	79.8%	83.0%	82.2%	80.5%	78.9%					80.5%		
CB_B13	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%	Cumulative
		Actual breaches		0	1	0	0	1	1	0	0					3		
		Actual Perf		100.0%	96.4%	100.0%	100.0%	95.0%	95.7%	100.0%	100.0%					98.3%		
CB_B14	Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	Target		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	Cumulative
		Actual breaches		1	1	0	0	1	0	0	0					3		
		Actual Perf		66.7%	75.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%					91.2%		
Long Term conditions																		
EC	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	Target		80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	Cumulative
		Glos		75.0%	81.1%	82.4%	93.2%	79.6%	68.3%	83.6%	87.8%							
Community Care Referral to Treatment (GLOUCESTERSHIRE only)																		
Paediatric																		
Local	Percentage of patients referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		100.0%	100.0%	100.0%	99.3%	98.9%	100.0%	96.0%	95.0%					98.0%		
Local	Percentage of patients referred to the Paediatric OccupationalTherapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		100.0%	100.0%	95.0%	96.0%	100.0%	97.0%	100.0%	100.0%					98.0%		
Local	Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		99.0%	99.0%	97.0%	99.0%	99.3%	100.0%	98.0%	99.0%					99.0%		
Adult																		
Local	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%					99.0%		
Local	Percentage of patients referred to the Podiatry Service who are treated	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative

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Local	within 8 Weeks	Actual		99.0%	99.0%	99.0%	99.0%	98.0%	97.0%	98.0%	98.0%					98.0%		Cumulative
Local	Percentage of patients referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					99.0%		
Local	Percentage of patients referred to the Adult Physiotherapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		100.0%	100.0%	98.0%	96.0%	95.7%	95.2%	96.0%	97.0%					97.0%		
Specialist Nurses																		
Local	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%		
Local	Percentage of patients referred to the Diabetic Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%		
Mental Health and Learning Disabilities																		
Adults of Working Age																		
CB_B19	Proportion of those patients on a Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	Target				95.0%			95.0%			95.0%			95.0%	95.0%	95.0%	Cumulative
		Glos				100.0%			99.5%							99.8%		
Improving Access to Psychological Therapies (IAPT)																		
CB_S5	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Glos target				2.9%			5.9%			9.3%			13.0%			Cumulative
		Glos actual				3.4%			6.6%									
CB_S5	The proportion of people who complete therapy who are moving towards recovery	Glos target				50.0%			50.0%			50.0%			50.0%	50.0%	50.0%	Cumulative
		Glos actual				50.4%			50.6%									
Quality																		
Quality Indicators																		
CB_B17	Eliminate mixed-sexed accommodation breaches at all providers sites	GHT		4	10	6	0	6	0	0	4							Cumulative
		GCS		0	0	0	0	0	0	0	0							
		2gether		0	0	0	0	0	0	0								
	Number of Never Events	GHT		1	0	0	0	1	0	1	0							Cumulative
		Care Services Actual		0	0	0	0	0	0	0	0							
		2gether		0	0	0	0	0	0	0								
		SWAST		0	0	0	0	0	0	0								
		Ramsay Healthcare		0	0	0	0	0	0	0								
	Percentage of all adult inpatients who have had a VTE risk assessment	Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	Cumulative
		GHNHSFT		95.0%	95.5%	95.7%	95.3%	94.8%	94.2%	93.5%								
		GCS		98.7%	97.8%	98.3%	98.5%	97.2%	94.9%	93.9%	96.4%					97.0%		
Cleanliness and HCAIs																		
Methicillin Resistant Staphylococcus Aureus (MRSA)																		
CB_A15	Number of MRSA infections (Health Community)	Glos HC target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative
		Glos HC actual		1	0	0	1	1	2	0	0							
	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative
		GHNHSFT actual		0	0	0	0	1	0	0	0							
Clostridium Difficile (C.Diff)																		
CB_A16	Number of total C Diff infections (Health Community)	Glos HC target		15	13	13	16	16	8	12	10	10	17	17	15		162	Cumulative
		Glos HC actual		16	20	18	18	25	25	11	12						145	
	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target		6	5	4	5	6	2	4	4	4	4	4	5		52	Cumulative
		GHNHSFT actual		4	8	5	1	8	9	3	4						42	
local Priorities																		
LP1	Reduction in COPD admmission	Glos HC target	1,020			n/a			12 (1%) 0r 492			24 (2%) or 738			36 (3%) or 984	984	97.0%	Cumulative
		Glos HC actual				n/a			395									
LP2	Provide an enhanced level of health service into the homes over 50% of Care homes in Gloucestershire	Glos HC target				n/a			10%			35%			50%		50.2%	Cumulative
		GHNHSFT actual				n/a												
LP3	The number of people, who are eligible to be offered a weight management intervention, who take up a weight management referral	Glos HC target				n/a			300			800			1,700		1.5%	Cumulative
		GHNHSFT actual																

Appendix 2

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position as at 31st December (Month 9)

AS AT Month 9 2013/14	2013/14 R	2013/14 NR	2013/14 TOTAL	Cash Limit
	£000	£000	£000	£000
2013/14 baseline excl growth	**660,548**		**660,548**	**660,548**
Growth	15,193		15,193	15,193
Running costs	15,090		15,090	15,090
B/f surplus		6,629	6,629	6,629
Specialised Commissioning adj (South)	(4,456)		(4,456)	(4,456)
Specialist Commissioning further adj	(12,839)		(12,839)	(12,839)
adjustment to prior year surplus		23	23	23
Transfer from AT- Comm Midwifery	120		120	120
Transfers to AT - Newborn Screening/Dentistry	(5,259)		(5,259)	(5,259)
SCG Transfer to CCG - Dean Neurological	231		231	231
Winter Pressure		2,023	2,023	2,023
Rev Trf Secondary Care Dental		(131)	(131)	(131)
Trf SCG for RNHRD CRPS		(28)	(28)	(28)
Trf SCG for Networks		(54)	(54)	(54)
Last month total	**668,628**	**8,462**	**677,090**	**677,090**
Adjustments in month				
Ambulance Winter Pressures		422	422	422
Maximum Cash Drawdown exercise				(34,235)
Adjustments actioned in month		**422**	**422**	**(33,813)**

Appendix 3

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Summary Financial Position

Overall financial position as at 31st December 2013 (Month 9)

	Year to Date			Forecast Outturn		
	Budget	Actual	(Under)/Over spend	Annual Budget	Forecast Outturn	(Under)/Over spend
	£000	£000	£000	£000	£000	£000
Acute services						
Acute contracts -NHS (includes Ambulance services)	238,650	243,006	**4,356**	317,503	318,416	**913**
Acute contracts - Other providers	11,992	9,806	**(2,186)**	15,988	18,130	**2,142**
Acute - NCAs	4,833	5,146	**313**	6,444	6,945	**501**
Pass-through payments						
Sub-total Acute services	**255,475**	**257,958**	**2,483**	**339,935**	**343,491**	**3,556**
Mental Health Services						
MH contracts - NHS	56,290	56,366	**76**	75,051	74,916	**(135)**
MH contracts - Other providers	937	855	**(82)**	1,312	1,444	**132**
Sub-total MH services	**57,227**	**57,221**	**(6)**	**76,363**	**76,360**	**(3)**
Community Health Services						
CH Contracts - NHS	57,889	57,866	**(23)**	77,185	77,584	**399**
CH Contracts - Other providers	1,132	1,251	**119**	1,325	1,070	**(255)**
CH - Other						
Sub-total Community services	**59,021**	**59,117**	**96**	**78,510**	**78,654**	**144**
Continuing Care Services						
Continuing Care Services (All Care Groups)	12,454	12,281	**(173)**	16,522	16,371	**(151)**
Local Authority / Joint Services	3,787	3,754	**(33)**	5,050	4,989	**(61)**
Free Nursing Care	6,616	6,443	**(173)**	8,822	8,590	**(232)**
Sub-total Continuing Care services	**22,857**	**22,478**	**(379)**	**30,394**	**29,950**	**(444)**
Primary Care services						
Prescribing	67,010	66,398	**(612)**	89,366	88,551	**(815)**
Enhanced services	3,283	3,204	**(79)**	4,378	4,298	**(80)**
Other	3,664	3,906	**242**	4,886	5,214	**328**
Sub-total Primary Care services	**73,957**	**73,508**	**(449)**	**98,630**	**98,063**	**(567)**
Other Programme services						
Re-ablement funding	1,546	1,567	**21**	2,062	2,089	**27**
Other	3,644	3,657	**13**	5,330	5,262	**(68)**
Sub-total Other Programme services	**5,190**	**5,224**	**34**	**7,392**	**7,351**	**(41)**
Total - Commissioned services	**473,727**	**475,506**	**1,779**	**631,224**	**633,869**	**2,645**
Specific Commissioning Reserves (Inc headroom and Contingency)	18,028	16,574	**(1,454)**	24,441	22,120	**(2,321)**
Total - Programme Costs (excl Surplus)	**491,755**	**492,080**	**325**	655,665	655,989	324
Running Costs (incl reserves)	11,311	10,986	**(325)**	15,090	14,766	**(324)**
Total - Programme Costs (excl Surplus)	**11,311**	**10,986**	**(325)**	15,090	14,766	(324)
Surplus	5,068		**(5,068)**	6,757		**(6,757)**
Total Application of Funds	**508,134**	**503,066**	**(5,068)**	**677,512**	**670,755**	**(6,757)**

Appendix 4

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

QIPP Programme 2013/14 as at 31st December (Month 9)

Theme	Planned Gross Savings 2013/14 £'000	Forecast £'000	Variance £'000	Theme RAG	Savings RAG	Recurrent / Trend RAG
Unscheduled Care / Long Term Conditions	2,720	2,369	-351	A	A	A
Planned Care	2,384	1,970	-414	A	A	R
Community Care	3,521	1,271	-2,250	A	R	A
Prescribing	4,087	4,000	-87	G	G	G
Mental Health	495	370	-125	A	A	G
Learning Difficulties	982	982	0	G	G	G
Continuing Health Care	1,756	1,756	0	G	G	G
Transactional QIPP	2,000	2,000	0	A	G	A
Other - GHFT	255	255	0	R	G	R
Grand Total	**18,200**	**14,973**	**-3,227**			
Additional Schemes - increased usage of the ISTC		500	500	A	A	R
Additional QIPP schemes / Slippage / Contingent resources / Application of QIPP rule		2,727	2,727			
Grand Total	**18,200**	**18,200**	**0**			

Appendix 5

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

QIPP Programme 2013/14 as at 31st December (Month 9)

