

Governing Body

Meeting to be held at 2pm on Thursday 29th May 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 27 th March 2014 | 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's Update | Mary Hutton | Information |
| 9 | Joining Up Your Care: Two and Five Year Plan Update | Mary Hutton | Information |
| 10 | Constitution | Chair/ Alan Potter | Approval |
| 11 | Mental Health Crisis Care Concordat | Eddie O'Neil | Approval |
| 12 | Co-Commissioning of Primary Care | Helen Goodey | Approval |
| 13 | West of England Academic Health Science Network Report and Plan | Mary Hutton | Information |
| 14 | Performance Report | Cath Leech | Information |
| 15 | 2013/14 Assurance Framework | Cath Leech | Information |
| 16 | Audit Committee Annual Report | Colin Greaves | To Accept |
| 17 | Integrated Governance Committee Minutes | Julie Clatworthy | Information |

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|--|--------------------------|-------|--|
| 18 | Any Other Business (AOB) | Chair | |
| Date and time of next meeting: Thursday 31 st July 2014 at 2pm in Board Room at Sanger House | | | |
| There will also be an extraordinary Governing Body meeting to take place at 2pm on Tuesday 3 rd June 2014 in the Board Room, Sanger House, Brockworth, Gloucestershire GL3 4FE. | | | |

Questions should be sent in advance to the Associate Director of Corporate Governance: alan.potter1@nhs.net by 12 noon on Tuesday 27th May 2014. Questions must relate to items on the agenda.

Please note: there is very limited parking available at Sanger House and all spaces must be booked in advance. If parking is required by members of the public, please e-mail Alan Potter (as above) to establish if there are any visitor spaces available.

**Gloucestershire Clinical Commissioning Group (CCG)
Governing Body**

**Minutes of the Meeting held on Thursday 27th March 2014
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 |
| Mark Branton | MB | Assistant Director of Adult Social Care Commissioning, GCC |
| Dr Charles Buckley | CBu | GP Liaison Lead |
| Julie Clatworthy | JC | Registered Nurse |
| Alan Elkin | AE | Lay Member – Patient & Public Engagement |
| Dr Malcolm Gerald | MGe | GP Liaison Lead |
| Dr Martin Gibbs | MGi | 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 |
| In attendance: | | |
| Kelly Matthews | KM | Associate Director Strategic Planning |
| Alan Potter | AP | Associate Director Corporate Governance |
| Fazila Tagari | FT | Board Administrator |
| There were 10 members of the public present. | | |

1 Apologies for Absence

1.1 Apologies were received from Margaret Wilcox.

2 Declarations of Interest

2.1 GP members declared an interest in the Two and Five year plan.

3 Minutes of the Meeting held on Thursday 30th January 2014 and Extraordinary Meeting held on 13th March 2014

3.1 The minutes of the meeting held on Thursday 30th January 2014 were approved subject to the following amendments:

- Section 13.3 to be amended read – ‘.....were some areas where action plans had not been delivered.’
- Section 14.2 to be amended to read – ‘MAE informed the Governing Body that the draft Quality Strategy....’
- Section 18.1 to be amended to read – ‘...and advised that the Local Medical Committee have held this discussion with the Area Team.’

3.2 The minutes of the extraordinary meeting held on Thursday 13th March 2014 were approved.

4 Matters Arising

4.1 30.01.14 AI 5.2 – The patient’s story had been deferred for logistical reasons. It was noted that this would be delegated to the IGQC for review prior to presentation at a future Governing Body meeting.

4.2 30.01.14 AI 8.3 – Further specifics on the 7 day working had been circulated to members and it was noted that a full report would be presented at a future Governing Body meeting. **Complete**

4.3 30.01.14 AI 12.15 – The Staff survey had been completed and an initial report had been received which was currently being analysed. It was noted that the full report would be discussed at a business session prior to presentation at a future Governing Body meeting. **Complete**

4.4 30.01.14 AI 12.16 – Item covered on the agenda. **Complete**

5 Public Questions

5.1 There were no questions received from the public.

MGe joined the meeting at 14:10

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

6.1 This report was taken as read, with a summary of key issues that arose during February and early March 2014 being highlighted.

6.2 HM took part in a clinical debate entitled 'Breath' that was organised by 'Medicine Unboxed' with support from the CCG. This event explored the experiences of patients and clinicians along the respiratory disease pathway. Particular issues were highlighted of the role of carers and the transition between paediatric into adult services. It was acknowledged that further work was required.

6.3 Other key issues highlighted were:

- Better Care Fund
- Jon Glasby Event

6.4 **RESOLUTION:** The CCG Governing Body noted the contents of this report.

7 Gloucestershire Clinical Commissioning Group Accountable Officer's Report

7.1 The Accountable Officer introduced this report which was taken as read and provided a summary of key issues arising during February and March 2014. The key issues highlighted were:

7.2 Urgent Care - Performance across the Urgent Care system remains challenging with particular pressure on the Emergency Department 4 hour and Red 1 and 2 ambulance targets. A significant amount of work has taken place, working with South Western Ambulance Service to support improvement of these targets. It was also noted that this was also being reviewed by the Health and Care Overview and Scrutiny Committee.

- 7.3 MH informed the Governing Body that the CCG had provided winter funding to increase the nursing and medical staff within the Emergency Department. It was also noted that the CCG had also been liaising with the NHS 111 service to provide extra clinical triage to ensure that patients are following the appropriate pathway.
- 7.4 Integrated Community Teams – It was noted that the Gloucester City service went live on the 22nd January 2014 and was continuing to be jointly reviewed with GCS. It was anticipated that the roll out across Cheltenham would be in May 2014.
- 7.5 Cheltenham Emergency Department – MH highlighted that a review of the changes had been undertaken and that a full comprehensive report was reviewed at the Health and Care Overview and Scrutiny Committee.
- 7.6 **RESOLUTION:** The CCG Governing Body noted the contents of this report.

8 Business Continuity Plan

- 8.1 MAE presented this plan and advised that Andy Ewens (Civil Protection Officer) whose post was jointly shared with Public Health was leading this project. MAE advised that this plan identified the processes required to respond to any incident that may affect the business of the GCCG and the delivery of its core services.
- 8.2 MAE informed the Governing Body that Andy Ewens had undertaken a business impact analysis and the identified risks and the proposed actions were outlined on Appendix 7 of the report. It was noted that the appendix highlighted the length of time the CCG can continue to function.

8.3 MAE advised that this was an overall plan and a guide to support those charged with implementing its contents. Members were informed that a workshop was run for deputy directors in order to support them in carrying out departmental assessments and developing action plans. MAE reassured the Governing Body that senior staff had been trained in taking this forward. MAE also reported that provider organisations business continuity plans had been reviewed as part of the assurance process.

8.4 **RESOLUTION: The CCG Governing Body adopted the paper within the Gloucestershire CCG framework.**

KM joined the meeting at 14:20

9 **Five and Two Year Plans**

9.1 JJ gave a presentation to the Governing Body which summarised the draft Five Year Strategic Plan and final Two Year Plan.

9.2 The presentation covered:

- Timeline for the approval of plans
- Our Shared Vision
- Two Year Plan
- Two Year Financial Plan
- Better Care Fund Plan

9.3 HM invited questions or comments from the Governing Body members relating to these Plans. The Governing Body reviewed the two year and five year plan individually.

Two Year Plan

9.4 SA queried page 17, bullet point 1 of the document and was advised by MGe that this was work in progress and still needs to be agreed.

- 9.5 Page 22 - MH requested further details on prevention should be added to this section and suggested that a review of the previous work is undertaken in conjunction with Public Health. AW commented that there is further work being undertaken in 2014/15 which would require to be joined up with the CCG programme of work on prevention. CBu raised concerns relating to the national disinvestment of the Public Health service and felt their contribution was vital for the development of the CCG. AW noted the concerns and advised that a Memorandum of Understanding was currently being developed with the CCG which would be key going forward and to be used as a basis for the continued investment and support for the CCG.
- 9.6 Page 23 – MGe commented that the section on Primary Care was not explicit enough.
- 9.7 Page 26 – MH requested that further details should be added on the phase 2 ICTs.
- 9.8 Page 27 – AW felt it was important that Secondary Care Prevention was included in this section.
- 9.9 Page 31 – MH requested that the Clinical Programme Priorities section was rephrased as she felt that the description was narrow and needed to be expanded to ensure that there was clarity on what we were trying to achieve.
- 9.10 The Governing Body expressed gratitude to JJ's team and particularly to KM's team, and had recognised the hard work in completing this plan within the parameters set.
- 9.11 CBu highlighted that the NHS had significantly lower administration costs compared to many major public sector organisations and expressed concerns on the plans to continue to cut funding in this area. He felt that this would be unsustainable in the longer term.

- 9.12 CL commented on the management of the 10% reduction and advised that there was a marginal underspend on the 14/15 budget which would be retained. CL advised that the contract with CSU had been running for a year and that the initial costing was based on a 'best estimate' and further review suggested that there cross subsidisation between larger and smaller CCGs. It was noted that a discussion was ongoing with the CSU to agree how that area of cross subsidisation would be released. CL reassured the Governing Body that a plan was in place to review this and that work is ongoing to address these issues. It was agreed that this information would be brought to a future Governing Body meeting. CL
- 9.13 WH enquired if a communication exercise would be undertaken to inform all relevant individuals of their roles in implementing the Plan. MH advised that there would be a key lead assigned to each of the programmes who would be responsible to ensure a clear action plan was developed which would also involve coordinating with the Providers. It was noted that the Providers had recognised that there would be a cultural challenge for all involved.
- 9.14 SA stated that to make any transformational changes, it would be necessary to resource the change programme and believed that the reforms were intended to enable local empowerment. SA felt that our role was to develop plans that had scope for improvement, were clear and would take into account any investment that is required. He considered this to be the real strategic challenge.
- 9.15 AE requested assurance on how the CCG Governing Body would monitor the 'one system approach' going forward. MH accepted that there was further work to complete on the joint governance arrangement for the Better Care Fund but recognised that the CCG had a robust Programme Management Office who managed these projects. MH reported that discussions were underway to agree closer alignment between commissioner and provider Programme Management Offices and to develop an agreed set of measures for each scheme.

5 Year Plan

9.16 It was noted that this was a draft initial plan and was subject to revisions and amendments. JC felt that there was further scope for improvement and requested further details (i.e. Preventive and Self Care) to be added to this Plan.

9.17 AS requested the section on page 24 to be amended as it stated that all GP Practices will be using the same IT system and members noted that this was inaccurate.

9.18 RESOLUTION:

The CCG Governing Body:

- **Noted the latest version of the five year strategic plan 'Joining up Your Care' and acknowledged that a final version will come to the Governing Body for sign off ahead of the submission to NHS England on 20th June 2014;**
- **Approved the final two year delivery plan as presented with the amendments requested;**
- **Approved the attached Better Care Fund plan, including financials and performance indicators as presented;**
- **Acknowledged the risks to delivery and mitigating actions.**
- **Formally signed off the Shared Vision.**

10 2014-15 CCG Annual Budget

10.1 CL presented the paper which outlined the 2014/15 budget for the CCG and highlighted that a surplus of £6.9m was planned.

10.2 CL reported that the contracts with the CCG's main providers are not yet signed. However, the estimated impact of final contracts had been included in the CCG's budgets. It was noted that any further changes to contract values will be reflected in the budgets, and future finance reports to the Governing Body.

10.3 The CCG's budget assumed delivery of savings programme of £17.9m. A breakdown of schemes was shown at Appendix 3 of the report. CL advised that the plans and proposals for each of the schemes had been risk assessed and the savings plans reflected those risks. However, it was noted that there was still a significant amount of savings to be made and that this would require robust control on expenditure to ensure that budgets are not exceeded. CL reported that the CCG Financial Management Framework had been reviewed and was attached for approval at Appendix 5.

10.4 **RESOLUTION:**

The CCG Governing Body:

- **Approved the 2014/15 budgets and noted the risks inherent within the plan**
- **Approved the Financial Management Framework**

KM left the meeting at 15:45

11 **Performance Report**

11.1 CL presented the Performance Report which provided an overview of Gloucestershire CCG performance against the organisational objectives for the period to the end of February 2014.

11.2 The report was broken down into the five sections of the GCCG performance framework as highlighted in Section 1 of the report. CL advised a Lead Director had been assigned to each area.

Clinical Excellence

11.3 Cancer 62 day performance - MW informed the Governing Body that a recovery plan was in place with GHFT but advised that it was anticipated that the target would not be sustainably met until June 2014, although there was an agreed trajectory for improvements during April and May. One of the key area of concerns was regarding access to diagnostics tests and it was reported that GHFT had increased CT and Pathology capacity to address the identified issues. It was also noted that histology staff and an National Vocational Training coordinator had been recruited in order to improve the system although it was recognised that there is still further work needed to be done.

- 11.4 Ambulance Response Time Performance Category A – It was reported that SWAST was achieving the target overall. However, despite improvements in Quarter four, it was noted that the target would not be achieved in the North Division. MW advised that a recovery plan was in place which involved deploying additional crews in the North Division and a dedicated Performance Clinical Manager. Members also noted that an additional requirement was being included in the contract which would outline the local target and would also include a detailed performance recovery action plan.
- 11.5 MAE reported that the current year to date performance for C.Difficile was 180 cases against a target of 162 cases. It was noted that next year target was being set at 201. It was explained that a great deal of effort had been undertaken to review this area. MAE advised that there were no further Never Events to report.
- 11.6 JC enquired if any financial penalties were imposed for poor performance and was advised by MW that contractual penalties were applied as authorised in the contract. However, MW indicated that it was endeavoured to reach a sustainable solution which included recruiting of additional capacity.

Finance and Efficiency

- 11.7 CL advised on the financial position to the Governing Body members and reported that the CCG was forecasting to deliver its planned surplus of £6.7m.
- 11.8 CL reported that the major variance to note was on the GHFT contract as the provider continued to show significant over performance in excess of those levels planned within the year end forecast and it was noted this had been reflected in the current operating position. CL advised that discussions were still ongoing with GHFT in order to reach an agreement on the level of over performance and various aspects of the contract prior to formal sign off of the 2014/15 contract.

- 11.9 MH commented that in terms of the formal contract sign off, there had been good progress with the 2gether Trust and that GCS had signed the Head of Terms and is awaiting formal sign up to the QIPP risk share. It was noted that formal sign up to the risk share programme was in progress and that this would be reported at the May Governing Body meeting. CL
- 11.10 JC raised a query relating to the Serious Incidents system and it was noted that a review was currently being undertaken in this area and the outcome of the review would be reported at the IGQC.
- 11.11 4 hour A&E Emergency Department performance - MW reported that the latest performance to date was 92% against a target of 95% and it was reassured to the Governing Body members that there was a key focus on measures particular around the discharge programme. It was noted that there was also additional resources allocated to the admissions at the start of the week where particular pressures were emerging. It was noted that GHFT had commenced additional sessions over the weekend in order to improve patient flow and to ensure that the appropriate level of discharge was maintained over the weekend. MW indicated that a formal review would be undertaken at the end of April to review the additional winter schemes and to identify which schemes the CCG would want to maintain over the year. It was also noted that additional investment had been allocated to the Integrated Discharge Team and the Care Home Select Process.
- 11.12 **RESOLUTION: The CCG Governing Body**
- **Noted the financial position as at 28th February 2014 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.**
 - **Noted the update to the Annual Operating Plan 2013/14 and the mitigating actions taken to resolve areas of concern.**

12 Assurance Framework

12.1 CL presented the Assurance Framework for 2013/14 which was presented to the IGQC on the 20th February 2014. The Assurance Framework identified gaps in assurances and controls regarding the organisational objectives, along with details of the principal risks that have been identified by lead managers.

12.2 **RESOLUTION:** The CCG Governing Body noted this paper which was provided for information.

13 Integrated Governance Committee Minutes

13.1 The Governing Body received the minutes of the meeting of the Integrated Governance Committee held on the 19th December 2013.

13.2 **RESOLUTION:** The CCG Governing Body noted these minutes.

14 Audit Committee Minutes

14.1 The Governing Body received the minutes of the meeting of the Audit Committee held on the 10th December 2013.

14.2 **RESOLUTION:** The CCG Governing Body noted these minutes.

15 Any Other Business

15.1 There were no items of any other business.

16 **The meeting closed at 16:00.**

17 **Date and Time of next meeting: Thursday 29th May 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 – March 2014

| Item | Description | Response | Action with |
|---------------------------------|-------------------------|--|-------------|
| 30.01.14 Agenda Item 5.2 | Patient's Story | MAE requested members to feedback to Becky Parish and it was noted that a briefing paper on any further patient's stories will be circulated to members prior to being presented at the Governing Body meetings. <i>27/03/14 It was noted that this would be delegated to the IGQC for review prior to presentation at a future Governing Body meeting.</i> | ALL |
| 27.03.14 Agenda Item 9.12 | Five and Two Year Plans | It was noted that a discussion was ongoing with the CSU to agree how that area of cross subsidisation would be released. CL reassured the Governing Body that a plan was in place to review this and that work is ongoing to address these issues. It was agreed that this information would be brought to a future Governing Body meeting. | CL |
| 27.03.14 Agenda Item 11.9 | Performance Report | It was noted that formal sign up to the risk share programme was in progress and that this would be reported at the May Governing Body meeting. | CL |

Governing Body

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| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | Patient Story – Integrated Community Team, Rapid Response |
| Executive Summary | <p>This Patient Story describes an individual’s experience of receiving support from the Integrated Community Team (ICT), Rapid Response, in Gloucester City shortly after implementation of the ICT in the Locality earlier this year.</p> <p>Learning points are identified (below).</p> <p>Proposed subjects for future Patient Stories are identified (below).</p> |
| Key Issues | <p>Integrated Community Teams Integrated Community Teams (ICT) bring together GPs, community nurses, physiotherapists, social workers, occupational therapists, reablement workers and other key support staff and join up health and social care services for adults so that local people experience a co-ordinated approach to their care. The service operates 24 hours a day, 7 days a week. Rapid response (urgent and there within 1 hour) is a high intensity service (where an individual gets a specific package of additional care).</p> <p>Gloucester City Locality was the first area in the county to offer an ICT Rapid Response service.</p> |

Patient Story - methodology and presentation

The ICT, Rapid Response, Patient Story was collected with support from Gloucestershire Care Services NHS Trust (GCS), the ICT service provider. Representatives from GCS and Gloucestershire Clinical Commissioning Group (GCCG) Patient Experience team visited the patient and their family at home. An audio recording was made of the feedback and a transcript produced. An edited version of this recording will be used to illustrate this Patient Story at the Governing Body meeting. The extended version of this recording was presented to the GCCG Integrated Governance and Quality Committee.

Patient Story - outline

This elderly gentleman has COPD for which he has had multiple hospital admissions. Exacerbation of his condition resulted in GP referral to the Rapid Response Team. Over a 3 day period he was intensively treated at home by the team and after this successful management of the acute exacerbation was referred on to the Community Respiratory Team for ongoing care.

Patient Story - learning points:

- Communications: appreciation of the style of communication, positive experience of information sharing between clinicians the patient and family
- Proactive shared decision making
- Confidence in clinical professionals involved achieved – reduced reliance upon GP
- Preference for staying at home respected

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| | <p>Proposed subjects for future Patient Stories and suggested dates:</p> <ul style="list-style-type: none"> • Stroke Pathway (July 2014) • Discharge (September 2014) • Patient Transport Services (November 2014) |
| Risk Issues: Original Risk Residual Risk | n/a |
| Financial Impact | £3.9 million invested by GCCG in the development of Integrated Community Teams |
| Legal Issues (including NHS Constitution) | n/a |
| Impact on Health Inequalities | n/a |
| Impact on Equality and Diversity | n/a |
| Impact on Sustainable Development | n/a |
| Patient and Public Involvement | Patient Stories are collected as part of GCCG's patient experience data. |
| Recommendation | <p>Paper for information.</p> <p>Consideration of proposed future patient story subjects and suggested dates.</p> |
| Author | Becky Parish |
| Designation | Associate Director, Patient and Public Engagement |
| Sponsoring Director (if not author) | Marion Andrews-Evans Executive Nurse and Quality Lead |

Gloucestershire Clinical Commissioning Group

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|---|--|
| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | Gloucestershire Clinical Commissioning Group Chair's Report |
| Executive Summary | This report provides a summary of key issues arising during April and early May 2014 |
| Key Issues | The key issues arising include: <ul style="list-style-type: none"> • CCG Clinical Commissioning Event - 12 June • Healthy Living Pharmacies • Commissioning Support Functions • Homeless Healthcare • 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) | |

Gloucestershire Clinical Commissioning (GCCG) Clinical Chair's Report

1 Introduction

- 1.1 This report provides a summary of key issues arising during April and early May 2014.

2 GCCG Clinical Commissioning Event, 12 June

- 2.1 Practice Teams have been invited to register for the Gloucestershire Clinical Commissioning Event on 12 June at Cheltenham Racecourse.
- 2.2 This event offers attendees the opportunity to review CCG progress and explore the opportunities and challenges for clinical commissioning and primary care in Gloucestershire.
- 2.3 The programme includes a clinically focussed morning facilitated by Dr Simon Curtis of "Hot Topics" fame. The afternoon commences with a key note speaker from The King's Fund on 'Integration' and there will be four multidisciplinary workshops. The full programme can be seen at:
www.gloucestershireccg.nhs.uk/event

3 Healthy Living Pharmacies

- 3.1 Nigel Acheson the Medical Director for South Region has asked to visit one of the Gloucestershire Healthy Living Pharmacies. His visit is designed to raise the profile of the contribution pharmacies can make to the health and well-being of a local community.
- 3.2 He is positively supporting of community pharmacies in their contribution to improving self-care, as well as health promotion activities.
- 3.3 Gloucestershire has 8 Healthy Living Pharmacies and there are currently 43 further pharmacies working towards accreditation, which includes a structured training programme based on the NHS Portsmouth model.

- 3.4 This initiative is jointly funded by the CCG and public health following on from a presentation to the Health and Well-being Board last year.
- 3.5 By the end of 2014 it is anticipated that 50% of all pharmacies in Gloucestershire will be offering a Healthy Living service, with a plan to train the remaining 50% in 2015.
- 3.6 To support this we have implemented 'Pharmaoutcomes' which is a web based monitoring system enabling commissioners to view in real time the activities of individual pharmacies. This includes a record of the number of people who have asked for support with smoking cessation, life-style changes, exercises and healthy eating etc. as part of the CCG and Public Health Healthy Individuals Programme.

4 Commissioning support functions

- 4.1 Following a formal consultation process with all staff involved on the 1st May Finance and Provider Performance staff from Central Southern Commissioning Support transferred to the CCG. This is in line with our assessment that these functions are 'core' to the work of the CCG and we are pleased to welcome these new colleagues.

5 Homeless Healthcare

- 5.1 The Time to Heal pilot to support hospital discharges in Gloucestershire has won two unsung heroes awards. These were presented in the House of Commons to the project worker Steve Pankhurst and GHFT Consultant Dr Pippa Medcalf.
- 5.2 Pippa has recently been appointed as the Royal College of Physicians lead for work with excluded groups. The CCG are currently reviewing the pilot model and pulling together an evaluation report to be able to discuss the service in the context of ongoing funding.

6 Meetings Attended

- 6.1 Attended NHS Commissioning Assembly Development Working Group in Leeds on 10th April.
- 6.2 Visited St Vincent's & St George's Association, Cheltenham
- 6.3 Attended the NHSCC Conference in London
- 6.4 Met with Col DJ Morgan-Jones MBE, Medical Director HQ ARRC

7 Recommendation

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

Governing Body

| | |
|---|---|
| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | Gloucestershire Clinical Commissioning Group Accountable Officer's Report |
| Executive Summary | This report provides a summary of key issues arising during April and May 2014 |
| Key Issues | The key issues arising include: <ul style="list-style-type: none"> • Winter Plan Review • OOH (Out of Hours) Procurement • ICT's (Integrated Community Teams) Update • 2014/15 Contracting Round • 2nd version of Active Planning Toolkit launched • Prescribing Improvement Plan (PIP) • Meetings Attended |
| Risk Issues: Original Risk Residual Risk | None. |
| Financial Impact | None. |
| Legal Issues (including NHS Constitution) | None. |
| Impact on Health Inequalities | None. |
| Impact on Equality and Diversity | None. |
| Impact on Sustainable Development | None. |
| Patient and Public Involvement | Not applicable. |
| Recommendation | The Governing Body is requested to note this report which is provided for information. |
| Author | Mary Hutton |
| Designation | Gloucestershire CCG Accountable Officer |
| Sponsoring Director (if not author) | |

Gloucestershire Clinical Commissioning Group (GCCG) Accountable Officer's Report

1. Introduction

This report provides a summary of key issues arising during April and May 2014.

2. Winter Plan Review

The CCG led the production of the Gloucestershire Winter Plan and Escalation Policy which involved working closely with providers and co-commissioners from across Health and Social Care. It was reviewed by key partner organisations to ensure robustness of the conclusions reached around demand and capacity, both for normal winter activity, and pandemic flu. The plan built upon previous proven approaches to capacity planning and incorporated learning from previous years. A significant amount of work in preparation for the winter was based upon agreeing service developments that would have an impact on the urgent care system throughout the winter period. Planning assumptions included an assessment of patient Length of Stay (LOS), bed occupancy and predicted activity growth.

In particular a range of interventions were developed to ensure patients progressed through the discharge pathway in a timely and effective manner. This work was supported by week long "Getting Mrs Foster Home" events which focussed upon reviewing "blocks" within the discharge pathways and agreeing actions to take forward into everyday practice. Other interventions included the further development and expansion of the Integrated Discharge Teams, introduction of Care Home Select who support patients and carers in selecting and accessing care homes and introduction of enhanced 7 day working, including improved access to diagnostics, senior medical staff board rounds and access to social workers.

Predicted growth in emergency admissions was below the winter planning assumptions and the success of this has been attributed to the large number of admission avoidance schemes which were introduced prior to winter. These include the roll out of the Integrated Community Teams across the

Gloucester City Locality, continuation and further development of the enhanced primary care support service to residential and nursing homes across Gloucestershire as well as a number of new winter initiatives providing successful alternatives to Emergency Department attendance and subsequent hospital admission.

3. OOH Procurement

The Primary Care OOH Service Procurement is now underway. An advert was placed on 28th March and the CCG has received a number of expressions of interest from prospective bidders; the advert closes on 8th May and bidders will be required to submit a completed Pre-Qualification Questionnaire (PQQ) by 15th May. The PQQ will be evaluated and successful bidders will then be invited to submit a full tender. The full service specification, which has been informed by stakeholder engagement events with input from the Primary Care Foundation, is now being finalised. A Stakeholder Engagement Group is being set up and will review the specification before it goes out to bidders during the first week of June. Following a full evaluation of all the bids, including presentations from all bidders, a contract award recommendation will go to the GCCG Governing Body at the end of September.

4. Strengthening Adult Health & Social Care Integrated Community Teams (ICTs) update

In order to develop the capacity and capability of community services to help reduce the demand on secondary care services and keep people as independent for as long as possible, we are introducing 24 hour single point of clinical access (SPCA), rapid response (urgent visit within 1 hour) and high intensity (enhanced level of planned interventions over an agreed period of time) functionality in addition to the existing range of core ICT services provided by Gloucestershire Care Services . This is being carried out as part of a phased geographical roll out during 2014. The following provides the key actions and output of the last few weeks: -

- As previously reported, service live in Gloucester since 22nd January 2014;
- Engagement and communication with Cheltenham practices completed and service live in Cheltenham from Wednesday 7th May 2014;
- Planning for launch in Tewkesbury (Tewkesbury town, Churchdown, Brockworth, Bishops Cleeve and Winchombe practices) commencing – tentative ‘go live’ date before the end of September 2014;
- In Gloucester from 22nd January to 4th May 2014, 192 cases have been completed. These cases required 921 interventions – an average of around 4 to 5 interventions per patient. 40% of the activity is attributed to planned high intensity care and 60% is attributed to rapid response care;
- To meet Case for Change requirements, there was a minimum target of 133 cases for Gloucester, which has been met. As previously reported, the implementation plan assumed a greater number of interventions per patient. It should be noted though that the number of interventions per case is increasing over time as high intensity functionality and staff skill mix begins to change. For the month of February, there was an average of around 3 interventions per case and for the month of April 2014, this increased to around 5 to 6 interventions per case;
- There has been successful weekly snagging meetings between Gloucester locality Executive GPs and ICT members, which has really helped in tackling operational start-up problems. This has now been changed to monthly review. Fortnightly snagging meetings have set up in Cheltenham for the first two months of operation;
- A review of the test and learn period for the service in Gloucester has started. This includes patient feedback, interviews with staff, a GP survey, case review findings and key performance, outcome and finance information. A report is being produced for the ICT Steering Group in June 2014 to inform service development;
- Interim financial model in place and key requirement to finalise financial requirements, particularly around daytime funding for high intensity functionality;
- Fortnightly joint programme team meetings remain in place;

- Recruitment of additional staff to support existing teams to deliver high intensity functionality for Gloucester and Cheltenham teams almost complete. Target of around 21.5 wte staff – currently 20 staff offered and accepted roles with most in post;
- Regular case reviews seen by the strengthened ICT with local Gloucester City GPs, GCS staff and ICT Programme members;
- Governance review for next stage of programme currently being completed and currently finalising the precise scope for a phase 2 programme of work, which will focus on connection with mental health services and the implementation of the Living Well Operating Model to start in the summer of 2014;
- Submitting a Change management support application to NHSIQ. (Mary to explain what this organisation is)

5. 2014/15 Contracting round

The CCG has reached agreement on Heads of Terms with all providers. It is anticipated that all contracts will be signed by the end of May. As well as incorporating key national and local priorities from our published two year plan, the contracts also incorporate local agreements relating to our QIPP programme and approach to managing financial risk within the system.

6. Second Version of the Pioneering Active Planning Toolkit is launched.

Gloucestershire Clinical Commissioning Group recognises that the built and natural environment in which we live has a huge influence upon how active we are in our daily lives. Many people are not physically active enough and the health risks of sedentary lifestyles are identified as a growing problem. GCCG is proud to be a part of a group in Gloucestershire that has produced a new and updated version of the Active Planning Toolkit. The Active Planning Toolkit 2 provides case studies, checklists and resources to enable professionals to create buildings and natural environments that will support people to be more active.

The local partnership in Gloucestershire includes Gloucestershire County Council, the University of Gloucestershire, and the Voluntary and Community Sector

(VCS). The group originally formed to consider how to implement the NICE public health guidance 2008, which provided the evidence as to which types of environments encourage physical activity. The original Active Planning Toolkit was the culmination of this work and received commendation from the Royal Town Planning Institute in 2011. Planning law has changed significantly since 2011; the new version of the Active Planning Toolkit reflects this. The Active Planning Toolkit will be published on the Gloucestershire Clinical Commissioning Group website.

7. Prescribing Improvement Plan (PIP)

Prescribers and practice support pharmacists again achieved impressive prescribing quality and cost improvements across Gloucestershire in 2013/14.

As an example, the prescribing of venlafaxine in Gloucestershire is now the most cost effective in England as a result of the move away from slow release products. This change alone has produced recurring savings of £300,000 pa.

Payments achieved under the PIP 2013/14 have now been made to practices as discussed at recent locality prescribing review meetings.