Theme	Work Programme	Component Projects	Comments	Project RAG	Savings RAG	Recurrent / Trend RAG
Unscheduled Care / Long Term Conditions	Frail Elderley	OPAL	Locum now recruited to backfill x2 GOAM consultants and project underway. KPI monitoring commenced.	A	G	R
		Care Home ES	One year enhanced service for primary care support to residential & nursing homes; 74 Practices participating in ES (88%) - most commenced Q3 2013/14.	G	R	A
	Access	ADU / AEC	Interim service implemented GRH Sept 13. CGH service to commence Q4, subject to business case. Working through development of long term solution ('Streamlining Urgent Care') overseeing a suite of Urgent Care services.	A	G	R
		GP in ED	One month pilot complete and evaluated. Winter 13/14 solution being developed. Longer term considered as part of 'Streamlining Urgent Care.'	G	N/A	N/A
		MIU Utilisation	The new protocols and criteria have been rolled out across the MIUs. Communications campaign underway.	A	G	A
	Community Care	Telehealth (previously not quantified to include)	Continuation of Telehealth programme. In year savings resultant of contract reduction. Evaluation and future provision to be considered by GCCG - pathway redesign and integrated care model to be developed as part of ICT.	A	G	A
		IV Therapy	Continuation of community based IV Therapy service delivered by GCS FYE of 12/13 implementation. Consideration of future service model i.e. expansion of infusions and link to ICT model to be considered.	G	G	A
	Integrated Care	Diabetes Service Re-Design	Service redesign includes an intermediate tier service, along with an enhanced service and education programme for primary care.	G	G	G
		Respiratory: Specialist Team	Team fully recruited to to provide Pulmonary Rehab, specialist telehealth, medicines optimisation and management of complex patients.	G	G	G
		IDT	Further development of Integrated Discharge Team to ensure joint primary/community/secondary care approach - limitations of current service impact being considered as part of Discharge Programme - ongoing pathway work across community/acute care.	G	R	R
	Paediatrics	Paediatric Admissions	Paediatric CPG work programme to include a focus on reducing emergency admissions, alongside acute to community diversion across various care pathways.	R	A	R
	Maternity	Maternity pathways	Review of maternity pathways to inform 14/15 developments.	A	N/A	N/A
Planned Care	MSK CPG	MSK: Interface Service	Developing the existing infrastructure for MSK services in primary and community care to ensure equity of access; implementation pan-county slipped but working to Q4 rollout	R	G	R
		MSK: Pathways	End to end pathway re-design completed across the full range of sub-specialties and service providers i.e. spine, foot & ankle. Pathways published on Map of Medicine.	G	G	R
	Opthamology CPG	Opthalmology: Wet AMD and Cataracts	Schemes : community based pathway for treatment of Wet AMD; standardisation of a Cataract 1:1:1 pathways across GHFT sites. Slippage in both schemes being progressed with CPG.	R	R	R
	Dermatology CPG	Dermatology: Intermediate Tier	Development of Dermatology intermediate tier providing equity of service provision across Gloucestershire.	R	A	A
	Demand Management	Peer Review	Continuation of Referral Peer Review project - full year effect. Further practice sign-up achieved. Referral increases in 13/14 have reduced any benefit from demand management schemes and therefore delivery adjusted to zero.	G	R	A
		Advice and Guidance Roll out	Continuation of rollout of GHNHSFT advice and guidance service, from three to nine specialties by end 13/14. Referral increases in 13/14 have reduced any benefit from demand management schemes and therefore delivery adjusted to zero.	G	R	A
	Follow Up Care	Follow Up Care	GHNHSFT led scheme to implement optimal follow-up pathways across specialties.	R	G	R
Community Care	Community Care	Integrated Commmunity Teams and Rapid Response	Development of Integrated Community Team model with Rapid Response that focuses on case management of high risk patients. Business case approved; implementation slipped - working to late Jan '14 launch in Gloucester City and March for Cheltenham locality.	R	R	A
		Frequent attenders - utilising ICT & RR for 200 pts for Q3-4 13/14	Mobilising community support (via Rapid Response) for a identified patient cohort of ICT roll out; to support relieving pressure in the urgent care system in 13/14. Non recurrent scheme utilised to support high risk patients	A	R	R
		Community Hospitals	Effective utilisation of the community hospitals through a reduction in length of stay; and increasing the number of patients diverted to community facilities from the acute ED. 13/14 savings delivered through risk share agreement, recurrent	A	G	A
		Living Well	Programme of change that supports a shift to supporting people before they reach a crisis and away from unsustainable dependence on services. Evaluation of current service underway to inform ICT programme.	R	R	R
		Reablement progressions - no more than 20> 6 weeks	Ensuring an efficient use of reablement services, in recognition of the key role reablement plays to the delivery of care closer to home.	A	N/A	N/A
		LOS Reductions - community hospitals	Effective utilisation of the community hospitals through a reduction in length of stay; and increasing the number of patients diverted to community facilities from the acute ED.	A	N/A	N/A
	Paediatric CHC	Paediatric CHC	Increased capacity of the Children's Community Nursing Team to create a 24/7 service in order to improve the quality of care and reduce current risks to children receiving care packages.	G	G	G
Prescribing	Oxygen Prescribing	Oxygen Assessment	Development of Home Oxygen Service within GCS Respiratory Team to ensure appropriate prescribing and patient management.	A	R	A
	Primary Care	Prescribing Plan	Primary Care prescribing initiatives to include reducing waste, joint formulary and implementation of best practice. Prescribing budget is forecast to exceed the 13/14 savings plan by c.£1m in part due to category M prescribing re-pricing of £400k.	G	G	G
Mental Health	Placements	OOC Placements	On-going management to bring OOC patients back into Gloucestershire.	G	G	G
	Liaison	Liaison Services (Acute)	Implementation of model to enable rapid access and turnaround of patients presenting at A&E and on the wards of acute and community hospitals with a potential mental health problem. Work being undertaken to assess financial delivery in 13/14, therefore 50% savings anticipated, subject to validation.	A	A	G
		Liaison Services (Community)		A	N/A	N/A
Learning Disabilities	Joint Funding	Joint Funding	Develop an agreed Joint Funding Policy and Process for health and social care.	G	G	G
	LD Community Care	LDISS	Review of current LD community services to ascertain current services available and any gaps in provision.	A	N/A	N/A
Continuing Health Care	CHC	CHC	Improving Health and Social Care compliance with the National Framework. Commission services for Fast Track End of Life care in each locality.	G	G	G
Transactional QIPP	Transactional QIPP	Transactional QIPP	GHNHSFT led : Schemes to incl: Outpatient attendances during an inpatient stay, Multiple new outpatient attendances within the same specialty, Outpatient procedures undertaken as follow ups – move to initial appt.	A	G	R
		Pathology Pricing	GHNHSFT led : A reduction in Pathology pricing to achieve an overall saving in year. On-going work to reduce individual test prices and develop an average cost per request.	A	G	A
		Pharmacy Homecare	GHNHSFT led : A homecare medicine delivery and services to deliver ongoing medicine supplies and, where necessary, associated care, initiated by the hospital prescriber, direct to the patient's home.	A	G	A
GHFT Additional	GHFT Unidentfied	(covered by Urology One Stop & CPAP Change)	GHNHSFT led : Contributed to by expansion of the urology one-stop clinic across GHNHSFT	R	G	R
Additional Schemes - increased usage of the ISTC	Contract Utilisation	UKSH Utilisation	Increased utilisation of ISTC contract, through local outpatient clinic and patient choice	A	A	R

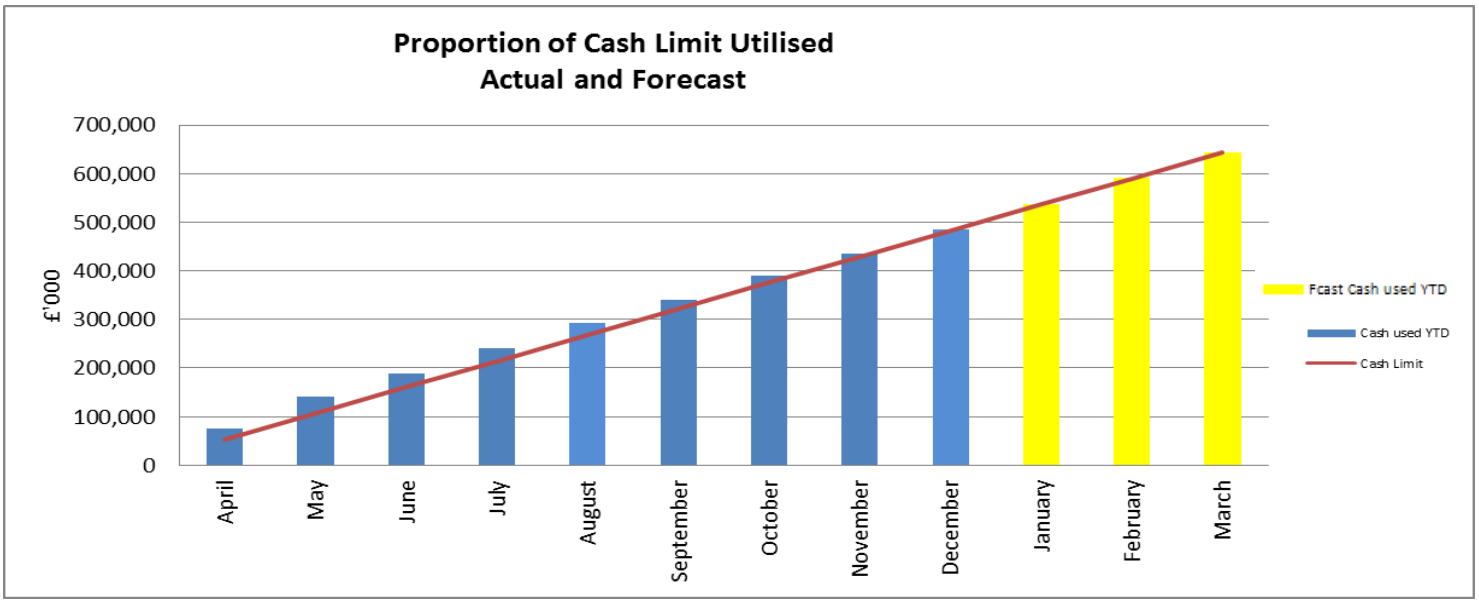
Appendix 6

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 31st December 2013 (Month 9)

		Actual/Forecast Charges in Month					YTD	CASH	Mth end	Cash Limit	Ratio of
		Drawn	Prescribing	Home Oxygen	Advance Drugs Payments	TOTAL	TOTAL	LIMIT	Balance	Drawn	Bal/Cash Limit
Month	Status	£000	£000	£000	£000	£000	£000	£000	£000	%	%
April	Act	75,000				75,000	75,000	53,606	12,285	11.66%	1.91%
May	Act	66,000		130		66,130	141,130	107,213	7,608	21.94%	1.18%
June	Act	42,000	6,506	135	(208)	48,433	189,563	160,819	2,067	29.47%	0.32%
July	Act	45,000	6,622	129	122	51,873	241,436	214,426	5,997	37.53%	0.93%
August	Act	44,000	6,218	132	192	50,542	291,978	268,032	8,526	45.39%	1.33%
September	Act	41,000	6,782	131	(114)	47,799	339,777	321,639	6,084	52.82%	0.95%
October	Act	43,000	6,531	132	(37)	49,626	389,403	375,245	6,503	60.53%	1.01%
November	Act	39,000	6,371	135	47	45,553	434,956	428,851	84	67.62%	0.01%
December	F'cast	43,000	6,605	128	171	49,904	484,860	482,458	6,616	75.37%	1.03%
January	F'cast	46,590	6,605	128		53,323	538,183	536,064		83.66%	0.00%
February	F'cast	45,814	6,605	128		52,547	590,730	589,671		91.83%	0.00%
March	F'cast	45,814	6,605	128		52,547	643,277	643,277		100.00%	0.00%



Overview of current position

The CCG is currently undergoing a national exercise to establish its cash limit but has an estimated maximum cash limit of £643m in 2013/14.
This exercise is expected to be completed by the end of December
At the end of December £485m had been drawn down (75%) of the anticipated cash limit.
This is in line with the cashflow forecast based on the expected maximum cash limit

Appendix 7

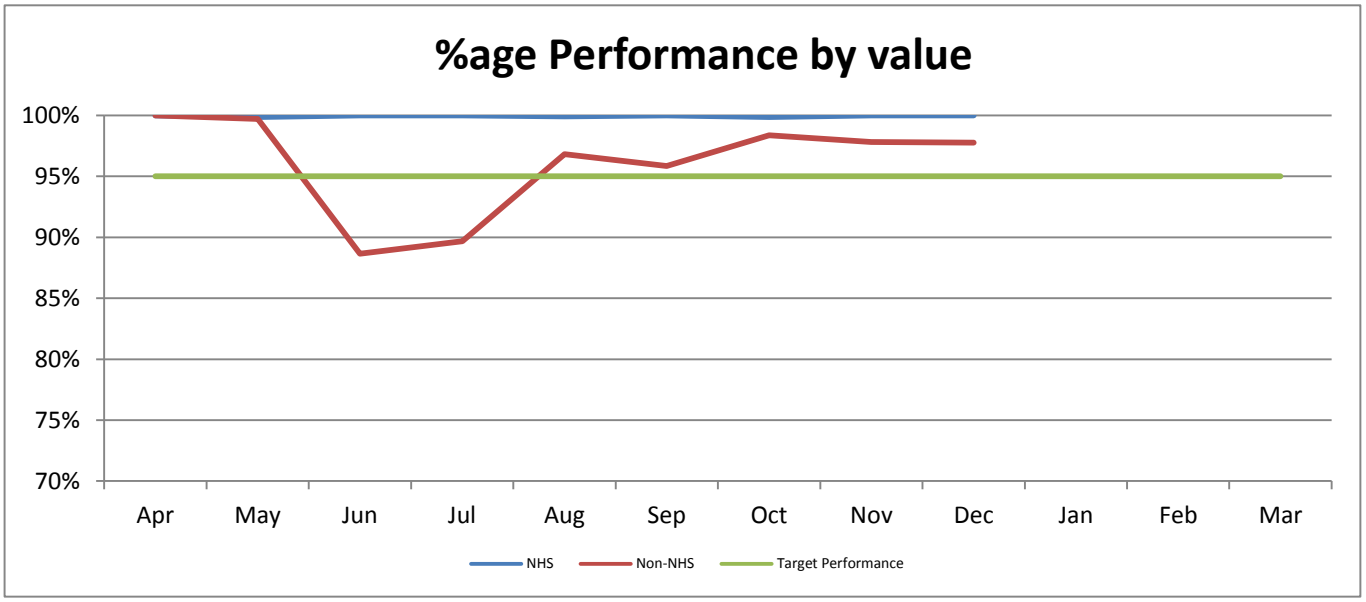
NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

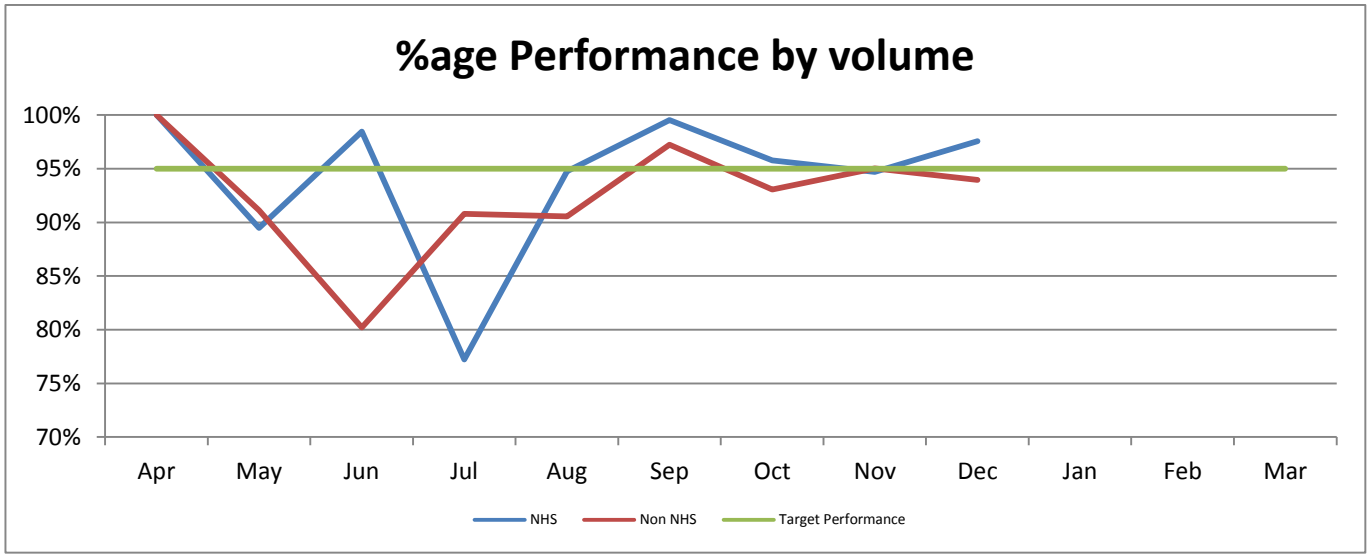
Performance against better payment practice code