For further information, contact mark.gregory1@nhs.net

8. Meetings Attended

- 27th March - Kingfisher Performance Arts Show, Gloucester
- 1st April - Extra-Ordinary Health & Wellbeing Board – Better Care Fund (BCF) Sign Off, Shire Hall, Gloucester
- 3rd April – Visit (with Helen Miller) to St Vincent's & St George's Association, Cheltenham
- 14th April – Challenging Behaviour Concordat Launch & Signing Event, Shire Hall, Gloucester
- 30th April – Review of Winter Planning with NHS England, Swindon
- 30th April/1st May – Attendance (with Helen Miller) at NHSCC Conference, London
- 21st May – NHSCC Leadership Group Meeting, London

- 22nd May – Meeting with Col DJ Morgan-Jones MBE,
Medical Director HQ ARRC

9. Recommendation

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

Agenda Item 9

**Gloucestershire Clinical Commissioning Group
Governing Body**

| | |
|------------------------------------|--|
| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | Joining Up Your Care: Two and Five Year Plan Update |
| Executive Summary | <p>Joining Up Your Care (2014-2019) (JUYC) was shared with the Governing Body in March 2014, setting out the draft five year strategic plan for Gloucestershire. Informed by discussion with our partners and stakeholders (including patients, carers and the public), JUYC set out what our priorities will be over the next five years for our community to achieve our vision 'To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people'. This paper provides the governing body with updates planned to the draft plan ahead of the final submission to NHS England on 20th June 2014; highlighting any changes to be made as a result of engagement and feedback received alongside identifying the process for signing off the strategy.</p> <p>Within the Governing Body meeting in March 2014 the two year plan was approved. There have been a couple of minor amendments made to this plan in discussion with NHS England Area Team as part of our final submission. This paper describes the changes made, and attaches the final plan including amended appendices for ratification.</p> |
| Key Issues | <p>The key issues arising within JUYC and the two year plan are:</p> <ul style="list-style-type: none"> • The transformational change priorities for |

| | |
|--|--|
| | <p>GCCG and our health and care community;</p> <ul style="list-style-type: none"> • Enabling strategies required to support delivery. <p>The two year plan also specifically identifies:</p> <ul style="list-style-type: none"> • An overview of national targets and outcomes to be delivered, including the Better Care Fund indicators and local quality premium targets; • Financial plan assumptions, including the required QIPP programme; • Key risks to delivery for GCCG in 2014/15 and 2015/16. |
| Risk Issues: Original Risk Residual Risk | All risks are identified within section 14.4 of the two year plan. |
| Financial Impact | GCCG is planning to deliver a surplus in line with requirements. |
| Legal Issues (including NHS Constitution) | GCCG will meet its legal commitments contained within the NHS Constitution and other national guidance. These are set out in the main body of the report. |
| Impact on Health Inequalities | The priorities identified seek to make a positive impact on health inequalities within Gloucestershire. These are set out in the main body of the report. |
| Impact on Equality and Diversity | A due regard statement has been completed for the Better Care Fund. The finalised plans include an Equality Impact Assessment. |
| Impact on Sustainable Development | There are no direct sustainability implications contained within this report |
| Patient and Public Involvement | The plans are based on the JUYC strategic plan, which was subject to extensive public and partner engagement. Where required, individual areas of service transformation will subject to engagement, as appropriate. |

| | |
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| Recommendation | <p>The Governing Body is asked to:</p> <ul style="list-style-type: none"> • Note the planned developments to the five year plan; • Approve the timetable and support the authority for sign off by the Accountable Officer and Chair for the five year plan; • Note the latest version of the final two year delivery plan as presented. |
| Author & Designation | Kelly Matthews, Associate Director of Strategic Planning |
| Sponsoring Director (if not author) | Mary Hutton, Accountable Officer |

Governing Body

Thursday 29th May 2014

Joining Up Your Care: Two & Five Year Plan Update

1.0 Introduction

- 1.1 Joining Up Your Care (2014-2019) (JUYC) was shared with the Governing Body in March 2014, setting out the draft five year strategic plan for Gloucestershire. Informed by discussion with our partners and stakeholders (including patients, carers and the public), JUYC set out what our priorities will be over the next five years for our community to achieve our vision 'To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people'. This paper provides the governing body with updates planned to the draft plan ahead of the final submission to NHS England on 20th June 2014; highlighting any changes to be made as a result of engagement and feedback received alongside identifying the process for signing off the strategy.
- 1.2 Alongside the five year plan the final two-year plan is presented, identifying amendments made to the previous version of the two-year plan that was signed off at by the Governing Body on the 27th March 2014. The final versions of the amended elements are included within the appendices.
- 1.3 This two year plan provides an overview of our priorities to:
- Deliver improvements and change programmes in line with the vision and ambitions set out in JUYC, alongside the priorities identified in the national planning guidance ('Everyone Counts: Planning for Patients in 2014/15 to 2018/19');

- Ensure achievement of our performance and patient outcome improvements, including those identified within 'Everyone Counts' alongside the 'NHS Mandate 2013 to 2015';
- Ensure focus is maintained on the provision of high quality, safe services;
- Support the delivery of financial sustainability, ensuring value for money.

2.0 Update to the Five Year Plan

2.1 A draft version of the five year plan was shared with the Governing Body in March 2014 (and this remains the most up to date version), setting out the draft five year strategic plan for Gloucestershire. Informed by discussion with our partners and stakeholders (including patients, carers and the public), JUYC sets out what our priorities will be over the next five years for our community to achieve our vision 'To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people'.

2.2 We have been further developing the plan, in conjunction with our partners; whilst incorporating feedback received from stakeholder and partners including the Bath, Gloucestershire, Swindon, and Wiltshire NHSE Area Team to further refine the strategic ambition across the community.

The key themes of our development areas are not expected to fundamentally change the content of the strategy, but provide additional context and clarity to our community on how services will evolve for our patients over the coming five years. These developments include:

- 2.3
- **Developing the context within which our strategy is framed within; with a focus on the demographics and health of our population.**

The description of the health needs and health inequalities described as part of the plan generated by the iJSNA and based on the locality population profiles will be further expanded. GCCG will work collaboratively with Gloucestershire County Council Public Health colleagues to provide a more detailed picture of the specific needs and inequalities; ensuring a focus across ‘communities of interest’, those with ‘protected characteristics’ and groups frequently referred to as ‘seldom heard’.

- 2.4 Alongside this we will agree to continue developing the role of our local network from a housing perspective; to understand key demographic changes expected at a locality level over the next five years and the impact this will have on local health services.
- 2.5 **• Increased clarity through the articulation of the fundamental strategic building blocks to achieve our vision and ambitions as set out in the plan.**

The five year plan states the vision and ambitions for the community as outlined below.

Our shared vision for the next five years:

To improve health and wellbeing, we believe that by all¹ working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people.

Our ambitions

- People are provided with support to enable them to take more control of their own health and wellbeing. Those that are particularly vulnerable will benefit from additional support;
- People are provided with more support in their homes and local communities where safe and appropriate to do so,

¹ The health and care community in Gloucestershire consists of the Clinical Commissioning Group and main NHS service providers in the county, the County Council and District Councils, and colleagues representing the public and those representing the voluntary sector.

thus moving away from the traditional focus on hospital-based care;

- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

The five year plan will provide increased clarity on the strategic building blocks essential for whole systems development across all of our partner organisations, and delivery of the vision and ambitions as presented. This will identify the key strategic priorities and the priority change programmes to deliver real change for the people of Gloucestershire.

- 2.6
- **Ensuring there is a clear balance between the strategic intentions and key deliverables we expect to achieve; with a particular focus on the quality developments we will expect for our population.**

The final strategy will work towards defining the key deliverables for achieving the fundamentals of quality as described as part of the plan. We will incorporate key elements of the CCG Quality Implementation Plan to demonstrate how these fundamentals will form part of our everyday work.

- 2.7
- **The plan will identify the changes we would expect within our system on successful delivery of our vision and ambitions.**

Further development will be made to describe the current landscape across Gloucestershire and the change expected as a consequence of our strategic ambition. This will allow the impact expected to be demonstrated; so that the Gloucestershire population will have increased clarity on what the impact of our strategy will mean at an individual level. Alongside providing detail of the Gloucestershire landscape further discussion as part of the Joining Up Your Care Programme Board (JUYC PB) will provide understanding of the capacity and capability development required for delivery; for example what the changes proposed will mean from a workforce perspective.

3.0 Five Year Plan Timetable

3.1 During the coming months our priority will be finalising the five year plan and ensuring a focus on delivery. The five year plan is due for submission to NHS England on 20th June 2014; and the outline timetable below identifies the steps we intend to take prior to submission.

| | |
|----------------------------|--|
| May – 10th June 2014 | Plan re-draft under development |
| 10 th June 2014 | Final draft ready for discussion / sharing with key community partners (including the voluntary sector). |
| 17 th June 2014 | Final presentation to GHNHSFT, GCS, 2G and GCC for support (at JUYC PB). |
| 19 th June 2014 | Final plan shared with GCCG Development session for support. |
| 19 th June 2014 | Final sign off by Accountable Officer and Chair under delegated authority. |
| 20 th June 2014 | Final submission of five year plan to NHSE. |

3.2 There will be no GCCG Governing Body meeting in June 2014. Based upon the submission timescales set by NHS England, as detailed above, delegated authority is sought from the GCCG Governing Body for the GCCG Accountable Officer and Chair to sign off the final version of the 5 year plan.

4.0 Updates made within the two-year plan (JUYC, 2014/15 and 2015/16).

4.1 There have been some minor amendments to increase clarity of the component parts of the plan, including the process undertaken to develop and agree the plan. These are included within the two year plan (appendix A) and summarised as:

- As part of the introduction (section 1.0) a paragraph has

been added to describe the Equality Impact Assessment carried out and the organisations plans to periodically review the plan throughout the two-year period;

- Within Section 5.1, we described our expected activity growth, which has been updated to match our latest estimations of 2.1% per annum;
- In Section 7.2 (Ensuring quality and safe services) we have highlighted our approach to use the CQUINs to drive improvement;
- Within the Primary Care section (section 10.2) further clarification on the role of the unplanned admissions Directed Enhanced Service (DES) has been included;
- An increased focus on public health preventative schemes was highlighted within section 10.6;
- The financial allocations table displayed within section 13.1 has been revised to align to the latest estimations in terms of demand and activity shift, whilst the QIPP challenge table has been updated to represent the latest agreed savings expectations from themes in 2014/15.

4.2 In addition the paper strengthens the CCGs support to pump-prime change programmes (as also detailed within the annual budget paper), highlighting the financial risk mitigation strategies the CCG has in place to support financial management.

4.3 Following discussions with NHS England changes were made in respect of our performance priorities:

4.3.1 **NHS Constitution**

4.3.1.1 GCCG has highlighted its performance challenges in relation to the NHS Constitution. Both the 62-day cancer wait and 4 hour Emergency Department wait are highlighted as risks to delivery currently. Whilst both indicators are challenging GCCG have discussed our concerns with NHS England with regard to consistent delivery and will ensure action plans are in place to

assure end of year delivery.

4.3.2 7 Key Outcome Measures

4.3.2.1 There has been an update to the avoidable emergency admissions target. The number of emergency admissions / unplanned attendances counted within the composite metric has risen by an average of 4.7% per year. The original submission reflected a reduction in this growth value as opposed to an absolute reduction in the overall number of emergency admissions. Based on further review this now reflects the expected impact of QIPP schemes, alongside the quality premium impact, which will further reduce emergency admissions in 2014/15 and 2015/16. The overall reduction in growth is presented at 1.17% in each year.

4.3.3 Better Care Fund

There have been two small, technical changes to the Better Care Fund metrics which are summarised as:

4.3.3.1 Delayed Transfers Of Care (DTC) – The baseline value for this indicator has been adjusted to ensure a more accurate representation across the system. Subsequently the same level of ambition has been applied to the baseline metric and the numerator is now representative of monthly average instead of the total for the time period;

4.3.3.2 Avoidable Admissions - Changes are presentational and conform to an NHS England request for the metric to reflect monthly average as opposed to combined emergency admissions for the whole of the reporting period.

5.0 Recommendation(s)

5.1 The Governing Body is asked to:

- Note the planned developments to the five year plan;
- Approve the timetable and support the authority for sign off by the Accountable Officer and Chair for the five year plan;
- Note the latest version of the final two year delivery plan as presented.

6.0 Appendices

Appendix A – Final Two Year Plan (2014-2016)

Appendix B – Final Two Year Plan Performance Appendix.
(2014-2016)

Two Year Delivery Plan 2014/15 - 2015/16

Working towards delivering:



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1.0 Introduction

Joining Up Your Care (2014-2019), hereafter referred to as JUYC, sets out the five year plan for the development of Health and Social Care in Gloucestershire, as supported by all our community partners. This operational plan will outline the key priorities we will take forward in the first two years, in collaboration with our community partners and other stakeholders, to ensure the five year ambitions are realised. It acknowledges the commitment to delivering the objectives laid out in the five year plan, alongside working within the core principles as laid out in JUYC.

It is recognised both nationally and locally that health and social care faces significant challenges, and this plan will set out what that means for Gloucestershire over the next two years alongside the plans in place to ensure continued quality and value for money care.

This plan provides an overview of the priorities to:

- Deliver improvements and change programmes in line with the vision and ambition set out in JUYC;
- Ensure achievement of our performance and patient outcome improvements, including those identified within 'Everyone Counts: Planning for Patients in 2014/15 to 2018/19' alongside the 'NHS Mandate' 2013 to 2015;
- Ensure focus is maintained on high quality, safe services;
- Support the delivery of financial sustainability ensuring value for money.

Delivery of the priorities will be achieved by working with our partners across the system; most significantly through our work on integration (supported by the Better Care Fund), multi-stakeholder programme groups (including the Clinical Programme Groups (CPGs)), our localities and GP member practices; underpinned by patient and public involvement.

It should be noted that the plan has also been assessed using the Equality Impact Assessment, conducted on behalf of the CCG via the Central Southern Commissioning Support Unit, offering an independent evaluation that our delivery plan meets the needs of diverse population. The Commissioning plan

will be regularly reviewed during the two-year period, to take account of emerging priorities as they arise.

2.0 About Us

Gloucestershire Clinical Commissioning Group (CCG) is a single countywide CCG and is one of the largest in the country, serving a population of approximately 620,000. Our membership includes all of the 85 GP practices in Gloucestershire; the practices fall within the seven localities covering Cheltenham, North Cotswolds, South Cotswolds, Forest of Dean, Gloucester City, Stroud and Berkeley Vale, and Tewkesbury, Newent and Staunton.

Each locality has a GP Liaison Lead sitting on the CCG Governing Body and a Locality Executive Group, which supports two-way engagement with GP practices and ensures practices are not only able to input into the work of the CCG but also support delivery of priorities through the locality development plans. We also acknowledge that our GP practices provide vital intelligence for the CCG on local health needs and the reality of providing services on the ground; we therefore work with localities to drive local service developments and nurture strong links with local communities. Our plans reflect priorities that require delivery locally, in recognition of the role our member practices play in delivering the changes we propose (including delivery of our QIPP¹ challenge).

3.0 Developing the Plan

As part of developing JUYC we have undertaken extensive engagement with the public, staff, and key partners across our Health and Care Community to inform the priorities laid out in this plan. Initially we held multi agency groups, with a focus on utilising CPGs where lay representation is established, to review the opportunities for change within Gloucestershire; informed by evidence, best practice, outcomes and comparative performance (included spend). This allowed us to develop proposed priorities for discussion with the public.

¹ QIPP = Quality, Innovation, Productivity and Prevention; and is the term used to identify the change programme in place to deliver our required financial savings.

The public engagement was based upon patient illustration, using the fictional character of Jack, to tell people about the scale of the challenge we face in Gloucestershire, and by realising our plans 'Jack' illustrated what we want to achieve. The public engagement exercise for JUYC commenced on 2nd January 2014 for an eight-week period, and finished on 28th February 2014. A broad range of engagement methods were used to promote and facilitate feedback from patients, the public, local stakeholders, including elected representatives, and staff. We have used innovative approaches to help us reach a wider range of people than historically would be involved in such engagement work, both in terms of age and socio-economically.

The feedback from the engagement exercise has been incorporated into the priorities laid out in JUYC, and reflected into our two year priorities. We will continue to ensure the approach to patient engagement, as laid out in JUYC, is embedded within our work. There are two key elements to our approach: empowerment of individuals in terms of their own health and wellbeing and engaging citizens in service redesign and future change. Linked to this, following endorsement of this plan by the Board, we will produce a public facing document identifying our priorities over the next five years, and more specifically the two years covered by this plan.

4.0 Our Objectives

The tables below highlight the vision and ambitions across the Gloucestershire Health and Care Community, as supported by our partner organisations; alongside the objectives we as a CCG will work within to ensure our organisation delivers against our priorities, and achieves the vision and ambitions we have developed across the community.

Our Vision and Ambition as a Health and Care Community

As defined in the JUYC 2014-2019 plan, our shared vision across the Health and Care Community is:

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

Our ambitions are to ensure:

- People are provided with support to enable them to take greater responsibility for their own health and wellbeing. Those that are particularly vulnerable and can't help themselves will benefit from additional support;
- People are provided with more support in their homes and local communities where safe and appropriate to do so, thus moving away from the traditional focus on hospital-based care;
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

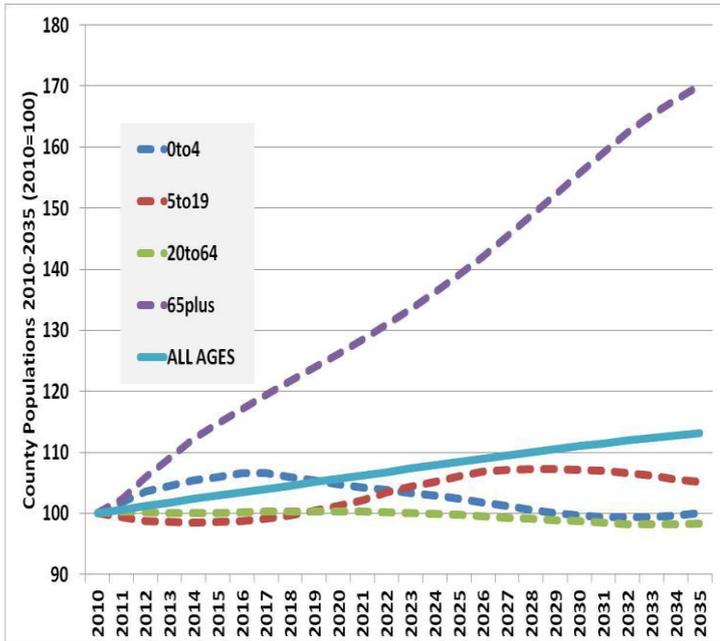
Our Objectives as an Organisation

Within Gloucestershire CCG we are committed to ensuring delivery of the ambitions laid out in JUYC (2014-2019) through the following objectives:

- (1) Develop strong, high quality, clinically effective and innovative services;
- (2) Work with patients, carers and the public to inform decision making;
- (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;
- (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;
- (6) Develop strong leadership as commissioners at all levels of the organisation, including localities.

5.0 Our Challenge

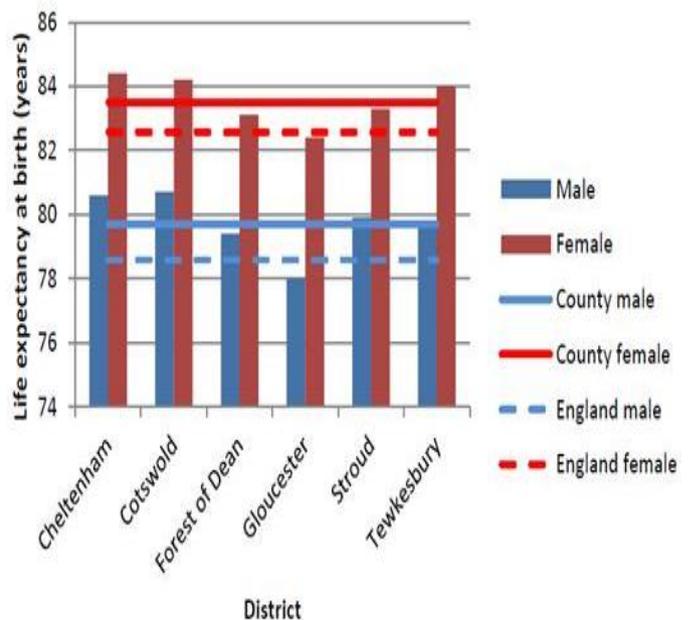
5.1 Demographic Growth



- A significant proportion of the population is over 65 years old; and this segment of our population is growing. The number of people aged 90 and over is growing at an even faster rate and will double over the next 15 years.
- By 2035, people aged over 65 will account for over a quarter of Gloucestershire’s population. As life expectancy increases so will the number of people who live with a long-term condition.
- If nothing changes, emergency and elective activity is expected to grow at circa 2.1% per annum

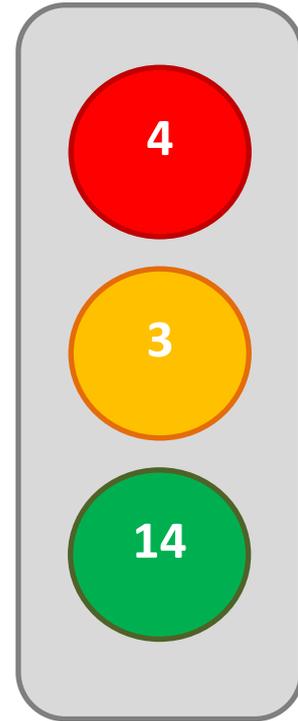
5.2 Health Inequalities

- In Gloucestershire whilst the average life expectancy for men is 79.3 years and women it is 83.2 years across the entire county, there are noted differences between localities within our county.
- Gloucester City residents live fewer years than any other district.
- In Gloucester City on average men live to 78.0 years compared to 80.7 years in the Cotswolds. Women in Gloucester live 82.4 years compared to 84.4 years in Cheltenham.
- The life expectancy of Gloucester City residents is below the England average for both men and women.

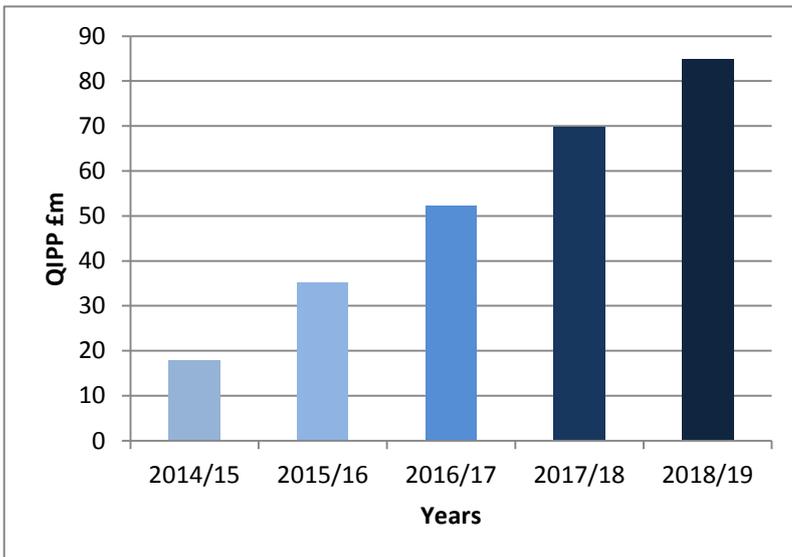


5.3 Our Performance Challenge

- Based on our 2013/14 performance, out of 21 key indicators, 14 are Green rated, 3 are Amber and 4 are Red rated.
- We are aware of our challenges and are committed to improving:
 - Consistency of 18 week Referral-To-Treatment access target (including a focus on long waiters);
 - 4 hour wait within Emergency Departments;
 - Category A (Red 1 & 2)* ambulance response times;
 - 62 day cancer target;
 - 2 week wait target (Breast Specific).



5.4 Our Financial Challenge



- Our cumulative financial challenge stands at £85m over the next five years.
- This equates to £17.8m in 2014/15 and £35.5m in 2015/16.

The priorities presented in this plan will set out how we intend to meet these challenges.

*8mins response at least 75% of all **Category A (Red 1)** incidents (immediately life threatening conditions), and **Category A (Red 2)** incidents may be life threatening conditions but less time critical

6.0 What We Strive To Achieve

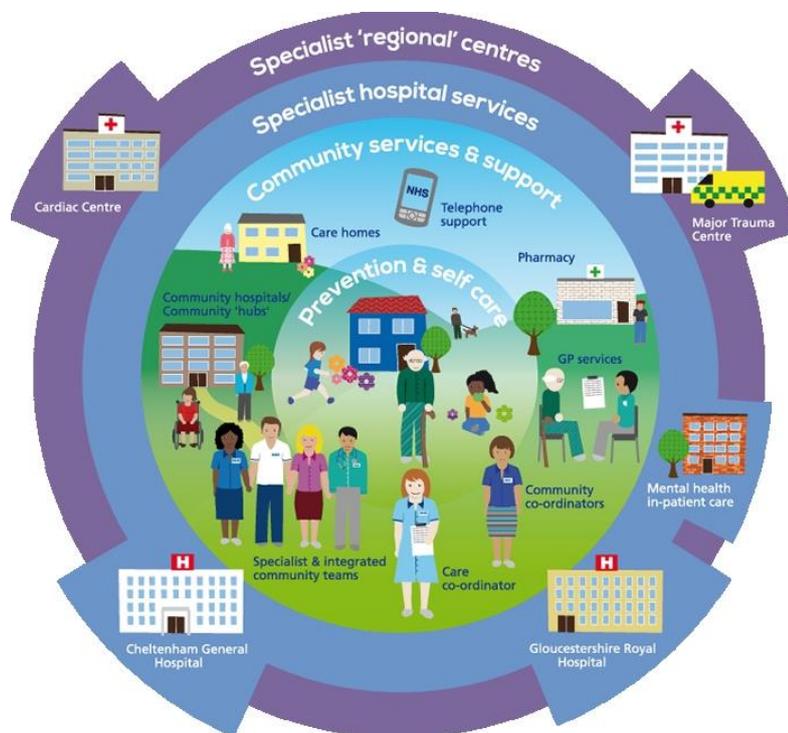
Our Shared Vision for the next Five years:

To improve health and wellbeing, we believe that by all² working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people.

Our Ambitions

- People are provided with support to enable them to take more control of their own health and wellbeing. Those that are particularly vulnerable will benefit from additional support;
- People are provided with more support in their homes and local communities where safe and appropriate to do so, thus moving away from the traditional focus on hospital-based care;
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

This vision is illustrated in the following diagram:



² The health and care community in Gloucestershire consists of the Clinical Commissioning Group and main NHS service providers in the county, the County Council and District Councils, and colleagues representing the public and those representing the voluntary sector.

How are we going to work together to make all this happen?

We have agreed a set of principles as the foundation of our collaborative working:

- A person-centred approach, where organisational boundaries are less important than the outcome and experience for each individual;
- To build stronger, more sustainable communities and in turn improve the health and wellbeing of local people, we will draw upon, and stimulate the provision of, the diverse range of assets within each local community;
- We will adopt a “one system, one budget” approach. This means the money we have available can only be spent once to achieve the best possible outcomes for all local people, regardless of organisational boundaries. This will be implemented through:
 - Utilising a clinical programme approach, where we identify the budget for a specific condition and review the whole clinical and care pathway from prevention to end of life. The aims include achieving the best possible outcomes within available resources, whilst also reducing waste, harm and variation;
 - Exploring and testing the use of innovative forms of contracting, enabling individual providers to work together collaboratively to deliver elements of a care pathway or service, working to shared objectives;
 - Maximising the opportunities to commission services jointly across health and care organisations.

We will design the most efficient and effective services possible:

- Agreeing the best route people take through their care. Care pathways will be a key mechanism for change and will be developed based on evidence of best practice, maximising the use of available technology. The pathways must then be implemented to ensure people access the right care, in the

right place, at the right time; services, where appropriate, will be available seven days a week;

- We will create a systematic approach to delivering transformational change, training a wide range of staff across our Health and Care Community on an ongoing basis. When designing services, we believe a relentless focus on reducing the time patients spend waiting will deliver the most efficient care.

7.0 Focus on the Essentials

There are a number of essential elements that will apply across our delivery programme.

7.1 Equity of Access

In Gloucestershire the equality of access to services is a key component in the consideration and development of our programme, aiming to ensure equitable services across the community based on patient need. As part of this approach we seek to achieve parity of esteem for mental health in comparison to physical healthcare; ensuring that all patients receive the appropriate and tailored care they require to improve outcomes relating to the mental health of our local population. In addition as part of the 'Our Journey for Quality:2014-2019' strategy the CCG has developed an ethical framework to support the decision making process within commissioning.

Our focus on equality of access to services embodies the intelligence of local public health priorities and our commitment to the NHS Constitution, to improve outcomes and ensure safe services. Across both health and social care, we remain aware that minority groups need specifically tailored services, which suit their circumstances to enable them to access services. We undertake Equality Impact Assessments on our plans for engagement and communications in order to identify any groups who are likely to require targeted activities. A range of methods are employed to engage with such groups, frequently referred to as

'seldom heard' such as recruiting 'community surveyors' to undertake on the ground engagement within communities of interest.

7.2 Ensuring Quality and Safe Services

'Our Journey for Quality: 2014-2019' aims to weave quality throughout the operation and business of Gloucestershire CCG; working alongside our key partners. It has been informed and driven by the Francis Inquiries (2010 & 2013), the Winterbourne View Report, Berwick Report (2012), Keogh Reports (2013), 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 (HQIIP) influences and contributes to the strategy. Our quality plan on a page is set out in Appendix B.

The strategy sets out the approach to our journey for quality, providing clear expectations for all our provider organisations. We actively will ensure we do the right thing, at the right time for the right patient, on an ongoing basis. Discussions regarding quality will be at the centre of our provider relationship, with formalised quarterly Clinical Quality Review Groups for each provider contract in place, in conjunction with the formal provider contract board. Linkage between these two groups ensures quality and patient safety issues are integral, to support continual learning and improvement in patient care. The integral elements to ensuring implementation of our quality strategy are shown in Appendix B.

We are using the NHS Contract, specifically the Commissioning for Quality and Innovation (CQUIN) schedule, to ensure delivery of improvements in quality across our providers. Using the CQUIN we will be rolling out the Friends and Family Test (FFT) across services during 2014/15 (building into Day Cases, Outpatients, Mental Health and Community services alongside staff); with the rest of services to follow by the end of March 2015. This CQUIN will be included within all our major contracts, including our independent providers. The information provided will be reviewed with providers as part of the already established Clinical Quality Review Groups. Providers such as

GHNHSFT are working on offering real time feedback to hospital wards to support the identification of opportunities to improve patient experience

7.3 Equality and Diversity

Gloucestershire CCG is committed, in partnership with Gloucestershire County Council (GCC) 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.

Our equality objectives are 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 the demographic profile of Gloucestershire by protected characteristics and identify variations in health needs to enable staff to undertake meaningful equality impact analysis on the work as it develops;
- Support staff to put equality/reduction in health inequalities at the centre of the commissioning cycle.

8.0 Our Approach to Delivery

As part of the approach for the five-year strategic plan initiatives have been developed across the Health and Care Community. These have been subject to a prioritisation exercise within GCCG, to ensure the priority schemes for 2014/15 and 2015/16 are progressed.

The change programme is presented within three broad themes:

- **Transformation of the System:** Changes to be delivered across our system that fundamentally change the way that we work; impacting on multiple organisations and acting as key enablers to specific change programmes. A core part of this theme is our approach to delivering the Better Care Fund³.
- **Service Change Priorities:** Changes within key development areas of prevention and self-care, primary care, urgent care and planned care. These changes will focus on the improvements within each area of the system to support delivery of our overall ambitions.
- **Clinical Programme Developments:** Identifies the priority developments to be led as an entire clinical programme area, where service improvement work is focused around a clinical pathway bringing together and joining-up all aspects of a person's clinical and social care needs.

A diagrammatic representation of the key schemes included for 2014/15 and 2015/16 is shown in Appendix A; with an overview description of each area shown in the following sections.

³ announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.

9.0 Transformation of the System

The following changes are to be delivered across our system that will fundamentally change the way that we work:

9.1 Integration

In Gloucestershire we have already made significant progress regarding integration, developing patient centred care across our community services. Our direction of travel is now supported by the Better Care Fund for more joined up care across Gloucestershire. Our Better Care Fund plans are shown within Appendix D. Key developments within the two year plan (explained in further detail within the Better Care Fund) include:



- Development of our Integrated Commissioning function to maximise the opportunities through joint commissioning, adopting the principle of “one system, one budget”;
- Exploring the contractual models available to us to support integrated, outcome focussed services;
- Our priorities for the integration of community services, as shown within section 9.4.

9.2 Care Pathways

Care Pathways are designed to support the implementation of clinical guidelines and protocols, providing structured, multidisciplinary plans of care including progress and outcome details. Our vision is for an accessible system which can be easily kept up to date; which ensures that pathway information is used routinely so that people receive the right care in the right place at the right time. Key developments within this two year plan include:



- Agree the Health and Care Community Approach to Care Pathway development;
- Ensure the required supporting technology is in place to ensure clinicians and patients can access information in a timely and accessible way;
- Implement within the priority pathways identified within the Clinical Programme Areas;
- Development and implementation of the Shared Decision Making approach, starting with Musculoskeletal Services (described in more detail in section 10.1).

A number of our work areas look at how we can proactively improve pathways, linking to the key principles highlighted by section 11. The clinical programme approach will include pathway redesign in our priority areas (such as Respiratory, MSK and Paediatrics, please see section 11 for further detail); in addition, we will look at:

- Women's Health: Evaluate and review maternity services pathway; with the aim of improving outcomes and patient experience for women and their families within Gloucestershire;

- Diabetes: The over-arching service development priority for diabetes is to re-design the overall model of care whereby all non-complex/generalist diabetes care is provided by primary and community healthcare teams; this to be achieved by our priority developments of:
 - Skilling up and resourcing of primary and community healthcare teams to deliver all generalist diabetes care;
 - Contracting with acute care to provide specialist care only;
 - Expanding structured and bespoke education programmes;
 - The provision of self-care/self-management tools.
- In addition to these priorities within Diabetes we will review (and re-design if necessary) the Diabetes Foot Care pathway, as well as the provision of Diabetes Care in care homes (with a focus on carers, staff and residents).

9.3 Innovation and System Wide Thinking

We will work across the Gloucestershire Health and Care Community to develop a sustainable model to drive innovation, service redesign and development. Over the next two years we will:

- Develop a joint approach (including the composite training programmes) to transformational change across the Health and Care Community;
- Build capacity around systems leadership, change management and service improvement tools and techniques;
- We intend to take advantage of innovation opportunities within our developments, establishing a robust framework to enable and



support clinical research and development in line with our Quality Strategy (see Appendix B).

9.4 Effective Utilisation of Sites and Services; with focus on Seven Day Services

We will work across the Gloucestershire Health and Care Community to ensure optimal and efficient utilisation of services and resources, where appropriate offering services seven days a week. Over the next two years we will:

- Develop and implement seven day services (as appropriate) initially focussing on the 10 Clinical Standards⁴ prescribed by NHS England to develop the key outcomes for seven-day provision. We will also be focussing on monitoring and reducing the mortality rates on the weekend, supporting the development of measurable indicators of equitable treatment throughout the care pathway. This will be reflected as ongoing developments within the contracts with our providers across the community. Our Approach is also reflected in the Better Care Fund;
- The development of a Community Services Commissioning Plan will include a focus on ensuring efficient utilisation of the range of community sites and services;
- Review of how we use physical premises to ensure effective utilisation. Part of this is to explore the development of community hubs to enable closer working between services (statutory and non-statutory), providing a patient-based focus.



⁴ NHS England Board held Dec 2013; issued 10 Clinical Standards ranging from Patient Experience to wait times for reviews and interventions as well as the link to diagnostics and Primary Care

9.5 Technology Innovation

Gloucestershire CCG is committed to supporting innovative ways of increasing the efficiency of Information Management systems, alongside managing patient data securely. Our plans support:

- Improvements to data quality, analytical tools and support services, allowing us to better monitor and forecast activity, costs, outcomes;
- Becoming smarter in the use of information and knowledge (the evidence-base) to inform our decision-making;
- Ensuring Information Management and Technology (IM&T) requirements and opportunities are routinely considered as an integral part of any proposed improvement plans.

The four main themes of the IM&T Plan we have developed with our partners, and will progress over the next two years are:

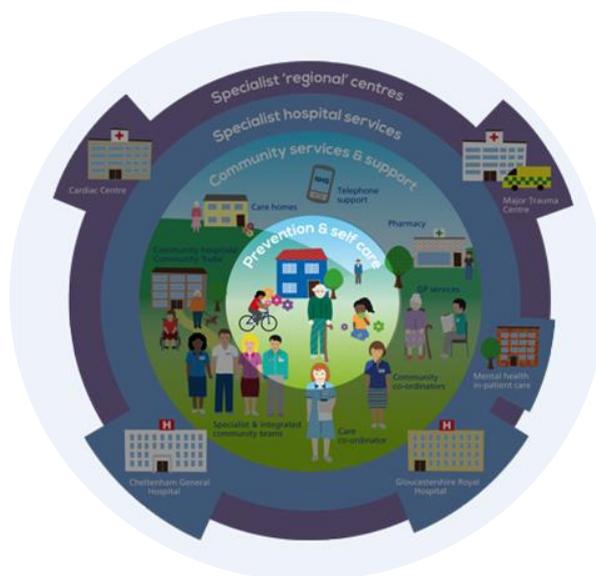
- (1) **Commissioning Enablement.** Fundamental to our Care Pathways work programme this work-stream will include clinician decision support tools; alongside looking at commissioning intelligence (linking to the risk stratification programme), knowledge management and corporate e-communications;
- (2) **Integrated Care included shared records.** This work-stream will involve developing secure patient and / or client record sharing across the Health and Care Community (in line with Information Governance principles), under the principles of integration and interoperability.
- (3) **Patient and Citizen Empowerment.** Fundamental to the self-care agenda this work stream will look at the range of tools and techniques to provide information, feedback or support (such as the use of telehealth, social media, and texting services).
- (4) **Enabling Infrastructure.** This will be developed as required to support the other work-streams, and covers Information Governance, data standards, Informatics and I.T. support services, training and I.T. infrastructure.

10.0 Service Change Priorities

These changes will focus on the improvements within each area of the system to support delivery of our overall ambitions.

10.1 Prevention and Self Care

Working jointly with a wide range of partners from the statutory, voluntary and community services (VCS) sector, we will ensure an increased emphasis is placed on prevention, self-care and self-management approaches across our community, to ensure that patients are empowered to take control of their own health and well-being. We recognise our partners across health, social care, voluntary care, alongside patients, carers and their families, will play a vital role in developing and embedding our Prevention and Self-care Strategy.



Key developments within the two-year plan include:

- Continue to jointly implement Weight Management Services across Gloucestershire;
- Ensure effective utilisation of the well-being services available at a locality level through a co-ordinated approach (termed Social Prescribing);
- Work with our partners to develop the role of Telehealth as part of the patient pathway, including establishing the link to the Integrated Community Teams (ICTs).
- The development of a Shared Decision-Making, Self-care and Prevention Strategy that will inform a systematic and evidence based approach to self-management. The focus will be to ensure patients are empowered to make decisions about their health, as

they often experience more favourable health outcomes. The approach will then be embedded into the clinical programme approach, for a consistent, formalised approach across pathways of care. This work will link into the further development of personalised care plans;

- An integral part of the self-care and prevention programme will be the key role carers play in supporting the care we provide, alongside understanding the needs of the person they care for. Locally we are progressing with the carers agenda and will continue to implement our local 'Joint Carers Commissioning Strategy 2013-2016', aimed at ensuring carers:
 - Have appropriate and timely advice and support;
 - Have access to take an individual budget;
 - Have appropriate support to access the services they need;
 - That flexible breaks provision is in place to meet the needs of carers and their families;
 - That support is available to carers to help maintain their health and wellbeing;
 - Are supported in their caring role and have opportunities to maintain a good quality of life.
- We acknowledge that personal health budgets offer a new tool to support self-management and care planning with patients as partners in the management of long-term conditions. We are aware of the challenges this will bring in terms of the way services are currently commissioned, funded, contracted for and provided and will ensure that in line with national guidance our local population is supported in their right to request a personal health budget. We are setting up a Personal Health Budget Steering Group to continue to work towards the implementation of personal health budgets over the coming year to ensure that a collaborative multi-organisational approach is developed.
- Alongside GCC we will continue to support preventative schemes aiming to improve lifestyles and reduce health inequalities such as the smoking cessation and Making Every Contact Count (MECC).

We consider effective working with Public Health essential to taking the self-care priorities forward.

10.2 Primary Care

As defined in JUYC, demand for primary medical care has grown over a number of years with patient consultation rates more than doubling and length of consultations increasing. With a rising older population and high prevalence of long-term conditions, primary care will need to adapt to new ways of working in order to remain sustainable for the future. As our work plans also reflect our commitment on the “£5 per head improving services for over 75 year olds” we will work in partnership with NHS England as the lead commissioner for primary care, to ensure we can face these challenges.



Key developments within the two-year plan include:

- Support primary care to develop new ways of working; including a greater role for technology in service delivery and expansion in the range of services offered locally. Developing innovative approaches to the provision of care will be fundamental to meeting the demand for primary care in the future, with a focus on empowering patients;
- Implementation of the Care Homes, DVT pathway and Diabetes pathway Enhanced Services, providing new integrated models for specialised care delivered in a phased approach and with extended rollout across the county;
- As part of the planning assumptions, invest in a Primary Care Offer Enhanced Service to support the development of quality services and the urgent care agenda. The table below highlights the key building blocks which support the development of the Primary Care Offer. The development of the new enhanced service has been undertaken in conjunction with local GPs and Practice Managers.

This co-production approach has been well received and the final specification has been supported by the Area Team (NHS England), Local Medical Committee and CCG Locality Executive Groups.

- Developing Care Pathways focussing on improving continuity of care and reduce duplication with professionals working closer together to coordinate the persons care;

Table 1 Primary Care Offer Building Blocks

The Building Blocks:

| | | | |
|---|--|--|---|
| <p>[1] <i>Improving Quality in Primary Care</i> MANDATORY (20%)</p> | <p>[2] <i>Enhanced Primary Care</i> OPTIONAL</p> | <p>[3] <i>Supporting the Urgent Care Agenda</i> OPTIONAL</p> | <p>[4] <i>Influencing Clinical Commissioning</i> OPTIONAL</p> |
|---|--|--|---|

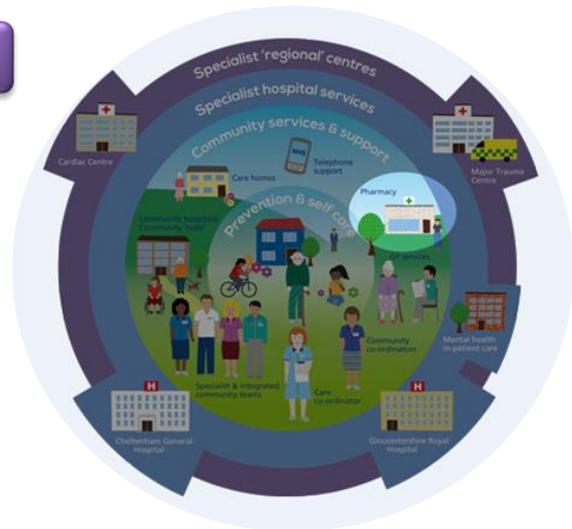
- Supporting the development of the Unplanned Admissions DES, this aims to reduce avoidable admissions, improving services for the most vulnerable patients. To support the delivery of the new Enhanced Service, GP practices will use a risk stratification tool to aid in identifying vulnerable patients at highest risk of unplanned admission for proactive case management.

This activity will contribute to the delivery of the five-year strategy for primary care, which aims to provide easy access to high quality primary care delivered close to patients’ homes and reduce unnecessary use of emergency hospital care. Joint commissioning of services across the health, social care and third sector communities will support the development of a more integrated approach to out of hospital care, with primary care at the centre of this system.

10.3 Medicines Optimisation

We will maintain the focus for medicines optimisation through five key areas, which are:

- Utilise current national best practice principles to maximise clinical effectiveness and cost effectiveness, encouraging increased prescribing of generic medicines and locally recommended formulary drug choices;
- Medicines optimisation will be a central element in the development of integrated care pathways and the review of care pathways, ensuring that appropriate clinically evidenced medicines are recommended for use;
- We will work collaboratively with the Gloucestershire health community, social care and public health to maximise clinical and cost effective medicine use, for the benefit and convenience of the patient;
- Maximise safe medicines use by the development of primary care initiatives to identify areas where safer medicines use could be achieved, and support the local implementation of associated actions;
- Reduce the amount of wasted medicines in Gloucestershire, working with colleagues in the Gloucestershire Health Community and Community Pharmacies, to ensure that patients receive the maximum benefit from the medicines they have been prescribed.



In 2015/16 the above work areas of focus will continue, including increased prescribing of key drugs with patents expiring and formulary compliance. Additional areas of focus will be centralised supply of ostomy products, rheumatology, pain management drugs reviews; and increased medicines optimisation in integrated care pathways.

This will be developed integrally with the clinical programme approach as part of a pathway of care.

10.4 Community Care

Significantly linked to our priority programmes of work, we recognise community development is fundamental over the next two years to realise our ambition. We will:

- Develop a detailed five year Community Care Commissioning Plan. Work streams will be developed through a series of 'How we care for people when they?':
 - Need a diagnostic test;
 - Have a minor injury;
 - Have one or more long term condition(s) and may or may not require reablement;
 - Require intensive specialist support in their own home;
 - Require rehabilitation and/or reablement following an acute clinical event;
 - Need surgery

This work will be underpinned by ensuring appropriate access to services across the community;

- Countywide Implementation of Integrated Community Health and Social Care Teams (ICT), covering Rapid Response and High Intensity Service to ensure patients receive care management and prevent escalation into an emergency admission;
- Development of the Community Hospitals programme which focuses on utilisation of hospital beds whilst ensuring appropriate use of resources.
- Development of the ICT model to incorporate a greater connection with Mental Health care pathways, alongside adopting Living Well Principles and an Asset Based Community Development (ABCD)



approach; ensuring the patient is at the centre of any care provided taking consideration of any well-being support required to help them to stay at home.

- Focus on the development of further key community pathways such as continence and enteral feeds;
- Maintain a focus on Continuing Healthcare.
- Work with our providers to improve utilisation of our theatres and outpatient Clinics across the county;
- Work collaboratively with our partners on the pathway of care for homeless patients to be discharged into accommodation. We will aim to reduce recurring emergency attendances through increasing access to mainstream community services

10.5 Urgent Care

Within urgent care it is essential we are building an equitable, sustainable and high quality service across the Health and Social Care Community. The challenges facing our urgent care system in Gloucestershire are clear, which provides us with a foundation for identifying the opportunities for improvement. The five key elements within our Urgent Care Plan for the next two years include:

- Self-Care: recognising the role self-care and self-management will make towards managing the demand within the urgent care system;
- Signposting: to ensure clear understanding of the services available hence promoting appropriate use of the urgent care system, for both clinicians and patients;
- Acute Care: When patients are admitted to ensure there are services available for the optimal pathways of care;



- Networks and Discharge: will focus on ensuring planning for discharge is paramount, enabled through services across the Health and Social Care Community.

Following the Keogh review of Urgent and Emergency Care Services (2013), we will maintain high quality emergency care services by developing plans for a Major Emergency Centre within Gloucestershire. We will continue to work on securing our strategic position in response to the Keogh Report and emergency care tiered approach.

Through the development of the Urgent Care Network, which is a multi-organisational group to understand our challenges within urgent care; we will work collaboratively in ensuring that when people require hospital care their discharge from hospital is communicated with GPs, undertaken in a timely and appropriate way. We will continue to build upon the work that has started within Gloucestershire with our major local NHS providers, which has identified key aspects of work that will ensure any delays within the system are minimised, alongside ensuring we effectively manage the demands on our urgent care system.

The following priorities have been identified within urgent care to address the key elements described above:

- Through a Streamlining Urgent Care programme ensure the Urgent Care pathway is clearly defined, and supported by a clear model of services;
- Continued development of the Ambulatory Emergency Care and Older People's Assessment and Liaison (OPAL) service's to support patient flow at the front door of the acute trust;
- Improve patient flow through the Emergency Department and emergency admissions through an Integrated Discharge Team through the support of alternative pathways at the front door alongside a focus on discharge planning;
- Ensure a clear model of care is in place across the community hospitals and teams, supporting emergency admissions through Single Point of Clinical Access alongside key rehabilitation pathways.

- Work across SWAST⁵, NHS111 and Gloucestershire Care Services (GCS) to ensure efficient use of Minor Injury Services across the community.
- Risk Stratification: Utilisation of the risk stratification tool to support the unplanned admissions Direct Enhanced Service which focuses on patients over 75 years of age, aimed at reducing the number of acute emergency attendances and admissions;
- SWAST Right Care: Working with the Ambulance Trust to increase the amount of patients being cared for at home either via telecommunications (Hear & Treat) or through a visit (See & Treat).

Further developments linked to CPGs and other priority areas include:

- Agree and implement an integrated urgent care respiratory pathway for children.
- Implementation of Respiratory pathway, supported by Integrated Specialist Teams;
- Expansion of the Mental Health Liaison service within the acute trust, developing flexible working in line with demand for services;
- The implementation of the ICTs is expected to have a considerable impact within urgent care admissions.

Delivery of the national and local performance indicators represents a major challenge for the urgent care work programme going forward, the schemes highlighted above identify the impacts to deliver the performance targets in line with the NHS Constitution and contribute to the seven core National Outcome Ambitions (see section 12).

⁵ South West Ambulance Service NHS Trust

10.6 Planned Care

Our aim for planned care continues to be ensuring that people access timely and high quality diagnostics, assessment and treatment. In order to achieve this, the following priorities have been identified within planned care:

- A focus on demand management to ensure consistency of referrals for our population. Initially in 2014/15 we will implement further recommendations within primary care (developed from our Peer Review scheme); to inform the longer term solution within which we can ensure patients are seen by the right person, in the right place, at the right time;
- Continued utilisation of Advice and Guidance services, providing consultant level advice to GPs in order to manage patients in Primary Care;
- Encouraging preventative measures prior to planned procedures such as the 'Stop before the Op' campaign to help improve outcomes following treatment;
- Develop clear pathways for follow up care based on agreed care pathways, focussing initially within Musculoskeletal and Respiratory services (working with the relevant CPGs such as Ophthalmology);
- Focus on evidence based pathways offering appropriate thresholds;
- Promotion of patient choice for a range of planned services including diagnostics (enabled through the Any Qualified Provider contracts), outpatients and a range of day case procedure's (to ensure effective utilisation of available providers).

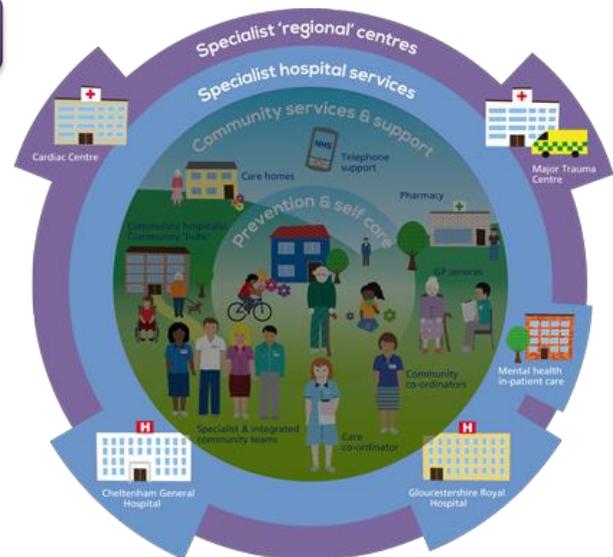


10.7 Specialised Services

Our vision for patients with complex or rare health needs; is that they should always receive the highest quality specialised care which should be seamlessly joined-up with all other aspects of their care, regardless of whether they are accessing local, regional or national specialised care.

Our approach to specialist commissioning is to work collaboratively with NHS England; the lead commissioner. During 2013/14 a key priority has been the introduction of the new National Service Specifications for specialised care. The majority of the specialised services for our population are compliant with the specifications.

For the few services that did not meet the specifications either the local provider is leading an agreed development plan or a redesign process to incorporate care within a wider regional pathway. So far, one service, Cystic Fibrosis in-patient care, has been moved to a regional centre with local outpatient and physiotherapy clinics, implementing a hub and spoke model. In the near future we anticipate a strategic review led by NHS England will examine a small number of other services, for example Primary Percutaneous Coronary Intervention (PPCI). We will ensure the patient voice is heard in this process and that local clinical experts are fully involved in this work.



11.0 Clinical Programme Priorities

We are asking groups of clinicians, supported by managers to own the entire pathways and maximise resources to deliver better outcomes for Gloucestershire. The Clinical Programme Groups (CPGs) will focus on opportunities to improve outcomes to ensure we offer the right care, at the right time, ensuring our services operate in an efficient and affordable way.

The objectives will be achieved by applying the following principles:

- Patients will be supported to self-care or self-manage where appropriate to do so;
- The development of integrated pathways, joining up care between primary, community and acute specialist services;
- More cost and clinically-effective prescribing;
- Focussing on outcomes of the service we commission;

The priority developments to be led as an entire clinical programme area, where service improvement work is focused around a clinical pathway, are summarised below.

11.1 Respiratory

The ongoing development of respiratory services continues; during the next two years we will continue to drive forward a wide and varied work programme including the following priorities:

- Further development of respiratory services such as Home Oxygen Assessment & Review Service and the (community based) Gloucestershire Respiratory Team (GRT);
- Reduction of non-elective admissions for chronic obstructive pulmonary disease (COPD) by developing further integration with the GRT and implementation of Respiratory Hot Clinics;

- Redesign of non-elective respiratory pathways including the application of a CQUIN to support a move to a more structured admission and the implementation of a Discharge Care Bundle to reduce length of stay;
- Review of other services and pathways including bronchiectasis, pleural effusion, cough, sleep apnoea and pneumonia;
- A review of the opportunities to introduce more cost-effective prescribing.

11.2 Cardiovascular

Cardiovascular Disease (CVD) is an overarching term that describes a family of diseases sharing a set of common risk factors. This plan largely focusses on conditions causing or resulting from atherosclerosis, in particular coronary heart disease and stroke. The CPG's objective is to improve the outcomes and quality of care for people with or at risk of cardiovascular disease, bringing care closer to home where possible.

The priority programmes of work will include:

- Review pathways of care, initially to include Arrhythmia and Heart Failure;
- Stroke Care: Identifying and addressing gaps in rehabilitation provision whilst increasing Thrombolysis rates in line with national benchmarks;
- Frail Older People CVD Reviews: Multi-Disciplinary Team (MDT) approach to reviewing frail/complex older people with cardiovascular problems;
- Leg Ulcers: Ensure provision of an equitable service within the community across Gloucestershire.

11.3 Cancer

Some cancers are preventable and we will support our population to make the healthy life choices that reduce their risk factors. However for everyone that does develop the disease we are committed to ensuring the best possible health outcomes and compassionate care.

Our priority work programmes will include:

- Supporting the NHS England national screening programme, we will aim to improve earlier diagnosis. The work programme will include an education programme, practice and locality support and advice and guidance; alongside alignment to the primary care offer;
- Launching a programme to develop our approach for Cancer Survivorship during 2014/15; working with partners across the health, social care and voluntary community services. Our plan is to adopt and develop the recommendations of the National Cancer Survivorship Initiative for our local population;
- A focus on patient experience, we will develop a systematic approach to understanding and improving patient experience across the entire pathway;
- A programme of best practice and affordable care audits against peer group health communities will be undertaken on selected pathways to ensure we are identifying areas where we can improve the financial sustainability and quality of cancer services.

The CCG will be working closely with our providers to improve performance with Gloucestershire CCG and Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) both reviewing the referral management process and increase GP engagement within this specialty through the Cancer CPG.

11.4 Mental Health

The Mental Health and Wellbeing Strategy for Gloucestershire reflects the national strategy “No Health without Mental Health”, seeking to achieve parity of esteem for mental health with physical healthcare and improve outcomes relating to the mental health of all the people of Gloucestershire. The strategy recognises that significant changes are required, and therefore sustained effort and strong partnership working will be required to deliver the proposed outcomes.

Our priority programmes of work will include:

- Improve access and pathways to mental health crisis services to develop a crisis care pathway agreement;
- Implement integrated clinical care pathway across mental and physical health care, ensuring increased access to psychological therapies. The integrated pathway approach will focus on ensuring a timely assessment process is in place, improving the interface between services, and embedding a ‘Think Family’ approach which encourages consideration of the wider needs of families and carers not just the referred person for equality of care across physical and mental health;
- Improve access to psychiatric liaison services, to ensure comprehensive assessment of both the mental and physical health of patients. This work programme will include aligning the service to meet demand, ensure comprehensive assessment and regular reviews are in place, educating and up-skilling health staff and supporting the early detection of mental health problems;
- Increase access to recovery focussed care pathways for people with serious mental health conditions, using an innovative approach;
- Ensuring a focus on the needs of vulnerable children, including looked after children, those with mental health needs (including self-harm), and children with long term conditions;

- Expansion of the Children and Adolescent Mental Health Service (CAMHS) to meet the increase in demand, working with mental health providers to support the delivery of: a wide range of therapeutic consultations, developing Improving Access to Psychological Therapies (IAPT) training, and undertaking of evidenced-based interventions such as Interpersonal Psychotherapy and Family Therapy.

11.5 Musculoskeletal

The CPG continues to develop the commissioning of integrated Musculoskeletal (MSK) services across the patient pathway.

Our priority programmes of work to progress towards this aim will include:

- Full implementation of an interface service across the county to ensure full exploration of options with patients; with review and evaluation to support the development of the full clinical pathway solution. This piece of work will include reviewing the use of diagnostics within the interface service;
- Pathways and Thresholds: This piece of work aims to build upon the successful clinical engagement on pathway development in 2013/14; in order to develop clear, clinically agreed thresholds for MSK related procedures (supported by using referral templates) and ensure that these are built into contractual arrangements with providers;
- Development of the Interface: This work stream will focus on the further development of the interface service to increase its effectiveness. The key component will be the structured use of shared decision making, increased MDT working with frail elderly and development and use of conservative management pathways and preventative approaches;

- We will review Physiotherapy and Podiatry services across the community, linking in with the pathway approach.
- Review the follow up pathways of care supporting patients to return home and be followed up, where required, closer to home;
- In addition, MSK will also have key priority areas to deliver best practice in the development of pathways for Fracture Neck of Femur, alongside reviewing opportunities within Rheumatology and Pain Management.

11.6 Ophthalmology

Intelligence from local and national sources has indicated the potential for increasing demand over the next five years, due to an increasing age profile, co-morbidities and improved identification of eye disease in primary and secondary care. There are also a number of ophthalmology related NICE Technology Appraisals (TA); which combined with the demand increases expected places real pressure on the capacity and overall healthcare resources to fund this, if model remains unchanged within local Ophthalmology services

In order to ensure delivery of a quality ophthalmology service, underpinned by clear clinical outcomes, our proposed priority over the next two years is to develop an outcome based contractual model, to support the delivery of integrated care across primary and secondary care to offer more effective mechanisms to deliver outcomes and improved pathways within the available resource.

11.7 Paediatrics

The overall aim of the Children's CPG is to support improvements in health outcomes, secure high quality services for the local population and to ensure effective use of resources.

In order to achieve these aims our priority work programmes over the next two years will be:

- Responding to national requirements such as:
 - Developing processes and systems to allow for the introduction of Personal Health Budgets;
 - Implications of legislative changes from the Children and Families Bill for services for children with Special Educational Needs and Disabilities (SEND);
- Ensure a focus on the emergency care pathway (in particular respiratory), supported by an Urgent Telephone Advice Service and other service redesign initiatives across the pathway, to ensure children are seen by the most appropriate clinician in the most appropriate place, and reducing unnecessary unplanned hospital admissions where possible;
- In response to the increase in demand for mental health services and the increased incidence in deliberate self-harm amongst children & young people, we will:
 - Work with partners across the statutory and voluntary sectors (including the County Council, the three NHS Trusts, the Police, Schools) to redesign pathways and systems to ensure timely access to assessment and support in the most appropriate settings;
 - This will include monitoring the use of additional investment in the 2gether NHS Foundation Trust Children & Young People Service in order to target its use as effectively as possible including the use of evidenced-based interventions;
- Further pathway reviews will include non-urgent respiratory care and continence services;
- Implement a new contract for the provision of initial Health Assessments for looked after children (tender process undertaken in 2013/14);
- Introduce changes to responsibilities for aspects of purchasing and supply of specialist equipment to other providers in line with the review of the Integrated Community Equipment Service.

11.8 Learning Disabilities

A key responsibility is to address health inequalities amongst people with a learning disability responding to recommendations made in both the Mansell Report (2007) and Winterbourne View Report (2012). Gloucestershire CCG will ensure a joined up approach between health and social care and other services providing for a community based network of support.

Our priorities for the next two years will include:

- The development of a Learning Disabilities Intensive Support Service (LDISS) in the community to increase patients ability to stay in their own home reducing the need for patients to require crisis emergency support and reducing our dependence on assessment and treatment beds;
- Reconfiguration of Assessment and Treatment Beds enabling us to provide a more person centred service that safely meets complex needs for people;
- Review of Specialist Community Teams to ensure the service is reflective of the health needs within Gloucestershire;
- We will focus on the integration of health and social services for people with Learning Disabilities, to ensure we deliver services in a joined up way;
- Offering community based services to transform the delivery of care to people with Learning Disabilities away from institutional or defined packages of care, and towards a fully integrated and inclusive lifestyle model.

11.9 Frail Elderly

Frailty describes a limited ability to withstand stresses such as co-morbidities, and as such is complex and challenging for health and social care planning. The vision for Gloucestershire is that frail older people will live well in their communities.

Our priorities for the next two years will include:

- **Dementia:** The programme continues to build on the themes and priorities identified in the National Dementia Strategy (2009) as described in a county action plan based on joint health and social care investment: Engaging our partners including people living with dementia and carers, we will achieve deliverables such as improving training and education, and reducing the wait time for diagnostics including for younger people, this programme of work fundamentally links to delivery of our performance trajectory, as outlined in Appendix C
- **Falls and Bone Health:** We recognise there is an opportunity for reducing falls and fractures by shifting resources from acute interventions; to prevention and community support. This will require both pathway mapping that informs a service redesign and a multi-agency approach to deliver person centred care.
- **Frailty pathway:** embedding a frailty pathway to reduce falls and resulting fractures as well as impacting on emergency admissions activity and costs.
- **OPAL (Older Peoples Assessment and Liaison):** the CPG has a role to delivering this initiative as described as part of the Streamlining Urgent Care Model (see Urgent Care Section on pg14).

12.0 Improved Outcomes for Patients

The focus of 'Joining up Your Care' is to transform services in a way that improves outcomes for our population both now and in the future. Within this approach we will focus on:

- Improvement in outcomes (including the five domains and seven outcomes indicators as prescribed by NHS England⁶);
- Improving the health of people in Gloucestershire, not just managing them when they are ill;
- Maintaining emphasis on reducing health inequalities, including tackling variation between our commissioning localities;
- We are committed in our work to ensure parity of esteem with equality between mental health and physical health;
- Ensuring the voice of our patients and public is heard to inform our priorities and ensuring we deliver in line with our aspirations.

The clinical programme approach supports this focus, providing a transparent framework for defining the best health outcomes possible for the population within the resource available and commissioning services to deliver these outcomes.

- The CPGs have utilised the Spend Outcome factsheets and Tool (SPOT) to identify benchmarked outcomes; which has informed our priority programmes for 2014 to 2016 alongside our benchmarked financial outcomes;
- We are aware, however, that the outcome set is limited within this tool and we are working locally to expand the outcome information available to the CPGs, starting with Ophthalmology and MSK (NB Cancer already has a substantial national outcome set and other CPGs require review for which additional support has been employed by the Quality Team);

⁶ Everyone Counts: Planning for Patients 2014/15 to 2018/19, NHS England, December 2013

- The principles for developing an outcomes approach are summarised as:
 - Outcomes should be meaningful and measurable;
 - Measures are for the whole population impacted within a given clinical programme area and not based on provider performance indicators;
 - The measures should be applied to conditions that can demonstrate amenability and sensitivity to intervention;
 - The scope of outcomes measured should include patient reported and service level outcome measures;
 - Process measures can be used as proxies if useful where no suitable outcome measure exists (particularly in order to capture intermediate measures where outcomes are longer term);
 - Measures should take account of the whole pathway, ideally across all interventions including where a patient has declined or not been accepted for an intervention (e.g. where shared decision-making has been part of the process).

- The outcomes already available and those required for the future have been mapped, based on the relevant evidence and recommendations from professional bodies. We will be working towards developing and embedding this through 2014 – 2016;

- The outcomes will form part of a dashboard available to CPGs, accounting for the fact that delivery of improved outcomes in some areas will be incremental.

Alongside our local developments the national performance standards set by NHS England are designed for a more outcome focussed approach. The national framework categorises the outcomes we aim to achieve through three main requirements:

- ‘Everyone Counts’: Ambitions for Gloucestershire CCG for seven key outcome measures;
- Quality Premium ambitions (including one locally defined);

- Better Care Fund national and local ambitions.

Appendix C highlights our key ambitions and target performance over the next two financial years for each of these areas; identifying the actions we will undertake to ensure delivery in line with our trajectory.

12.1 NHS Constitution

Gloucestershire CCG is committed to delivering the constitutional rights and pledges for patients in Gloucestershire. The NHS constitution forms an integral part of the Gloucestershire CCG performance framework. The constitutional rights are monitored along with other key local and national measures which form an overview of Gloucestershire CCG in year performance. The framework is reviewed by the CCG Governing Body bi-monthly with interim reports review by the CCG Directors.

Constitutional measures are also reported to NHS England as part of the CCG Assurance Framework and to Gloucestershire Health Care Overview and Scrutiny Committee (HCOSC) bi-monthly.

Commissioning performance dashboards cover the 2013/14 'Everyone Counts' targets, NHS Constitution commitments and key 'local offer' commitments. These are available to all CCG staff via the Gloucestershire CCG intranet and are updated regularly.

Gloucestershire CCG performance against the constitutional rights and pledges is monitored by NHS England. Domain two of the CCG assurance framework is based on the key deliverables set out within the 'Everyone Counts' planning guidance.

For 2014/15 the framework will reflect the level of challenge and actions required to ensure delivery over the course of the next two years, for further information please see Appendix C.

The CCG is committed to deliver all NHS constitutional performance targets; however we have concerns regarding the aggregate full year achievement of the following two targets in 2014/15:

- **62 Day Cancer Wait:** An action plan is in place to address capacity issues within certain specialties, alongside focusing on diagnostic delays within the pathway. It is anticipated that sustainable achievement will be achieved from July 2014 onwards.
- **4 hour Emergency Department Wait:** Delivery of the 4 hour wait is achievable, but felt to be very challenging and has been highlighted as a high risk for us. GCCG has focussed on working with providers and co-commissioners to make improvements across the urgent care system, and this work will continue during 2014/15. An independent assessment will be commissioned to determine the root causes of the underperformance, to ensure detailed action plans are in place in support of delivery against this target.

13.0 Financial Overview

13.1 The Financial Challenge

The CCG receives two financial allocations from NHS England, a programme allocation and a running cost allocation. The programme allocation funds all expenditure on health care services, the running cost allocation funds the cost of the CCG. The table below identifies the allocations we would expect to receive in 2014/15 and 2015/16:

| | 2013/14 £m | 2014/15 £m | 2015/16 £m |
|------------------------------------|---------------|---------------|---------------|
| Programme Cost Allocation | 653.538 | 667.524 | 678.872 |
| Impact of 13/14 changes | | (3.189) | (3.189) |
| Revised Allocation | 653.538 | 664.335 | 675.683 |
| Programme Allocation Growth | | 2.14% | 1.7% |

| | 2013/14 £m | 2014/15 £m | 2015/16 £m |
|--|---------------|---------------|---------------|
| Running Cost Allocation | 15.090 | 15.053 | 13.535 |
| Change in running cost allocation | | -0.25% | -10.08% |

The changes in allocation represents minimum growth as per national funding formulae, with programme increases of 2.14% in 2014/15 and 1.7% in 2015/16. The 2015/16 position also includes a 10% reduction in the running cost allocations.

The key planning assumptions applied over 2014/15 and 2015/16 are summarised as:

- A required surplus of 1% is assumed each year;
- Contingency is assumed at 1% each year;
- In line with national guidance headroom is planned at 2.5% in 2014/15 (£16.7m) and 1% in 2015/16 (£6.9m).
- Further detail is provided within the Annual Budget paper

13.2 Better Care Fund

The Better Care Fund was announced in the summer of 2013 as a mechanism to transform local services so that people are provided with better integrated care and support. The 2014/15 and 2015/16 Gloucestershire position is made up as follows:

| Gloucestershire Position | 2014/15 £000's | 2015/16 £000s |
|---------------------------|-------------------|------------------|
| Social Care Capital Grant | | 1,409 |
| Disabled Facilities Grant | | 2,550 |
| Existing Funding Transfer | 11,596 | 11,596 |
| New Funding Transfer | | 24,393 |
| Total Fund | 11,596 | 39,948 |

These monies are not new monies to the community and in order to release monies for investment elsewhere savings schemes must deliver transformational changes.