As at 31st December 2013 (Month 9)

	In Month		Year to Date	
	NHS	Non NHS	NHS	Non NHS
By volume				
Total number of invoices	287	595	1,755	3,616
Number paid within target	280	559	1,667	3,320
Performance	**97.6%**	**93.9%**	**95.0%**	**91.8%**
By value				
Total value of invoices (£'M)	39.37	2.76	373.91	71.51
Value paid within target (£'M)	39.37	2.70	373.91	69.95
Performance	**100.0%**	**97.8%**	**100.0%**	**97.8%**

The target performance level is 95%





Appendix 8

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Statement of Financial Position

As at 31st December 2013 (Month 9)

	Current Month end Position	Forecast Position as at 31 March 2014
	£000	£000
Non-current assets:		
Premises, Plant, Fixtures & Fittings	0	0
IM&T	0	0
Other	0	0
Long Term Receivables	0	0
Total non-current assets	**0**	**0**
Current assets:		
Inventories	0	0
Trade and other receivables	9,417	5,000
Cash and cash equivalents	6,616	1
Total current assets	**16,033**	**5,001**
Total assets	**16,033**	**5,001**
Current liabilities		
Payables	(33,774)	(20,318)
Provisions	0	(1,000)
Borrowings	0	0
Total current liabilities	**(33,774)**	**(21,318)**
Non-current assets plus/less net current assets/liabilities	**(17,741)**	**(16,317)**
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(465)	0
Borrowings	0	0
Total non-current liabilities	**(465)**	**0**
Total Assets Employed:	**(18,206)**	**(16,317)**
Financed by taxpayers' equity:		
General fund	(18,206)	(16,317)
Revaluation reserve		
Other reserves		
Total taxpayers' equity:	**(18,206)**	**(16,317)**

NHS
Gloucestershire
Clinical Commissioning Group

Appendix 9

GCCG Performance Framework Overview

Each of the above sections is broken down into success criteria which when combined provide an overall rating for the domain. The development of the partnerships section has taken longer than expected; therefore, this initial report focuses on the other areas; a complete report for partnerships will be available from November onwards.

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

All indicators are RAG rated, based on the 2013/14 NHS Everyone Counts Planning for Patients thresholds.

Performance framework

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

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

Internal Perspective	**Organisational Objective**
Clinical Excellence	(1) Develop strong, high quality, clinically effective and innovative services. We will deliver this through a multi professional focus, with a particular emphasis on clinical programme approach and developing our member localities.
Finance and Efficiency	(3) Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation. (4) Build a sustainable and effective organisation, with robust governance

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

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Agenda Item 13

Governing Body

Governing Body Meeting Date	Thursday 30th January 2014
Title	Assurance Framework
Executive Summary	The attached Assurance Framework for 2013/14 provides details of the assurances that will be provided to the Governing Body regarding the achievement of the CCG's Annual Objectives. The Assurance Framework identifies gaps in assurances and controls regarding the objectives along with details of the principal risks that have been identified by lead managers. The attached document was presented to the meeting of the Integrated Governance Committee, held on the 19th December 2013. Updates will be provided to future meetings of both the Committee and the Governing Body in order to demonstrate the progress made against the action plans identified to address risks and the gaps in assurances or control.
Key Issues	A number of risks have been identified which could adversely affect achievement of the objectives. Action plans have, however, been devised are being implemented to minimise the effect of these risks.
Risk Issues:	The absence of a fit for purpose Assurance Framework could result in gaps in control or assurances not being

Original Risk **Residual Risk**	identified and addressed. 8 (2x4) 4 (1x4)
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note this paper which is provided for information.
Author	Alan Potter
Designation	Associate Director Corporate Governance
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 13

Governing Body

Thursday 30th January 2014

Assurance Framework

1. Introduction

1.1 The Assurance Framework provides the Governing Body with a structure and process that enables the organisation to:

- focus on those risks that might compromise achievement of the annual objectives;
- map out the key controls in place to manage the objectives; and
- identify the assurances that will be received by the Governing Body regarding the effectiveness of those controls.

1.2 The Assurance Framework is also a key source of evidence for the Annual Governance Statement.

1.3 The primary benefit of the Assurance Framework is that it provides a structure for individuals within the CCG to consider and plan for the achievement of the organisation's objectives in a proactive manner.

2. The Assurance Framework

2.1 The Assurance Framework is based upon the summary objectives detailed in the Annual Operating Plan that was approved at the meeting of the Governing Body held on the 30th May 2013.

2.2 The document outlines the principal risks, control systems and assurances that will be provided to the Governing Body regarding the achievement of each summary objective. Details of the action plans to address the risks, gaps in

controls or gaps in assurance are also provided for each objective.

2.3 The initial Assurance Framework was presented to the inaugural meeting of the Integrated Governance Committee (IGC) on the 9th May 2013 and updated versions have been presented to subsequent meetings of the Committee. The attached document, which was presented to the 19th December meeting of the IGC, incorporates further updates received from the lead managers responsible for each area of activity.

2.4 Progress regarding the achievement of each annual objective is monitored separately through the performance management process.

3. Monitoring

3.1 Updates of the Assurance Framework, outlining the progress made in relation to the action plans, will be reviewed at each meeting of the Integrated Governance Committee. In addition, the document will also be presented to the Governing Body for information.

4. Recommendation

4.1 The Governing Body is invited to note this paper and the attached Assurance Framework.

5. Appendix

- Assurance Framework

Gloucestershire Clinical Commissioning Group Assurance Framework 2013/2014

Objective 1: Develop strong, high quality, clinically effective and innovative services.