14.0 QIPP Challenge

The cumulative QIPP gap for Gloucestershire CCG over the next five years represents a significant challenge of £85m. Within 2014/15 and 2015/16 the QIPP challenge equates to £17.8m and £17.7m respectively. The key work plans to deliver the QIPP savings required in 2014/15 are shown in the table below:

| Change Theme | Programmes of work which will generate financial savings | 2014/15 Impact expected from the change programme(s) (£'000) |
|-----------------------|---|--|
| Community Care | <i>Community Care programmes include the development of the community hospital bed service model, a focus on Counting Healthcare alongside the enhanced service model for Care Homes.</i> | £1,961 |
| Integration | <i>Countywide implementation of Integrated Community Teams</i> | £3,458 |
| CPGs | <i>The model for commissioning Telehealth</i> | £900 |
| | <i>Respiratory pathway developments.</i> | £830 |
| | <i>Clinical Programme Approach to Ophthalmology</i> | £683 |
| | <i>Musculoskeletal pathway developments (including threshold management and the use of the interface services)</i> | £600 |
| | <i>Other clinical programme areas including Diabetes, Frail Elderly, and Paediatrics</i> | £1,370 |

| Change Theme | Programmes of work which will generate financial savings | 2014/15 Impact expected from the change programme(s) (£'000) |
|------------------------------|---|---|
| Learning Disabilities | <i>Learning Disabilities Intensive Support Service, Assessment and Treatment Beds and Joint Funding</i> | £800 |
| Mental Health | <i>MH pathways of care, with a focus on Liaison Services</i> | £330 |
| Planned Care | <i>A focus on pathways & thresholds, including service utilisation, follow up care and adherence to agreed policies and specifications.</i> | £915 |
| | <i>Demand Management initiatives including primary care based demand management and the utilisation of advice and guidance services</i> | £621 |
| Prescribing | <i>An approach to medicines optimisation, including primary care prescribing, reduction of waste, working in partnership with secondary care and Oxygen Assessment for Home Oxygen Services.</i> | £2,710 |
| Unscheduled Care | <i>Integrated Discharge Team</i> | £530 |
| | <i>Effective pathways of care at the front door to the emergency department including Ambulatory Emergency Care, Hot Clinics in Cardiology and Respiratory, and clinical advice service within NHS 111.</i> | £507 |
| | <i>Enhanced Service in primary care for the DVT pathway.</i> | £290 |
| Other | <i>Other QIPP schemes</i> | £1,310 |
| Total | | £17,815 |

It should be noted the savings from the schemes above are intended to impact across the system, and some will require investment in order to deliver the changes required. The investment is outlined in the separate Annual Budget paper. We recognise the significant transformational change required to deliver the QIPP schemes and the role our partners will play in delivering the agenda.

In order to support delivery of the QIPP challenge, funding has been provided to pump prime transformational change. To enable the management of risks during the year, a 0.5% contingency reserve, alongside a demand reserve of a further 0.5%, has been included within the CCG's budgets. In order to mitigate the risk of QIPP delivery, the CCG will take an holistic approach to the release of such funds, together with other developments, and this will be carefully monitored throughout the year; their availability being dependent on the realisation of planned QIPP project milestones (financial and non-financial). This process will be operated in parallel to increasing the financial management awareness throughout the organisation (including member practices)

15.0 Governance: How We Will Ensure Delivery

Gloucestershire CCG will ensure a robust governance system is in place to support delivery of the priorities as laid out in the two-year operational plan.

15.1 Alignment to JUYC

The priorities identified within the two year plan ensure alignment and delivery of the strategic principles agreed across the Health and Care Community as part of JUYC; incorporating the national requirements to be delivered. This approach ensures sign up from key partners; alongside an effective governance framework involving clinical partners in support of delivery (as also presented in the five year plan). Due to the focus on system transformation within this plan a community governance structure is essential for delivery. The governance is well established, key points to note are:

- The entire structure includes integrated forums for the health, social care and other key stakeholders organisations to work together;
- The Terms of Reference for all the groups will be assessed to ensure clarity of decision making and advisory authority in relation to the key strategic components of the plan;
- Integrated delivery groups will be in place to support the various programmes of work; and will be accountable for designing, implementing, programme and performance managing the individual programmes and projects.

The strategy alignment also continues alongside recognising the operating plan defines some bespoke actions to be delivered as part of a wider programme of work for Gloucestershire CCG; encouraging evolution, development and enhancement to the way services are and will be commissioned.

15.2 Programme Management

A project and programme governance framework is in place which provides a rigorous, multi-disciplinary, assessment of schemes from initiation to implementation. The framework includes the following key components to ensure focus is placed on delivery:

- The framework is underpinned by an agreed decision making process, which defines authorisation sign off using the scheme of delegation;
- A Prioritisation Framework is in place, and has been applied through the development of the five and two year plans to assess the priorities for engagement, alongside inclusion within the five and two year plans. The prioritisation process is in place to ensure utilisation of resources is transparent, rational, fair and evidence based, whilst underpinned by patient experience and health outcomes.
- Scheme progress will be tracked through their development, implementation and benefits realisation via a web based reporting

system, which will help to ensure that they progress smoothly, quickly and effectively through their lifecycle and that slippage against progress will be highlighted.

Delivery of the expected changes and outcomes is fundamental to the enhancement of patient care. Benefits realisation across a range of indicators including patient outcomes and experience, clinical feedback, quality, safety, patient activities and financial elements are key to the evaluation and development of the service re-design programme.

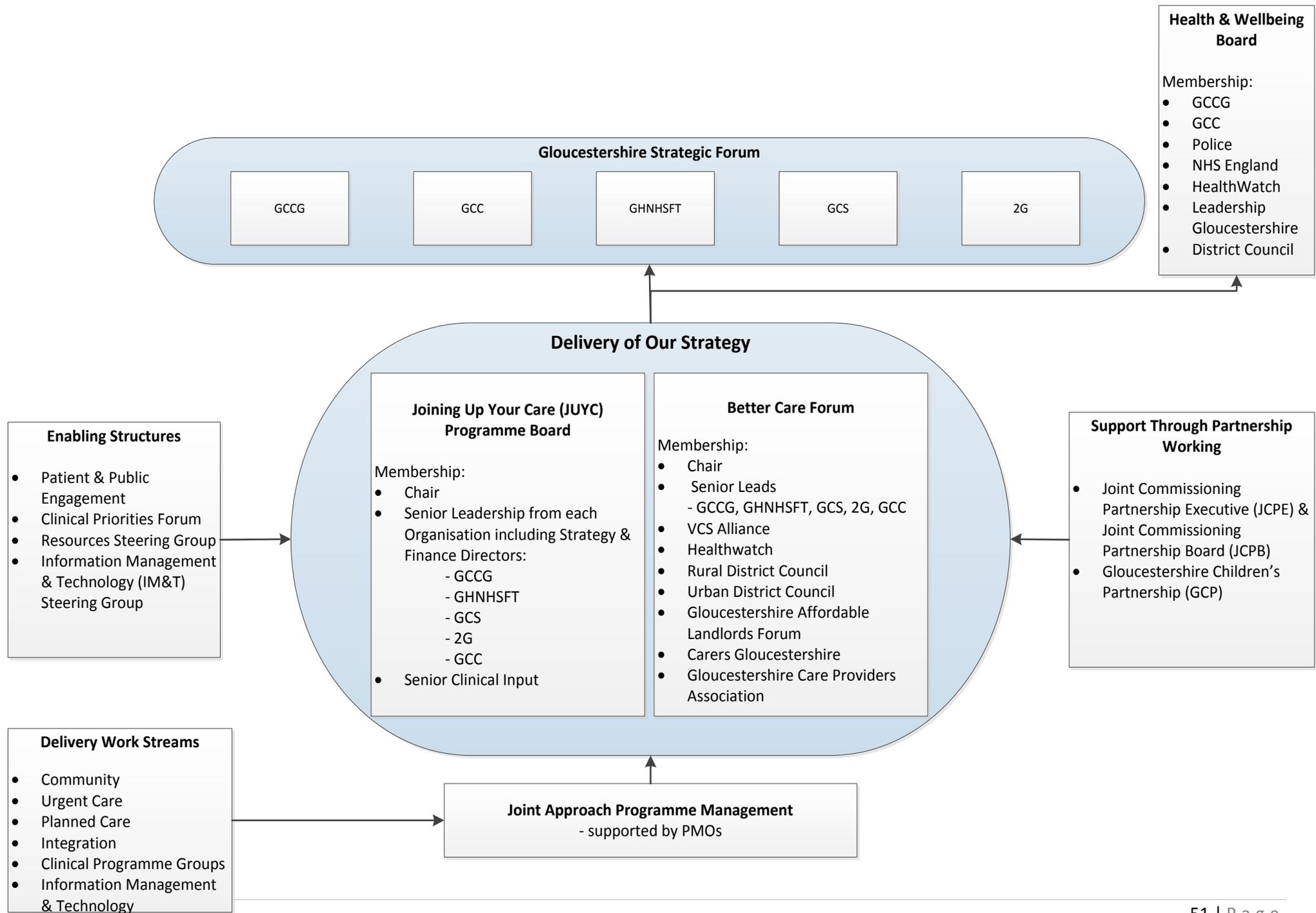


Figure 1 Gloucestershire Governance Roadmap

15.3 Contractual Management

The use of the NHS Standard Contract, including incentives and levers, will be applied to ensure the contractual frameworks support the CCG priorities for delivery. Within the contract agreements with our main providers the Service Development Improvement Plan (SDIP) schedule outlines the agreed QIPP programme for the financial year, including financial risk share agreements, supported by the CQUIN schedule for quality enhancements. Alongside this Gloucestershire CCG will progress the development of contractual approaches, which support delivery of the large scale system change presented. Of the transformational approaches that can be taken to care pathway commissioning, the main two for consideration in Gloucestershire are summarised in the table below:

| Approach | Benefits | Considerations | Pricing approach |
|--|--|---|--|
| Lead Contractor Contract with provider who is responsible for management and delivery of whole care pathway. This provider may not be largest provider in pathways but focuses on delivery | <ul style="list-style-type: none"> • Reduced inefficiency • Improved pathway coordination • Commissioner has one contract to manage | <ul style="list-style-type: none"> • How will patient choice be supported • Commissioner retains accountability for services commissioned, but is reliant on prime contractor holding subcontractors to account | <ul style="list-style-type: none"> • Risk share • Gain Share • Capitation funding (subject to payment by results (PbR) rules & code of conduct) |
| Alliance Contracting Separate contracts with individual providers but with shared objectives | <ul style="list-style-type: none"> • Reduced inefficiency • Improved pathway coordination | <ul style="list-style-type: none"> • Relies on strong working relationships between providers • Need to be clear about where responsibility for delivery lies. | <ul style="list-style-type: none"> • Risk share • Gain Share |

It will be clear that no one size fits all model could be deployed, and each programme area considered for an alternative approach to contractual models will be assessed in its own right.

Gloucestershire CCG is committed to working collaboratively with South Central Commissioning Support Unit (CSU) to provide some key functions to the CCG where the benefits of an operation at scale across numerous CCGs can be realised. The CCG will retain informatics, IT, HR and corporate service lines with South Central CSU with a contract being extended to April 2016. A condition of this extension is a review of the specifications, key performance indicators (KPIs), penalties and financial value associated with these service lines. A process of efficiency improvement has also been agreed with the CSU whereby they commit to realise savings in the provision of these services which will be passed on to the CCG over the next two years.

15.4 Risk Management

The responsibility for monitoring risk on behalf of Gloucestershire CCG is delegated to the Integrated Governance Committee (IGC). A corporate Risk Register is in place; collating organisational, programme and directorate risks. Managerial and clinical leadership to the management of risks (as appropriate) is in place; with routine updates in place.

In relation to the Two Year Delivery Plan specifically the following risks and mitigating actions should be noted:

| Risk | Level of Risk (H,M,L) | Action |
|---|-----------------------|---|
| Level of transformational QIPP is not realised, impacting ability to deliver recurrent savings. | High | Established Programme Management Office processes are in place. QIPP plan aligned to the agreed work programmes, building on developments already progressing in 2013/14. Accountability and risk share arrangements to be included in contracts. |
| Engagement of member practices in delivery. | Medium | Engagement with member practices and localities has commenced. Locality development plans are in place, and will be refreshed during 2014/15. |
| Individual organisation work plans divert resources from joint initiatives | Medium | Joint working arrangements in place. Alignment of organisational plans, as far as possible, is fundamental. |
| Demographic growth is higher than anticipated, creating a demand pressure within services. | Medium | Demographic growth and incidence rate has informed the calculation, with local knowledge incorporated into planning assumptions. Discussions are ongoing with partners to sign off. |
| Prescribing growth greater than expected levels | Medium | Robust Medicines Management QIPP plan and Joint Formulary in place. Engagement with clinicians is on-going and some contingency has been built into the plan. |
| In year cost pressures impact on affordability | Medium | Robust planning and modelling assumptions utilised to develop Medium Term Financial Planning; including feedback from commissioner leads and integration with developed commissioning intentions. Systems and processes being established for in year management. |

| Risk | Level of Risk (H,M,L) | Action |
|--|-----------------------|--|
| Challenges to deliver required performance targets | Medium | Robust performance management in place. Action plans to be in place for areas requiring improvement. Change programmes in place to contribute towards delivery. |
| Public, patients or stakeholders challenge plans. | Low | Engagement exercise completed regarding the priorities of JUYC. Regular representation within clinical programme developments. |
| Lack of staff engagement and staff development could limit the achievement of objectives | Low | Organisational Development plan is in place and will be refreshed to ensure it continues to meet the needs of the organisation. Senior Managers within organisation developing an appraisal process. |

Appendices

Appendix A – 2014-2016 Programme Map

Appendix B – Our Journey for Quality 2014-2019, Plan on a Page

Appendix C – Performance and Outcomes

Appendix D – Better Care Fund Overview

16.0 Recommendations

The Governing Body is asked to:

- Approve the final two year operating plan as presented;
- Approve the attached Better Care Fund plan including financials and performance indicator's as presented;
- Acknowledge the risks to delivery and mitigating actions.

Everyone counts – Ambitions for GCCG for 7 key outcome measures

| Outcome ambition | Outcome framework measure | Baseline | 2014/15 Ambition | 2015/16 Ambition | Support measures | Plans for delivery |
|--|--|----------|--------------------------|--------------------------|---|--|
| 1. Securing additional years of life for the people of England with treatable mental and physical health conditions. | Potential years of life lost to conditions amenable to healthcare in the respective calendar year per 100,000 population | 1753.6 | 1725.9 (1.6% reduction) | 1698.6 (1.6% reduction) | None | <ul style="list-style-type: none"> Map the impact of identified QIPP schemes on this measure Impact from our health promotion work agenda. |
| 2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions. | Health-related quality of life for people with long-term conditions | 75.0 | 75.1 | 75.2 | <p>Increase dementia diagnosis rate to 67% by March 2015 and maintain in 2015/16.</p> <p>Maintain IAPT recovery rate of 50%</p> | <ul style="list-style-type: none"> Outcome focus for Clinical programme groups Establish/ review pathways for specific cohorts of patients, prioritising diabetes, COPD, respiratory and stroke. Implementation of integrated care teams To promote improved quality of life GCCG have set a challenging target to improve dementia diagnosis rates from 56% to 67%. <ul style="list-style-type: none"> Revisit work to improve diagnosis of dementia in care home residents Primary Care Dementia Pathway to support increased diagnosis of dementia in primary care Cancer, focus on patient experience Alignment of mental health liaison services with acute provider |
| 3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital. | Composite of all avoidable emergency admissions | 1824.7 | 1803.4 (1.17% reduction) | 1784.2 (1.17% reduction) | None | <ul style="list-style-type: none"> Implementation of integrated community teams and creation of virtual wards and rapid response teams Urgent care strategy, OPAL, IDT and AEC Review of primary out of hours service provision SWAST right care right place initiative Emergency admissions for children with lower respiratory infections – review pathway |
| 4. Increasing the proportion of older people living independently at home following discharge from hospital. | No indicator available at CCG level. | | | | Adult social care outcomes framework indicator on re-ablement / rehabilitation | <p>BCF ambition to improve performance from 71.6% to 77.5% by March 2015.</p> <ul style="list-style-type: none"> Re-ablement pathway review Increased access to domiciliary care Stroke high intensity service <p>The Gloucestershire ambition is to increase access to the service, whilst improving the proportion of people who are able to live at home (see BCF ambition 4)</p> |
| 5. Increasing the number of people having a positive experience of hospital care. | Patient experience of inpatient care (average number of negative responses per 100 patients) | 147.0 | 146.1 | 145.2 | None | <ul style="list-style-type: none"> Patient experience CQUIN has been included in contracts to promote improvements Extension of the Friends and Family test across services during 2014/15 (building into Day Cases, Outpatients, Staff, Mental Health and Community services); with the rest of services to follow by the end of March 2015. |
| 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. | Patient experience of primary care (average number of negative responses per 100 patients) | 4.1 | 4.1 | 4.1 | None | <ul style="list-style-type: none"> Primary care LES – improving quality in primary care OOH tender |
| 7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care. | National indicator is in development. | | | | Health care acquired infections | <p>Gloucestershire have adopted the national set target for clostridium difficile of less than 201 cases & 0 cases of MRSA.</p> <ul style="list-style-type: none"> RCA (Root Cause Analysis (localised)) of each case continues. Local Task & Finish Group reviews C.diff outcome data and mitigating actions. Including: <ul style="list-style-type: none"> Practices to review all patients over 80 years on PPIs using Eclipse Live audits. Request prescribing of PPI as STAR PU by practice. Ribotyping of all C diff cases Continuous education and information to GPs via multi media |

Quality Premium ambitions

| NHS Outcome framework domain | Quality premium measure | Baseline | 2014/15 Ambition | Plans for delivery |
|--|--|----------|-----------------------------|--|
| 1. Preventing people from dying prematurely | Potential years of life lost to conditions amenable to healthcare in the respective calendar year per 100,000 population | 1753.6 | 1725.9 (1.6% reduction) | See 7 key ambition section – ambition 1 for further information. |
| 2. Enhancing quality of life for people with long term conditions | Improving access to psychological therapies (IAPT) | 12.0% | 15.0% | <ul style="list-style-type: none"> • Recurrent investment of £250k from 2014/15 onwards to increase capacity • Full implementation of intermediate care teams • New care pathways for anxiety and depression • IAPT working with GP practice to identify patients for intervention |
| 3: Helping people to recover from episodes of ill health or following injury | Composite of all avoidable emergency admissions | 1824.7 | 1803.4 (1.17% reduction) | <p>2014/15 ambition from 14/15 profiled quarterly.</p> <ul style="list-style-type: none"> • 0.6% reduction from Q1 to Q2 • 0.4% reduction from Q2 to Q3 • 0.2% reduction from Q3 to Q4 <p>See 7 key ambition section – ambition 3 for further information</p> |
| 4. Ensuring that people have a positive experience of care. | Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set | | | See 7 key ambition section – ambition 6 for further information |
| 5. Treating and caring for people in a safe environment and protecting them from avoidable harm | Improved reporting of medication-related safety incidents | | | This is in the process of being agreed with the HWB as plans are developed further iterations will be taken for discussion and sign off. |
| 6. Further local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England | Emergency admissions for children with lower respiratory tract infection. | 539 | 527 | <p>Emergency admissions for children with lower respiratory infections:</p> <ul style="list-style-type: none"> • A joint CCG, GCS and GHT work programme to review admissions and look at patient pathways has been established |

Better Care Fund national and local ambitions

| BCF ambition | NHS outcomes framework | Adult social care outcomes framework | BCF national / Local metric | Baseline | 2014/15 Ambition | 2015/16 Ambition | Plans for delivery |
|--|--------------------------------|--------------------------------------|-----------------------------|------------------------------------|------------------|------------------|--|
| Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population. | | 2A(ii) | ✓ national | 791 (April 2012 - March 2013) | N/A | 731.9 | <ul style="list-style-type: none"> Revise integrated discharge team pathways to improve timely discharge to reduce dependency enabling more people to remain in their normal place of residency. Impact of increased re-ablement capacity and review of re-ablement pathways Implementation of telecare ICTs enabling treatment in own home and reducing hospital admissions reducing dependency |
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services | 3.6(i) | 2B(i) | ✓ national | 71.6% (April 2012 - March 2013) | N/A | 77.5% | <ul style="list-style-type: none"> Review of re-ablement pathway with increased access to re-ablement services and domiciliary care. Integrated community teams, high intensity service implementation |
| Delayed transfers of care from hospital per 100,000 population (average per month) | | 2C(i) | ✓ national | 322.5 (Dec 2012 - May 2013) | 315.4 | 308.6 | <ul style="list-style-type: none"> Urgent care working group focus on delayed discharge |
| Avoidable emergency admissions (composite measure): <ul style="list-style-type: none"> Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) Unplanned hospitalisation for asthma, diabetes and epilepsy in children Emergency admissions for acute conditions that should not usually require hospital admission (all ages) Emergency admissions for children with lower respiratory tract infection. | 2.3(i) 2.3(ii) 3a 3.2 | | ✓ national | 162.1 (Oct 2012 - Sept 2013) | 159.3 | 158.0 | <ul style="list-style-type: none"> Revise IDT pathways Integrated community teams, rapid response and HIS CHC increase in capacity See 7 key ambition section – ambition 3 for further information and Quality Premium 3 Note: The methodology for this target is a monthly average. |
| Patient / service user experience (GCCG has chosen to use the national measure which is under development) | Domain 4 | Domain 3 | ✓ national | | | | <ul style="list-style-type: none"> Patient experience CQUIN has been included in contracts to promote improvements. Extension of the Friends and Family test across services during 2014/15 (building into Day Cases, Outpatients, Staff, Mental Health and Community services); with the rest of services to follow by the end of March 2015. |
| Adult Social Care Outcomes Framework - 1D: Carer-reported quality of life | | 1D | ✓ local | 7.7 | 7.9 | 8.1 | <ul style="list-style-type: none"> Review current results to establish areas of improvement Development of plan with GCC & implementation during summer 2014 Repeat of survey November 2014, evaluation of results to establish the impact of changes Further action plan if required in 2015 |

Measures of Success 2014/15 to 2015/16

NHS Constitution – National Standards for Access to Care with National Targets

| Reference | Description | Target | 2013/14 | 2014/15 (RAG status) | 2015/16 (RAG status) | Plan for Delivery |
|-----------|--|--------|---------|----------------------|----------------------|--|
| CB_B1 | The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis | 90% | 92.7% | | | <ul style="list-style-type: none"> Continued maintenance of target during 14/15 and 15/16 Clinical and diagnostic capacity issues within Urology. Recruitment of consultants and increased CT & pathology capacity to be completed by Q1 2014 Pressure on performance due to increase demand for services within Ophthalmology and Cardiology, schemes relating to demand management are being worked up to include expansion of Peer Review and Advice & Guidance. |
| CB_B2 | The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period | 95% | 97.4% | | | |
| CB_B3 | The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period | 92% | 95.1% | | | |
| CB_B4 | Diagnostic test waiting times – under 6 week waits | 99% | 99.2% | | | <ul style="list-style-type: none"> Demand pressures for endoscopy services driven partly by national screening programmes impacting on providers ability to deliver the 6 week target CCG are securing additional capacity for 2014/15 and retendering for AQP (Any Qualified Provider) diagnostic services. |
| CB_B6 | All Cancer 2 week waits | 93% | 94.0% | | | <ul style="list-style-type: none"> Continued maintenance of target during 14/15 and 15/16 |
| CB_B7 | Two week wait for breast symptoms (where cancer was not initially suspected) | 93% | 88.0% | Amber | | <ul style="list-style-type: none"> Increased referrals for breast services have impacted on GHT's ability to achieve the target. CCG has completed a capacity and demand review with GHT to ensure that improved performance is sustainable. Demand management - educational events for GPs and individual practice/locality support. |
| CB_B8 | Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat') | 96% | 99.3% | | | <ul style="list-style-type: none"> Continued maintenance of target during 14/15 and 15/16, targets are met on a continuous basis. No issues identified for 14/15 and 15/16 |
| CB_B9 | 31-day standard for subsequent cancer treatments - surgery | 94% | 98.9% | | | |
| CB_B10 | 31-day standard for subsequent cancer treatments – anti cancer drug regimens | 98% | 99.6% | | | |
| CB_B11 | 31-day standard for subsequent cancer treatments - radiotherapy | 94% | 100% | | | |
| CB_B12 | All cancer two month urgent referral to first treatment wait | 85% | 80.5% | Amber Red | | <ul style="list-style-type: none"> Pressures in achieving target throughout 2013/14 Demand management programme in place Capacity review has highlighted issues with Radiology, Pathology and Histology capacity at GHT, plans are in place to address these issues during 2014/15. Out of county performance issues are being reviewed with host commissioners. |
| CB_B13 | 62-day wait for first treatment following referral from an NHS cancer screening service | 90% | 98.2% | | | <ul style="list-style-type: none"> Continued maintenance of target during 14/15 and 15/16, targets are met on a continuous basis. No issues identified for 14/15 and 15/16 |
| CB_B14 | 62-day wait for first treatment for cancer following a consultants decision to upgrade the patient's priority | 90% | 92.7% | | | |
| CB_B5iii | A&E Department - % of A&E attendances under 4 hours | 95% | 94.1% | Amber Red | | <ul style="list-style-type: none"> Delivery during 2013/14 has been challenging with performance being achieved in Q2 and Q3 only Focus on making improvements across the USC system ensuring patients are seen at the right time and right place |

| Reference | Description | Target | 2013/14 | 2014/15 (RAG status) | 2015/16 (RAG status) | Plan for Delivery |
|-----------|--|--------|---------|-------------------------|-------------------------|---|
| | | | | | | <ul style="list-style-type: none"> Continued work during 2014/15 on managing demand at the front door which will be impacted by ICT/Rapid Response, Care Homes Programme, further development of SWAST "see and treat" and NHS 111 enhanced clinical advice service. |
| CB_B15i | Ambulance clinical quality – Category A (Red 1) 8 minute response time | 75% | 69.7% | Amber | | <ul style="list-style-type: none"> Performance challenges seen during 13/14, work is ongoing with the South West Ambulance Service FT (SWAST) to address the issues. Recovery plan is in place which will span across 14/15 and discussions are taking place with SWAST regarding delivery of key targets to redress the difference in performance between Northern and Southern divisions. |
| CB_B15ii | Ambulance clinical quality – Category A (Red 2) 8 minute response time | 75% | 72.3% | | | |
| CB_B16 | Ambulance clinical quality – Category A 19 minute transportation time | 95% | 94.9% | | | |
| CB_B17 | Mixed Sex Accommodation (MSA) Breaches | 0 | 48 | | | <ul style="list-style-type: none"> During 2013/14 GHT undertook a reconfiguration of some of their services onto a single site model. During the implementation phase a number of mixed sex breaches were reported. The reconfiguration is now complete and this is not perceived to be an ongoing issue for the Trust. |
| CB_B18 | Cancelled Operations – not rebooked within 28 days | 0 | 43 | | | <ul style="list-style-type: none"> It should also be noted that due to the recording against this target the breaches represent a GHT view not specifically for GCCG patients. |
| CB_B19 | Mental Health Measure – Care Programme Approach (CPA) 7 day follow up on discharge | 95% | 99.0% | | | <ul style="list-style-type: none"> Continued maintenance of target during 14/15 and 15/16, targets are met on a continuous basis. No issues identified for 14/15 and 15/16 |

Agenda Item 10

**Gloucestershire Clinical Commissioning Group
Governing Body**

| | |
|--|---|
| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | Constitution |
| Executive Summary | <p>This paper outlines proposed changes to the Clinical Commissioning Group's Constitution resulting from a review of the Committee Structure.</p> <p>The principal changes are proposed in order to:</p> <ul style="list-style-type: none"> • reflect the current NHS structure; • refine the CCG committee structure; and • update the detailed scheme of delegation. <p>The proposed changes were communicated to all member GP practices on the 24th April, 2014.</p> |
| Key Issues | Changes to the Constitution need to be agreed by member practices before approval can be sought from NHS England. |
| Risk Issues: | The absence of a fit for purpose Constitution could result in inappropriate actions being taken that may not comply with legislation, national guidance or good practice. |
| Original Risk | 3x3 = 9 |
| Residual Risk | 0x3 = 0 |
| Financial Impact | None |
| Legal Issues (including NHS Constitution) | Not Applicable. |

| | |
|--|--|
| Impact on Equality and Diversity | Not Applicable. |
| Impact on Health Inequalities | 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 | Not applicable |
| Recommendation | The Governing Body is asked to: <ul style="list-style-type: none"> • approve the amendments to the Constitution; and • recommend approval of the changes by NHS England. |
| Author and Designation | Alan Potter, Associate Director Corporate Governance |
| Sponsoring Director (if not author) | Helen Miller CCG Chair |

Agenda Item 10

**Gloucestershire Clinical Commissioning Group
Governing Body**

29th May 2014

Constitution

1. Introduction

- 1.1 The Constitution establishes the principles and values of the Clinical Commissioning Group (CCG) in commissioning care for the health community of Gloucestershire.
- 1.2 The Constitution sets out the arrangements the CCG has made to discharge its functions, the role of its Governing Body, and its key processes for decision making, including arrangements for securing transparency in the decision making processes.
- 1.3 The document, which is based on the Model Constitution Framework issued by the NHSCB, was drafted in April 2012 and since that time has been developed following a comprehensive consultation exercise. All 85 member GP practices signed-up to the original Constitution.

2. Changes proposed

- 2.1 The principal changes, as reflected in the attached document, are proposed in order to:
 - reflect the current NHS structure;
 - refine the CCG committee structure; and
 - update the Detailed Scheme of Delegation.

Further details of the changes relating to each of these areas are given in the paragraphs below:

NHS Structure

- 2.2 The Constitution has been updated to reflect the current NHS structure. In particular, all references to the 'NHS Commissioning Board' have been amended to read 'NHS England'.

CCG Committee Structure

- 2.3 The Terms of Reference of both the Audit and Integrated Governance Committees have been reviewed by Committee members and suggested revisions have been identified.
- 2.4 In addition, at the Extraordinary Governing Body meeting held on the 24th October 2013, the need for a Priorities Committee was discussed and a Terms of Reference agreed.

Detailed Scheme of Delegation

- 2.5 The Detailed Scheme of Delegation has been reviewed and refined in order to ensure meaningful and practical levels of authority over transactions.

Miscellaneous changes

- 2.6 In addition, a number of corrections have been made to address minor inaccuracies and grammatical errors. The principal amendments made have been highlighted on the attachment by way of 'tracked changes'.

3. Constitution change process

- 3.1 In accordance with the 'Procedures for clinical commissioning group constitution change, merger or

dissolution' issued by NHS England on the 24th May 2013, any changes to the constitution should be discussed and agreed with member practices before approval for the change is sought from NHS England.

3.2 The proposed changes were communicated to all GP member practices via the 'What's New This Week' GP e-bulletin, on the 24th April. Members were invited to notify the Associate Director Corporate Governance of any comments by the 6th May and advised that unless they indicated to the contrary, it would be assumed that they agreed with the changes. No comments have been received.

3.3 The NHS England guidance, referred to in paragraph 3.1 above, indicates that requests by CCGs to make changes to their constitutions must be received by the 1st June or the 1st November each year. Subject to the agreement of the Governing Body, it is proposed that the revised document will be submitted to NHS England prior to the 1st June 2014 deadline.

4. Recommendations

The Governing Body is asked to:

- approve the amendments to the Constitution; and
- recommend approval of the changes by, NHS England.

5. Appendix

A. Constitution

Appendix A

Gloucestershire Clinical Commissioning Group

Constitution

Version 8 (~~8th November 2013~~^{11th} April 2014)

Formatted: Superscript

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FOREWORD

Gloucestershire Clinical Commissioning Group (GCCG) will embed clinical leadership at the heart of commissioning in Gloucestershire, supporting transformation to the new model of Clinical Commissioning set out in the Health and Social Care Act 2012. Our approach is set out in our vision, values and mission statement:

Our Vision:

Joined up care for the people of Gloucestershire.

Values/Aims:

We will:

- Ensure effective communication and engagement with clinicians, patients, carers, community partners, the public and clinicians;
- Use our clinical experience to ensure high quality, safe and efficient services for the people of Gloucestershire;
- Focus on clinical benefit and health outcomes – making best use of the money and resources available;
- Use our clinical experience to lead innovation and change – right care, right place, right time;
- Be accountable and transparent in our decision making.

Mission Statement

- To commission excellent and modern health services on behalf of the NHS for all people in Gloucestershire through effective clinical leadership, with particular focus on patient safety and continuous improvements in the patient experience.

This Constitution establishes the principles and values of GCCG in commissioning care for the health community of Gloucestershire.

It also describes the governing principles, rules and procedures that GCCG will establish to ensure probity and accountability in the day to day running of GCCG, to ensure decisions are taken in an open and transparent way and that the interests of patients and the public remain central to the values/aims of GCCG.

This Constitution applies to all member practices, GCCG employees, individuals working on behalf of the Group including anyone who is a member of the Group's Governing Body (including the Governing Body's Audit and Remuneration Committees) and any other employee or other person working on behalf of the Group.

This Constitution will be reviewed in ~~September–March 2016~~ and updated as necessary to reflect the transfer of responsibility, and thereafter at least every 3 years with the involvement of clinicians, the public, patients, carers, community partners and staff.

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is Gloucestershire Clinical Commissioning ~~Gloucestershire Group~~ (“GCCG”, “the Group”).