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
L1	Insufficient clinical engagement from primary care.	Kelly Matthews Eddie O'Neil Kathryn Hall Andrew Hughes Stephen Rudd	12 (3x4)	8 (2x4)	⟺	Website and e-GP newsletter, clinical programme approach, locality structure and meetings, contracts with providers Development and Implementation of Engagement Plan.	Commissioning for Quality Report, Clinical Priorities Forum and Clinical Programme Groups.	Non-active Groups.	Implementation of the Clinical Programme Development Plan and Clinical Programme Plan. Appointment of Locality Managers and development of Locality Action Plans (March 2014)
Q1	Insufficient clinical engagement from secondary care clinicians.	Marion Andrews-Evans, Justine Rawlings.	12 (3x4)	8 (2x4)	⟺	Website and e-GP newsletter, clinical programme approach, locality structure and meetings, contracts with providers	Commissioning for Quality Report, Clinical Priorities Forum and Clinical Programme Groups.	Non-active Groups.	Implementation of the Clinical Programme Development Plan and Clinical Programme Plan. (June 2013) Implementation of 'CCG live'. (Sept 2013)
Q3	Specialised Commissioning transferring to the Area Team with lack of timely and appropriate specialised services for our residents	Marion Andrews-Evans	12 (3x4)	8 (2x4)	⟺	Monitoring service provision with local providers and provide feedback to Area Team	Assurance from Area Team	Non-active Groups.	Raise the concerns with the Area Team and get feedback to ensure the lead commissioner is involved in this specific area. (March 2014)
T4	Insufficient knowledge of specialised commissioning and impact on pathways due to significant change in specialised commissioning arrangements nationally.	Kathryn Hall	8 (4x2)	8 (4x2)	⟺	Website and staff engagement, CCG briefing, engagement with commissioners	Development plan update.		CCG specialised commissioning group established in June 2013. Discussion facilitated to review impact of new service specification with programme teams. Briefing provided to staff and to be uploaded on to CCG Live website. (Nov 2013)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
L2	GP Practices running at maximum capacity and certain practices not being financially viable. Potential risk that the quality of primary care could be compromised as a result.	Helen Goodey	12 (3x4)	8 (2x4)	⟺	Practice Visits by Executive Team and CCG Leads GPs. Senior Locality Manager attendance at Locality Executive Meetings. Implementation of Countywide Practice Manager Representative Group. Working closely with Area Team around joint responsibilities to ensure clarity, responsiveness and support.	Governing Body Reports		Appointment of Senior Locality Managers. To review issues and look for collective solutions how CCG can provide support Appointment of Primary Care Locality Development & Engagement Manager. (September 2013)
Objective 2: Work with patients, carers and the public to inform decision making.									
Q4	Failure to capture and ensure outcomes from patient, carer and public feedback and quality governance systems inform commissioning and contracting arrangements resulting in failure to maintain and improve the quality of services.	Marion Andrews-Evans, Mark Walkingshaw, Becky Parish	12 (3x4)	12 (3x4)	⟺	Communications and Engagement Strategy, 4Cs Policy and Procedure, Provider Clinical Quality Review Groups, HCOSC, Health Watch Gloucestershire (HWG) comments.	Commissioning for Quality Report, Outcome of Engagement/Consultation Reports.		Establish mechanism for 'feeding back' impact of patient, carer public experience date. Make available in public domain. (September 2013)
Objective 3: Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation.									
F1	Failure to deliver financial targets.	Cath Leech	12 (3x4)	12 (3x4)	⟺	Robust financial plan aligned to commissioning strategy. QIPP plans developed using robust process with appropriate governance processes including monitoring. Financial procedures being refreshed.	Budgets approved by the Governing Body. Monthly reporting to CCG Governing Body. Internal audit plan in place and internal audit reports and recommendations to be reported to Audit Committee.	Final CCG budgets being finalised following contract agreement . CCG QIPP plans to be finalised and approved by the Governing Body, monitoring processes to be finalised.	Final CCG budgets to be presented to Governing Body. CCG QIPP plans and monitoring being finalised. (May 2013) Financial procedure refresh. (July 2013)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
F2	Transformation projects may not deliver the service changes, improved outcomes and financial changes expected.	Cath Leech	12 (3x4)	12 (3x4)	⟺	Monitoring of QIPP plans monthly through the PMO. Risk sharing agreements for QIPP within contracts.	Monitoring reports from the PMO to be reported to the Governing Body and quarterly review by the Audit Committee. Monitoring of risk sharing agreements.	Process for new QIPP proposals is currently not complete. Inconsistent performance monitoring.	Finalisation of process to review and evaluate new proposals to be finalised. (May 2013) Performance monitoring arrangements being developed more fully. (September 2013)
C2	In March 2012 the Department of Health announced close down for any new cases which require assessment of eligibility for CHC for previously un-assessed episodes of care starting 1st April 2004 to 31st March 2012. Gloucestershire has received 697 applications for assessment. There is a risk that these estimates may be exceeded.	Mary Morgan	8 (2x4)	8 (2x4)	⟺	National directives and guidance.	Financial Reports		Work on retrospective reviews is currently suspended as staff cover the main CHC team vacancies and sickness. Initial assessments in Care Homes are delayed due to staff shortages. Once vacancies filled new team structure will manage both current and retrospective workloads. Staff will be in place January 2014 and cases will be shared across team members.
T7	Lack of clear engagement with public health jeopardises development of preventative strategies to reduce reliance on health services.	Justine Rawlings	12 (3x4)	12 (3x4)	⟺	Regular joint meetings and agreement of joint work plans with links to H&WB board	Performance Reports		Meetings established managerial CCG lead Work plans agreed with KPIs and links to localities. (March 2014)
F4	Activity is at variance with plan at Gloucestershire NHS FT and other providers.	Cath Leech	12 (3x4)	12 (3x4)	⟺	Robust contract management and activity monitoring and validation	Financial Reports		Analysis of areas of over-performance and challenge where there have been changes in clinical or recording practice. Real changes fed back to Practice based Commissioning clusters to address. (July 2013)
F5	Limited access to public sector capital to support operational capital schemes	Cath Leech	12 (3x4)	12 (3x4)	⟺	Capital programme submitted for public funding.	Financial Reports		Discuss with Area Team and regarding prioritisation of Gloucestershire schemes. (Sept 2013)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
F6	Detrimental impact of the economic downturn on planned revenue allocation growth over the medium term.	Andrew Beard	4 (1x4)	8 (2x4)		Review of medium term financial plan (MTFP)	Financial Reports		Scenario planning of the MTFP using worse case assumptions. Recurrent savings plans implemented. (Dec 2013)
C3	Increased risk of Trust receiving legal challenge as a result of competitive tendering following the introduction of the EU Remedies Act and the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 1 April 2013	David Porter	12 (3x4)	12 (3x4)		Ensure that EU procurement process is followed for all procurement exercises (above and below) the EU threshold in accordance with DoH, Cabinet Office and Government Procurement Service Guidelines.	Board Report	Revised guidance anticipated from NHS England/Monitor December 2013. Action plan will be developed on receipt of guidance.	Revised CCG contestability framework will be drafted for Governing Body approval following publication of Monitor (or NHS England) guidance on the application of the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations. Anticipated publication date: December 2013.
C27	Non-Emergency Patient Transport Service. Possible variance in predicted activity levels which could impact on delivery of KPIs and patient experience following Go Live on 1/12/13	Gill Bridgland	12 (3x4)	12 (3x4)		Risk to be managed consistently across Gloucestershire, Swindon, Wiltshire and B&NES CCGs	Performance Reports and dashboards		Weekly post-mobilisation meeting with ATSL and other commissioners Transfer of advance booking data from all incumbent providers ATSL have mitigations in place to manage high volume of incoming calls in the first few weeks post mobilisation and can draw on resources from their other operations if required. (December 2013)
C5	Non delivery of 7 prioritised Urgent Care Recovery Plan component schemes could adversely affect achievement of the A&E target.	Maria Metherall	12 (3x4)	12 (3x4)		Weekly Executive meeting	Performance Reports and dashboards		Weekly meeting to review progress. (March 2014)
C6	A&E 4 hour targets may not be delivered	Maria Metherall	12 (3x4)	12 (3x4)		Weekly Executive meeting	Performance Reports		Weekly meeting to review progress. (March 2014)
C8	Anticipated whole system benefit from NHS 111 may not be achieved.	Maria Metherall	16 (4x4)	12 (3x4)		Urgent Care Network Board, NHS 111 Contract Board	Performance Reports		Well constructed DoS and strong local buy-in of providers and developing process. (October 2014)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
C9	Winter Plan may not deliver the desired improvements in the urgent care system.	Maria Metherall	12 (3x4)	12 (3x4)	⟺	Weekly Executive meeting	Performance Reports		Winter plan and revised escalation process agreed across the healthcare community Weekly meeting to review progress. (March 2014)
C10	Delay in implementing Planned Care QIPP schemes, due to tender and tariff negotiation with providers, may result in failure to achieve desired outcomes including financial savings.	Kate Liddington	12 (3x4)	12 (3x4)	⟺	Robust project management planning and reporting to PMO	Performance Reports		All Project to have clear baseline monitoring with agreed KPIs, with set reporting timescales. Monthly project monitoring with focus on schemes at risk of non-delivery, with agreement of remedial action. (March 2014)
C13	Revised Clinical pathway from QIPP schemes may not be adhered to which could hinder intended changes.	Kate Liddington	12 (3x4)	12 (3x4)	⟺	CPG and commissioning contract to monitor activity flows monthly	Performance Reports		To develop robust mechanism to audit use of new clinical pathways. (March 2014)
C15	Failure to comply with national and local access targets, such as 18-week RTT, diagnostic 6-week target could result in inadequate care.	Kate Liddington	12 (3x4)	12 (3x4)	⟺	Acute provider contracts, including AQP	Performance Reports		Monthly monitoring with focus on specialties under pressure. Agree remedial action and apply contract penalties. Ensure robust process for offer and uptake of patient choice to encourage use of providers with shortest waits. (June 2013)
C16	AQP contracts could increase activity across the system increasing the financial risk to the CCG.	Kate Liddington	9 (3x3)	12 (3x4)	⟺	Robust monthly activity report	Performance Reports		Need to review activity associated with all AQP contract on a monthly basis to assess trends and increases across whole system, data to do this is being developed. (March 2014)
C17	Non-utilisation of ISTC contract could result in increased financial pressure.	Kate Liddington	12 (3x4)	12 (3x4)	⟺	Monthly monitoring of activity, supporting by Commissioner and CareUk action plan to increase utilisation	Performance Reports		With CareUK acquisition of UKSH, change to structure of contract monitoring meetings and operational forums to ensure focus action to increase utilisation. Implemented outreach clinic in Gloucester to increase utilisation. (July 2013)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
T9	Inability of GHNHSFT to gain re-accreditation of specialised services for specialised commissioning	Kathryn Hall	8 (2x4)	8 (2x4)	⟺	GHNHSFT Development plan for areas of derogation.	Updates by Specialist Commissioning Lead to the CCG's SC Management Group on a regular basis		Have worked with GHNHSFT and specialised commissioners to understand the areas of concern. (August - September 2013). CCG to formally review action plans for derogation in early October 2013.
C26	There is risk that the scale, complexity and unavoidable time constraints associated with the implementation of the agreed service model for strengthened health and social care integrated community teams across Gloucestershire means that the financial savings target allocated to this programme as part of the 2013/ 2014 Annual Operating Plan and prior to the completion of the Case for Change and Return of Investment are not realised along with the service objectives (given the significant change in the model of service delivery required.	Kim Forey/Andrew Hughes	12 (3x4)	12 (3x4)	⟺	ICT Programme Group QIPP Board Reports GCCG Board Reports	Report to IGC and Governing Body.		GCS have developed a detailed service delivery plan for go live of Rapid Response and extension of SPCA in Gloucester for January 2014 and Cheltenham w/c 10th February 2014. Recruitment of staff taking place, operational aspects being completed by GCS. Partial implementation to deliver part savings. Currently waiting for updated staff/ finance model. (January 2014)
Objective 4: Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.									
F8	Insufficient capacity and/or capability within the CSU could adversely affect the organisation's ability to adequately support the CCG.	Cath Leech	12 (3x4)	12 (3x4)	⟺	Contract/service level agreement signed between the CCG and CSU specifying the services to be delivered.	Monthly meetings between the CCG and the CSU to review service delivery. CCG service leads meet with their counterparts in the CSU to review more detailed aspects of delivery.	KPIs and schedule of monthly performance meetings not yet finalised.	KPIs to be finalised. (June 2013). Monitoring meetings schedule to be set up. (May 2013)
F10	CSU understanding of work areas which could impact on the organisation's ability to identify potential savings or increasing costs in a timely manner	Andrew Beard/Sarah Hammond/Jeremy Gough	12 (3x4)	12 (3x4)	⇩	Contract/service level agreement signed between the CCG and CSU specifying the services to be delivered.	Monthly meetings between the CCG and the CSU to review service delivery. CCG service leads meet with their counterparts in the CSU to review more detailed aspects of delivery.		Interim appointments progressed by CSU in finance and contract management to help refine and strengthen process; Action plans in place regarding financial reporting and PBC locality packs. (November 2014)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
Q9	Inadequate contingency planning across the whole system could result in an inadequate response to an emergency.	Simon Sethi	12 (3x4)	12 (3x4)	⟺	Major Incident Plan.	Cascade exercises undertaken.	Some training is outstanding, some procedural documentation requires updating.	Training plan in place for relevant staff and is being implemented. Update of procedure document. (November 2013)
Q6	Inadequate safeguarding processes could lead to issues regarding children and vulnerable adults.	Marion Andrews-Evans, Helen Chrystal	10 (2x5)	10 (2x5)	⟺	Safeguarding Children Policy, Multiagency Adult Safeguarding Policy and Procedure, South West Child Protection Procedure, Gloucestershire Local Safeguarding Children's Board.	Safeguarding Report to IGC/Governing Body.		Actions from Gloucestershire Safeguarding Adults Board audit of strategic and organisational arrangements. (September 2013)
F3	Patient information required to support service transformation is limited or not available due to changes in legislation and uncertainty over access arrangements.	Sarah Hammond	16 (4x4)	8 (2x4)	⟺		IGC report.	s251 applications completed and discussions with experts underway to work through implications	Work with information governance and informatics experts to ensure the implications of changes are understood and relevant applications for s251 access are completed correctly. Work with NHS England to ensure implications and future developments are understood. (March 2014)
L5	Transfer of existing Local Enhanced Services onto the new National Standard Contract for 2014-15 could result in delays in service provision.	Cherri Webb	12 (3x4)	8 (2x4)	New Risk	Having a robust contracting mechanism in place and ensuring continuity of delivery.	Governing Body Report		Work with Central Southern CSU to establish new contracts, with contracts for continuing services issued to practices by beginning of the New Year. (March 2014)
Objective 5: Work together with our partners to develop and deliver ill health prevention and care strategies designed to improve the lives of patients, their families and carers.									
A1	Failure to build positive relationships with the local health community and other commissioners could impact on joined-up service delivery and transformation.	Mary Hutton, Helen Miller	12 (3x4)	8 (2x4)	⟺	Joint Health and Well Being Strategy agreed. Membership of Health and Well Being Board. Joint Commissioning posts, Joint Commissioning Boards and Executives in place between the CCG and the Local Authority.	Performance reports.	Risk to partner engagement due to austerity measures	Continued engagement with all partners.

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
A2	Failure to build positive relationships with key local stakeholders (HCOSC, HWG) could impact on implementation of service delivery and transformation.	Mary Hutton, Helen Miller, Becky Parish, Anthony Dallimore	12 (3x4)	8 (2x4)	⟺	Attend HCOSC meetings. NHS Reference Group 'No surprises' discussions. Attend HWG Partner Meetings. Timely written briefing of stakeholders.	C4Q Reports, Outcome of Engagement/Consultation Reports, Written stakeholder briefings as part of integrated communication plans	Communications and Engagement Strategy requires revision.	Design new HCOSC report template (May 2013). Approval of GCCG Communications and Engagement Strategy (December 2013)
A3	Failure to build positive relationships with local media could impact on the ability of the CCG to promote its work effectively and promote engagement opportunities	Anthony Dallimore, Helen Miller, Mary Hutton	12 (3x4)	8 (2x4)	⟺	CCG Communication and Engagement Strategy, Quarterly meeting with Editors, 'no surprises' briefing on key announcements .	Sponsorship/partnership agreements, briefings arrangements within individual communication plans.	Communications and Engagement Strategy requires revision.	Communications and Engagement Strategy (December 2013)
L4	Fragmentation of payments to practices across Area Team, CCG and Public Health around enhanced services across 3 organisations, potentially destabilising GP Practices.	Jeremy Gough Stephen Ball	12 (3x4)	8 (2x4)	⟺	Enhanced Services payment being accurately made. To have clear payment schedules of what everyone is being paid by practice.	Performance reports.		Working closely with Area Team, Public Health and Commissioning Support Unit. In process of moving budgets from Area Team so this will be managed by CCG. Managing communications between finance, the practices and localities. (March 2014)
Q7	National targets set for MRSA and C Diff. MRSA bacteraemia and C Diff levels are not within trajectory, both have been exceeding set levels and both commissioner and provider targets are unlikely to be achieved in 2013/14	Teresa Middleton, Karyn Probert	12 (4x3)	12 (4x3)	⟺	Countywide HCAI action plan.	Performance reports.		County wide HCAI action plan. To include RCAs to be completed for all cases. Serious incident review for all C Diff and MRSA deaths. (March 2014)
Q8	Delay in financial investment for health staff in the Multi-agency Safeguarding Hub will mean day one will start without some partners on board, including health.	Helen Chrystal	8 (4x2)	8 (4x2)	⟺	Input to the MASH project team, MASH Board and workstreams will ensure momentum is not lost whilst funding is identified	Report to IGC/Governing Body		Project Initiation Document to be presented to QIPP Assurance Group on 17 October, seeking funding for contract variation with Gloucestershire Care Service NHS Trust, (November 2013)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Change since August IGC	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
Objective 6: Develop strong leadership as commissioners at all levels of the organisation, including localities.									
F9	Lack of staff engagement and staff development could limit the achievement of financial balance.	Cath Leech	10 (2x5)	10 (2x5)	⟺	Organisational development plan in place.	Organisational Development Plan progress reports.	Organisational Development Plan update needed to reflect new information.	Refresh of the Organisational Development Plan. (September 2013)
								Appraisal process needs to be developed to fit the organisation's needs.	Senior Manager's Group developing an appraisal process. (September 2013)

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Agenda Item 14

Governing Body

Governing Body Meeting Date	Thursday 30th January 2014
Title	**Our Journey for Quality 2014 to 2019 – Summary**
Executive Summary	This is a summary of Our Journey for Quality which is for members, member practices and staff of Gloucestershire Clinical Commissioning Group, acknowledging our partnership organisations.
Key Issues	It provides a Summary of how our CCG will provide assurance that quality is a 'golden thread' running throughout the operation and business of Gloucestershire CCG.
Risk Issues: Original Risk Residual Risk	Failure to articulate a clinical strategy, to secure quality, safe services for the population of Gloucestershire, may contribute to potential confusion within the organisation.
Financial Impact	Financial implications relating to NICE publications will be variable and must be accounted financially.
Legal Issues (including NHS Constitution)	Compliance with the NHS Constitution and recommendations from NICE and CQC.
Impact on Health Inequalities	A focus on the delivery of equitable services for the residents of Gloucestershire and which will reflect the diversity of the population served.
Impact on Equality and Diversity	**No** There are no direct health and equality implications contained within this report.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.

Patient and Public Involvement	Collection of patient and carer experience data and engagement with patients and the public in line with GCCG Annual Operating Plan: Objective 2: *Work with patients, carers and the public; to inform decision making and give them a higher profile in our work.*
Recommendation	Paper for information
Author	Teresa Middleton
Designation	Deputy Director of Quality
Sponsoring Director (if not author)	Marion Andrews-Evans Executive Nurse and Quality Lead

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OUR JOURNEY FOR QUALITY 2014-2019

INTRODUCTION

- Our Journey for Quality is a strategy is for members, member practices and staff of Gloucestershire Clinical Commissioning Group (CCG). Acknowledging the contribution made by our partnership organisations comprising of, our main provider organisations, Gloucestershire County Council, Healthwatch and voluntary organisations.
- The aim of Our Journey for Quality is to weave quality throughout the operation and business of Gloucestershire CCG
- Our Journey for Quality has been informed and driven by Francis inquiries 2010, 2013. By Winterbourne View report, Berwick report (2012), Keogh (2013 x2), Compassion in Practice (2012) and the respective government responses. In addition National Institute of Health and Care Excellence (NICE), National Quality Board, Healthcare Quality Improvement Partnership (HQUIP) influences and contributes to the strategy.
- Our Journey for Quality is influenced by the NHS mandate, the NHS outcomes framework and the National Operating Plan.
- The strategy is compiled of three documents, this summary, a reference document and an implementation plan.

PATIENT SAFETY

- We will monitor serious incidents and never event action plans to ensure learning is cascaded across the organisations
- We will maintain a ' no blame' attitude so encouraging open and transparent reporting of incidents
- We will monitor our providers to ensure clinical areas are adequately staffed by individuals who are appropriately trained.
- We will work in partnership with our providers to ensure infection control measures are in place and achieve high standards of cleanliness.
- We will have regular fora with our providers to discuss quality and patient safety issues to support continual learning and improvement in patient care.
- We will work with our providers to create an environment where our patients feel safe.

PATIENT EXPERIENCE/STAFF SATISFACTION

CULTURE

- We will promote through organisational leadership a commitment to develop and embed the culture of learning from patient experience throughout the health and social care community in Gloucestershire.

EXPERIENCE-LED COMMISSIONING

- We will develop a wide range of patient experience information to be used to influence the commissioning cycle and to inform the redesign of healthcare services using CQUINs and the NHS contract.

DELIVERY

- We will agree clear expectations with providers for the effective use of patient experience feedback, in the continuous improvement of services and patient outcomes. Providers will continue to roll out the Friends and Family Test and respond to patient opinion.

LEARNING AND CO-PRODUCTION

- We will promote and support clinical staff to implement shared decision making with their patients (and carers) so ensuring patients are fully involved and informed about their care and options.

STAFF SATISFACTION

- We will promote a culture that values staff feedback, demonstrating a listening approach with action taken based on staff opinions and suggestions.

CLINICAL EFFECTIVENESS/OUTCOMES

- The ambition of Gloucestershire CCG is to do the right thing, at the right time for the right patient.
- We willl continue to develop a culture where clinical effectiveness underpins the decisions we make.
- We will establish systems and processes to ensure our staff and Clinical Programme Groups (CPGs) have up to date clinical evidence to support their work.
- We will utilise our ethical framework for decision making.
- We will utilise evidence, guidelines and standards to identify and implement best practice, working with CPGs on pathway development and review.
- We will ensure that patient outcomes will become a key currency in future CCG service specifications.
- We will proactively support staff education and high quality mentorship.

MAKING IT HAPPEN

- We will have an annual 'Our Journey for Quality' implementation plan linked to the Annual Operating Plan by April 2014
- We will consult with our main stakeholders on the strategy by June 2014, updating the local implementation plan accordingly.
- A Quality team work programme will be developed by June 2014, to support the work and prioritisation of the CCG
- We will identify a number of system wide quality measures by May 2014
- We will establish quality assurance frameworks for CPGs and our main providers by June 2014
- We will prepare an annual quality report by May 2014.
- We will undertake an annual refresh of 'Our Journey for Quality' by May 2015
- We will hold quality summits twice a year to undertake a stocktake of the quality of services provided locally.
- We will engage and work closely with commissioning staff to embed 'Our Journey for Quality' into the work of the CCG.

MEASUREMENT

- We will develop system wide quality measures focusing on outcomes for patients/clients.
- We commit to turn data into meaningful information.
- We will work together with colleagues across the health and social care system, to develop meaningful outcome measures to promote continuous improvement.
- We will continue to work towards the achievement of the CCG outcome indicator set of measures.
- We will introduce a Gloucestershire CCG quality assurance framework linked to the national CCG outcomes indicator set. This approach will contribute to understanding and informing local patient outcomes and experience.
- We will actively seek to measure and review staff satisfaction from our main providers, and from within our own organisation and member practices through active listening processes.

COMPASSION IN PRACTICE (6Cs)

Care, Compassion, Competence, Communication, Courage and Commitment

- We will ensure the 6 C's are embedded in all contractual arrangements
- We will provide health system leadership through local teams to improve reported experiences of patients as an overarching approach to quality improvement.
- We will ensure provider organisations have embedded the 6C's into their organisation at every level and demonstrate this at every opportunity.
- We will audit the effectiveness of providers strategic plans by reporting 6 monthly to the contract quality review group on a continuous improvement cycle.
- We will use professional and clinical networks to actively share examples of good practice which can be replicated by others.
- We will require providers to undertake a review of their organisational culture and publish the results. This should include feedback from staff and people the organisation cares for.

SAFEGUARDING

- We will promote partnership working to safeguard children, young people and vulnerable adults in Gloucestershire
- We will clarify the roles and responsibilities of the CCG for safeguarding, including relationships to education and training
- We will provide a shared understanding of how the CCG will operate, in particular demonstrating how it will be held to account both locally and nationally
- As laid out in our policies and procedures, we will establish a series of principles and ways of working that are equally applicable to the safeguarding of children, young people and adults in vulnerable situations, recognising that safeguarding is everyone's responsibility.
- We will ensure responsibilities are assigned to individual roles, and fully support the Mult-Agency Safeguarding Hub (MASH).

INNOVATION/RESEARCH

- We will establish a robust framework to enable and support clinical research and development.
- We will engender a culture of encouragement for research and innovation, working with the Gloucestershire collaborative for clinical research and development.
- We will be more innovative through streamlined behaviours and processes, horizon scanning, and encouragement to become early adopters where effective and appropriate, to understand potential clinical innovation and actively work with the Academic Health Science Network (AHSN).
- We will develop links with local universities to support research, audit and education.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 15

Governing Body

Governing Body Meeting Date	Thursday 30th January 2014
Title	**Equalities Information – Annual Report**
Executive Summary	This report is being published as a requirement under the specific equality duty of the Equality Act 2010. Under this requirement, an Equalities Annual Report has to be published each January.
Key Issues	The report highlights the work Gloucestershire CCG has undertaken towards meeting its general Public Sector Equality Duty, gaps it has identified and action it is planning to take to improve its performance on equalities.
Risk Issues: **Original Risk** **Residual Risk**	Failure to consider health outcomes and patient experience in all commissioning decisions and reducing health inequalities from an equality and diversity perspective in particular regard to the nine protected characteristics as outlined in the Equality Act 2010.
Financial Impact	The role of the Governing Body is to ensure that the organisation is making best use of the money available and buying and developing health services that meet the needs of local people.
Legal Issues (including NHS Constitution)	The NHS Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Impact on Health Inequalities	A focus on the delivery of equitable services for the residents of Gloucestershire and which will reflect the diversity of the population served.
Impact on Equality and Diversity	**No** A range of data and information is used by the CCG to develop policies, set strategies, design and deliver services based on the Gloucestershire population by protected characteristics.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	We aim to develop a strong clinical and multi-professional focus with significant member engagement and meaningful involvement of patients, carers and the public in all our work.
Recommendation	The Governing Body is asked to note the contents of this annual report.
Author	Marion Andrews-Evans
Designation	Executive Nurse and Quality Lead
Sponsoring Director (if not author)	

Governing Body

Equalities Information – Annual Report

30th January 2014

1. Introduction

1.1 *Gloucestershire Clinical Commissioning Group* (CCG) is publishing this report as required under the specific equality duty of the Equality Act 2010. The report highlights the work Gloucestershire CCG has undertaken towards meeting its general Public Sector Equality Duty, gaps it has identified and action it is planning to take to improve its performance on equalities. It is a requirement of the Department of Health that the report must be published in January of each year.

2. Who are we and what we do?

2.1 The CCG is a membership organisation of local GP practices. From April 2013 it took over responsibility from NHS Gloucestershire Primary Care Trust for buying (commissioning) health services to meet the needs of local people. CCG members bring their clinical knowledge of patient care to look at how services are planned and how the patient's journey through care can be improved.

2.2 All 85 member GP practices have signed up to the Gloucestershire CCG's constitution which guides the CCG's operations. The constitution is available to read at www.gloucestershireccg.nhs.uk under the publications tab.

2.3 Our Governing Body is the main decision making body of Gloucestershire CCG. We are also required by law to take account of the NHS Constitution in our decisions and actions. The NHS Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

2.4 The role of our Governing Body is to ensure that the organisation is making best use of the money available and buying and developing health services that meet the needs of local people. It oversees the clinical programmes e.g. Dermatology, Mental Health and Cancer, looks at specific conditions and how the patient's journey through care can be improved. The Governing Body also makes sure that there is transparency and accountability in decision making and supports localities with the development of programmes and projects to support local communities.

2.5 The Governing Body is chaired by a Clinical Chair, a local GP, Dr Helen Miller and includes a Deputy Clinical Chair, GP liaison leads who represent the localities (e.g. Forest of Dean, North Cotswold) and lay members (members of the public who represent the views of local people and communities). Gloucestershire CCG is led by a range of experienced healthcare professionals who are passionate about securing the highest quality NHS services for local people. Mary Hutton is the Accountable Officer for Gloucestershire CCG.

2.6 Gloucestershire CCG is responsible for planning and buying local NHS services such as emergency care services, operations or treatments that can be planned in advance, mental health and community services.

2.7 These services are provided by a range of 'provider' healthcare organisations, such as NHS Trusts.

2.8 On becoming a statutory public authority with effect from 1 April 2013 Gloucestershire CCG assumed responsibility for commissioning (buying) healthcare services to meet the reasonable needs of the persons in Gloucestershire (i.e. principally for patients registered with their member practices, together with and unregistered patients living in their area). It does not include patients registered with GPs outside of Gloucestershire, members of the armed forces, nor their families if they are registered with Defence Medical Services rather than a NHS GP practice. Nor does it include those detained in prison or other custodial settings.

2.9 Gloucestershire CCG is not responsible for services which are commissioned directly by NHS England or Gloucestershire County Council but the CCG is able to influence the provision of these services by providing timely input as and when appropriate. To understand services which fall under the respective remits of the Clinical Commissioning Groups, NHS England (previously called NHS Commissioning Board) and Local Authority please visit http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf.

Local Authorities provide public health advice and information for example via the Joint Strategic Needs Assessment to the CCGs with respect to commissioning.

3 Profile of Gloucestershire population by protected characteristics

3.1 We use a range of data and information when we develop policies, set strategies, design and deliver our services. We believe that it is important to understand the composition of our population by protected characteristics as this enables us to:

- Engage effectively with different communities to understand their varying health and self-care support needs
- Commission services to meet their health and self-care needs in an appropriate manner
- Assess the likely impact of our decisions on the diverse communities and
- Work with these communities to minimise any adverse impact and maximise any positive impact

3.2 Data published by the Office for National Statistics shows that in mid-2010 Gloucestershire's total population was estimated to be 593,527 persons residing in one of the six districts namely Cheltenham, Cotswolds (North & South), the Forest of Dean, Gloucester City, Stroud and Berkeley Vale, and Tewkesbury. Analysis of Gloucestershire's population by protected characteristics reveals significant variations in different districts. The data below with respect to each protected characteristic is taken from reports published by Gloucestershire County Council.

3.3 **Protected characteristic - Age**

Overall 23.4% (vs. UK average of 23.7%) of our population is between 0-19 years old, 57.8% (vs. UK average of 59.7%) is between 20-64 years old and 18.8% (vs. 16.6% UK average) 65 years plus. There are district variations with Gloucester featuring the highest representation of children and young people, and Cotswolds, the Forest of Dean and Tewkesbury having the highest proportion of older people.

3.4 **Protected characteristic – Disability**

The Equality and Human Rights Commission defines someone with a disability in the context of assessing equality as those *'if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities'.* This is consistent with the Census definition of limiting long-term illness.

There were about 99,712 people across Gloucestershire reporting a limiting long-term illness (LLTI) to the Census 2011, representing 16.8% of the total population. This is substantially higher than estimates based on for example disability-related benefits claim. The incidence of LLTI Is highly linked to old age. Nearly 56% of people aged 75+ had a LLTI compared to 16% among 45-59 year old.

3.5 **Protected characteristic – Gender**

The overall gender split of Gloucestershire population is slightly skewed towards female – a 49.1% male/50.9% female which mirrors the gender distribution in the UK. As ages increase however, the numbers of women are outnumbering men by increasing margins. For 65+ age group the gender split is 44.6% male/55.4% female. For the age group 85+, the gender split is 1:2, as women's life expectancy outlasts men's. This has resulted in the majority of single-pensioner households in the county being headed by a woman. This

pattern persists across districts. It is also estimated that among the single –parent households with dependent children, estimated to be around 15,000 in Gloucestershire, about 88% are headed by a woman and 12% by a man.

3.6 Protected characteristic – Gender reassignment

There is no definitive data or official estimates of the number of people with gender reassignment or the number of transgender people in Gloucestershire as nationally publicly collected data on transgender people is virtually non-existent. However, various research reports suggest that between 300,000 to 500,000 adults in the UK are experiencing some degree of gender variance, and therefore could face inequality as a result. These figures are equivalent to 0.6% -1% of the UK adult population.

Applying the same proportion to the Gloucestershire adult population, the number of transgender people in the county could be estimated at between 2,800 – 4,700.

3.7 Protected characteristic – Pregnancy and Maternity

There were around 6,900 pregnancies in Gloucestershire in 2010, slightly higher than the average of 6,500-6,700 in previous years. The highest numbers of pregnancies fall into the 30-34 and 25-29 year age groups, continuing the trend of later motherhood. These are also the ages when women employment rate is one its highest 77.5%.

More than 25% of county pregnancies were in Gloucester, where the under-18 pregnancy rate was also the highest (14.2 per 1,000) in the county.

3.8 Protected characteristic – Sexual Orientation

There is no definitive data on sexual orientation among the local population. Previous estimates by Stonewall, suggest that around 5-7% of the adult population (aged 16+) are gay, lesbian or bisexual. This would translate into between 24,000 and 34,000 adults in Gloucestershire. However, a more recent estimate from the ONS Integrated Household Survey put it at 1.9%. This would equate to around 9,200 adults in the County.

Compared to heterosexual people, gay, lesbian and bisexual people are found to be more likely to be younger (16-44), male, white have no religion, are better qualified and have managerial/professional occupations. (Source: Integrated Household Survey ONS, September 2010).