1.2. Statutory Framework

1.2.1. Clinical commissioning groups are established under the Health and Social Care Act 2012 (“the 2012 Act”).¹ They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 (“the 2006 Act”).² The duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.³

1.2.2. NHS England is responsible for determining applications from prospective groups to be established as clinical commissioning groups⁴ and undertakes an annual assessment of each established group.⁵ It has powers to intervene in a clinical commissioning group where it is satisfied that a group is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so.⁶

1.2.3. Clinical commissioning groups are clinically-led membership organisations with constituent members. The members of the ~~C~~linical ~~C~~ommissioning ~~G~~roup are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.⁷

1.3. Status of this Constitution

1.3.1. This Constitution is made between the members of Gloucestershire Clinical Commissioning Group and has effect from 1st April 2013, when NHS England established the Group.⁸ The Constitution will be published on the Group’s dedicated website, and will also be available on request from GCCG.

1.3.2. Documentation will be available upon request for inspection at:

¹ See section 1I of the 2006 Act, inserted by section 10 of the 2012 Act

² See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act

³ Duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act

⁴ See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act

⁵ See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act

⁶ See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act

⁷ See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued

⁸ See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act

Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucestershire GL3 4FE

~~1.3.3 This information will also be available from PALS who can be contacted on 0800 0151548 or email: gleccg.pals@nhs.net~~

1.4. Amendment and Variation of this Constitution

1.4.1. This Constitution can only be varied in two circumstances:⁹

- a) where the Group applies to NHS England and that application is granted;
- b) where in the circumstances set out in legislation NHS England varies the Group's Constitution other than on application by the Group.

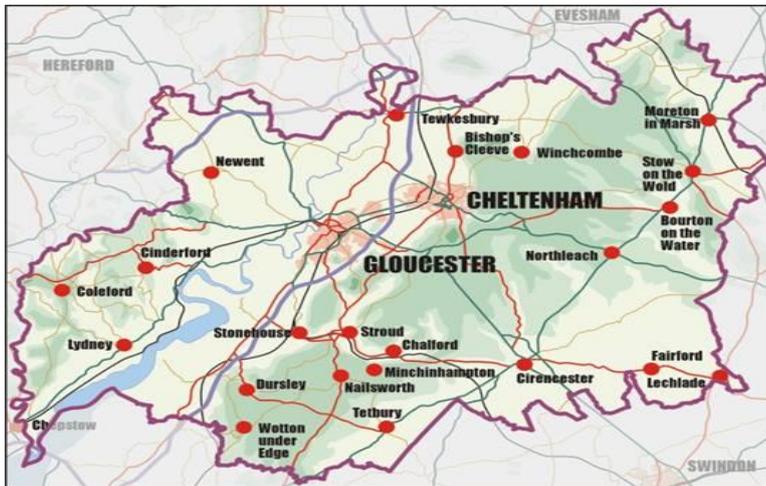
⁹ See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

2. AREA COVERED

2.1. The geographical area covered by Gloucestershire Clinical Commissioning Group is coterminous with that covered by Gloucestershire County Council, covering 271,207 hectares with a population of **616,340** which is divided into the following dDistrict cCouncils:

- Cheltenham District Borough Council;
- Cotswold District Council;
- Forest of Dean District Council;
- Gloucester District City Council;
- Stroud District Council;
- Tewkesbury District Borough Council.

2.2 All constituent practices are located within the same local authority boundary.



3. MEMBERSHIP

3.1. GP Practice Membership of Gloucestershire Clinical Commissioning Group

3.1.1. The following practices comprise the members of Gloucestershire Clinical Commissioning Group.

| Practice Name | Address (Main Surgery Only) |
|--------------------------------|--|
| Cheltenham Locality | |
| Berkeley Place Surgery | 11 High Street, Cheltenham, Gloucestershire |
| Corinthian Surgery | St Paul's Medical Centre, 121 Swindon Road, Cheltenham |
| Crescent Bakery Surgery | Crescent Bakery, St Georges Place, Cheltenham |
| Leckhampton Surgery | Lloyd Davies House, 17 Moorend Park Road, Cheltenham |
| Overton Park Surgery | Overton Park Road, Cheltenham, Gloucestershire |
| Royal Crescent Surgery | 11 Royal Crescent, Cheltenham, Gloucestershire |
| Royal Well Surgery | St Paul's Medical Centre, 121 Swindon Road, Cheltenham |
| Seven Posts Surgery | Prestbury Road, Cheltenham, Gloucestershire |
| Sixways Clinic | London Road, Charlton Kings, Cheltenham |
| Springbank Surgery | Springbank Way, Cheltenham, Gloucestershire |
| St Catherine's Surgery | St Paul's Medical Centre, 121 Swindon Road, Cheltenham |
| St George's Surgery | St Paul's Medical Centre, 121 Swindon Road, Cheltenham |
| Stoke Road Surgery | 4 Stoke Road, Bishops Cleeve, Cheltenham |
| The Portland Practice | St Paul's Medical Centre, 121 Swindon Road, Cheltenham |
| Underwood Surgery | 139 St George's Road, Cheltenham, Gloucestershire |
| Winchcombe Medical Centre | Greet Road, Winchcombe, Cheltenham |
| Yorkleigh Surgery | 93 St George's Road, Cheltenham, Gloucestershire |
| Forest of Dean Locality | |
| Blakeney Surgery | Millend, Blakeney, Gloucestershire |
| Brunston Practice | Cinderhill, Coleford, Gloucestershire |

| Practice Name | Address (Main Surgery Only) |
|-------------------------------------|---|
| Coleford Health Centre | Railway Drive, Coleford, Gloucestershire |
| Dockham Road Surgery | Dockham Road Surgery, Cinderford, Gloucestershire |
| Drs Andrew, Edwards, Hayes & Cleary | Yorkley Health Centre, Bailey Hill, Yorkley, Lydney |
| Drybrook Surgery | Drybrook, Gloucestershire |
| Forest Health Care | The Health Centre, Dockham Road, Cinderford |
| Lydney Practice | The Health Centre, Albert Street, Lydney |
| Mitcheldean Surgery | Brook Street, Mitcheldean, Gloucestershire |
| Newnham Surgery | High Street, Newnham on Severn, Gloucestershire |
| Severbank Surgery | Tutnalls Street, Lydney, Gloucestershire |
| Gloucester City Locality | |
| Barnwood Medical Practice | 51 Barnwood Road, Gloucester, Gloucestershire |
| Bartongate Surgery | 115 Barton Street, Gloucester, Gloucestershire |
| Cheltenham Road Surgery | 16 Cheltenham Road, Gloucester, Gloucestershire |
| Gloucester City Health Centre | The Park, Gloucester, Gloucestershire |
| Gloucester Health Access Centre | Eastgate House, 121-131 Eastgate Street, Gloucester |
| Hadwen Medical Practice | Glevum Way Surgery, Abbeydale, Gloucester |
| Heathville Medical Practice | 5 Heathville Road, Gloucester, Gloucestershire |
| Hucclecote Surgery | 5A Brookfield Road, Hucclecote, Gloucestershire |
| Kingsholm Surgery | Alvin Street, Gloucester, Gloucestershire |
| London Road Medical Practice | 97 London Road, Gloucester, Gloucestershire |
| Longlevens Surgery | 19b Church Road, Longlevens, Gloucester |
| Matson Lane Surgery | Taylor House, 4 Matson Lane, Matson |
| Partners in Health | Pavilion Family Doctors, 153a Stroud Road, Gloucester |
| Quedgeley Medical Centre | Olympus Park, Quedgeley, Gloucester |

| Practice Name | Address (Main Surgery Only) |
|---------------------------------|---|
| Rosebank Health | 153b Stroud Road, Gloucester, Gloucestershire |
| Saintbridge Surgery | Askwith Road, Saintbridge, Gloucestershire |
| St. Johns Avenue Surgery | Churchdown, Gloucester, Gloucestershire |
| The College Yard Surgery | Mount Street, Westgate, Gloucester |
| The Surgery | Abbotswood Road, Brockworth, Gloucestershire |
| North Cotswolds Locality | |
| Chipping Campden Surgery | Back Ends, Chipping Campden, Glos |
| Cotswold Medical Practice | Moore Road, Bourton on the Water, Cheltenham |
| Mann Cottage Surgery | Oxford Street, Moreton in Marsh, Cheltenham |
| Stow Surgery | Well Lane, Stow on the Wold, Gloucestershire |
| White House Surgery | High Street, Moreton in Marsh, Gloucestershire |
| South Cotswolds Locality | |
| The Avenue Surgery | 1 The Avenue, Cirencester, Gloucestershire |
| Hilary Cottage Surgery | Keble Lawns, Fairford, Gloucestershire |
| LechladeMedical Centre | Oak Street, Lechlade, Gloucestershire |
| The Park Surgery | Old Tetbury Road, Cirencester, Gloucestershire |
| Phoenix Surgery | 9 Chesterton Lane, Cirencester, Gloucestershire |
| Rendcomb Surgery | Rendcomb, Cirencester, Gloucestershire |
| Romney House | 41-43 Long Street, Tetbury, Gloucestershire |
| St Peter's Road Surgery | 1 St Peter's Road, Cirencester, Gloucestershire |
| Stroud Locality | |
| Acorn Practice | May Lane Surgery, Dursley, Gloucestershire |
| Beeches Green Surgery | Beeches Green, Stroud, Gloucestershire |
| Chipping Surgery | Symn Lane, Wotton under Edge, Gloucestershire |
| Culverhay Surgery | Wotton under Edge, Gloucestershire |

| Practice Name | Address (Main Surgery Only) |
|---|--|
| Frithwood Surgery | 45 Tanglewood Way, Bussage, Stroud |
| High Street Medical Centre | 31 High Street, Stonehouse, Gloucestershire |
| Hoyland House | Gyde Road, Painswick, Gloucestershire |
| Locking Hill Surgery | Locking Hill, Stroud, Gloucestershire |
| Marybrook Medical Centre | Marybrook Street, Berkeley, Gloucestershire |
| Minchinhampton Surgery | Bell Lane, Minchinhampton, Gloucestershire |
| Prices Mill Surgery | New Market Road, Nailsworth, Gloucestershire |
| Regent Street Surgery | 72 Regent Street, Stonehouse, Gloucestershire |
| Rowcroft Medical Centre | Stroud, , Gloucestershire |
| St Lukes Medical Centre | 53 Cainscross Road, Stroud, Gloucestershire |
| Stonehouse Health Clinic | High Street, Stonehouse, Gloucestershire |
| Stroud Valleys Family Practice (Staniforth) | Beeches Green Health Centre, Stroud, Gloucestershire |
| The Orchard Medical Centre | Fairmead, Cam, Dursley, Gloucestershire |
| The Surgery | Whitminster Lane Frampton on Severn, Gloucestershire |
| Uley Surgery | 42 The Street, Uley, Dursley, Gloucestershire |
| Walnut Tree Practice | May Lane Surgery, Dursley, Gloucestershire |
| Tewkesbury Locality | |
| Church Street Practice | 77 Church Street, Tewkesbury, Gloucestershire |
| Holts Health Centre | Watery Lane, Newent, Gloucestershire |
| Jesmond House Practice | Chance Street, Tewkesbury, Gloucestershire |
| The Surgery | Corse, Staunton, Gloucester |
| Watledge Surgery | Barton Road, Tewkesbury, Gloucestershire |

3.1.2. Appendix B of this Constitution contains the list of member practices, together with the signatures of the practices' representatives confirming their agreement to this Constitution.

3.2. Eligibility

3.2.1. Providers of primary medical services to a registered list of patients under a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract will be eligible to apply for membership of this Group¹⁰.

No GP practice shall become a member of GCCG unless that practice:

- (a) is a holder of a primary medical contract;
- (b) is a primary care services provider in the relevant Locality;
- (c) has completed an application for membership to GCCG;
- (d) has submitted an application to NHS England and had its application approved; and
- (e) has been entered into the Register of Members.

¹⁰ See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012. Regulations to be made
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4. MISSION, VALUES AND AIMS

4.1. Mission

- 4.1.1. The mission of Gloucestershire Clinical Commissioning Group is to commission excellent and modern health services on behalf of the NHS for all people in Gloucestershire through effective clinical leadership, with particular focus on patient safety and continuous improvements in the patient experience.
- 4.1.2. The Group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

4.2. Values and Aims

- 4.2.1. Good corporate governance arrangements are critical to achieving the Group's objectives.
- 4.2.2. The values/aims that lie at the heart of the Group's work are to:
- Ensure effective communication and engagement with patients, carers, community partners, the public and clinicians;
 - Use our clinical experience to ensure high quality, safe and efficient services for the people of Gloucestershire;
 - Focus on clinical benefit and health outcomes – making best use of the money and resources available;
 - Use our clinical experience to lead innovation, variation, equity and change – right care, right place, right time;
 - Be accountable and transparent in our decision making.

4.3. Principles of Good Governance

- 4.3.1. In accordance with section 14L(2)(b) of the 2006 Act,¹¹ the Group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:
- a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
 - b) *The Good Governance Standard for Public Services*;¹²
 - c) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles';¹³

¹¹ Inserted by section 25 of the 2012 Act

¹² *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

¹³ See Appendix G

- d) the seven key principles of the *NHS Constitution*;¹⁴
- e) the Equality Act 2010;¹⁵
- f) GCCG will adopt the 'Standards for Members of NHS Boards and Clinical Commissioning Group governing bodies in England' issued by the Professional Standards Authority.

4.4. Accountability

4.4.1. The Group will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by:

- a) publishing its Constitution;
- b) appointing independent lay members and other healthcare professionals to its Governing Body;
- c) holding meetings of its Governing Body in public (except where the Group considers that it would not be in the public interest in relation to all or part of a meeting);
- d) meaningful engagement, communication and consultation with the population of Gloucestershire;
- e) publishing annually a commissioning plan;
- f) complying with local authority health overview and scrutiny requirements;
- g) meeting annually in public to ~~publish and~~ present its annual report (which must be published);
- h) producing annual accounts in respect of each financial year which must be externally audited;
- i) having a published and clear complaints process;
- j) complying with the Freedom of Information Act 2000; and
- k) providing information to NHS England as required.

4.4.2. In addition to these statutory requirements, the Group will demonstrate its accountability by:

- a) Publishing a public-facing guide to GCCG setting out its priorities;

¹⁴ See Appendix H

¹⁵ See <http://www.legislation.gov.uk/ukpga/2010/15/contents>

b) A dedicated on-line presence, including social media channels.

4.4.3. The Governing Body of the Group will throughout each year have an on-going role in reviewing the Group's governance arrangements to ensure that the Group continues to reflect the principles of good governance.

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

5.1.1. The functions that the Group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health's *Functions of clinical commissioning groups: a working document*. They relate to:

- a) commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
 - i) all people registered with member GP practices, and
 - ii) people who are usually resident within the area and are not registered with a member of any clinical commissioning group;
- b) commissioning emergency care for anyone present in the Group's area;
- c) paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the Group's employees;
- d) determining the remuneration and travelling or other allowances of members of its Governing Body.

5.1.2. In discharging its functions the Group will:

- a) act¹⁶, when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and NHS England of their duty to ***promote a comprehensive health and wellbeing service***¹⁷ and with the objectives and requirements placed on the NHS England through *the mandate*¹⁸ published by the Secretary of State before the start of each financial year by:
 - i) Specifying guidelines and policies that set out how GCCGG, its committees, sub committees and employees are to exercise, monitor and report on GCCG's delegated powers and responsibilities;
 - ii) The GCCG Clinical Chair is the Vice Chair of Gloucestershire Health & Wellbeing Board (GH&WB) and is supported by a GP/Other Health Professional (OHP) Clinical Commissioning Lead.

b) ***meet the public sector equality duty***¹⁹ by:

¹⁶ See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

¹⁷ See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

¹⁸ See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

¹⁹ See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

- i) Encouraging patient experience feedback from communities of interest;
 - ii) Making services accessible and information available in all formats as required through interpretation and translation contracts;
 - iii) Being an active participant at the Overview and Scrutiny Committee;
 - iv) Being a member of the Public Sector Partnership;
 - v) Publishing at least annually, sufficient information to demonstrate compliance with this general duty across all GCCG functions;
 - vi) Preparing and publishing specific and measurable equality objectives, revising these at least every four years;
 - vii) Being committed to the equality agenda and recognising the value of the Equality Delivery Scheme in achieving the public sector equality duty.
- c) work in partnership with its local authority[ies] to develop **joint strategic needs assessments**²⁰ and **joint health and wellbeing strategies**²¹ by:
- i) Continuing to work with Public Health in refreshing and further developing the Joint Strategic Needs Assessment (JSNA). (The JSNA is accessible from the Group's website, and is also available on request from GCCG.);
 - ii) Using the JSNA to underpin commissioning decisions and plans;
 - iii) Working with Gloucestershire Health & Wellbeing Board (GH&WB).

5.2. General Duties - in discharging its functions the Group will:

- 5.2.1. Make arrangements to **secure public involvement** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements²² by:
- a) Adhering to the duties as described in Section 14z2 of the Health & Social Care Act in relation to service change;
 - b) Adopting a Communication and Engagement Strategy;
 - c) Paying due regard to standards set out in the NHS Constitution in relation to public involvement;

²⁰ See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

²¹ See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

²² See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act

d) Using GCCG toolkit to support engagement in localities.

5.2.2. **Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution**²³ by:

- a) Paying due regard to involvement throughout the communications cycle in order to ensure patient voice influences commissioning intentions;
- b) Producing a guide for patients on the NHS Constitution (information available on website);
- c) Continuing to support the role of GCCG GP Public and Patient Involvement Champion;
- d) Ensuring provider contracts pay due regard to the NHS Constitution;
- e) Continuing with the six-monthly stocktake with NHS England on GCCG and all providers.

5.2.3. Act **effectively, efficiently and economically**²⁴ :

- a) See the attached Prime Financial Policies (Appendix F).

5.2.4. Act with a view to **securing continuous improvement to the quality of services**²⁵ through:

- a) Prime Financial Policies;
- b) Commissioning for Quality and Innovation (CQUINS) framework;
- c) Robust commissioning contracts;
- d) Best Practice Tariffs;
- e) National Institute for Health and Clinical Excellence (NICE) Quality Standards;
- f) Commissioning Outcomes Frameworks;
- g) National and local audits;
- h) Academic Health Science Networks;
- i) Quality, Innovation, Productivity and Prevention (QIPP) transformational programmes.

5.2.5. Assist and support NHS England in relation to the Governing Body's duty to **improve the quality of primary medical services**²⁶ by:

²³ See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)

²⁴ See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

²⁵ See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

²⁶ See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act

- a) Continuously improving the quality of services and the patient experience within primary care, which is a key objective of GCCG, including;
- Patient access to services;
 - Patient satisfaction surveys;
 - Clinical audit;
 - Primary care clinical governance arrangements;
 - Patient safety;
 - Health promotion;
 - Reducing health inequalities;
 - Reduce variation;
 - Focus on clinical benefit and outcomes;
 - Medicines management;
 - Peer review and referral management.

5.2.6. Have regard to the need to **reduce inequalities**²⁷ by:

- a) Using the JSNA to underpin commissioning decision and plans. (The JSNA is accessible from the Group's website, and is also available on request from GCCG.);
- b) Using the Joint Health and Wellbeing Strategy, using the principles outlined in the Marmot Review (Fair Society, Healthy Lives) on health inequalities. The framework for the Strategy will map to Marmot's life course approach and address the areas for action set out in 'Healthy Lives Healthy People'.

5.2.7. **Promote the involvement of patients, their carers and representatives in decisions about their healthcare**²⁸ by:

- a) Adopting a quality framework regarding patient experience which requires provider organisations to involve patients, their carers and representatives in decisions about their healthcare;
- b) Adopting the new Individual Funding Request (IFR) process ('No decision about me without me');
- c) The new Clinical Programme Groups will be charged with ensuring Public and Patient Involvement (PPE/PPI) in their work.

5.2.8. Act with a view to **enabling patients to make choices**²⁹ by:

- a) Adopting the 'Choice programme' and 'Choose Well Programme';
- b) Adopting the new Individual Funding Request (IFR) process (supporting the principle of 'No decision about me without me');

²⁷ See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

²⁸ See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act

²⁹ See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

- c) ~~Working with Patient Advice Liaison Service (PALS) to ensure patients can~~
~~Providing support to individuals to help them to~~ navigate through the healthcare system.

5.2.9. **Obtain appropriate advice**³⁰ from persons who, taken together, have a broad range of professional or specialist expertise in health and social care and public health by working with and through:

- a) Expert Patient Groups;
- b) Locality Commissioning Groups and constituent practices;
- c) Locality Commissioning Lay Members;
- d) Agreeing changes and improvements to clinical services with secondary and tertiary services colleagues through appropriate forums, for example the Clinical Priorities Forum;
- e) Working closely with Public Health professionals;
- f) Working with the Registered Nurse or OHP on the Governing Body to ensure a multi-professional view is sought and incorporated;
- g) Social Care services;
- h) Third sector providers.

5.2.10. **Promote innovation**³¹ by:

- a) Using an evidence-based best practice approach to the commissioning of services;
- b) Ensuring that services commissioned are outcome-focused;
- c) Measuring improvements in patient health and experience;
- d) Keeping abreast of any new advances in technology;
- e) Being proactive in the management of medicines;
- f) Using tools such as the Annual Operating Plan (AOP), which outlines the opportunities for innovation and quality improvements that CCG intends to implement ~~from 2013/14 onwards~~.

5.2.11. **Promote research and the use of research**³² by:

- a) Working with and through the Gloucestershire Research & Development Support Unit (R&DSU);
- b) Improving the environment for health research by facilitating and encouraging sharing of best practice and working with other organisations;
- c) Supporting the development of services and healthcare practice based upon clear evidence.

5.2.12. Have regard to the need to **promote education and training**³³ for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the

³⁰ See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

³¹ See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

³² See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act

³³ See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act

discharge of his related duty³⁴ by carrying out annual appraisal and personal development review with staff (annual appraisal documentation, guidance notes and training courses are available on the internal website).

5.2.13. Act with a view to **promoting integration** both of health services with other health services and of health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities³⁵ by being actively involved in:

- Gloucestershire Total Place;
- Joint Commissioning Partnership (JCP);
- Gloucestershire Health & Wellbeing Board (GH&WB);
- Leadership Gloucestershire;
- Childrens' Partnership;
- Safeguarding Boards.

5.3. General Financial Duties – the Group will perform its functions so as to:

5.3.1. **Ensure its expenditure does not exceed the aggregate of its allotments for the financial year**³⁶:

a) See Prime Financial Policies (Appendix F).

5.3.2. **Ensure its use of resources** (both its capital resource use and revenue resource use) **does not exceed the amount specified by NHS England for the financial year**³⁷:

a) See Prime Financial Policies (Appendix F).

5.3.3. **Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the Group does not exceed an amount specified by NHS England.**³⁸

a) See Prime Financial Policies (Appendix F).

5.3.4. **Publish an explanation of how the Group spent any payment in respect of quality** made to it by NHS England³⁹ by:

- a) Embedding the continuous improvement to the quality of services within contractual agreements and monitoring outputs with all provider types;
- b) Using the Commissioning for Quality and Innovation (CQUIN) payment framework to reward excellence, by linking a proportion of providers' income to the achievement of local quality improvement goals. The quality goals

³⁴ See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act

³⁵ See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

³⁶ See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

³⁷ See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act

³⁸ See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

³⁹ See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

reflect local priorities, which are stretched and focused. They will concentrate on innovation and improvement to reduce variation and improve outcomes. They are influenced by:

- Local and national priorities;
 - Commissioner/provider discussions;
 - Local clinical engagement;
 - Patient and public engagement and involvement;
 - Academic Health Science Networks;
- c) In addition to the CQUIN framework, by including key performance and quality indicators within the contracts which are monitored on a monthly basis. Some indicators are nationally mandated, others are locally identified related to specific quality areas where the commissioners would wish to see a year on year improvement in performance;
- d) All providers producing annual quality accounts which are reviewed by the GCCG and which will receive a formal sign off;
- e) Having, for each main provider contract, a Clinical Quality Review Group. This is a sub group to the Contract Board and reviews quality issues with the provider, identifying any areas of concern, which then require remedial action plans to be implemented. The Group considers progress against CQUIN schemes and output from the provider clinical audit programme, reviews Serious Incidents (SIs) and patient complaints, and oversees Never Events. It will also review the output from any Care Quality Commission (CQC) review and report, ensuring appropriate remedial actions are identified and implemented.

5.4. Other Relevant Regulations, Directions and Documents

5.4.1. The Group will:

- a) comply with all relevant regulations;
- b) comply with directions issued by the Secretary of State for Health or NHS England; and
- c) have regard to guidance issued by NHS England.

5.4.2. The Group will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this Constitution, its scheme of reservation and delegation and other relevant Group policies and procedures.

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

6.1.1. GCCG is accountable for exercising the statutory functions of the group. It may grant authority to act on its behalf to:

- a) any of its members;
- b) its Governing Body;
- c) employees;
- d) a committee or sub-committee of the Group.

6.1.2. The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the Group as expressed through:

- a) the Group's Scheme of Reservation and Delegation; and
- b) for committees, their terms of reference.

6.2. Scheme of Reservation and Delegation⁴⁰

6.2.1. The Group's Scheme of Reservation and Delegation will set out:

- a) those decisions that are reserved for the membership as a whole;
- b) those decisions that are the responsibilities of its Governing Body, the Group's committees and sub-committees, individual members and employees.

6.2.2. Gloucestershire Clinical Commissioning Group remains accountable for all of its functions, including those that it has delegated.

6.3. General

6.3.1. In discharging functions of the Group that have been delegated to them, its Governing Body (and its committees)⁴¹ and individuals must:

- a) comply with the Group's principles of good governance,⁴²
- b) operate in accordance with the Group's scheme of reservation and delegation,⁴³

⁴⁰ See Appendix D

⁴¹ See CCG Proposed Structure in Appendix J.

⁴² See section 4.4 on Principles of Good Governance above

⁴³ See appendix D

- c) comply with the Group's Standing Orders,⁴⁴
- d) comply with the Group's arrangements for discharging its statutory duties,⁴⁵
- e) where appropriate, ensure that member practices have had the opportunity to contribute to the Group's decision making process.

6.3.2. When discharging their delegated functions, committees, sub-committees and joint committees must also operate in accordance with their approved terms of reference.

6.3.3. Where delegated responsibilities are being discharged collaboratively, the joint (collaborative) arrangements must:

- a) identify the roles and responsibilities of those clinical commissioning groups who are working together;
- b) identify any pooled budgets and how these will be managed and reported in annual accounts;
- c) specify under which clinical commissioning group's Scheme of Reservation and Delegation and supporting policies the collaborative working arrangements will operate;
- d) specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;
- e) identify how disputes will be resolved and the steps required to terminate the working arrangements;
- f) specify how decisions are communicated to the collaborative partners.

6.4. Committees of the Group

6.4.1. Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the Group or the committee they are accountable to.

6.5. Joint Arrangements

6.5.1 See Appendix J for a diagram showing the CCG's Governance Structure.

6.5.2 GCCG will delegate authority to members or employees participating in joint arrangements to make decisions on its behalf (the Group thereby retaining accountability for such decision). Therefore, it will be the individual member / employee who has the delegated authority to make a decision rather than any joint arrangement.

⁴⁴ See appendix C

⁴⁵ See chapter 5 above

6.5.3 The Group has joint committees with the following local authority(ies):

- a) Joint Commissioning Boards for Adults, Children, Mental Health and Learning Disabilities with Gloucestershire County Council.

6.6. The Governing Body

6.6.1 **Functions** - the Governing Body has the functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations.⁴⁶

- a) ensuring that the Group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the groups *principles of good governance*⁴⁷ (its main function);
- b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the Group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;
- c) approving any functions of the Group that are specified in regulations;⁴⁸ that the membership will delegate to their Governing Body;
- d) ensuring that the register(s) of interest is reviewed regularly, and updated as necessary;
- e) ensuring that all conflicts of interest or potential conflicts of interest are declared.

6.6.2 **Quorum** - Any quorum of GCCG or its sub-committees shall exclude any member affected by a conflict of interest. If this paragraph has the effect of rendering the meeting inquorate, then the Chair shall decide whether to adjourn the meeting to permit the appointment or co-option of additional members.

6.6.3 **Eligibility to Serve** - People who are ineligible for appointment to the GCCG Governing Body include anyone who:

- is not eligible to work in the UK;
- has received a prison sentence or suspended sentence of 3 months or more in the last 5 years;
- is the subject of a bankruptcy order or interim order;
- has been dismissed (except by redundancy) by any NHS body;

⁴⁶ See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act

⁴⁷ See section 4.4 on Principles of Good Governance above

⁴⁸ See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

- is subject to a disqualification order set out under the Company Directors Disqualification Act 1986;
- has been removed from acting as a trustee of a charity.

6.6.4 **Composition of the Governing Body** - the Governing Body shall not have less than 18 and (in line with national guidance) will include some or all of:

- Clinical Chair;
- Deputy Clinical Chair;
- Vice Chair (Lay Member - Patient Public Engagement);
- Accountable Officer (AO);
- Chief Finance Officer (CFO);
- Seven GP Clinical Commissioning Leads or Other Healthcare Professional (OHP) Clinical Commissioning Leads;
- Three lay members (Patient Public Engagement, Business and Governance);
- Director of Public Health;
- Secondary Care Specialist;
- Registered Nurse;
- Director of Adult Social Care;
- Director of Commissioning Implementation (and Deputy AO);
- Director of Transformation and Service Redesign.

6.6.5 **Appointment of the Clinical Chair and Vice Chair of the Governing Body**

- The Clinical Chair and Deputy Clinical Chair shall serve on the GCCG Governing Body for a period in accordance with national guidance after which the positions shall be subject to reappointment. No Clinical Chair shall serve on the Governing Body for a period that exceeds national guidance without a break as specified in national guidance.
- The Clinical Chair and Deputy Clinical Chair will be subject to national assessment and local appointment.
- Where the Clinical Chair is a GP, the Vice Chair shall be a lay member.
- The roles of the Clinical Chair and Accountable Officer shall not be held by the same individual.
- The Chair of the Audit and Remuneration Committees could be the Vice Chair of the Governing Body but would be precluded from being its Clinical Chair.
- Where the Clinical Chair of the Governing Body is also the senior clinical voice of the Group that person will take the lead in interactions with stakeholders, including NHS England.

6.6.6 In respect of the Governing Body, subject to provision made in regulations, GCCG will set out in its Standing Orders:

- how the Group will appoint such members of the Governing Body;
- the tenure of office;
- how such a person would resign from their post;
- the grounds for removal from office.

6.6.7 **The Clinical Chair:** The procedure for appointing the Clinical Chair of the Governing Body, is set out in the Group's Standing Orders (see Appendix C of this Constitution) and is subject to national guidance.

6.6.8 **Seven GP/OHP Clinical Commissioning Leads acting on behalf of member practices:** The procedure for appointing the GP/OHP Clinical Commissioning Leads acting on behalf of members practices of the Governing Body, is set out in the Group's Standing Orders (see Appendix C of this Constitution).

6.6.9 **Four lay members:** one to lead on audit, remuneration and conflict of interest matters; two to lead on patient and public engagement (one of whom being appointed as Non-clinical Vice-Chair) and one to lead on business.

6.6.10 The procedure for appointing the lay members of the Governing Body is set out in the Group's Standing Orders (subject to national guidance).

6.6.11 **One Registered Nurse:** The procedure for appointing the Registered Nurse of the Governing Body is set out in the Group's Standing Orders (see Appendix C of this Constitution).

6.6.12 **One Secondary Care Specialist:** The procedure for appointing the Secondary Care Specialist of the Governing Body is set out in the Group's Standing Orders (see Appendix C of this Constitution).

6.6.13 **The Accountable Officer (Manager)**

6.6.14 **The Chief Finance Officer (Manager)**

6.6.15 **Other individuals who do not fall into the above categories:** Director of Adult Social Care and Director of Public Health.

6.6.16 ***Committees of the Governing Body*** - the Governing Body has appointed the following committees and sub-committees:

- Audit Committee** – The Audit Committee, which is accountable to the Group's Governing Body, provides the Governing Body with an independent and objective view of the Group's financial systems, financial information and compliance with laws, regulations and directions governing the Group in so far as they relate to finance. The Governing Body has approved ~~and~~ keeps under review and may amend the terms of reference for the Audit Committee, which includes information on the membership of the

Committee⁴⁹. Changes to the Audit Committee terms of reference must be approved by the Governing Body.

In addition the Group or the Governing Body has conferred or delegated a number of functions, connected with the Governing Body's main function⁵⁰, to its Audit Committee (see Appendix K).

b) ~~b)~~ — Remuneration Committee – The Remuneration Committee, which is accountable to the Group's Governing Body, makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme. The Governing Body has approved ~~and~~ keeps under review and may amend the terms of reference for the Remuneration Committee, which includes information on the membership of the Committee⁵¹. Changes to the Remuneration Committee terms of reference must be approved by the Governing Body.

In addition the Group or the Governing Body has conferred or delegated a number of functions, connected with the Governing Body's main function, to its Remuneration Committee (see Appendix L).

c) ~~c)~~ — Integrated Governance and Quality – Committee (IGQC)⁵² - The Governing Body has approved ~~and~~ keeps under review and may amend the terms of reference for the Integrated Governance and Quality Committee, which includes information on the membership of the Commissioning for Quality Group (CfQG), which has been established to help the IGQC discharge its duties and powers: see Appendix M. The aim of the Integrated Governance and Quality Committee is to continuously improve the delivery of healthcare services to the people of Gloucestershire, so ensuring that the services are of high quality, clinically effective and safe, within available resources. This will be delivered through a culture of openness supported by sound governance arrangements. The Committee will ensure that controls are in place and are operating efficiently and effectively to deliver the principal objectives of the Governing Body and to set in place processes to manage identified risks, minimising the Clinical Commissioning Group's exposure to corporate, financial and clinical risks. The Committee will have a pro-active approach to the management of risk and quality, ensuring the organisation learns and takes appropriate corrective action. Changes to the IGQC terms of reference must be approved by the Governing Body.