3.9 **Protected characteristic – Marriage and Civil Partnership**

Information based on a Gloucestershire County Council's local projection which incorporates official data on marriage trends suggests that cohabitations are increasingly common across all ages and this trend is expected to continue. By contrast, the number of marriages has become static and is predicted to remain so in the near future. The number of lone parents is predicted to rise slightly. With respect to Civil Partnerships total number of formations during the period 2008-2010 was 191.

3.10 **Protected characteristic – Race (Including Gypsy and Traveller)**

The latest Office for National Statistics data on ethnic population suggests that the number of people in Gloucestershire from Black and Ethnic Minority (BME) origin was around 36,700 in mid-2009, this equates to 6.2% of our population. Almost one in four of these were Asian or Asian British. The largest numbers of BME population were in Gloucester (11,300) and Cheltenham (9.100).

The recent ethnic trends suggest that the largest growing ethnic groups in Gloucestershire between 2001-2009 were 'White – Other White' (up by 7,400 people, most likely to be from Eastern Europe) and Indian/Indian British (up by 4,800).

Gypsies and travellers – 2001 Census identifies a total of 2,400 households in the county were living in caravans or other mobile homes. This figure does not distinguish between travellers and non-travellers. In January 2011 there were 395 caravan households of these two-thirds (261) were in Tewkesbury. There is no available data as to the number of residents living in these caravans.

3.11 **Protected characteristic –Religion**

The only reliable data available on people's religion in the county is taken from the Census 2001. This data suggests that Christianity was the most common religion in Gloucestershire (75.9%), followed by "no religion" (15%) and Muslims (0.6%). The recent increases in East European and Indian/Indian British people suggests that the proportion of people in Gloucestershire whose religion is Christian, Muslims and Hindu may have increased since 2001.

4 Health Inequalities (information below is abstracted from Gloucestershire's Joint Health and Wellbeing Strategy)

4.1 Health inequalities arise from differences in the social and economic conditions in which people are born and live. These in turn influence people's behaviours and lifestyle choices, their risk of illness and the actions they take to deal with illness when it occurs. This inequality is driven by a complex range of factors including; how much we earn; what our job is; our education; where we live and play; our relationships with friends and family; our social networks; the type of community we live in and our access to services and leisure opportunities. These factors change as we progress through the key points in life – from conception to infancy and childhood, through our teenage years, to adulthood, working life, retirement and the end of life. But the healthier we are in early life, the healthier we are likely to be in later life.

4.2 The burden of ill health falls disproportionately on individuals, families and communities in Gloucestershire that have lower incomes and lower educational levels. The people that are most likely to have the very worst health and wellbeing outcomes in our county include those living in the most deprived geographical areas and people who may be vulnerable to experiencing inequalities because of: race, disability, age, religion or belief, gender, sexual orientation and gender identity. Some vulnerable groups, for example people with learning disabilities, or the homeless, have significantly poorer life expectancy than would be expected based on their socioeconomic status alone.

4.3 Local data tells us that in Gloucestershire our main public health challenges, and the three main causes of death and

serious illness, are the same as for the rest of the country. These are:

- Circulatory diseases (heart disease and strokes)
- Cancers
- Respiratory diseases (lung diseases) such as Chronic Obstructive Pulmonary Disease (COPD).

4.4 Health inequalities exist for all of these illnesses linked to deprivation. In the most deprived areas of the county early deaths from coronary heart disease (CHD) and stroke are more than double the county rate and the numbers of early deaths from cancer is well above those for the county.

4.5 The pattern is similar for COPD (chronic lung disease, usually caused by smoking), other types of respiratory (lung) disease as well as for diabetes (strongly linked to obesity) and liver disease (usually caused by alcohol misuse). For COPD death rates for all ages and for under 75's are more than double the county rate in the most deprived areas and for diabetes the death rate is one and a half times that of the county.

4.6 National data shows that there is also an association between deprivation and lifestyle behaviours, with those residents in the most deprived areas also being the ones least likely to take exercise and the most likely to have a poor diet. Both national and local data show links between deprivation and the likelihood of being overweight or obese. The overall effect of this ‘social gradient’ in health is demonstrated by the differences in life expectancy that exist in the county. Life expectancy is a commonly used measure of overall health status. Someone born in Gloucestershire today can expect to live, on average, 79.7 years for men and 83.5 years for women. That’s a little longer than the national norm of 78.6 and 82.6 years.

4.7 Whilst the life expectancy of the county overall continues to increase, the health of the less well-off is improving more slowly than the rest of the population and the gap in life expectancy between the most and least deprived areas in Gloucestershire is not narrowing. This is shown using a measure known as the Index of Multiple Deprivation (IMD). This is measured nationally by ranking all neighbourhoods in

the country by their deprivation status and grouping them into quintiles or fifths. Gloucestershire's most deprived quintile contains neighbourhoods mainly located in central Gloucester City and central Cheltenham which are comparable with the 20% poorest neighbourhoods nationally. Our least deprived quintile contains those neighbourhoods that are comparable with the most affluent 20% of neighbourhoods nationally; include areas from all six districts in the county. According to the IMD 2010, 7.4% of Gloucestershire residents (about 45,000 people) live in neighbourhoods considered to be among the fifth most deprived in England. In contrast, 32.8% of Gloucestershire residents live in the fifth most affluent areas in England.

4.8 In Gloucestershire, men living in the fifth most deprived communities live, on average, 5.3 fewer years than those living in our fifth least deprived areas –the pattern is similar for women with those living in the most deprived areas living on average 4.1 fewer years than those in the least deprived areas. Gloucestershire Health and Wellbeing Strategy 2012-2032 – Fit for the Future gives detailed account of health variations across the county. This strategy may be viewed by following the link below.

http://www.gloucestershire.gov.uk/CHttpHandler.ashx?id=53311&p=0

5 Key health priorities for our population

5.1 In Gloucestershire many people live long, healthy and active lives. Life expectancy is increasing and whilst this is a good thing, not everyone who lives longer does so in good health. The CCG has published a summary of its plans for 2013/14 in its prospectus which can be obtained using the following link:

http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2012/12/Prospectusweb1.pdf

5.2 As life expectancy increases there will be more people living with illness or disability unless we can prevent those illnesses from happening or help people to recover and maintain their independence. This is why Gloucestershire CCG is an active

partner of the Gloucestershire Health and Wellbeing Board. Our Chair, Helen Miller is the Vice-chair of this Board.

5.3 Led by the County Council, the Health and Wellbeing Board has developed a joint Health and Wellbeing strategy to help tackle the challenges of the future and to support communities. Following a public consultation in 2012 (*Fit for the future*), the Board has agreed that the CCG's focus will be on the following priority areas for improvement:

- Tackling health inequalities
- Improving mental health
- Reducing obesity (promoting healthy weight)
- Improving health and well-being
- Reducing the harm caused by alcohol

5.4 A *fit for the future* plan has been developed involving all organisations on the Health and Wellbeing Board. This plan includes a whole range of initiatives to make the most of the skills and expertise within communities, make connections and to support the most vulnerable.

5.5 Some examples of the initiatives we are developing include dementia friendly communities, training programmes for 'front line' staff and 'community builders' to promote healthy lifestyles (including mental health) and a marketing programme with families and schools in communities where there are higher levels of childhood obesity.

5.6 **Local Public Health priorities**

Using the latest intelligence available (Joint Strategic Health Needs Assessment – www.jsna.gloucestershire.gov.uk), public health priorities have been identified for each CCG locality. Many of these relate to the main priorities set out above. The CCG has established Locality Executive Groups to implement local priorities in each of the districts. The Local Executive Groups are working with Public Health, local Councils and other community partners to develop public health plans at a local level. This will help to inform what services and community support the CCG localities commission (buy) for their residents.

6 Our approach to meeting the Public Sector Equality Duty

6.1 We have adopted an integrated and holistic approach to understanding health care needs of the CCG's population and commissioning services to meet these needs. We aim to develop a strong clinical and multi-professional focus with significant member engagement and meaningful involvement of patients, carers and the public in all our work. Our constant clinical focus is on improving quality and patient outcomes/experience. Health outcomes and patient experience are therefore key considerations in all our commissioning decisions and reducing health inequalities with particular regard to the nine protected characteristics as outlined in the Equality Act 2010 is viewed as a key factor in all our decision-making. Our aim is to consider equality considerations into our day to day business and not as an after-thought. To this end:

- ✓ The Governing Body of Gloucestershire CCG has designated accountability for ensuring that the CCG's policies, procedures and operation comply with its statutory obligations with respect to equality, Human Rights and health inequalities to its Integrated Governance and Quality Committee.
- ✓ The Governing Body has assigned lead responsibility for equalities to two of its members, namely Dr Marion Andrews-Evans, Executive Nurse and Quality Lead and Ms Valerie Webb, Lay Member, Business.
- ✓ With the support of Central Southern Commissioning Support Unit Gloucestershire CCG has completed a comprehensive equality and diversity internal audit which has identified what the CCG is doing well (for example engagement with diverse communities) and where improvements (for example more effective use of outcomes from our Equality Impact Analysis to inform our decision-making) are required in delivering the Public Sector Equality Duty most effectively
- ✓ As a result of the recommendation of the Internal Audit Gloucestershire CCG has revised its equality impact analysis process so that it is an integral part of the planning process and output of the impact analysis is effectively used to influence the Governing Body's decisions

- ✓ The CCG has delivered training on the new Equality Impact Analysis process to key staff.
- ✓ Members of the CCG's Governing Body have participated in Equality and Diversity Awareness Raising Workshop and other Equality and Diversity Training delivered by local providers
- ✓ Introduced equality clauses in all our contracts to monitor the equality performance of our providers.
- ✓ Published its equality objectives as follows:

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

6.2 Gloucestershire CCG is committed to taking the necessary action and working in partnership with Gloucestershire County Council and diverse communities across Gloucestershire to ensure that promotion of equality and reduction of health inequalities is at the heart of commissioning. We believe that this will enable the CCG to deliver tangible improvement to patient outcomes and experiences in a variety of settings. We are also committed to developing an inclusive workplace and support staff to develop their equality competency.

7 Workforce Equality

7.1 Equality, diversity and inclusion in employment continue to be at the heart of the NHS strategy.

7.2 Gloucestershire CCG recognises that investing in a diverse NHS workforce is essential to the delivery of more inclusive services and improvements required in patient care. This is why we are committed to developing, maintaining and supporting an inclusive workplace where staff are treated fairly, equitably, and where they can realise their potential whatever their age, race, colour, nationality, ethnic origin, creed, disability, sexual orientation, sex, gender identity, marital or civil partnership status, parental status, religion, belief or non-belief, social or economic class, employment status, or any other criteria that cannot be shown to be properly justifiable.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 16

Governing Body

Governing Body Meeting Date	**Thursday 30th January 2014**
Title	**Integrated Governance Committee (IGC) minutes.**
Executive Summary	The attached minutes provide a record of the IGC meeting held on the 17th October 2013.
Key Issues	The following issues were discussed: • HR Policies • IGQC Terms of Reference • Clinical Effectiveness Group Terms of Reference • Quality Strategy Outline • Quality Report • Annual Report for Children in Care 2012/13 • Clinical Governance Briefing • Equality and Diversity Update • Risk Register • Assurance Framework • Information Governance Update
Risk Issues: Original Risk Residual Risk	Not applicable.
Financial Impact	Not applicable.
Legal Issues (including NHS Constitution)	Not applicable.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.

Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director Corporate Governance
Sponsoring Director (if not author)	Julie Clatworthy IGC Chair and Registered Nurse

NHS Gloucestershire Clinical Commissioning Group

NHS GLOUCESTERSHIRE CCG

Integrated Governance and Quality Committee (IGQC)

Minutes of the meeting held on Thursday 17th October 2013, Board Room, Sanger House

Present:		
Dr Charles Buckley	CBu	Chair
Dr Steve Allder	SA	Secondary Care Specialist
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Caroline Bennett	CBe	GP - North Cotswolds Locality
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Dr Martin Gibbs	MGi	GP - Forest of Dean Locality
Colin Greaves	CG	Lay Member – Governance
Mary Hutton	MH	Accountable Officer
Nevila Kallfa	NK	Deputising for the Interim Director of Public Health
Cath Leech	CL	Chief Finance Officer
Dr Helen Miller	HM	Clinical Chair of CCG
Mark Walkingshaw	MW	Deputy Accountable Officer
Valerie Webb	VW	Lay Member - Business

In Attendance:		
Alan Potter	AP	Associate Director Corporate Governance
Mary Coupe	MC	Board Administrator
Elspeth Griffiths	EG	Associate Director of HR - CSCSU
Teresa Middleton	TM	Head of Medicines Management

1. Apologies for Absence

1.1 Apologies were received from Julie Clatworthy and Alice Walsh.

2. Declarations of Interest

2.1 There were no declarations of interest received.

3. Minutes of the meeting held on 29th August 2013

3.1 The minutes of the meeting were accepted as a true

and correct record, subject to the following amendments:

3.2 Section 6.2 of the minutes to read: '*MAE advised that the Clinical Effectiveness Sub-group is being re-established with revised draft terms of reference and will be chaired by CBu and supported by the Deputy Director of Quality*'

3.3 Section 9.4 of the minutes to read: '*The Committee were pleased to see the support for Primary Care development and expressed concerns at the lack of support from the Area Team. It was felt that a consistent approach is needed at a national level and HM advised that the Mandate needs to be reassessed. CL advised that conflicts of interest issues may emerge within the Area Team relating to Specialist Commissioning allocations.'*

4. Matters Arising

4.1 **IGQC3 – Serious Incidents** - AP reported that he has received the benchmarking data from NHS England which showed the levels of Serious Incidents reported by all providers within the area. The data did not indicate that the levels of reporting by any of the Gloucestershire providers was significantly at variance with other trusts, although the lack of activity figures made comparisons difficult. MAE referred to national statistics that had recently been received regarding the levels of incidents reported by all providers. This Item will be reported further at the next meeting.