⁴⁹ See appendix K for the terms of reference of the Audit Committee

⁵⁰ See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act

⁵¹ See appendix L for the terms of reference of the Remuneration Committee

⁵² See appendix M for the terms of reference of the Integrated Governance and Quality Committee

d) ~~d)~~ **Priorities Committee**⁵³ - The Governing Body has approved, ~~and~~ keeps under review ~~and may amend~~ the terms of reference for the Priorities Committee. The purpose of the Priorities Committee is to advise the local NHS health economy as to the health care interventions and policies that should be given high or low priority. The Priorities Committee helps the CCG and its Localities choose how to allocate its resources to promote the health of the local community, based on the local health needs assessment. The Terms of Reference for the priorities Committee are shown at Appendix N. Changes to the Priorities Committee terms of reference must be approved by the Governing Body.

⁵³ See appendix N for the terms of reference of the Priorities Committee

7. ROLES AND RESPONSIBILITIES

7.1 Gloucestershire Clinical Commissioning Group (GCCG)

7.1.1 A key part of GCCG's commitment is to build GCCG as a 'membership organisation'.

7.1.2 GCCG membership comprises 85 practices from seven constituent localities. Each locality appoints one of the GPs or other healthcare professionals in the constituent practices to lead and chair the locality, and to sit as a member of the Governing Body as a GP Clinical Commissioning Lead or OHP Clinical Commissioning Lead. A locality's GP/OHP Clinical Commissioning Lead chairs and holds regular meetings involving the Commissioning Leads from each constituent practice of the locality.

7.2 GCCG Role will be to:

- Set a commissioning strategy and policy (which is responsive to the needs assessment and priorities for the population and reflects the views of individual localities).
- Implement a clinical strategy using a co-production approach and defining quality outcomes and best value that meets the needs of our population.
- Be clinical leaders - engaging member practices and the wider clinical community.
- Establish governance arrangements that establish GCCG as a membership organisation.
- Establish and lead a clinical programme-based approach to commissioning.
- Ensure transparency and accountability with decision making.
- Manage devolved commissioning budgets.
- Support localities with the development of programmes and projects agreed with GCCG and where appropriate holding localities and others to account for delivery.

7.3 Locality Executive Groups

7.3.1 There is a need to review and strengthen engagement with constituent practices through the seven localities:

- Cheltenham;
- Forest of Dean;
- Gloucester City;
- North Cotswolds;
- South Cotswolds;

- Stroud and Berkeley Vale;
- Tewkesbury.

7.3.2 The establishment of localities is a key part of GCCG's commitment to building a 'membership organisation'.

7.3.3 A county-wide clinical commissioning group has been agreed with seven constituent localities, each with a Locality Lead (i.e. GP or other healthcare professional who will act as a conduit for the views of the locality on behalf of member practices sitting on GCCG. Each locality is chaired by a GP/OHP Clinical Commissioning Lead, has an executive and holds regular meetings involving the commissioning leads from each practice. This is in addition to other regular development sessions (including Practice Learning Time) and locality-specific project groups. ⁵⁴Terms of Reference for Locality Executive Groups can be found [at](#) Appendix O.

7.3.4 The commitment to the continuation of localities was designed to ensure:

- Two way engagement with constituent practices – sharing Gloucestershire wide developments, ensuring a two-way conversation on key issues, including monthly locality meetings and an annual member practice council meeting.
- A locality approach to delivery of key service developments and a means to pilot new approaches;
- Continuity – in particular building on Practice Based Commissioning (PbC) as a mechanism for budgetary management;
- A focus for local service developments and Quality, Innovation, Productivity and Prevention (QIPP) delivery (including the management of demand);
- Maintain support to the PbC localities and ensuring good links with the local community, including Local Strategic Partnerships (LSPs), Councils and others.

7.3.5 Arrangements have been designed to increase the level of practice engagement to fulfil GCCG's ambition to establish a vibrant membership organisation.

7.4 Communications Approach

7.4.1 GCCG will be responsible for ensuring that patients and the public are properly consulted and involved in the commissioning cycle. This will include publishing a Communication and Engagement Strategy. The Communication and Engagement Strategy sets out how GCCG will communicate and engage with the local population including key stakeholders such as patients, carers, community representatives, the clinical community and the media.

⁵⁴ See appendix O for the terms of reference for Locality Executive Groups
Gloucestershire Clinical Commissioning Group's Constitution

- 7.4.2 GCCG will produce an e-bulletin, in addition to the prescribing newsletter published each month with key messages for practices hoping to reach all clinical staff and Practice Managers and will include links to further detail.
- 7.4.3 Face-to-face events such as commissioning and prescribing events support two-way communication and engagement.
- 7.4.4 Opportunities will be put in place using events planned for member practice representatives to meet with the locality executives of GCCG to discuss the activities and plans of GCCG.
- 7.4.5 Our GCCG Clinical Leads are important ambassadors for GCCG and part of the communication structure. We anticipate that they will be supported in work-streams by other member clinicians, particularly those with a special interest. This will encourage a bottom-up approach to service redesign.
- 7.4.6 It is important to have close links with the Practice Managers' Group to capture their knowledge and expertise. They are a vital resource when communicating with practices and effecting change. Using the Practice Managers' Network, it is anticipated Practice Managers will work collectively in their roles with GCCG to identify common issues and opportunities, feedback at locality level and to communicate and work with GCCG.
- 7.4.7 Community pharmacists and the Information Team will work with practices to understand both demand and capacity. Practice support pharmacists will work with practices to encourage and support safe and cost effective prescribing. Both will offer informal opportunities for communication regarding GCCG work.
- 7.4.8 GCCG is committed to expanding this approach to other areas of practice performance and the approach to comparing and reviewing practice will look at the following principles:
- A need to understand and where appropriate minimise variation;
 - To support cost effective use of resources;
 - To optimise health outcomes;
 - To reduce health inequalities.

7.5 Role of GP/OHP Clinical Commissioning Leads:

- 7.5.1 The GP/OHP Clinical Commissioning Lead from each locality will play an important role in locality engagement as well as taking on a lead role on county-wide projects. GCCG will be responsible for supporting each Lead in a locality role and in specialist lead areas. The GP/OHP Clinical Commissioning Leads:
- Provide a two-way engagement route for the Governing Body to communicate with practices and to gain practice input into the work of GCCG.
 - Act as a vital source of intelligence for GCCG – on local health needs, the reality of services on the ground, etc.

- Focus for devolved commissioning budget management – share performance information with practices and where appropriate challenge practice.
- Act as a vehicle to translate county-wide commissioning plans into ‘operationalised’ locality plans.
- Pilot new approaches.
- Liaise with local councillors, local people and the local tertiary sector.

7.6 Practice Representatives

7.6.1 Practice representatives represent their practice’s views and act on behalf of the practice in matters relating to the Group. The role of each practice is to:

- Nominate commissioning and prescribing leads to:
 - a) represent the practice at GCCG/locality meetings; and
 - b) represent the needs of the practice’s patient population within the GCCG;
- Actively engage with GCCG to help improve services within the area;
- Share all appropriate information and data and any other data relating to commissioning priorities to support delivery of equitable quality care of referral and other prescribing and emergency admissions data;
- Adopt the Clinical Programme Group approach, and follow the clinical pathways and referral protocols agreed by GCCG (except in individual cases where there are justified clinical reasons for not doing this) which are fed back appropriately;
- Manage the practice’s prescribing budget within allocated resources;
- Participate in and deliver, as far as possible, the clinical, quality, safety effectiveness (and cost effective) strategies agreed by GCCG and GH&WB;
- Establish a practice reference group and other means determined, to obtain the views and experiences of patients and carers;
- Work constructively with the locality sub-committee/GCCG;
- Respond in a timely manner to reasonable commissioning-related information requests from GCCG.

7.7 Memorandum of Agreement

- 7.7.1 The effective participation of each member practice will be essential in developing and sustaining high quality commissioning arrangements.
- 7.7.2 A Memorandum of Agreement between individual member practices and GCCG clarifies the expectations and obligations of both parties⁵⁵.
- 7.7.3 The Memorandum of Agreement will document any commissioning agreements reached between the member practice and GCCG and will be the formal mechanism for determining eligibility to any future incentive payment (currently referred to as the Quality Premium). Accordingly it will be updated on an annual basis.
- 7.7.4 The Memorandum of Agreement includes:
- Parties to the Agreement;
 - Values, Aims and Mission of GCCG;
 - Commissioning responsibilities of the member practice;
 - Responsibilities of GCCG;
 - Annual commissioning objectives/targets agreed with the member practice;
 - Monitoring arrangements and frequency of meetings;
 - Practice budgets of the member practice;
 - Dispute resolution;
 - Review of the Agreement;
 - Signatures to the Agreement.

7.8 Other Key Roles

- 7.8.1 GCCG will have, at times, specific 'tasks' where it will need GP or other healthcare professional input, working on behalf of GCCG. This will be on a voluntary basis where individuals are keen to be involved and/or are interested in the subject matter and where their practice is agreeable to them participating. Where this is deemed to be significant, and outside the role of normally-funded activities and/or responsibilities funded by the commissioning Locally Enhanced Service (LES), then GCCG will provide limited remuneration or backfill to allow full participation in the task on a time limited basis.
- 7.8.2 By using GPs and other healthcare professionals in this way, GCCG aspires to gain involvement from a broader membership of primary care in developing and delivering its work programme than just those members involved in GCCG and the executive leadership of the localities.
- 7.8.3 When working for GCCG, individuals from practices will need to be aware of GCCG policies and work within them. Specific attention is drawn to the 'Declaration of Interests and resolution of conflicts'⁵⁶.

⁵⁵ See appendix P - terms of reference for Memorandum of Understanding

⁵⁶ See Section 8 Standards of Business conduct and Managing Conflicts of Interest
Gloucestershire Clinical Commissioning Group's Constitution

7.9 All Members of GCCG's Governing Body

7.9.1 The Governing Body shall consist of a maximum of 23 members, ~~of whom the majority shall be practising clinicians,~~ as set out in paragraph 6.6.4.

7.9.2 All members of the Governing Body will share responsibility in ensuring that GCCG exercises its functions effectively, efficiently and with good governance and in accordance with the terms of GCCG's Constitution as agreed by its members.

7.9.3 This Constitution and any future iterations of it will be publicly available on GCCG's website, and will also be available on request from GCCG.

7.9.4 Individual members will bring their unique perspective, informed by their expertise and experience. This will underpin decisions made by the Governing Body and will help ensure that as far as reasonably practicable:

- The values and principles of the NHS Constitution are actively promoted;
- The interests of patients and the community remain at the heart of discussions and decisions;
- The Governing Body and the wider GCCG acts in the best interests of the local population at all times;
- GCCG commissions the highest quality services and best possible outcomes for their patients within their resource allocation; and
- Good governance remains central at all times.

7.10 Clinical Chair of the Governing Body

7.10.1 The Clinical Chair of the Governing Body is responsible for:

- Leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities;
- Building and developing the Group's Governing Body and its individual members;
- Ensuring that the Group has proper constitutional and governance arrangements in place;
- Ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;
- Supporting the Accountable Officer in discharging the responsibilities of the organisation;
- Contributing to building a shared vision of the aims, values and culture of the organisation;
- Leading and influencing to achieve clinical and organisational change to enable the Group to deliver its commissioning intentions;
- Overseeing governance and particularly ensuring that the Governing Body and the wider Group behave with the utmost transparency and responsiveness at all times;

- Ensuring that public and patients' views are heard and their expectations understood and, as far as possible, met;
- Ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;
- Ensuring that the group builds and maintains effective relationships, particularly with the Gloucestershire Health and Wellbeing Board (GH&WB).

7.11 The Deputy Clinical Chair of the Governing Body

7.11.1 The Deputy Clinical Chair of the Governing Body deputises for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act.

7.12 Role of the Accountable Officer

7.12.1 The Accountable Officer of the Group is a member of the Governing Body.

7.12.2 The Governing Body will select and appoint an Accountable Officer following ratification by NHS England. The Accountable Officer will be an ex-officio member of the Governing Body.

7.12.3 The Accountable Officer will have specific responsibilities for ensuring that GCCG complies with its financial duties, promotes quality improvements and demonstrates value for money.

7.12.4 The Accountable Officer must be either:

- A GP who is a member of GCCG;
- An employee of GCCG or any member of GCCG; or
- In the case of a joint appointment, an employee or any member of any of the groups in question or any member of those groups.

7.12.5 The Accountable Officer will be responsible for ensuring that GCCG fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money.

7.12.6 The Accountable Officer will ensure that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems.

7.12.7 The Accountable Officer will work closely with the Chair of the Governing Body and will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Governing Body) of the organisation's on-going capability and capacity to meet its duties and responsibilities. This will include arrangements for the on-going developments of its members and staff.

7.12.8 In addition to the Accountable Officer's general duties, where the Accountable Officer is also the senior clinical voice of the group he or she will take the lead in interactions with stakeholders, including NHS England.

7.13 Role of the Chief Financial Officer

7.13.1 The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the Clinical Commissioning Group and for supervising financial control and accounting systems.

7.13.2 This role of Chief Finance Officer has been summarised in a national document⁵⁷ as:

- a) being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
- b) making appropriate arrangements to support and monitor the Group's finances;
- c) overseeing robust audit and governance arrangements leading to propriety in the use of the Group's resources;
- d) being able to advise the Governing Body on the effective, efficient and economic use of the Group's allocation to remain within that allocation and deliver required financial targets and duties; and
- e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England.

7.14 Role of Lay Members

7.14.1 There are four lay members appointed to the Governing Body, one with responsibility for audit, remuneration and conflict of interest matters, two with responsibility for patient and public participation matters (one of whom acts as non-clinical Vice Chair), and a fourth with responsibility for business matters.

7.14.2 The role and focus of the lay member with responsibility for audit, remuneration and conflict of interest matters is strategic and impartial, to provide an external view of the work of GCCG that is removed from the day-to-day running of the organisation. Specific responsibilities include:

- overseeing key elements of governance including audit, remuneration and managing conflicts of interest;

⁵⁷ See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

- chairing the Audit Committee; ensuring that the Governing Body and the wider CCG behaves with the utmost probity at all times; and
- ensuring that appropriate and effective whistle blowing and anti-fraud systems are in place.

7.14.3 The lay members with responsibility for patient and public participation matters will be members of the local community and bring that insight to the work of the Governing Body. These members will ensure that for all aspects of GCCG's business, the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the GCCG. Specific responsibilities include ensuring that:

- public and patients' views are heard and their expectations understood and met as appropriate;
- the Group builds and maintains an effective relationship with Local HealthWatch and draws on existing patient and public engagement and involvement expertise; and
- GCCG has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public.

7.14.4 The lay member with responsibility for business matters will be a member of the local business community and bring that insight to the work of the Governing Body. This member will be removed from the day-to-day running of the organisation, but will have specific responsibilities ensuring that:

- a robust business infrastructure exists and oversees key elements of business including the development of business plans and conflicts of interest;
- act as a specialist reference point in business management;
- understand the impact and operational demands of delivering GCCG strategic priorities in the annual integrated plan, and oversees budgeting decisions around key projects.

7.15 Role of the Registered Nurse

7.15.1 The registered nurse on the Governing Body is to be filled by a qualified individual with a high level of professional expertise and knowledge. A key aspect of the role is to bring a broader view, from their perspective as a registered nurse, on health and care issues to underpin the work of the Group, especially the contribution of nursing to patient care. Specific responsibilities include:

- giving an independent strategic clinical view on all aspects of CCG business;
- bringing detailed insights from nursing and perspectives into discussions regarding service re-design, clinical pathways and system reform.

7.16 Role of the Secondary Care Specialist

7.16.1 The purpose of the secondary care specialist is to bring an understanding of patient care in the secondary care setting to the work of the Governing Body. The individual appointed will have a high level of understanding of how care is delivered in a secondary care setting, preferably with experience working as a leader across more than one clinical discipline and/or specialty with a track record of collaborative working. A specific aspect of this role involves bringing appropriate insight to discussions regarding service redesign, clinical pathways and system reform.

7.17 Joint Appointments with other Organisations

- 7.17.1 At present GCCG does not have any joint appointments with other organisations.
- 7.17.2 Should joint appointments be made in the future, these joint appointments will be supported by a memorandum of understanding between the organisations who are party to these joint appointments.

8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1. Standards of Business Conduct

- 8.1.1. Employees, members, committee and sub-committee members of the Group and members of the Governing Body (and its committees) will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the Group and should follow the *Seven Principles of Public Life*, set out by the Committee on Standards in Public Life (the Nolan Principles). The Nolan Principles are incorporated into this constitution at Appendix G.
- 8.1.2. They must comply with the Group's policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy is available on the Group's website, and is also available on request from GCCG.
- 8.1.3. Individuals contracted to work on behalf of the Group or otherwise providing services or facilities to the Group will be made aware of their obligations with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

8.2. Conflicts of Interest

- 8.2.1. GPs who serve on GCCG also work for, or are partners running, general medical practices in the county. For the avoidance of doubt, in what follows there will be no prima facie conflict of interest sufficient to require a GP member of GCCG to withdraw from any discussion of services to be commissioned by GCCG from general medical practices if the service is to be offered to more practices than those to which the member, or members, involved in the discussion belong.
- 8.2.2. As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, GCCG will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the Group will be taken and seen to be taken without any possibility of the influence of external or private interest.
- 8.2.3. Where an individual, i.e. an employee, Group member, member of the Governing Body, or a member of a committee or a sub-committee of the Group or its Governing Body has an interest, or becomes aware of an interest which could lead to a conflict of interest in the event of the Group considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution.
- 8.2.4. A conflict of interest will include:
 - a) a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

- b) an indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;
- c) a non-pecuniary interest: where an individual holds a non-remunerative or not-for-profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);
- d) a non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);
- e) any duty whatsoever imposed on any member of the Governing Body or its sub-committees', CCG members/clinicians by any other codes of conduct to which the member is subject.
- f) any other interest whatsoever that should be dutifully declared under The Health and Social Care Act 2012 and guidance issued by Department of Health from time to time.
- g) where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.
- h) if the individual is registered with the General Medical Council (GMC), any interest that the individual would be required to declare in accordance with paragraph 55 of the GMC's publication "Management for Doctors" or any successor code, including the referral of any patient to a provider in which the individual has an interest.
- i) if the individual is registered with the Nursing and Midwifery Council (NMC) or other professional body would be required to declare in accordance with paragraph 7 of the NMC's publication Code of Professional Conduct or any successor code including the referral of any patient to a provider in which the individual has an interest.

8.2.5. If in doubt, the individual concerned should assume that a potential conflict of interest exists.

8.3. Declaring and Registering Interests

8.3.1. The Group will maintain one or more registers of the interests of:

- a) the members of the Group;
- b) the members of its Governing Body;

- c) the members of its committees or sub-committees and the committees or sub-committees of its Governing Body; and
- d) its employees.

8.3.2. The registers will be published on the Group's website, and will also be available on request from GCCG.

8.3.3. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the Group, in writing to the Governing Body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

8.3.4. Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

8.3.5. The Accountable Officer will ensure that the registers of interest are reviewed regularly, and updated as necessary.

8.4. **Managing Conflicts of Interest: general**

8.4.1. Individual members of the Group, the Governing Body, committees or sub-committees, ~~the committees or sub-committees of its Governing Body~~ and employees will comply with the arrangements determined by the Group for managing conflicts or potential conflicts of interest.

8.4.2. The Accountable Officer will oversee the management of conflicts of interest on behalf of the Group and will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the Group's decision making processes.

8.4.3. Arrangements for the management of conflicts of interest are to be determined by the Accountable Officer and will include the requirement to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration. The arrangements will confirm the following:

- a) when an individual should withdraw from a specified activity, on a temporary or permanent basis;
- b) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

8.4.4. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the Group's exercise of its commissioning functions, they have received confirmation

of the arrangements to manage the conflict of interest or potential conflict of interest from the Accountable Officer.

- 8.4.5. Where an individual member, employee or person providing services to the Group is aware of an interest which:
- a) has not been declared, either in the register or orally, they will declare this at the start of the meeting;
 - b) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests.
- 8.4.6. The Chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.
- 8.4.7. Where the Chair of any meeting of the Group, including committees, sub-committees, or the Governing Body and the Governing Body's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the Vice Chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the Vice Chair may require the chair to withdraw from the meeting or part of it. Where there is no Vice Chair, the members of the meeting will select one.
- 8.4.8. Any declarations of interests, and arrangements agreed in any meeting of the Clinical Commissioning Group, committees or sub-committees, or the Governing Body, the Governing Body's committees or sub-committees, will be recorded in the minutes.
- 8.4.9. Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the Chair (or deputy) will determine whether or not the discussion can proceed.
- 8.4.10. In making this decision the Chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's Standing Orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential

conflicts of interests, the chair of the meeting shall consult with Accountable Officer on the action to be taken.

- 8.4.11. These arrangements must be recorded in the minutes. This may include:
- a) requiring another of the Group's committees or sub-committees, the Group's Governing Body or the Governing Body's committees or sub-committees (as appropriate) which can be quorate to progress the item of business or, if this is not possible,
 - b) inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the Governing Body or committee / sub-committee in question) so that the Group can progress the item of business:
 - i) a member of the Clinical Commissioning Group who is an individual;
 - ii) an individual appointed by a member to act on its behalf in the dealings between it and the Clinical Commissioning Group;
 - iii) a member of a relevant Health and Wellbeing Board;
 - iv) a member of a Governing Body of another clinical commissioning group.
- 8.4.12. In any transaction undertaken in support of the Clinical Commissioning Group's exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the Accountable Officer of the transaction.
- 8.4.13. The Accountable Officer will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

8.5. Managing Conflicts of Interest: contractors and people who provide services to the group

- 8.5.1. Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the Clinical Commissioning Group in relation to the potential provision of services or facilities to the Group, will be required to make a declaration of any relevant conflict / potential conflict of interest.

8.5.2. Anyone contracted to provide services or facilities directly to the Clinical Commissioning Group will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

8.6. Transparency in Procuring Services

8.6.1. The Group recognises the importance of making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The Group will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

8.6.2. The Group will publish a Procurement Strategy approved by its Governing Body which will ensure that:

- a) all relevant clinicians (not just members of the Group) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;
- b) service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way.

8.6.3. Copies of this Procurement Strategy will be available on the Group's dedicated website, and will also be available on request from GCCG.

9. GCCG AS AN EMPLOYER

- 9.1. GCCG recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the group.
- 9.2. GCCG will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its employment practices are designed to promote diversity and to treat all individuals equally.
- 9.3. The Group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the Group. All staff will be made aware of this Constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.
- 9.4. The Group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The Group will also maintain and publish policies on all aspects of human resources management, including grievance and disciplinary matters.
- 9.5. The Group will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.
- 9.6. The Group will ensure that employees' behaviour reflects the values, aims and principles set out above.
- 9.7. The Group will ensure that it complies with all aspects of employment law.
- 9.8. The Group will ensure that its employees have access to such expert advice and training opportunities as they may require in order to exercise their responsibilities effectively.
- 9.9. The Group will adopt a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned staff have means through which their concerns can be voiced.
- 9.10. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the Group's website, and will also be available on request from GCCG.

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1. General

- 10.1.1. The Group will publish annually a commissioning plan and an annual report, presenting the Group's annual report to a public meeting.
- 10.1.2. Key communications issued by the Group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers will be published on the Group's website, and will also be available on request from GCCG.
- 10.1.3. The Group may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.

10.2. Standing Orders

- 10.2.1. This Constitution is also informed by a number of documents which provide further details on how the group will operate. They are the Group's:
 - a) ***Standing Orders (Appendix C)*** – which sets out the arrangements for meetings and the appointment processes to elect the Group's representatives and appoint to the Group's committees, including the Governing Body;
 - b) ***Scheme of Reservation and Delegation (Appendix D)*** – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the Group's Governing Body, the Governing Body's committees and sub-committees, the group's committees and sub-committees, individual members and employees;
 - c) ***Detailed Scheme of Delegation (Appendix E)***
 - d) ***Prime Financial Policies (Appendix F)*** – which sets out the arrangements for managing the Group's financial affairs.

APPENDIX A DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

| | |
|-------------------------------------|--|
| 2006 Act | National Health Service Act 2006 |
| 2012 Act | Health and Social Care Act 2012 (this Act amends the 2006 Act) |
| Accountable officer (AO) | <p>an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by NHS England, with responsibility for ensuring the group:</p> <ul style="list-style-type: none"> • complies with its obligations under: <ul style="list-style-type: none"> ○ sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), ○ sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), ○ paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and ○ any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by NHS England for that purpose; • exercises its functions in a way which provides good value for money. |
| Area | the geographical area that the Group has responsibility for, as defined in Chapter 2 of this constitution |
| Chair of the Governing Body | in line with national process, the individual appointed will act as Chair of the Governing Body |
| Chief Finance Officer (CFO) | the qualified accountant employed by the Group with responsibility for financial strategy, financial management and financial governance |
| Clinical Commissioning Group | a body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act) |
| Committee | <p>a committee or sub-committee created and appointed by:</p> <ul style="list-style-type: none"> • the membership of the Group • a committee / sub-committee created by a committee created / appointed by the membership of the Group • a committee / sub-committee created / appointed by the Governing Body |
| Financial year | this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March |
| GH&WB | Gloucestershire Health and Wellbeing Board |
| Governing Body | <p>the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with:</p> <ul style="list-style-type: none"> • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it. |
| Governing Body member | any member appointed to the Governing Body of the Group |

| | |
|---------------------------------|--|
| Group | Gloucestershire Clinical Commissioning Group, whose constitution this is |
| Lay Member | a lay member of the Governing Body, appointed by the Group. A lay member is an individual who is not a member of the Group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations |
| Member | a provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix B) |
| Practice representatives | an individual appointed by a practice (who is a member of the Group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act) |
| Registers of interests | registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: <ul style="list-style-type: none"> • the members of the group; • the members of its governing body; • the members of its committees or sub-committees and committees or sub-committees of its governing body; and • its employees. |
| Register of members | sets out the GP practices who are members of GCCG. |

APPENDIX B - LIST OF MEMBER PRACTICES

| Practice Name | Address (Main surgery Only) | Practice Representative's Signature & Date Signed |
|--------------------------------|--|---|
| Cheltenham Locality | | |
| Berkeley Place Surgery | 11 High Street, Cheltenham, Gloucestershire | |
| Corinthian Surgery | St Paul's Medical Centre, 121 Swindon Road, Cheltenham | |
| Crescent Bakery Surgery | Crescent Bakery, St Georges Place, Cheltenham | |
| Leckhampton Surgery | Lloyd Davies House, 17 Moorend Park Road, Cheltenham | |
| Overton Park Surgery | Overton Park Road, Cheltenham, Gloucestershire | |
| Royal Crescent Surgery | 11 Royal Crescent, Cheltenham, Gloucestershire | |
| Royal Well Surgery | St Paul's Medical Centre, 121 Swindon Road, Cheltenham | |
| Seven Posts Surgery | Prestbury Road, Cheltenham, Gloucestershire | |
| Sixways Clinic | London Road, Charlton Kings, Cheltenham | |
| Springbank Surgery | Springbank Way, Cheltenham, Gloucestershire | |
| St Catherine's Surgery | St Paul's Medical Centre, 121 Swindon Road, Cheltenham | |
| St George's Surgery | St Paul's Medical Centre, 121 Swindon Road, Cheltenham | |
| Stoke Road Surgery | 4 Stoke Road, Bishops Cleeve, Cheltenham | |
| The Portland Practice | St Paul's Medical Centre, 121 Swindon Road, Cheltenham | |
| Underwood Surgery | 139 St George's Road, Cheltenham, Gloucestershire | |
| Winchcombe Medical Centre | Greet Road, Winchcombe, Cheltenham | |
| Yorkleigh Surgery | 93 St George's Road, Cheltenham, Gloucestershire | |
| Forest of Dean Locality | | |
| Blakeney Surgery | Millend, Blakeney, Gloucestershire | |
| Brunston Practice | Cinderhill, Coleford, Gloucestershire | |
| Coleford Health Centre | Railway Drive, Coleford, Gloucestershire | |
| Dockham Road Surgery | Dockham Road Surgery, Cinderford, Gloucestershire | |
| Drs Andrew, | Yorkley Health Centre, Bailey Hill, | |

| Practice Name | Address (Main surgery Only) | Practice Representative's Signature & Date Signed |
|---------------------------------|---|---|
| Edwards, Hayes & Cleary | Yorkley, Lydney | |
| Drybrook Surgery | Drybrook, Gloucestershire | |
| Forest Health Care | The Health Centre, Dockham Road, Cinderford | |
| Lydney Practice | The Health Centre, Albert Street, Lydney | |
| Mitcheldean Surgery | Brook Street, Mitcheldean, Gloucestershire | |
| Newnham Surgery | High Street, Newnham on Severn, Gloucestershire | |
| Severnbank Surgery | Tutnalls Street, Lydney, Gloucestershire | |
| Gloucester City Locality | | |
| Barnwood Medical Practice | 51 Barnwood Road, Gloucester, Gloucestershire | |
| Bartongate Surgery | 115 Barton Street, Gloucester, Gloucestershire | |
| Cheltenham Road Surgery | 16 Cheltenham Road, Gloucester, Gloucestershire | |
| Gloucester City Health Centre | The Park, Gloucester, Gloucestershire | |
| Gloucester Health Access Centre | Eastgate House, 121-131 Eastgate Street, Gloucester | |
| Hadwen Medical Practice | Glevum Way Surgery, Abbeydale, Gloucester | |
| Heathville Medical Practice | 5 Heathville Road, Gloucester, Gloucestershire | |
| Hucclecote Surgery | 5A Brookfield Road, Hucclecote, Gloucestershire | |
| Kingsholm Surgery | Alvin Street, Gloucester, Gloucestershire | |
| London Road Medical Practice | 97 London Road, Gloucester, Gloucestershire | |
| Longlevens Surgery | 19b Church Road, Longlevens, Gloucester | |
| Matson Lane Surgery | Taylor House, 4 Matson Lane, Matson | |
| Partners in Health | Pavilion Family Doctors, 153a Stroud Road, Gloucester | |
| Quedgeley Medical Centre | Olympus Park, Quedgeley, Gloucester | |
| Rosebank Health | 153b Stroud Road, Gloucester, Gloucestershire | |
| Saintbridge Surgery | Askwith Road, Saintbridge, | |

| Practice Name | Address (Main surgery Only) | Practice Representative's Signature & Date Signed |
|---------------------------------|---|---|
| | Gloucestershire | |
| St. Johns Avenue Surgery | Churchdown, Gloucester, Gloucestershire | |
| The College Yard Surgery | Mount Street, Westgate, Gloucester | |
| The Surgery | Abbotswood Road, Brockworth, Gloucestershire | |
| North Cotswolds Locality | | |
| Chipping Campden Surgery | Back Ends, Chipping Campden, Glos | |
| Cotswold Medical Practice | Moore Road, Bourton on the Water, Cheltenham | |
| Mann Cottage Surgery | Oxford Street, Moreton in Marsh, Cheltenham | |
| Stow Surgery | Well Lane, Stow on the Wold, Gloucestershire | |
| White House Surgery | High Street, Moreton in Marsh, Gloucestershire | |
| South Cotswolds Locality | | |
| The Avenue Surgery | 1 The Avenue, Cirencester, Gloucestershire | |
| Hilary Cottage Surgery | Keble Lawns, Fairford, Gloucestershire | |
| LechladeMedical Centre | Oak Street, Lechlade, Gloucestershire | |
| The Park Surgery | Old Tetbury Road, Cirencester, Gloucestershire | |
| Phoenix Surgery | 9 Chesterton Lane, Cirencester, Gloucestershire | |
| Rendcomb Surgery | Rendcomb, Cirencester, Gloucestershire | |
| Romney House | 41-43 Long Street, Tetbury, Gloucestershire | |
| St Peter's Road Surgery | 1 St Peter's Road, Cirencester, Gloucestershire | |
| Stroud Locality | | |
| Acorn Practice | May Lane Surgery, Dursley, Gloucestershire | |
| Beeches Green Surgery | Beeches Green, Stroud, Gloucestershire | |
| Chipping Surgery | Symn Lane, Wotton under Edge, Gloucestershire | |
| Culverhay Surgery | Wotton under Edge, Gloucestershire | |
| Frithwood Surgery | 45 Tanglewood Way, Bussage, Stroud | |
| High Street Medical | 31 High Street, Stonehouse, | |

| Practice Name | Address (Main surgery Only) | Practice Representative's Signature & Date Signed |
|---|--|---|
| Centre | Gloucestershire | |
| Hoyland House | Gyde Road, Painswick, Gloucestershire | |
| Locking Hill Surgery | Locking Hill, Stroud, Gloucestershire | |
| Marybrook Medical Centre | Marybrook Street, Berkeley, Gloucestershire | |
| Minchinhampton Surgery | Bell Lane, Minchinhampton, Gloucestershire | |
| Prices Mill Surgery | New Market Road, Nailsworth, Gloucestershire | |
| Regent Street Surgery | 72 Regent Street, Stonehouse, Gloucestershire | |
| Rowcroft Medical Centre | Stroud, Gloucestershire | |
| St Lukes Medical Centre | 53 Cainscross Road, Stroud, Gloucestershire | |
| Stonehouse Health Clinic | High Street, Stonehouse, Gloucestershire | |
| Stroud Valleys Family Practice (Staniforth) | Beeches Green Health Centre, Stroud, Gloucestershire | |
| The Orchard Medical Centre | Fairmead, Cam, Dursley, Gloucestershire | |
| The Surgery | Whitminster Lane Frampton on Severn, Gloucestershire | |
| Uley Surgery | 42 The Street, Uley, Dursley, Gloucestershire | |
| Walnut Tree Practice | May Lane Surgery, Dursley, Gloucestershire | |
| Tewkesbury Locality | | |
| Church Street Practice | 77 Church Street, Tewkesbury, Gloucestershire | |
| Holts Health Centre | Watery Lane, Newent, Gloucestershire | |
| Jesmond House Practice | Chance Street, Tewkesbury, Gloucestershire | |
| The Surgery | Corse, Staunton, Gloucester | |
| Watledge Surgery | Barton Road, Tewkesbury, Gloucestershire | |

APPENDIX C – STANDING ORDERS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

1.1.1. The Standing Orders will regulate the proceedings of the Gloucestershire Clinical Commissioning Group (GCCG) so that the Group can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date GCCG is established.