4.2 **IGQC4 – Incident Report Analysis -** MGi reported that there continues to be perceived problems with the Datix system which could result in a reluctance to report incidents. MAE reported that the processes and communication issues are being reviewed and there will be a further report at a later meeting.

4.3 **IGQC7 – Any Other Business -** The Chair had suggested arranging a development session to

discuss the basics around the Governance Systems and a separate development session covering Quality Standards, in the autumn. MAE will link this Item with the Quality Strategy and present it to the next meeting.

4.4 **IGQC9 – Terms of Reference -** JC had recommended that a map of all sub-committees is produced to facilitate the understanding of the inter-connecting relationships of these groups. MAE reported that this work is currently in progress.

4.5 **IGQC11 – Quality Report -** VW had informed the Committee of a recent safeguarding project she took part in, which included participation from the Police, Info Buzz, Prospect, etc. VW informed the Committee that there is a hard copy of "Youth Support Service". The Committee will be supplied with the Aims and Approach.

4.6 **IGQC17 – Risk Register -** AP reported that the Risk Register is now on CCG Live and updated regularly. **Item Closed**

4.7 **IGQC19** – **Policies for Approval** - The previous meeting had a discussion on ethics, deciding that an Ethics Panel could be convened as and when necessary. MAE considered that this matter should be linked to the development of the research governance policy. MAE will investigate how local Providers deal with ethical issues and manage research and report back to the next meeting.

4.8 **IGQC20** – **Policies for Approval -** The Committee had discussed the Public Health attendance at the IFR Panel and it was agreed that Public Health advisors can be invited when necessary. MW has discussed this Item with AW and will continue to request Public Health input going forward. **Item Closed.**

4.9 **IGQC21** – **Business Continuity Strategy** - NK informed the meeting that Andy Ewens started work

as Civil Protection Officer on the 16th October. He will work two days per week with the CCG and one day with Public Health. **Item Closed.**

5. HR Policies

5.1 The Committee was presented with revised HR policies by EG, which are intended to outline the CCG's approach in the following areas:

- Career Breaks
- Adoption Leave
- Retirement
- Maternity Leave
- Paternity Leave
- Parental Leave

5.2 The Committee were advised that the CCG had already adopted eight core policies and the policies listed above were the next group to be reviewed. The Committee were assured that all were in line with current legislation and would be available to view on the ConSultHR portal.

5.3 **Career Breaks Policy** – EG explained that this policy is designed to provide a framework for allowing employees the opportunity to take an unpaid break from their employment of up to five years. There was discussion regarding the maximum length of the break and the problems that this may cause in terms of maintaining services and the potential need for re-training. EG stated that the length of break was dependent on the relevant line manager's approval and that on their return, members of staff would be entitled to the same level of pay but not necessarily the same post.

5.4 **Adoption Leave Policy** – This policy is designed to provide a framework for a consistent and timely approach to employees' statutory rights to leave following the placement of a child for adoption. EG stated that leave may be applied for after 12 months continuous service by an employee.

5.5 **Retirement Policy** – This policy is intended to assist employees who are considering, or have taken the decision, to retire from service. It outlines the options available and the support that can be expected from the organisation. The Committee were advised that there is no compulsory retirement age for GPs.

5.6 **Maternity Leave Policy** – This policy is designed to provide a framework for the new and expectant mother. EG explained that the policy includes a detailed Maternity User Guide to which includes all of the necessary forms.

5.7 **Paternity Leave Policy** – This policy is designed to provide a framework to allow employees time away from work following the birth or adoption of a child

5.8 **Parental Leave Policy** – This policy is designed to provide a framework for parental leave, whereby employees may take time off work to look after a child or make arrangements for a child's welfare.

5.9 MAE enquired whether there was a Carer's Leave Policy. MW confirmed there was and EG stated that she will check to make sure it is in line with current legislation. EG

5.10 EG informed the meeting that there are more policies to be approved and MAE suggested a separate policy meeting. EG said she will prepare a list of rolled over HR policies and the new ones and will liaise directly with AP before next meeting. EG

5.11 CBe enquired whether lawyers were asked to check policies before they were submitted for approval. EG replied that she is fully qualified to design policies but there are lawyers available to consult if necessary.

5.12 NK enquired if there was a Study Leave Policy and EG informed the meeting that there was one currently being updated.

5.13 RECOMMENDATION:
The Committee approved the following policies:

- **Career Breaks**
- **Adoption Leave**
- **Retirement**
- **Maternity Leave**
- **Paternity Leave**
- **Parental Leave**

6. Terms of Reference

6.1 MAE introduced this item and referred to the original Terms of Reference for the Integrated Governance 7 Quality Committee (IGQC) which were approved as an element of the Constitution at the inaugural meeting of the CCG Governing Body on the 2nd April 2013.

6.2 MAE advised that the draft Terms of Reference presented had been revised to reflect the discussions at the last meeting of the Committee.

6.3 RECOMMENDATION: The Committee agreed with the revised Terms of Reference and recommended submission to the Governing Body for approval in November.

7. Clinical Effectiveness Group Terms of Reference

7.1 TM gave a verbal update regarding this item and explained that she has been in discussions regarding the development of these Terms of Reference and that these would be updated and presented to the IGQC for approval. TM

8. Quality Strategy Outline

8.1 MAE introduced this item stating that the Quality Strategy is intended to provide assurance to the Committee and Governing Body that quality, clinical effectiveness and patient safety issues are given priority in the commissioning function. MAE invited

suggestions regarding the format of this document. The title will be “Our Journey for Quality”

8.2 A discussion followed on this item, the principal issues being:

- How can quality be embedded and the subsequent improvement of services be evaluated?

- The Quality Strategy should be designed around the Pathways of Care.
- Culture should be embedded in everything from ground level up.
- There should be an improvement in capturing the “soft” patient experience data.
- How are the Committee members, as Commissioners, going to bring about change?
- The IGQC has 18 months to get the Quality Strategy correct from the beginning, improving quality while balancing the budget – agreement is needed on how this is to be done.
- IGQC would like to see uniform agreement between all providers and clinicians, and to be in the country’s top ten of CCGs.
- There should be a joint agreement with GHFT, and patients/clinicians should be involved.
- Any strategies implemented should be measured against the three themes: Patient Safety; Patient Experience; Clinical Effectiveness.

8.3 MAE agreed to further develop the Quality Strategy outline to reflect the comments made by members. MAE

8.4 RECOMMENDATION: The Committee noted this paper and requested an update at the next meeting.

9. Quality Report

9.1 MAE presented the Quality Report which provided assurance to the Committee that quality and patient

safety issues are given the appropriate priority and that there are clear actions to address them.

9.2 MAE drew attention to the Never Events that had occurred within the GHT theatres and advised that a member of staff will be going into the theatres to review the compliance with procedures.

9.3 MAE informed the Committee that AP attends a monthly meeting with GHT to discuss Serious Incidents. She highlighted concerns that there seem to be inconsistencies in the reporting of SIs in comparison with other Trusts and with other information provided by GHT. For example, no falls have been reported as Serious Incidents recently although there is information indicating that there have been serious falls. MAE agreed to investigate this further and report back to the next meeting. MAE

9.4 MAE highlighted concerns regarding the number of overdue Serious Incident action plans with all the providers. Although there has been a small improvement since the last report to the Committee, 17% of the actions are now overdue and assurances have yet to be received by the CCG to indicate that these issues have been resolved.

9.5 MAE stated that there is an on-going concern regarding C.Diff. CBu reported that at the C.Diff Summit, it was discovered that the problem is nationwide, not just in Gloucestershire. Re-infection is sporadic and no pattern has emerged as to why, where or how C.Diff infects people.

9.6 MH stated that a Patient Experience Strategy is needed and AE indicated that it would be beneficial to learn the experience of patients currently in the Pathway, rather than after completion of Pathway.

9.7 MAE stated that there is a concern that people are complaining to the Ombudsman rather than directly to the hospital involved. Wards 4a and 4b at GRH are particular areas of concern but steps are being taken

to improve the situation by, for example, employing supernumerary Band 7s.

9.8 MAE reported that there have been low response rates for the Friends and Family Test. MH suggested putting an article in the local press encouraging prospective patients to fill in the Friends and Family form, stressing that the information provided will be valuable for helping the service to improve. SA stated that he felt that patients would feel empowered by the process.

9.9 MAE drew attention to the poor response that had been received by the 2gether Trust from the Staff Survey and that they have discussed their action plan with the CCG.

9.10 RECOMMENDATION

The Committee:

- **Noted the contents of this report;**
- **Considered the recommendation to endorse a robust process for obtaining and reviewing patient experience information and data from provider organisations; and**
- **Endorsed the measures to ensure maximisation of the impact of patient experience on improving the quality of services commissioned by GCCG.**

10. Annual Report for Children in Care 2012/13

10.1 MAE introduced this report stating that children in care and care leavers have been identified as a vulnerable group, in need of additional support and interventions in order to improve their outcomes and reduce inequalities, particularly for health and education.

10.2 MAE reported that there have been improvements in immunisations but 30% of children are still not

receiving dental checks.

10.3 NK stated that she has not yet seen the Annual Report despite being Lead Consultant. MH invited her to contact the report owner and offer support.

10.4 Some members of the Committee felt that the report was not well written. Whilst some content was valid, it was felt that it was not presented in a very readable form.

11. Clinical Governance Briefing

11.1 The Interim Director of Public Health had requested this briefing for the Committee, as part of the process of strengthening clinical governance arrangements within Gloucestershire County Council.

11.2 NK presented the report for information and advice from the Committee and stated that Gloucestershire County Council has the same concerns as the CCG in respect of patient safety, clinical effectiveness and patient experience with regard to public health services.

12. Equality and Diversity Update

12.1 MAE presented this paper and explained that NHSE has prescribed certain actions the CCG are required to take to ensure on-going compliance with Equality and Diversity. The report provided assurance to the Committee by describing the actions being taken to ensure the organisation is compliant with the NHSE requirements and statutory duties.

12.2 VW and MAE are working together to identify the legal requirements and how the CCG is complying with them.

12.3 MAE stated that the Equality Objectives, referred to in the report, will be completed and open for comment by the end of October and not the 13th

October, as stated in the report.

12.4 MAE emphasised that it is important for Senior Managers to be thoroughly trained in Equality and Diversity.

12.5 RECOMMENDATION: The Committee noted this paper and recommended the £28k required to commission CSCSU to undertake the additional Equality and Diversity work in this financial year.

13. Risk Register

13.1 AP presented the CCG Risk Register which highlights the risks facing the organisation that have been identified by responsible managers and which could affect the achievement of the objectives detailed within the Annual Operating Plan.

13.2 AP reported that the total number of risks has risen by two since the last report to the Committee although there are now no risks classified as 'red'.

13.3 AP stated that the Risk Register is now on CCG Live.

13.4 RECOMMENDATION: The Committee noted the paper and the attached Risk Register.

14. Assurance Framework

14.1 AP presented the Assurance Framework for 2013/14 which provides details of the assurances that will be provided to the Governing Body regarding the achievement of the CCG's Annual Objectives.

14.2 AP brought to the attention of the Committee the fact that the document now incorporates a column indicating the changes to individual risk levels reported since the last version was presented to the Committee.

14.3 CG expressed concern regarding the risk relating to AQP (ref c16). The related Action Plan suggested

that activity should be reviewed on a monthly basis. However, data to do this is delayed by the AQP. CG requested that the rating of this risk should be reviewed.

14.4 RECOMMENDATION: The Committee noted the paper and the attached Assurance Framework.

15. Information Governance Update

15.1 CL presented this paper which provided an update on the organisation's information governance arrangements and included the minutes of the Information Governance Steering Group meeting held on the 1st October.

15.2 CL informed the meeting that work is progressing on the IG Toolkit and that the CCG Information Governance Lead is completing the IG Toolkit action plan.

15.3 The Committee were advised that, to date, only 50 members of staff have completed the mandatory e-learning IG training modules. A further reminder of the need to complete this training is being sent to staff.

15.4 CL advised that the Caldicott principles are to be refreshed following a national review.

15.5 **RECOMMENDATION: The Committee noted the contents of the report and the attached minutes of the Information Governance Steering Group.**

16. Any Other Business

There was no other business.

17. The meeting closed at 12.19pm

Date and time of next meeting: Thursday 19th December 2013 in the Board Room at 9am.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 17

Governing Body

Governing Body Meeting Date	**Thursday 30th January 2014**
Title	**Audit Committee minutes**
Executive Summary	The attached minutes provide a record of the Audit Committee meeting held on the 1st October 2013.
Key Issues	The following principal issues were discussed: • Internal Audit • External Audit • Counter Fraud Plan • QIPP report • Summary of Procurement Decisions • Register of Waivers of Standing Orders • Aged Debtor Report
Risk Issues: Original Risk Residual Risk	Not applicable.
Financial Impact	Not applicable.
Legal Issues (including NHS Constitution)	Not applicable.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director Corporate Governance
Sponsoring Director (if not author)	Colin Greaves Audit Committee Chair and Lay Member

NHS GLOUCESTERSHIRE CCG
AUDIT COMMITTEE

Tuesday 1st October 2013
Video Conferencing Room, Sanger House

Minutes

Present:		
Colin Greaves	CG	Chair
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Dr Hein Le Roux	HLR	GP Liaison Lead
Valerie Webb	VW	Lay Member - Business

In Attendance:		
Sallie Cheung	SC	Counter Fraud Manager
Paul Dalton	PD	Price Waterhouse Coopers
Cath Leech	CL	Chief Finance Officer
Alan Potter	AP	Associate Director Corporate Governance
Peter Smith	PS	Grant Thornton
Fazila Tagari	FT	Board Administrator

1. Apologies

1.1 Mary Hutton, Dr Andy Seymour, Lyn Pamment and Liz Cave.

2. Declarations of Interest

2.1 HLR – GP Provider and Commissioner

3. Minutes From Previous Meeting held on 4th July

3.1 The minutes of the previous meeting held on 4th July 2013 were approved as an accurate record with the following amendments:

- Section 5.7 should read ‘It has emerged there are transitional issues within CSU and it was felt the regularity of this audit area should be increased.’

- Section 6.1 should read ‘PS advised the fee rebate will be paid to the CCG under separate cover, this is anticipated in early autumn 2013.’
- Section 7.4 should read ‘It was noted a dual approach might be required and a discussion with the Local Area Team may be needed.’

4. Matters Arising

4.1 Item 5.5 – Regularity of the audit has increased and incorporated within the plan. CL advised this will be assessed in quarter 1 of 2014/15 and noted that further guidance on the quality audit is awaited which will establish the schedule of regularity going forward. **Complete**

4.2 Item 5.7 – CL advised that this action is initially being addressed through the CSU recovery action plan which includes HR implementation issues. It was noted that Internal Audit will be used as a secondary option to address these concerns if issues are not resolved. CL to present a report on the CSU action plan at the December Committee. CL

4.3 Item 5.10 – PD advised that the CSU internal auditors had sent a letter to all Chief Financial Officers explaining the programme of work that they will be undertaking within the CSU. The audit will monitor the controls and effectiveness of the financial systems and it was noted a report is expected at the end of October 2013 which will flag any key control issues. The Committee noted that the CSU internal auditors will be undertaking a detailed review in early 2014 which will also link in with the CCG Internal Audit plan. CL advised that in order to provide assurance, the CSU report will be presented at the December Audit Committee. **Complete**

4.4 Item 7.4 – SC advised that she had met with the CSU to discuss the Counter Fraud arrangements and that the funding had been agreed. It was agreed that the funding from the CCG Counter Fraud action plan will be used to provide Counter Fraud awareness training to CSU staff

and to develop a joint working system. The Committee is content that the CCG is making a pragmatic choice of investing in a service to cover the current interface and noted that this will be raised at performance meetings with the Local Area Team. **Complete**

4.5 Item 7.11 – CL advised that negotiations with Glebe will not be undertaken. It was noted that a letter to Glebe has been sent advising that payment will not be made and reasons for non-payment. It was also noted that any outstanding claims will not be pursued and legal advice will be obtained if necessary. **Complete**

4.6 Item 8.6 – CL advised a system is being developed with the Information Centre regarding the provision of patient data and progression has been made. The Committee recognised the data inaccessibility is a national issue. **Complete**

4.7 14.3 – The Terms of Reference has been actioned and will be presented at the Governing Body in November. **Complete**

4.8 The Chair requested an update on Section 15.1 of the minutes relating to the PCT accounts and was updated by CL that the legacy balances have transferred to receiving organisations (Local Authority, CCG, Area Team, NHS PropCo and GCS). CL advised that Rupert Boex from the CSU has undertaken this work to agree and split all closing balances to all receiver organisations and that the validation process is well underway. It was noted that all transactions since 1st April 2013 onwards needs to be matched and that Andrew Beard will be working alongside Rupert. The Committee also noted that NHS England balances are transferring to a new ledger which is not part of the CCG ledger. The Chair expressed concerns and requested an update for the December Audit Committee. PS advised that External Audit will be involved in the monitoring of the validation process in order to provide assurance but details and timing have not been notified yet. CL

5. Internal Audit

5.1 PD presented the progress report which sets out the progress against the 2013/14 internal audit plan. PD highlighted page 2 of the report and advised he has met with CL to discuss the schedule for mapping these areas.

5.2 PD advised that two draft reports have been issued. These are the Procurement and Service Level Agreement Performance review reports. It was noted that Procurement was identified as a low risk area and the Service Level Agreement was identified as a medium risk.

5.3 PD advised that the key issues identified within the Service Level Agreement review were due to the number of contracts that are yet to be signed. It was noted that 41 out of 73 contracts had been signed although it was acknowledged that this is an on-going process. CL informed the Committee that higher value contracts have been prioritised and that generally the smaller value contracts are those yet to be signed.

5.4 Internal Audit Tracker - PD presented the tracker which details the internal audit recommendations relating to the former PCT which have continuing relevance to the CCG. The Chair advised that he had reviewed these and felt he had not identified any issues which will cause any particular concern. CL advised that issues had been circulated to relevant leads to ensure these are being addressed appropriately and it was noted that there are no high risk areas identified.

5.5 <u>RECOMMENDATION:</u>
The Audit Committee noted the reports.

6. External Audit

6.1 PS presented the Annual Audit Letter which summarised the key findings arising from the work that had been carried out at the Gloucestershire Primary Care Trust for the year ending 31 March 2013.

6.2 PS felt that the information from this work could be helpful

for the CCG. Attention was drawn to page 5 which indicates the key findings from the audit of the financial statements. It was noted this gave the PCT a clear audit opinion and Value for Money conclusion. An audit opinion was given on regularity as well which whether expenditure has been incurred 'as intended by Parliament'.

6.3 PS advised there was one area identified where the PCT was required to make an adjustment to the accounts. Another issue identified during the year is where all commissioning bodies faced similar situation of having to provide for future settlement of retrospective claims for Continuing Healthcare due to a national deadline for the submission of claims. This led to a significant number of claims being made and the need for an overall estimate of the future liabilities based on limited information. PS advised a commentary was included in the accounts and the risk has now transferred to the CCG.

6.4 PS presented the initial progress report and advised that the interim audit will be commencing soon. Attention was drawn to page 5 of the report which details the areas of work being audited and the schedule of these. PS advised that the timings of audit visits are estimates only as resource planning and allocation has not yet been completed for CCG audits.

6.5 PS advised the key areas of work are:

- Agree detailed audit plan
- Review of the risk involved with the financial systems control environment
- Final account audits
- Value for Money conclusion

6.6 The Committee also noted that the paper included a summary of emerging national issues and developments that may be relevant to the CCG and these are detailed on page 7-16.

6.7 The Committee reviewed the emerging issues and considered the challenge questions for each area.

6.8 **NHS Manual for Accounts 2013/14**

CL advised that the financial accountant is reviewing the issues as they emerge and will prepare a timetable for delivery of the annual accounts. CL advised that the task will be similar to that of the PCT and any accounting issues will be dealt with as they emerge. It was noted that any significant policy changes will come to the Audit Committee and the joint work between the CCG and CSU was recognised by members.

6.9 **Good data quality**

CL advised that this is part of the contract with the CSU and members recognised the issues of patient information data flow and noted that improvements are being made with the Patient Information Centre. CL advised that in terms of the overall performance, a report is routinely presented to the Governing Body.

6.10 **Integrated care**

The Committee noted that there are joint posts within Children, Commissioning, Learning Disability, Mental Health services. There are section 75 and 265 agreements with a number of services. It was also noted that there is joint working with the Joint Commissioning Partnership Board and the Health and Wellbeing Board and to develop relationships between working closely with partners on the medium term financial position.

6.11 **Managing the transition to the reformed health system** CL

It was noted that the finding from the review from the national audit report should be presented to the Governing Body and it was agreed a summary will be presented at the November Governing Body meeting.

6.12 **Auditing the accounts**

CL advised that as part of the assurance for the Governing Body, members receive a report on the budget, financial position and financial risks. It was noted that the 5 year financial plan is being revised which will take into account the growth of the population, allocation budgets and any other risks and factors. The information that members receive will give an overview on the financial

sustainability of the organisation and also test the financial resilience.

6.13 **Equality and Diversity**
VW advised that she had met with Marion Andrews-Evans to discuss this issue and advised that she had expressed concerns that the CCG is non-compliant. It was stated that the CCG are on a very tight deadline in terms of establishing the 5 year and 12 month plans. It was noted that the CCG decided not to commission CSU to provide this service and to only use them in an advisory capacity due to the decision in managing this in-house. VW advised that this had been referred to the executives and felt this to be a big risk. It was noted that the CSU are being approached to cost out the charge for providing this service for this year only. CL responded by stating that there is a programme beyond compliance and that the CSU are being used as a short term fix to cover the gap. It was noted that the CSU has quoted for providing this service at £24k. The Chair recommended that this should go to the next IGQC and proposed action from executives to resolve this issue as soon as possible. It was noted that there is a wider issue of ethos and we need to embrace this going forward.

6.14 <u>RECOMMENDATION:</u>
The Audit Committee noted the reports.

7. Counter Fraud Plan

7.1 SC provided an updated action plan with highlights activity that had been achieved to date. The Committee noted that 15 out of the 40 allocated days had been used. It was noted that the awareness presentation is progressing well; 7 days have been completed so far and a further 4 days are scheduled. SC advised that the presentation days are planned to be completed by the end of October. SC informed that the feedback received from staff acknowledged that the session had been adapted to fit with their specific areas.

7.2 SCh advised that NHS Protect are providing training to LCFS in procurement fraud and fraud prevention and

therefore Fraud Awareness Month, focusing on procurement fraud and originally scheduled for September/October 2013, has been deferred until after the new year. The Committee noted that the Fraud Awareness Month is an activity to stimulate those organisations to drive forward fraud initiatives for at least one day during the year.

7.3 AE highlighted section 3.2 of the action plan which agreed to 'Undertake a programme of review of all providers' counter fraud provisions in accordance with new standard contract' and queried why it had been suspended. It was noted a review was going to be undertaken for each organisation that held a contract with the CCG but further details revealed that only NHS organisations will be subjected to this review process. SC advised that although further guidance is awaited from NHS Protect, smaller organisations will not be required to undertake the review tool. The programme was suspended as GHFT, GCS and 2gether are the only organisations that will be reviewed. SC advised that these organisations have had to submit their crime organisation profile and the self-assessment tool to NHS Protect and members noted that GCS will be subject to a national review. The Committee were assured that the contract monitoring process has mechanisms in place for Counter Fraud provisions.

7.4 The Chair suggested that the layout of the report needed re-formatting and requested a key to be added. It was also noted that if any additional days are required for Counter Fraud, these will be requested from the Audit Committee. SC

7.5 The Committee discussed the Fraud Focus newsletter and considered this to be excellent work achieved from SC and her team.

7.6 <u>RECOMMENDATION</u>
The Audit Committee noted the report.

8. QIPP Report

8.1 CL presented the QIPP Report which provided an overview of the 2013/14 QIPP Programme; including

contractual agreements with key providers. It reports the performance, to the end of July 2013, on a scheme by scheme basis.

8.2 CL advised that we have arrangements with organisations to help share risks across the health community. The providers have entered into these agreements which is proving challenging for them as they have their own cost improvement programme target to reach.

8.3 The Committee noted that the CCG is aiming to achieve QIPP savings through the transformation of services which will help to deliver the sustainable position within the system in terms of delivering and improving quality.

8.4 CL highlighted the table in Section 4.1 which forecasts delivery for the QIPP Programme by theme. The Committee noted slippages within the scheme and it was advised:

- Care Home Enhanced Service implementation is taking longer than anticipated
- Integrated Discharge Team is taking longer to develop joint working between our partners and developing the system. It was noted that interim appointments have been made and believed significant benefits will be delivered from this.

8.5 <u>RECOMMENDATION</u>

The Audit Committee:

- **Noted the 2013/14 QIPP programme performance at Month 4 including the savings delivery forecast position; work programme, contract agreements and associated risks.**

9. Summaries of Procurement Decisions

9.1 CL presented the document which outlines decisions relating to the procurement of services between the 26th June to 13th September 2013.

9.2 <u>RECOMMENDATION:</u>

The Audit Committee noted the report.

10. Register of Waiver of Standing Orders

10.1 DP presented the document which outlined all approved/rejected applications for waiver of standing orders between the 26th June and 13th September 2013.

10.2 The Committee requested that going forward, an audit check needs to be in place to ensure any future waivers are signed by the Accountable Officer and the Chief Finance Officer.

10.3 The Committee queried the end date for the Map of Medicine Waiver as the form indicated June 2016 but the detail stated June 2014. CL believed there could be a break clause within the contract but will check and confirm. The Chair proposed that this waiver should be re-visited next year. CL

10.4 <u>RECOMMENDATION:</u>
The Audit Committee noted the report.

11. Aged Debtor Report

11.1 CL presented this report which provided a summary of the aged debt raised up to 30th August 2013. It was noted that the major NHS debt is with GHFT which related to the £3.5m overdue contribution to non-recurring QIPP scheme. The non-NHS debt related to GCC which includes £1.4m for mental health integrated services.

11.2 The Committee queried the better payment practice code and whether GHFT complies with this target. CL advised that GHFT aim to comply with this target and the Committee requested that CL to find out the performance for GHFT and report back. CL

11.3 <u>RECOMMENDATION:</u>
The Audit Committee noted the current position of debtor balances and the actions being taken to recover these debts.

12. Debts Proposed for Write-Off

12.1 The Audit Committee noted there are no debts to be cancelled.

13. Losses and Special Payments Register

13.1 The Committee was advised that there have been no losses or special payments since 1st April 2013.

14. Any Other Business

14.1 There were no items of any other business

16. The meeting closed at 10.50am.

Date and time of next meeting:
Tuesday 10th December 2013 in the Video Conferencing Room at 9am.