1.1.2. The Standing Orders, together with the Group's Scheme of Reservation and Delegation⁵⁸, provide a procedural framework within which the Group discharges its business. They set out:

- a) the arrangements for conducting the business of the Group;
- b) the appointment of member practice representatives;
- c) the procedure to be followed at meetings of the Group, the Governing Body and any committees or sub-committees of the Group or the Governing Body;
- d) the process to delegate powers,
- e) the declaration of interests and standards of conduct.

These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate⁵⁹ of any relevant guidance.

1.1.3. The Standing Orders, Scheme of Reservation and Delegation (within the Standing Financial Instructions) have effect as if incorporated into the Group's constitution. Group members, employees, members of the governing body, members of the Governing Body's committees and sub-committees, members of the Group's committees and sub-committees and persons working on behalf of the Group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the Standing orders, scheme of reservation and delegation may be regarded as a disciplinary matter that could result in dismissal.

1.2. Schedule of matters reserved to the Clinical Commissioning Group and the Scheme of Reservation and Delegation

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the Group's functions and those of the Governing Body to certain

⁵⁸ See Appendix D

⁵⁹ Under some legislative provisions the group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.

bodies (such as committees) and certain persons. The Group has decided that certain decisions may only be exercised by the Group in formal session. These decisions and also those delegated are contained in the Group's Scheme of Reservation and Delegation (see Appendix D).

2. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESS

2.1. Composition of Membership

2.1.1. Chapter 3 of the Group's Constitution provides details of the membership of the Group (also see Appendix B).

2.2. Governing Structures

2.2.1. Chapter 6 of the Group's Constitution provides details of the governing structure used in the Group's decision-making processes, whilst Chapter 7 of the Constitution outlines certain key roles and responsibilities within the Group and its Governing Body, including the role of practice representatives (paragraph 7.6 of the Constitution).

2.2.2. The membership of the Governing Body shall be:

- a) Chair; elected from the clinician members of the Governing Body
- b) Not less than 18 members including the following:
 - i) Deputy Clinical Chair;
 - ii) Accountable Officer;
 - iii) Chief Finance Officer;
 - iv) Seven Clinical Commissioning Leads
 - v) Four lay representatives (one as Vice Chair);
 - vi) Secondary Care Specialist;
 - vii) Registered Nurse.

2.2.3. The Governing Body will function as a corporate decision-making body. Their roles as members of the Governing Body will be to consider the key strategic and managerial issues facing the Group in carrying out its statutory and other functions.

2.2.4. The Group may from time to time delegate such functions as it deems appropriate to any and/or all of the governing structures. A list of reserved and delegated functions is included in the groups Scheme of Reservation and Delegation (See Appendix D)

2.3. Key Roles

2.3.1. Paragraph 6.6.4 of the Group's Constitution sets out the composition of the Group's Governing Body whilst Chapter 7 of the Group's Constitution identifies certain key roles and responsibilities within the Group and its Governing Body.

These Standing Orders set out how the Group appoints individuals to these key roles.

2.3.2. The **Accountable Officer**, as described in paragraph 7.12 of the group's constitution, is subject to the following appointment process:

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- a) **Nominations** – subject to the national process as identified by NHS England. All GPs in member practices have the opportunity to apply.
- b) **Eligibility** – compliance with criteria for each post and through sponsorship of GCCG and subject to the provisions of paragraph 6.6.3 of this constitution
- c) **Appointment process** – national process as identified by NHS England;
- d) **Grounds for removal from office** – subject to the Code of Conduct: code of accountability in the NHS publication or any superseding publication,⁶⁰
- e) **Notice period** – 6 months.

2.3.3. The **Clinical Chair**, as described in paragraphs 6.6.7 and 7.10 of the Group's Constitution, is subject to the following appointment process:

- a) **Nominations** – subject to the national process as identified by NHS England. All GPs in member practices have the opportunity to apply;
- b) **Eligibility** – compliance with the criteria for the post and through sponsorship of CCG and subject to the provisions of paragraph 6.6.3 of this constitution, as well as in line with the national guidance;
- c) **Appointment process** – national process as identified by NHS England;
- d) **Term of office** – 4 years;
- e) **Eligibility for reappointment** – subject to national guidance;
- f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution pertaining to eligibility to serve on the Governing Body or following a vote of no confidence taken by two thirds or more of the Member Practice Council at a properly constituted meeting called in line with the provisions of this Constitution ;
- g) **Notice period** –6 months.

2.3.4. The **Deputy Clinical Chair**, as listed in paragraphs 6.6.7 and 7.11 of the Group's Constitution, is subject to the following appointment process:

- a) **Nominations** – sponsorship through CCG;

⁶⁰ Code of Conduct: code of accountability in the NHS published by the DH NHS Appointments Commission
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- b) **Eligibility** – sponsorship through CCG and subject to the provisions of paragraph 6.6.3 of this constitution;
- c) **Appointment process** – sponsorship through CCG;
- d) **Term of office** – 4 years;
- e) **Eligibility for reappointment** – subject to national guidance;
- f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution pertaining to eligibility to serve on the Governing Body or following a vote of no confidence taken by two thirds or more of the Member Practice Council at a properly constituted meeting called in line with the provisions of this constitution ;;
- g) **Notice period** – 6 months.

2.3.5. The Chief Finance Officer (CFO), as listed in paragraph 7.13 of the Group's Constitution, is subject to the following appointment process:

- a) **Nominations** – subject to the national process as identified by NHS England;
- b) **Eligibility** - sponsorship through CCG/NHS and subject to the provisions of paragraph 6.6.3 of this constitution;
- c) **Appointment process** – national process as identified by NHS England;
- d) **Eligibility for reappointment** – subject to national guidance;
- e) **Grounds for removal from office** – subject to the Code of Conduct: code of accountability in the NHS publication or any superseding publication
- f) **Notice period** –6 months.

2.3.6. The **Locality Clinical Commissioning Leads**, as listed in paragraph 6.6.8 and 7.5 of the Group's Constitution, are subject to the following appointment process:

- a) **Nominations** – local election process carried out in conjunction with the LMC;
- b) **Eligibility** –subject to the provisions of paragraph 6.6.3 of this Constitution;
- c) **Appointment process** – local election process carried out in conjunction with the LMC;
- d) **Term of office** – subject to national guidance;
- e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this Constitution pertaining to eligibility to serve on the Governing Body or following a vote of no confidence taken by two thirds or more of the Member Practice Council at a properly constituted meeting called in line with the provisions of this Constitution;

g) **Notice period** – 3 months.

2.3.7. The **Lay Members**, as listed in paragraphs 6.6.9 and 7.14 of the Group's Constitution, is subject to the following appointment process:

a) **Nominations** – local process based on national guidance;

b) **Eligibility** – subject to the provisions of paragraph 6.6.3 of this Constitution;

c) **Appointment process** – national process;

d) **Term of office** – subject to national guidance;

e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this Constitution;

g) **Notice period** –3 months.

2.3.8. The **Nurse Representative**, as listed in paragraphs 6.6.11 and 7.15 of the Group's Constitution, is subject to the following appointment process:

a) **Nominations** – local process;

b) **Eligibility** –subject to the provisions of paragraph 6.6.3 of this Constitution;

c) **Appointment process** – appointment by Chair of CCG following nomination;

d) **Term of office** – subject to national guidance;

e) **Eligibility for reappointment** – subject to national guidance;

f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this Constitution;

g) **Notice period** –3 months.

2.3.9. The **Secondary Care Specialist**, as listed in paragraphs 6.6.12 and 7.16 of the group's constitution, is subject to the following appointment process:

- a) **Nominations** – subject to local process, ensuring there are no conflicts of interest in relation to CCG commissioning responsibilities;
- b) **Eligibility** –subject to the provisions of paragraph 6.6.3 of this constitution;
- c) **Appointment process** – appointment by Chair of CCG following nomination;
- d) **Term of office** – subject to national guidance;
- e) **Eligibility for reappointment** – subject to national guidance;
- f) **Grounds for removal from office** – subject to the provisions of paragraph 6.6.3 of this constitution;
- g) **Notice period** –3 months.

2.3.10. The roles and responsibilities of each of these key roles are described in paragraph 6.6. and Chapter 7 of the Group’s Constitution.

3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1. Calling meetings

- 3.1.1. Ordinary meetings of the Group shall be held at regular intervals at such times and places as the Group may determine and not less than annually.
- 3.1.2. The Chair of the Group may call a meeting at any time.

3.2. Agenda, supporting papers and business to be transacted

- 3.2.1. Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Associate Director Corporate Governance at least 10 working days (i.e. excluding weekends and bank holidays) before the meeting takes place.
- 3.2.2. The request should state whether the business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten working days before a meeting may be included on the agenda at the discretion of the Chair.
- 3.2.3. Supporting papers for such items need to be submitted at least 10 working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least 5 working days before the date the meeting will take place.
- 3.2.4. The Group may determine that certain matters will appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

The Group may also determine that all papers presented should be in a prescribed format. However, the Chair may waive this requirement if, in their opinion, urgency requires that a paper be presented in another format.

- 3.2.5. Agendas and certain papers for the Group's Governing Body – including details about meeting dates, times and venues - will be published on the Group's website, and will also be available on request from GCCG.

3.3. Petitions

- 3.3.1. Where a petition compiled by practice members has been received by the Group, the chair of the Governing Body shall include the petition as an item for the agenda of the next meeting of the Governing Body.

3.4. Chair of a meeting

- 3.4.1. At any meeting of the Group or its Governing Body or of a committee or sub-committee, the chair of the Group, Governing Body, committee or sub-committee, if any and if present, shall preside. If the chair is absent from the meeting, the Vice Chair, if any and if present, shall preside.

- 3.4.2. If the chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If both the chair and Vice Chair are absent, or are disqualified from participating, or there is neither a chair or deputy, a member of the Group, Governing Body, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

3.5. Chair's ruling

- 3.5.1. The decision of the Chair of the Governing Body on questions of order, relevancy and regularity and their interpretation of the constitution, standing orders, scheme of reservation and delegation and prime financial policies at the meeting, shall be final.

3.6. Quorum

- 3.6.1 A quorum will be reached when at least seven members of the Governing Body are present. The attendees should **include specifically**:-
- the Chair or Vice Chair;
 - the Accountable Officer (or deputy);
 - the Chief Finance Officer (or deputy);
 - One Lay Member
 - Three GP/OHP Clinical Commissioning Leads acting on behalf of member practices.
- 3.6.2 If the Chair or a member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards quorum. If a quorum is then not available for discussion and/or the passing of a

resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.6.3 The Accountable Officer (or deputy) will reserve the right to refer a decision to the Governing Body should an item or issue arise where it is judged that approval would secure essential corporate governance.

3.6.4 For all other of the Group's committees and sub-committees, including the Governing Body's committees and sub-committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference.

3.7 Decision making

3.7.3 Chapter 6 of the Group's Constitution, together with the Scheme of Reservation and Delegation, sets out the governing structure for the exercise of the Group's statutory functions. Generally it is expected that decision making at meetings will be by consensus of members. Should this not be possible then a vote of members will be required, the process for which is set out below:

3.7.4 For votes at meetings of the Governing Body:

- **Eligibility** – only designated members of the Governing Body are allowed to vote.
- **Voting Process** - At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot;
- **Majority necessary to confirm a decision** – 75% of members required to make a decision;
- **Casting vote** – In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) shall have a second and casting vote;
- **Dissenting views** – A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

3.7.5 Should a vote of the Governing Body be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

3.7.6 For all other meetings of the Group's committees and sub-committees, including the Governing Body's committees and sub-committees, the process for holding a vote is set out in the appropriate terms of reference.

3.8 Emergency powers and urgent decisions

- 3.8.3 The Chair of GCCG may call a meeting of the Governing Body at any time.
- 3.8.4 Once fully authorised the powers which GCCG has reserved to itself may, in an emergency or where an important decision must be made urgently, be exercised by the Chair or Vice Chair together with the Accountable Officer after having consulted at least two non-officer members. The exercise of such powers by the Chair (or Vice Chair) and Accountable Officer shall be reported to the next formal meeting of GCCG in public session for ratification. In the interim, the power remains with the Chair and the Accountable Officer.
- 3.8.5 One third or more of the member practices of GCCG may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.9 Suspension of Standing Orders

- 3.9.3 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these Standing Orders may be suspended at any meeting, provided at least two thirds of those members present at the meeting of the Governing Body signify their agreement to suspension.
- 3.9.4 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.
- 3.9.5 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Governing Body's Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.
- 3.9.6 No formal business shall be transacted while the Standing Orders are suspended and the decision to do so shall be considered by the Audit Committee

3.10 Variation and amendment of Standing Orders

- 3.10.1 Standing Orders can be varied in the following situations:
- a) upon a recommendation of the Chair and/or Accountable Officer included on the agenda for the meeting;
 - b) two-thirds of the members are present at the meeting where the variation or amendment is being discussed and that at least half of the members vote in favour of the amendment;
 - c) providing that any variation or amendment does not contravene a statutory provision, direction made by the Secretary of State or guidance issued by NHS England.

3.11 Record of Attendance

3.11.1 The names of all members of the meeting present at the meeting shall be recorded in the minutes of the Group's meetings. The names of all members of the Governing Body present shall be recorded in the minutes of the Governing Body meetings. The names of all members of the Governing Body's committees / sub-committees present shall be recorded in the minutes of the respective Governing Body committee / sub-committee meetings.

3.12 Minutes

3.12.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.12.2 The minutes will be formally signed off by the Chair of the meeting and (where appropriate) will be made available to attendees and members of the public.

3.13 Admission of public and the press

3.13.1 The Group will hold meetings in public on a regular basis at such times and places as the Governing Body may determine. Members of the public and representatives of the press may attend all meetings of Governing Body.

3.13.2 The public and representatives of the press, shall be required to withdraw upon the Governing Body resolving as follows:

“that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”

Section 1(2), Public Bodies (Admissions to Meetings) Act 1960.

3.13.3 The above resolution shall be taken in public and there shall be a public statement, either on the agenda or made by the Chair of the meeting, setting out in broad terms the nature of the business to be discussed (which does not breach the confidentiality of the subject matter).

3.13.4 Matters to be dealt with by GCCG following the exclusion of representatives of the press, and other members of the public shall be referred to as “Part II meeting”) and shall be confidential to the members of GCCG.

3.13.5 Members and officers or any employee of GCCG in attendance shall not reveal or disclose the contents of papers or minutes from a Part II meeting outside of GCCG, without the express permission of the Accountable Officer or Chair. This prohibition shall apply equally to the content of any discussion during the Part II meeting which may take place on such reports or papers.

4 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.11 Appointment of committees and sub-committees

4.11.1 The Group may appoint committees and sub-committees of the Group, subject to any regulations made by the Secretary of State⁶¹, and also make provision for the appointment of committees and sub-committees of its Governing Body. Where such committees and sub-committees of the Group, or committees and sub-committees of its Governing Body, are appointed they are included in Chapter 6 of the Group's Constitution.

4.11.2 Other than where there are statutory requirements, such as in relation to the Governing Body's Audit Committee or Remuneration Committee, the Group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the Group.

4.11.3 The provisions of these Standing Orders shall apply where relevant to the operation of the Governing Body, the Governing Body's committees and sub-committee and any other committees and sub-committees of the Group unless stated otherwise in the committee or sub-committee's terms of reference.

4.12 Terms of Reference

4.12.1 Terms of reference shall have effect as if incorporated into the constitution and are set out in Appendices to the Constitution.

4.13 Delegation of Powers by Committees to Sub-committees

4.13.1 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Group.

4.14 Approval of Appointments to Committees and Sub-Committees

4.14.1 The Group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those of the Governing Body. Where the Group determines that persons, who are neither members nor employees, shall be appointed to a committee or sub-committee the terms of such appointment shall be within the powers of the Group. The Group shall define the powers of such appointees and shall agree such travelling or other allowances as it considers appropriate.

⁶¹ See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act

5 DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

5.11 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Governing Body for action or ratification. All members of the Group and staff have a duty to disclose any non-compliance with these Standing Orders to the Accountable Officer as soon as possible.

6 USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1 Clinical Commissioning Group's seal

6.1.1 The Group may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

- a) the Accountable Officer;
- b) the Chair of the Governing Body;
- c) the Chief Finance Officer.

6.2 Execution of a document by signature

6.2.1 The following individuals are authorised to execute a document on behalf of the group by their signature.

- a) the Accountable Officer;
- b) the Chair of the Governing Body;
- c) the Chief Finance Officer.

7 OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS / PROCEDURES AND REGULATIONS

7.1 Policy statements: general principles

7.1.1 The Group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by Gloucestershire Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the Group's Standing Orders.

APPENDIX D – SCHEME OF RESERVATION & DELEGATION

1. SCHEDULE OF MATTERS RESERVED TO THE CLINICAL COMMISSIONING GROUP AND SCHEME OF DELEGATION

- 1.1. The arrangements made by the Group as set out in this scheme of reservation and delegation of decisions shall have effect as if incorporated in the Group's Constitution.
- 1.2. GCCG remains accountable for all of its functions, including those that it has delegated.
- 1.3 The paragraphs below indicate GCCG has reserved and delegated decisions.

1.3.1 Regulation and Control

GCCG will:

- Make arrangements by which the members of GCCG approve the decisions that are reserved for the membership.
- Approve applications to NHS England on any matter concerning changes to the GCCG Constitution, including terms of reference for the Group's Governing Body, its committees, membership of committees, the overarching Scheme of Reservation and Delegated Powers, arrangements for taking urgent decisions, standing orders and Prime Financial Policies.
- Exercise or delegate GCCG functions which have not been retained as reserved by the Group, delegated to the Governing Body, delegated to a committee or sub-committee of the Group or to one of its members or employees.
- Prepare GCCG's overarching Scheme of Reservation and Delegation, which sets out those decisions of the Group reserved to the membership and those delegated to the:
 - Group's Governing Body;
 - committees and sub-committees of the Group; or
 - the Group's members or employees,

and sets out those decisions of the Governing Body reserved to the Governing Body and those delegated to the:

- Governing Body's committees and sub-committees;
- members of the Governing Body;
- an individual who is member of the Group but not the Governing Body or a specified person;

for inclusion in the GCCG Constitution.

- Approve the GCCG overarching Scheme of Reservation and Delegation.
- Prepare GCCG operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of GCCG, not for inclusion in the Group's Constitution.
- Approve GCCG's operational scheme of delegation that underpins the Group's 'overarching Scheme of Reservation and Delegation' as set out in its Constitution.
- Prepare detailed financial policies that underpin the GCCG Prime Financial Policies.
- Approve detailed financial policies.
- Approve arrangements for managing exceptional funding requests.
- Set out who can execute a document by signature / use of the seal.

1.3.2 Practice Member Representatives and Members of the Governing Body

Responsibilities of member practices to GCCG will include:

- Actively engage with GCCG to help improve services within the area.
- Share all appropriate information and data to support delivery of referral and other prescribing and emergency admissions data.
- Through a Clinical Programme Group approach, follow the clinical pathways and referral protocols agreed by GCCG (except in individual cases where there are justified clinical reasons for not doing this) which are fed back appropriately.
- Manage the practice's prescribing budget within allocated resource.
- Participate in and deliver, as far as possible, the clinical, quality, safety and cost effective strategies agreed by GCCG and GH&WB.
- Establish a practice reference group as a means of obtaining the views and experiences of patients and carers.
- Work constructively with the locality sub-committee/GCCG.
- Respond in a timely manner to reasonable information requests from GCCG.
- Approve the appointment of governing body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.
- Approve arrangements for identifying the group's proposed Accountable Officer.

1.3.3 Strategy and Planning

GCCG will:

- Agree the vision, values and overall strategic direction of GCCG.
- Approve GCCG operating structure.
- Approve GCCG commissioning plan.

- Approve GCCG corporate budgets that meet the financial duties as set out in paragraph 5.3 of the main body of the Constitution.
- Approve variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the group's ability to achieve its agreed strategic aims.

1.3.4 Annual Reports and Accounts

GCCG will:

- Approve GCCG annual report and annual accounts.
- Approve arrangements for discharging GCCG statutory financial duties.

1.3.5 Human Resources

GCCG will:

- Approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.
- Approve terms and conditions of employment for all employees of GCCG including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group.
- Approve any other terms and conditions of services for GCCG's employees.
- Determine the terms and conditions of employment for all employees of the Group.
- Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.
- Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.
- Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the clinical commissioning group) and for other persons working on behalf of the Group.
- Review disciplinary arrangements where the Accountable Officer is an employee or member of another clinical commissioning group
- Approval of the arrangements for discharging GCCG's statutory duties as an employer.
- Approve human resources policies for employees and for other persons working on behalf of GCCG.

1.3.6 Quality and Safety

GCCG will:

- Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.
- Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.

1.3.7 Operational and Risk Management

GCCG will:

- Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within GCCG.
- Approve GCCG's counter fraud and security management arrangements.
- Approve the Group's risk management arrangements.
- Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).
- Approve a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of GCCG.
- Approve proposals for action on litigation against or on behalf of GCCG.
- Approve GCCG arrangements for business continuity and emergency planning.

1.3.8 Information Governance

GCCG will:

- Approve GCCG's arrangements for handling complaints.
- Approve arrangements for ensuring appropriate confidentiality in relation to GCCG's records, including patients' medical records, and for the secure storage, management and transfer of information and data.

1.3.9 Tendering and Contracting

GCCG will:

- Approve GCCG contracts for any commissioning support.
- Approve GCCG contracts for corporate support (for example finance provision).

1.3.10 Partnership Working

GCCG will:

- Approve decisions that individual members or employees of CCG participating in joint arrangements on behalf of the Group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.
- Approve decisions delegated to joint committees established under section 75 of the 2006 Act.

1.3.11 Commissioning and Contracting for Clinical Services

GCCG will:

- Approve arrangements for discharging GCCG's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement

in the quality of services, obtaining appropriate advice and public engagement and consultation.

- Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate

1.3.12 Communications

GCCG will:

- Approve arrangements for handling Freedom of Information requests.
- Determine arrangements for handling Freedom of Information requests.

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|------------------------|--|----------------------------|---|---------------------|-----------------------|----------------|
| REGULATION AND CONTROL | | | | | | |
| | Determine the arrangements by which the members of the Group approve those decisions that are reserved for the membership. | ✓ | | | | |
| | Consideration and approval of applications to NHS England on any matter concerning changes to the Group's Constitution, including terms of reference for the Group's Governing Body, its committees, membership of committees, the overarching Scheme of Reservation and Delegated powers, arrangements for taking urgent decisions, Standing Orders and Prime Financial Policies. | ✓ | | | | |
| | Exercise or delegation of those functions of the Clinical Commissioning Group which have not been retained as reserved by the Group, delegated to the Governing Body or other committee or sub-committee or [specified] member or employee. | | | ✓ | | |
| | Require and receive the declaration of interests from members of the Governing Body. | | ✓ | | | |
| | Require and receive the declaration of interests from members, practice representatives and employees of the Group. | | | ✓ | | |
| | Approve arrangements for dealing with Complaints. | | ✓ | | | |
| | Adopt the organisation structures, processes and procedures to facilitate the | | ✓ | | | |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|-------------|---|----------------------------|---|---------------------|-----------------------|----------------|
| | discharge by the Group of its statutory and other functions and to agree modifications thereto. | | | | | |
| | Receive reports from committees that the Group is required by statute or other regulation to establish and to take action upon those reports as necessary. | | ✓ | | | |
| | Confirm the recommendations of the Group's committees where the committees do not have executive powers. | | ✓ | | | |
| | Approve arrangements relating to the discharge of the Group's responsibilities as a corporate trustee for funds held on trust. | | ✓ | | | |
| | Note the terms of reference of sub-committees established by committees of the Group and/or Governing Body. | | ✓ | | | |
| | Manage members of the Group, practice representatives, members of the Governing Body or employees who are in breach of statutory requirements or the Group's Standing Orders. | | ✓ | | | |
| | Approve any urgent decisions taken by the Chair of the Governing Body and the Accountable Officer for ratification by the Group in public session. | | ✓ | | | |
| | Ratify or otherwise instances of failure to comply with the Standing Orders brought to the attention of the Accountable Officer. Such failures to be reported to the Group in formal session. | | ✓ | | | |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|--|--|----------------------------|---|---------------------|-----------------------|----------------------|
| | Approve procedure for the declaration of hospitality and/or hospitality received. | | ✓ | | | |
| PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY | | | | | | |
| | Appoint and remove practice representatives. | | | | | ✓ Member Practice |
| | Appoint the Chair of the Governing Body. | | ✓ | | | |
| | Remove the Chair of the Governing Body in advance of their term of office expiring. | ✓ | | | | |
| | Appoint the Deputy Chair(s) of the Governing Body. | | ✓ | | | |
| | Remove the Deputy Chair(s) of the Governing Body in advance of their term of office expiring. | ✓ | | | | |
| | Appoint and dismiss other committees (and individual members) that are directly accountable to the Governing Body. | | ✓ | | | |
| | Appoint, appraise, discipline and dismiss employee members of the Governing Body. | | ✓ | | | |
| | Confirm the appointment of members of any committee of the Group as representatives of the Group on outside bodies. | | ✓ | | | |
| | Note the proposals of the Remuneration Committee and to note the proposals of the Accountable Officer for those staff not considered by the Remuneration Committee | | | | | |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|-----------------------|---|----------------------------|---|---------------------|-----------------------|----------------|
| STRATEGY AND PLANNING | | | | | | |
| | Define the strategic aims and objectives of the Group. | | ✓ | | | |
| | Identify key strategic risks, evaluate them and ensure adequate responses are in place and are monitored. | | ✓ | | | |
| | Approve plans in respect of the application of available financial resource to support the agreed local commissioning priorities. | | ✓ | | | |
| | Approve proposals for ensuring quality and developing clinical governance in services provided by the groups contractors having regard to any guidance issued by NHS England. | | ✓ | | | |
| | Approve the Group's annual commissioning strategy and plan. | | ✓ | | | |
| | Approve outline and final business cases for capital investment if this represents a variation from the strategic plan. | | ✓ | | | |
| | Approve all budgets of the Group. | | ✓ | | | |
| | Approve annually the organisational development proposals of the Group. | | ✓ | | | |
| | Ratify the Governing Body's proposals for the development of the Group. | ✓ | | | | |
| | Ratify proposals for the acquisition, disposal or change of use of real property. | | ✓ | | | |
| | Approve banking arrangements. | | ✓ | | | |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|------------------------------------|---|----------------------------|---|---------------------|-----------------------|----------------|
| | Approve proposals in individual cases for the write off of losses or making special payments above the limits of delegation to the Accountable Officer and Chief Finance Officer (for losses and special payments). | | ✓ | | | |
| | Approve individual compensation payments. | | ✓ | | | |
| | Approve the Group's strategies as recommended by committees or the employee members of the Governing Body. | | ✓ | | | |
| | Ratify the Group's strategies as recommended by the Governing Body. | ✓ | ✓ | | | |
| | Note the Group's corporate and clinical policies as advised by committees with delegated powers of approval as contained in their terms of reference to approve policies on behalf of the Governing Body. | | ✓ | | | |
| | Approve Group policies as defined for Governing Body approval. | | ✓ | | | |
| | Note Group policies as approved by the Governing Body and/or its committees. | ✓ | | | | |
| ANNUAL REPORTS AND ACCOUNTS | | | | | | |
| | Ratify the appointment (and where necessary dismissal) of External Auditors including arrangements for the separate audit of funds held on trust. | ✓ | ✓ | | | |
| | Receive the annual management letter received from the External Auditor, taking account of the advice, where appropriate, of the Audit Committee. | | ✓ | | | |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|------------------------|--|----------------------------|---|---------------------|-----------------------|-----------------------------|
| | Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee. | | ✓ | | | |
| | Receipt and approval of the Group's Annual Report and Accounts. | | ✓ | | | |
| | Receipt and approval of the Annual Report and Accounts for funds held on trust, if any. | | ✓ | | | |
| | Receipt of such reports as the Governing Body sees fit from its committees and/or other committees of the Group in respect of their exercise of powers delegated to them. | | ✓ | | | |
| HUMAN RESOURCES | | | | | | |
| | Approve the terms and conditions, remuneration and travelling and other allowances for members of the Governing Body, including pensions and gratuities. | | | | | ✓ Remuneration Committee |
| | Approve terms and conditions of employment for all employees of the Group, including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the Group. | | | | | ✓ Remuneration Committee |
| | Approve any other terms and conditions of service for the Group's employees. | | | | | ✓ Remuneration Committee |
| | Determine the terms and conditions of employment for all employees of the Group. | | | | | ✓ Remuneration Committee |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|--------------------|---|----------------------------|---|---------------------|-----------------------|--|
| | Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group. | | | | | ✓ Remuneration Committee |
| | Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group. | | | | | ✓ Remuneration Committee |
| | Approve disciplinary arrangements for employees, including the Accountable Officer (where they are an employee and/or member of the Clinical Commissioning Group) and for other persons working on behalf of the Group. | | | | | ✓ Remuneration Committee |
| | Review disciplinary arrangements where the Accountable Officer is an employee or member of another clinical commissioning Group. | | | | | ✓ Remuneration Committee |
| | Approval of the arrangements for discharging the Group's statutory duties as an employer. | | | | | ✓ Remuneration Committee |
| | Approve human resources policies for employees and for other persons working on behalf of the Group. | | | | | ✓ Remuneration Committee Integrated Governance and Quality Committee |
| QUALITY AND SAFETY | | | | | | |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|---------------------------------|---|----------------------------|---|---------------------|-----------------------|---|
| | Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes. | | | | | ✓ Integrated Governance and Quality Committee |
| | Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services. | | ✓ | | | |
| OPERATIONAL AND RISK MANAGEMENT | | | | | | |
| | Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the Group. | | | ✓ | | |
| | Approve the Group's counter fraud and security management arrangements. | | | | | ✓ Audit Committee |
| | Approve the Group's risk management arrangements. | | | | | ✓ Integrated Governance and Quality Committee |
| | Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006). | | ✓ | | | ✓ Integrated Governance Audit Committee |
| | Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and | | | | | ✓ Audit Committee |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|---------------------------|--|----------------------------|---|---------------------|-----------------------|---|
| | economic operation of the Group. | | | | | |
| | Approve proposals for action on litigation against or on behalf of the Clinical Commissioning Group. | | ✓ | | | |
| | Approve the Group's arrangements for business continuity and emergency planning. | | | ✓ | | |
| INFORMATION GOVERNANCE | | | | | | |
| | Approve the Group's arrangements for handling complaints. | | | | | ✓ Integrated Governance <u>and</u> Quality Committee |
| | Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data. | | | | | ✓ Integrated Governance <u>and</u> Quality Committee |
| TENDERING AND CONTRACTING | | | | | | |
| | Approval of the Group's contracts for any commissioning support. | | ✓ | | | |
| | Approval of the Group's contracts for corporate support (for example finance provision). | | ✓ | | | |
| PARTNERSHIP WORKING | | | | | | |
| | Approve decisions that individual members or employees of the Group participating in | | ✓ | | | |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|---|--|----------------------------|---|---------------------|-----------------------|--|
| | joint arrangements on behalf of the Group can make. Such delegated decisions must be disclosed in this Scheme of Reservation and Delegation. | | | | | |
| | Approve decisions delegated to joint committees established under section 75 of the 2006 Act. | | ✓ | | | |
| COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES | | | | | | |
| | Approval of the arrangements for discharging the Group's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation. | | | | | ✓ Integrated Governance <u>and</u> <u>Quality</u> Committee |
| | Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate. | | | | | ✓ <u>Integrated</u> <u>Governance</u> <u>Committee</u> <u>Governing</u> <u>Body</u> |
| COMMUNICATIONS | | | | | | |
| | Approving arrangements for handling Freedom of Information requests. | | | | | ✓ Integrated Governance <u>and</u> |

| Policy Area | Decision | Reserved to the Membership | Reserved or delegated to Governing Body | Accountable Officer | Chief Finance Officer | Other (stated) |
|-------------|--|----------------------------|---|---------------------|-----------------------|--|
| | | | | | | <u>Quality</u> Committee |
| | Determining arrangements for handling Freedom of Information requests. | | | | |  Integrated Governance <u>and</u> <u>Quality</u> Committee |

APPENDIX E – DETAILED SCHEME OF DELEGATION

- The Detailed Delegated Limits outlined below represent the lowest level to which authority within the CCG is delegated
- Delegation to lower levels or other offices is not permitted without the specific authority of in writing of the Accountable Officer or the Chief Finance Officer. All items concerning Finance must be carried out in accordance with Prime Financial Policies and Standing Orders.
- Delegated authority may be exercised by a **formally nominated deputy** in the absence of the primary delegate.
- In certain circumstances the limits of authorisation in this document may be temporarily amended. Such amendments will be communicated by the Accountable Officer or Chief Finance Officer using cascade e-mails.

| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|--------------------------------------|---|---|------------------------|
| Prime Financial Policies - Sec 7 | <p>1. Management of Budgets</p> <p>Responsibility to keep expenditure within budgets and to ensure that budgets are only used for the type of expenditure for which they have been set.</p> <p>At individual budget level (Pay and Non Pay)</p> <p>At Directorate level</p> <p>All Other Areas</p> <p>Accountable officer for the CCG</p> | <p>Budget Holder</p> <p>Director</p> <p>Chief Finance Officer/<u>Accountable Officer</u> Accountable Officer</p> | |
| Prime Financial Policies - Sec 11 | <p>2. Maintenance/Operation of Bank Accounts</p> <p>2.</p> | <p>Chief Finance Officer</p> <p>Governing Body</p> | In accordance with PFP |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|--------------------------------------|--|--|---------------------|
| | a) Approval of banking arrangements b) Variation to approved signatories | Chief Finance Officer | |
| Prime Financial Policies - Sec 17 | 3. Non Pay Revenue and Capital Expenditure / Requisitioning / Ordering a) Payment of Goods and Services <ul style="list-style-type: none"> • Stock/non-stock requisitions up to £1,000 • Stock/non-stock requisitions up to £10,000 • Stock/non stock requisitions up to £249,999 | Budget Manager Budget Holder Directors | |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|----------------------------------|--|---|---------------------|
| | <ul style="list-style-type: none"> • Stock/non stock requisitions from £250,000 to £499,999 • Stock/non stock requisitions from £500,000 to £999,999 • Stock/non stock requisitions from £1,000,000 | <p>Chief Finance Officer</p> <p>Accountable Officer</p> <p>Governing Body</p> | |
| | b) Authorisation of Payments against an signed NHS Contract or signed s75 or s256 with the Local Authority | Accountable Officer Chief Finance Officer, Director, Deputy Director of Commissioning, Deputy CFO | |
| Prime Financial Policies - Sec 7 | <p>f) Approval of Virements</p> <p>Between commissioning budgets up to £50,000 or between admin budgets/provider patient services non-recurrently up to £10,000</p> <p>Between commissioning budgets up to</p> | <p>Budget Holder</p> <p>Chief Finance Officer</p> | |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|-----------------------------------|---|--|---------------------|
| | £100,000 or between admin budgets recurrently and/or up to £50,000 Above £100,000 between commissioning budgets or above £50,000 between admin budgets | Accountable Officer | |
| | g) Orders exceeding 36 month period | Accountable Officer or Chief Finance Officer | |
| | h) All contracts for Non Health Care goods & services and subsequent variations to contracts | As section 3a | |
| | i) Prepayments over £1,500 | Chief Finance Officer or Deputy CFO | |
| Prime Financial Policies - Sec 18 | 4. Capital Schemes a) Delegated Limits for Capital Investment for buildings, PFI, IM&T | | |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
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| | <p>and equipment investments, and property leases</p> <ul style="list-style-type: none"> • Up to £35 million • From £35 million and above • Selection of Architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations • Financial monitoring and reporting | <p>NHS Commissioning Board <u>England – subject to full business case approval and following approval by Governing Body</u></p> <p>Department of Health and HM Treasury</p> <p>Accountable Officer or Chief Finance Officer</p> <p>Chief Finance Officer</p> | |

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| | on all capital scheme expenditure | | |
| Prime Financial Policies - Sec 13 | <p><u>5.1 Quotation, Tender and & Contract Procedures (including secondary, primary and community healthcare services) where no suitable nationally negotiated framework agreements / contracts are available for use:</u></p> <p><u>(Values are the total value of expenditure excluding VAT for the total duration of any time period committed to):</u></p> <p>a) <u>No requirement to obtain quotes for single items up to £1,000</u></p> <p>b) <u>2 written quotes for goods / services between £1,000 and £5,000.</u></p> <p>c) <u>Obtaining a minimum of 3 written quotations for goods / services from £5,000 to £50,000</u></p> | <p><u>As per section 3</u></p> <p><u>As per section 3</u></p> <p><u>As per section 3</u></p> | |

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| | <u>d) Obtaining a minimum of 3 written competitive tenders for goods / services from £50,000 (process by delegated procurement personnel).</u> | <u>As per section 3</u> | |
| | <u>e) Contracts above European Union (OJEU) limits.</u> | <u>Chief Finance Officer / Deputy CFO</u> | |
| | <u>f) Approval to accept quote / tender other than the lowest that meet the award criteria Quotations & tenders <£99,999</u> <u>Tenders >£100,000</u> | <u>Chief Finance Officer</u> | |
| | <u>g) Waiving of quotations & Tenders subject to SOs & PFP</u> | | |
| | <u>Up to £99,999</u> | <u>Chief Finance Officer</u> | |
| | <u>£100,000 - £249,999</u> | <u>Accountable Officer</u> | |

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| | <p>£250,000+</p> <p><u>Opening Quotations:</u></p> <p>5. Opening Tenders: Quotation, Tendering & Contract Procedures including secondary, primary and community healthcare services (Values are the total value of expenditure including VAT for the total duration of any time period committed to)</p> <p>a) No requirement to obtain quotes for single items up to £1,000 or for items to be purchased using a nationally negotiated contract (via Purchasing and Supply Agency)</p> <p>b) 2 written quotes for expenditure between £1,000 and £5,000.</p> | <p><u>Governing Body</u></p> <p><u>Directors and Senior Manager</u></p> <p><u>Accountable Officer and Directors, Deputy CFO, Associate Director of Corporate Governance</u></p> <p><u>As per section 3</u></p> | <p>Report to Audit & Assurance Committee</p> |

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| | <p>e) Obtaining a minimum of 3 written quotations for goods/services from £5,000 to £50,000</p> <p>d) Obtaining a minimum of 3 written competitive tenders for goods and services from £50,000 process by Purchasing & Supplies Dept</p> <p>e) Contracts above EU OJEU limits, process by Purchasing & Supplies Dept</p> <p>f) Approval to accept quote/tender other than the lowest that meet the award criteria</p> <p>— Quotations & tenders < £100,000</p> <p>— Tenders > £100,000</p> | <p>As per section 3</p> <p>As per section 3</p> <p>As per section 3</p> <p>Chief Finance Officer / Deputy CFO</p> <p>Chief Finance Officer</p> | |

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| | <p><u>5.2. A Mini-Competition* or Direct Call-Off* for goods or services of any value (including secondary, primary and community healthcare services) against a suitable nationally negotiated framework agreements / contracts:</u></p> <p><u>*In accordance with framework terms and conditions of contract.</u></p> <p><u>Up to £1,000</u></p> <p><u>Between £1,000 and £5,000</u></p> <p><u>From £50,000</u></p> <p><u>g) Waiving of quotations & Tenders</u> <u>— subject to SOs & PFP</u></p> <p><u>— Up to £99,000</u></p> | <p><u>As per section 3</u></p> <p><u>As per section 3</u></p> <p><u>As per section 3</u></p> <p><u>Chief Finance Officer</u></p> | <p><u>Report to Audit Committee</u></p> |

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| | <p>£100,000 – £249,999</p> <p>£ 250,000 +</p> <p>Opening Quotations:</p> <p>Opening Tenders:</p> | <p>Accountable Officer</p> <p>Governing Body</p> <p>Directors and Senior Managers</p> <p>Accountable Officer and Directors, Deputy CFO, Associate Director of Corporate Governance</p> | |
| Prime Financial Policies - Sec 12 | <p>6. Setting of Fees and Charges</p> <p>a) Private Patient, Overseas Visitors, Income Generation and other patient related services</p> <p>b) Price of NHS Contracts</p> <p>c) Price of Non NHS Contracts</p> | <p>Chief Finance Officer or Deputy CFO</p> <p>Chief Finance Officer or Deputy CFO</p> <p>Chief Finance Officer or</p> | |

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| | | Deputy CFO | |
| | <p>7. Income Collection</p> <ul style="list-style-type: none"> • Cancellation of invoices incorrectly raised <£75,000 • Cancellation of invoices incorrectly raised >£75,000 • Authority to pursue legal action for bad debts • Write off of bad debt <£5,000 • Write off of bad debt >£5,000 • Approval of write offs relating to over payment of salary | <p><u>Chief Finance Officer or Deputy CFO</u></p> <p>Chief Finance Officer</p> <p>Chief Finance Officer <u>or Deputy CFO</u></p> <p>Deputy CFO Chief Finance Officer</p> <p>Chief Finance Officer</p> | |
| Prime Financial Policies - Sec 14 | 8. Agreement and Signing of Contracts for the purchasing of Health Care and Agreements with the Local | | |

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| | <p>Authority</p> <p>Signing of Health Care Contracts</p> <p>3 years or less, and <u>Contracts of</u> less than £10,000,000</p> <p>3 years or less, and <u>Contracts greater than</u> £10,000,000 or greater</p> <p>Variations to contracts</p> <p>Signing of Agreements between the PCT <u>CCG</u> and the Local Authority</p> | <p>Director of Commissioning Implementation <u>or Chief Finance Officer</u></p> <p>Accountable Officer <u>or Chief Finance Officer</u></p> <p>Director of Commissioning Implementation <u>or Chief Finance Officer</u></p> <p>Accountable Officer / Chief Finance Officer or Director of Commissioning Implementation</p> | |

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| Prime Financial Policies - Sec 7 | <p>9. Engagement of Staff Not On the Establishment</p> <p>a) Non Medical Consultancy Staff or total commitment is <£20,000 in one year where budget is available >£20,000 or where no budget available</p> <p>b) Engagement of CCG's Solicitors</p> | <p>Accountable Officer and Chief Finance Officer</p> <p>Associate Director of Corporate Governance</p> | |
| | c) Booking of Bank or Agency Staff | Budget Manager | |
| Prime Financial Policies - Sec 20 | 10. Expenditure on Charitable and Endowment Funds | Designated Fund Managers in accordance with procedures and limits | |

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| | | laid down for charitable funds by the corporate trustee | |
| | <p>11. Agreements/Licences/Leases</p> <p>a) Preparation of all tenancy agreements/licences for all staff subject to PCT-CCG Policy on accommodation for staff</p> <p>b) Initial review of all proposed lease agreements to assess financial implications of lease agreement</p> <p>c) Authorisation to sign leases/licences</p> <p style="padding-left: 40px;">Signature of all tenancy agreements/licences (as above)</p> <p>d) extensions to existing licences and leases } </p> | <p>Director responsible for Estates</p> <p>Deputy CFO</p> <p>NHS Commissioning Board England</p> <p>Accountable Officer or Chief Finance Officer</p> <p>Chief Finance Officer</p> | |

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| | e) Letting of premises to outside organisations } | Chief Finance Officer | |
| | f) Approval of rent based on professional assessment | Chief Finance Officer | |
| Prime Financial Policies - Sec 18 | <p>12. Condemning & Disposal</p> <p>Maintain losses and special payments register</p> <p>a) Items obsolete, obsolescent, redundant, irreparable or cannot be required cost effectively</p> <p>1) with current/estimated purchase price <£499</p> <p>2) with current purchase new price >£500+</p> | <p>Chief Finance Officer</p> <p>Budget Manager</p> <p>Chief Finance Officer</p> | |

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| | 3) Disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale) | Chief Finance Officer | |
| | b) Disposal of property or land | Governing Body | |
| | 13.Losses, Write –off & Compensation | | |
| | a) Losses of cash due to: <ul style="list-style-type: none"> 1) Theft, Fraud, etc 2) Overpayments of Salaries, wages, fees & allowances 3) Other Causes including un-vouched or incompletely vouched payments, overpayments other than those included under item 2: physical losses of cash and cash equivalents, e.g. stamps due to fire (other than arson), accident and similar causes | | |
| | Up to £10,000 | Chief Finance Officer | |

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| | <p>Up to £215,000 Over £215,000</p> <p>Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> | <p>Accountable Officer Governing Body</p> <p>NHS Commissioning BoardEngland prior to submission to DH</p> <p>HM Treasury</p> | |
| | <p>b) Fruitless payments (including abandoned capital Schemes)</p> <p>Up to £10,000 Up to £215,000 Over £215,000</p> <p>Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> | <p>Chief Finance Officer Accountable Officer Governing Body</p> <p>NHS Commissioning BoardEngland prior to submission to DH</p> <p>HM Treasury</p> | |
| | <p>c) Bad debts and claims abandoned:-</p> <p>1) Private patients (Sect. 65/ 66 NHS</p> | | |

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| | <p>Act 1977)</p> <p>2) Overseas visitors (Sect. 121 NHS Act 1977)</p> <p>3) Cases other than 1) – 2)</p> <p>Up to £10,000 Up to £125,000 Over £215,000 Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> | <p>Chief Finance Officer Accountable Officer Governing Body NHS Commissioning BoardEngland prior to submission to DH</p> <p>HM Treasury</p> | |
| | <p>d) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:</p> <p>1) Culpable causes e.g. theft, fraud, arson or sabotage whether proved or suspected,</p> | | |

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| | <p>neglect of duty or gross carelessness</p> <p>2) Other causes Up to £10,000 Up to 215,000 Over £215,000</p> <p>Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> | <p>Chief Finance Officer Accountable Officer Governing Body</p> <p>NHS Commissioning BoardEngland prior to submission to DH</p> <p>HM Treasury</p> | |
| | e) Compensation payments made under legal obligation | Governing Body | |
| | <p>f) Extra contractual payments to contractors Up to £10,000 Up to £215,000 Over £215,000</p> | <p>Chief Finance Officer Accountable Officer Governing Body</p> | |

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| | Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05) | NHS Commissioning Board <u>England</u> prior to submission to DH HM Treasury | |
| | g) Ex gratia payments to patients & staff for loss of personal effects Up to £10,000 Up to £ 2 5,000 Over £ 2 5,000 Novel, contentious or repercussive cases Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05) | Chief Finance Officer Accountable Officer Governing Body NHS Commissioning Board <u>England</u> prior to submission to DH HM Treasury | |
| | h) For clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied (including | | |

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| | <p>plaintiffs costs)</p> <ul style="list-style-type: none"> • Up to £10,000 • Up to £215,000 • Over £215,000 <p>Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> <p>For Clinical negligence where the guidance relating to such payments has not been applied</p> <ul style="list-style-type: none"> • Up to £1,000 • Up to £5,000 | <p>Chief Finance Officer Accountable Officer Governing Body</p> <p>NHS Commissioning Board <u>England</u> prior to submission to DH HM Treasury</p> <p><u>Chief Finance Officer</u> <u>Accountable Officer</u></p> | |

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| | <ul style="list-style-type: none"> Over £5,000 <p>Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> | <p><u>Governing Body</u></p> <p>Chief Finance Officer Accountable Officer Governing Body</p> <p>NHS Commissioning Board<u>England</u> prior to submission to DH HM Treasury</p> | |
| | <p>i) For personal injury claims involving negligence where relevant guidance has been applied (including plaintiffs costs)</p> <ul style="list-style-type: none"> Up to £1,000 Up to £15,000 Over £15,000 | <p>Chief Finance Officer Accountable Officer Governing Body</p> | |

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| | <p>Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> <p>For personal injury claims involving negligence where legal advice obtained and relevant guidance has not been applied</p> <ul style="list-style-type: none"> • Up to £1,000 • Up to £5,000 • Over £5,000 <p>Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> | <p>NHS Commissioning Board<u>England</u> prior to submission to DH HM Treasury</p> <p>Chief Finance Officer Accountable Officer Governing Body</p> <p>NHS Commissioning Board<u>England</u> prior to submission to DH HM Treasury</p> | |
| | j) Other clinical negligence cases & | | |

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| | <p>personal injury claims</p> <p>Up to £1,000 Up to £15,000 Over £15,000</p> <p>Novel, contentious or repercussive cases</p> <p>Special severance payments (Dear Accounting Officer letter DAO (GEN) 11/05)</p> | <p>Chief Finance Officer Accountable Officer Governing Body</p> <p>NHS Commissioning Board<u>England</u> prior to submission to DH</p> <p>HM Treasury</p> | |
| | <p>k) Other, except cases of maladministration where there was no financial loss by claimant</p> <p>All</p> | <p>Governing Body</p> | |
| | <p>1) Others 2) Maladministration where there was no financial loss by claimant 3) Patient referrals outside the UK and EEA guidelines</p> | | |

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| | 4) Extra statutory and extra regulatory payments All | Governing Body | |
| Prime Financial Policies - Sec 4 | 14.Reporting of Incidents to the Police a) Where a criminal offence is suspected <ul style="list-style-type: none"> • criminal offence of a violent nature • other b) Where a fraud is involved | Appropriate Manager Chief Finance Officer or Accountable Officer | |
| Prime Financial Policies - Sec 12 | 15.Petty Cash Disbursements (not applicable to central Cashiers Office) <ul style="list-style-type: none"> • General Expenditure up to £25 per item | As determined by the Chief Finance Officer | |
| | 16.Receiving Hospitality Applies to both individual and | Declaration required in | |

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| | collective hospitality In excess of £25.00 per item received | CCG Hospitality Register | |
| Prime Financial Policies - Sec 3 | 17.Implementation of Internal and External Audit Recommendations | Budget Manager or Director | |
| Prime Financial Policies - Sec 2 | 18.Maintenance & Update of PCT Financial Procedures | Chief Finance Officer | |
| Prime Financial Policies - Sec 16 | 19.Personnel & Pay a) Authority to fill funded post on the establishment with permanent staff including the ability to alter skill mix within existing budget b) Authority to appoint staff to post not on the <u>b)</u> funded establishment c) The granting of additional salary increments to staff within budget | HR Lead and Budget Holder <u>Core Team</u> Accountable Officer HR Lead and Relevant Director | |

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| | d) All requests for upgrading or regrading shall be dealt with in accordance with CCG Procedure | | |
| | e) <u>Establishments</u> 1) Additional staff to the agreed establishment with specifically allocated finance. 2) Additional staff to the agreed establishment without specifically allocated finance | Director with the Chief Finance Officer Accountable Officer and Chief Finance Officer | |
| | f) <u>Pay</u> a) Authority to complete standing data forms effecting pay, new starters, variations and leavers b) Authority to complete and | HR Lead and Budget Manager Budget Manager | |

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| | authorise positive reporting forms | | |
| | c) Authority to authorise overtime | Budget Holder | |
| | d) Authority to authorise mileage claims, subsistence expenses & exam fees | Budget-Line Manager | |
| | e) Submission of travel and subsistence claims within 3 months of incurring expenditure | Employee | |
| | f) Authorisation of travel expenses over 3 months old | Chief Finance Officer | |
| | g) Authorisation of non travel, subsistence or exam fees through expenses claim form | Chief Finance Officer Budget Manager | Exceptional circumstances only, supplies procedure should be followed |
| | Approval of Performance Related Pay Assessment | Line/Departmental Manager | |

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| | g) <u>Leave</u> a) Approval of annual leave b) Compassionate leave up to 3 days c) Compassionate leave up to 6 days d) Special leave arrangements <ul style="list-style-type: none"> • Paternity leave • Carers leave 3/5 days e) Leave without pay | } } } } As per CCG policy } } } } } } | |
| | f) Time off in lieu | Line manager | |
| | g) Maternity Leave – paid and unpaid | As per CCG policy | |
| | h) <u>Sick Leave</u> <ul style="list-style-type: none"> • Extensions of sick leave beyond CCG terms and Conditions • Return to work part-time on full pay day to assist recovery in excess of PCT terms and conditions • Extension of sick leave on full pay | Director in conjunction with HR Lead Director in conjunction with HR Lead Accountable Officer or Chief Finance Officer and | |

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| | in excess of PCT terms and conditions | HR Lead | |
| | i) <u>Study Leave</u> <ul style="list-style-type: none"> Study leave outside the UK All study leave (UK) in excess of PCT <u>CCG</u> training procurement | Accountable Officer Accountable Officer or Director | |
| | j) <u>Removal Expenses, Excess Rent and House Purchases</u> Authorisation of payment of removal expenses in accordance with PCT <u>CCG</u> policy incurred by officers taking up new appointments (providing consideration was promised at interview) Up to £5,000 Over £5,000 to £8,000 maximum | Director Accountable Officer or Chief Finance Officer | |
| | k) <u>Grievance Procedure</u> All grievances cases must be dealt with strictly in accordance with the Grievance | HR Lead | CCG Grievance Procedure |

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| | Procedure and the advice of the Human Resource Manager must be sought when the grievance reaches the level of General Manager | | |
| | <p data-bbox="481 571 1037 603">l) <u>Authorised Car & Mobile Phone Users</u></p> <ul data-bbox="526 655 1037 1173" style="list-style-type: none"> <li data-bbox="526 655 1037 726">• Requests for new posts to be authorised as car users <li data-bbox="526 735 1037 885">• Requests for existing post to be authorised as car users from the current financial year– standard, regular or lease car users <li data-bbox="526 895 1037 1045">• Requests for existing post to be authorised as car users from the prior to current financial year– standard, regular or lease car users <li data-bbox="526 1054 1037 1173">• Requests for new posts to be authorised as mobile telephone users | <p data-bbox="1064 651 1361 683">Director and HR Lead</p> <p data-bbox="1064 730 1361 762">Director and HR Lead</p> <p data-bbox="1064 930 1350 962">Chief Finance Officer</p> <p data-bbox="1064 1137 1406 1208">Budget Holder <u>Director & and</u> HR Lead</p> | |

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| | m) <u>Renewal of Fixed Term Contract</u> | Director | |
| | n) <u>Redundancy</u> | Accountable Officer / Chief Finance Officer and HR Lead | Redeployment and Redundant policy |
| | o) <u>Ill Health Retirement</u> Decision to pursue retirement on the grounds of ill-health | Chief Finance Officer and HR Lead | |
| | p) <u>Dismissal</u> | Director or nominated deputy | Disciplinary policy |
| Prime Financial Policies - Sec 15 | 25. Insurance Policies and Risk Managment | Accountable Officer / Associate Director Corporate Governance | |
| | 26. Patients' & Relatives' Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively | Accountable Officer and Associate Director of Patient and Public | |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|--------------------|--|---|---------------------|
| | b) Responsibility for ensuring complaints relating to directorate are investigated thoroughly c) Medico – Legal Complaints - Coordination of their management | Involvement Accountable Officer and Associate Director Corporate Governance | |
| | 27. Relationships with Press a) Non-Emergency General Enquiries <ul style="list-style-type: none"> • Within Hours • Outside Hours b) Emergency <ul style="list-style-type: none"> • Within Hours | Communications Manager Manager on call or Associate Director of Communications Communications Manager | |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|--------------------|--|--|---------------------|
| | <ul style="list-style-type: none"> Outside Hours | Manager on call or Associate Director of Communications | |
| | 28. Infectious Diseases & Notifiable Outbreaks | Manager on call or Health Protection Unit Contact or Director of Public Health | |
| | 31. Facilities for staff not employed by the PCT to gain practical experience Professional Recognition, Honary Contracts, & Insurance of Medical Staff Work experience students | HR Lead HR Lead | |
| | 32. Review of Fire Precautions | Director responsible for Health & Safety | |
| | 33. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations | Director responsible for Health & Safety | |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|--------------------|---|------------------------------------|---------------------|
| | 34. Review of Medicines Inspectorate Regulations | Head of Medicines Management | |
| | 35. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal | Director responsible for Estates | |
| | 36. Review of PCT's compliance with the Data Protection Act | Chief Finance Officer | |
| | 37. Monitor proposals for contractual arrangements between the PCT and the outside bodies | Appropriate Director | |
| | 38. Review the PCT's compliance with the Access to Records Act | Chief Finance Officer | |
| | 39. Review of the PCT's compliance Code of Practice for handling confidential information in the contracting environment and the compliance with "safe Haven" per EL 92/60 | Chief Finance Officer | |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|-----------------------------------|---|---|---------------------|
| | 40. The keeping of a Declaration of Interests Register (a) Board and Executive Committee Members (b) Staff members | Associate Director of Corporate Governance | |
| | 41. Attestation of sealings in accordance with Standing Orders (a) custody (b) register of sealings | Chair, Accountable Officer <u>or Chief Finance Officer</u> | |
| | 42. The keeping of the register of Sealings | Accountable Officer | |
| | 43. The keeping of the Hospitality Register | Accountable Officer | |
| Prime Financial Policies – Sec 19 | 44. Retention of Records | Associate Director of Corporate Governance | |
| | 46. Security Management | Director responsible for Local Security | |
| | 48. Contractor's Responsibilities Ensuring contractors and their | All employees | |

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| Reference Document | Delegated Matter | Delegated Authority - Commissioner | Scope of Delegation |
|--------------------|--|------------------------------------|---------------------|
| | employees are aware of any requirement to comply with Standing Orders and Prime Financial Policies | | |

SUMMARY OF KEY RESPONSIBILITIES OF ALL EMPLOYEES UNDER STANDING ORDERS AND PRIME FINANCIAL POLICIES

| Responsibility: | Of |
|--|--------------------------|
| To comply with all procedures implemented by the Governing Body, Accountable Officer or Chief Financial Officer to ensure compliance with Standing Orders and Prime Financial Policies | All employees |
| To report instances of non-compliance with Standing Orders and Prime Financial Policies | All employees |
| To act in such a way as to maintain the security of all CCG property | All employees |
| To report losses immediately to the Chief Financial Officer following the process laid down | All employees |
| To inform the Chief Financial Officer following the process laid down of any income due to the PCT-CCG in respect of their area of responsibility | All employees |
| To inform the appropriate person, in accordance with the guidance and options laid down, of any suspicion of fraud or corruption | All employees |
| To declare in accordance with the procedures laid down, any gifts or hospitality or sponsorship received | All employees |
| To declare in accordance with the procedures laid down any interests which may conflict with fulfilment of their role | All employees |
| To comply with the Standards of Business Conduct for NHS Staff | All employees |
| To set in place arrangements to maintain the security of all CCG property within their area of responsibility | Senior managers |
| To comply with the Code of Conduct for NHS Managers | Senior Managers |
| To comply with Protocol for Avoidance of Potential Conflicts of Interest and Potential Unfair Competitive Advantage. | All staff as appropriate |

APPENDIX F - PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

- 1.1.1. These Prime Financial Policies and supporting Detailed Financial Procedures shall have effect as if incorporated into the Group's Constitution.
- 1.1.2. The Prime Financial Policies are part of the Group's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the Scheme of Reservation and Delegation found at Appendix D.
- 1.1.3. In support of these Prime Financial Policies, the Governing Body has prepared more detailed procedures, approved by the Chief Finance Officer known as *detailed financial* procedures. The Group refers to these Prime Financial Policies and Detailed Financial Procedures together as the Clinical Commissioning Group's financial policies.
- 1.1.4. These Prime Financial Policies identify the financial responsibilities which apply to everyone working for the Group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the Detailed Financial Procedures. The Chief Finance Officer is responsible for approving all Detailed Financial Procedures.
- 1.1.5. A list of the Clinical Commissioning Group's Detailed Financial Procedures will be published and maintained on the Group's website. Documentation will also be available upon request for inspection at:

Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucestershire GL3 4FE

This information will also be available from PALS who can be contacted on 0800 0151548 or email: glccg.pals@nhs.net

- 1.1.6. Should any difficulties arise regarding the interpretation or application of any of the Prime Financial Policies then the advice of the Chief Finance Officer must be sought before acting. The user of these Prime Financial Policies should also be familiar with and comply with the provisions of the Group's Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.1.7 Failure to comply with Prime Financial Policies and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these Prime Financial Policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Governing Body's Audit Committee for referring action or ratification. All of the Group's members and employees have a duty to disclose any non-compliance with these Prime Financial Policies to the Chief Finance Officer as soon as possible.

1.3. Responsibilities and delegation

1.3.1. The roles and responsibilities of the Group's members, employees, members of the Governing Body, members of the Governing Body's committees and sub-committees, members of the Group's committee and sub-committee (if any) and persons working on behalf of the Group are set out in chapters 6 and 7 of this Constitution.

1.3.2. All Governing Body members and employees who carry out a financial function must keep financial records and discharge their duties in a manner that is satisfactory to the Chief Finance Officer

1.3.3. The financial decisions delegated by members of the Governing Body are set out in the Group's Scheme of Reservation and Delegation (see Appendix D).

1.4. Contractors and their employees

1.4.1. Any contractor or employee of a contractor who is empowered by the Group to commit the Group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that such persons are made aware of this.

1.5. Amendment of Prime Financial Policies

1.5.1. To ensure that these Prime Financial Policies remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the Governing Body's Audit Committee, the Chief Finance Officer will recommend amendments, as fitting, to the Governing Body for approval. As these Prime Financial Policies are an integral part of the Group's Constitution, any amendment will not come into force until the Group applies to NHS England and that application is granted.

2. INTERNAL CONTROL

POLICY – the Group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.

- 2.1. The Governing Body is required to establish an Audit Committee with terms of reference agreed by the Governing Body (see paragraph 6.6.6 (a) of the Group's Constitution for further information).
- 2.2. The Accountable Officer has overall responsibility for the Group's systems of internal control.
- 2.3. The Chief Finance Officer will ensure that:
 - a) financial policies are considered for review and update annually;
 - b) a system is in place for proper checking and reporting of all breaches of financial policies; and
 - c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

POLICY – the Group will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews.

- 3.1. In line with the terms of reference for the Governing Body's Audit Committee, the person appointed by the Group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to Audit Committee members and the Chair of the Governing Body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.
- 3.2. The person appointed by the Group to be responsible for internal audit and the external auditor will have access to the Audit Committee and the Accountable Officer to review audit issues as appropriate. All Audit Committee members, the Chair of the Governing Body and the Accountable Officer will have direct and unrestricted access to the head of internal audit and external auditors.
- 3.3. The Chief Finance Officer will ensure that:
 - a) the Group has a professional and technically competent internal audit function; and

- b) the Governing Body approves any changes to the provision or delivery of assurance services to the Group.

3.4. The Chief Finance Officer or designated internal or external auditor is entitled, without necessarily giving prior notice, to require and receive:

- a) Access to all records, documents and correspondence relating to any financial or other relevant transactions including documents of a confidential nature with regards to the business of the Clinical Commissioning Group.
- b) Access at all reasonable times to any land, premises or property of the Clinical Commissioning Group.
- c) Explanations concerning any matter under investigation.

4. FRAUD AND CORRUPTION

POLICY – the Group requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered.

- 4.1. The Governing Body's Audit Committee will satisfy itself that the Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.
- 4.2. The Governing Body's Audit Committee will ensure that the Group has arrangements in place to work effectively with NHS Protect.

5. EXPENDITURE CONTROL

- 5.1. The Group is required by statutory provisions⁶² to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.
- 5.2. The Accountable Officer has overall executive responsibility for ensuring that the Group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.
- 5.3. The Chief Finance Officer will:
 - a) provide reports to NHS England in the form required by NHS England;

⁶² See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act
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- b) report the financial position of the Clinical Commissioning Group to the Governing Body.
- c) ensure money drawn from NHS England is required for approved expenditure only is drawn down only at the time of need and follows best practice;
- d) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. ALLOTMENTS⁶³

6.1. The Group's Chief Finance Officer will:

- a) periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the Group's entitlement to funds;
- b) prior to the start of each financial year submit to the Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and
- c) regularly update the Governing Body on significant changes to the initial allocation and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the Group will produce and publish an annual operating plan which spans the medium term (i.e. the current and next financial years) and includes reference to the QIPP programme and commissioning intentions, and that explains how the Group proposes to discharge its financial duties. The group will support this with comprehensive medium-term financial plans and annual budgets.

- 7.1. The Accountable Officer will compile and submit to the Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.
- 7.2. Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the Governing Body.
- 7.3. The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body. This report

⁶³ See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.

should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

- 7.4. Financial monitoring information will also incorporate an assessment of the forecast outturn position based on levels of expenditure being incurred and the risks to non-achievement of the plan.
- 7.5. The Accountable Officer is responsible for ensuring that information relating to the Group's accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.
- 7.6. The Governing Body will approve consultation arrangements for the Group's commissioning strategy⁶⁴.

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the Group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations⁶⁵, relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England.

- 8.1. The Chief Finance Officer will ensure the Group:
 - a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Governing Body;
 - b) prepares the accounts according to the timetable approved by the Governing Body;
 - c) complies with statutory requirements and relevant directions for the publication of annual report;
 - d) considers the external auditor's management letter and fully addresses all issues within agreed timescales; and
 - e) publishes the external auditor's management letter on the Group's website.. Documentation will be available upon request for inspection at:

Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucestershire GL3 4FE

⁶⁴ See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act

⁶⁵ See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012

Act.

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This information will also be available from PALS who can be contacted on 0800 0151548 or email: glccg.pals@nhs.net

9. INFORMATION TECHNOLOGY

POLICY – the group will ensure the accuracy and security of the group's computerised financial data.

9.1. The Chief Finance Officer is responsible for the accuracy and security of the Group's computerised financial data and shall:

- a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Group's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;
- b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
- c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
- d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.

9.2. In addition the Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10. ACCOUNTING SYSTEMS

POLICY – the Group will run an accounting system that creates management and financial accounts.

10.1. The Chief Finance Officer will ensure:

- a) the Group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England;
- b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and

timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

- 10.2. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

POLICY – the Group will keep enough liquidity to meet its current commitments.

- 11.1. The Chief Finance Officer will:

- a) review the banking arrangements of the Group at regular intervals to ensure they are in accordance with Secretary of State directions⁶⁶, best practice and represent best value for money;
- b) manage the Group's banking arrangements and advise the Group on the provision of banking services and operation of accounts;
- c) prepare detailed instructions on the operation of bank accounts.

- 11.2. The Accountable Officer shall approve the banking arrangements.

12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

POLICY – the Group will:

- operate a sound system for prompt recording, invoicing and collection of all monies due;
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions;⁶⁷
- ensure its power to make grants and loans is used to discharge its functions effectively.⁶⁸

- 12.1. The Chief Financial Officer is responsible for:

- a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;
- b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

⁶⁶ See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act

⁶⁷ See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.

⁶⁸ See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.

- c) approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by statute. Independent professional advice on matters of valuation shall be taken as necessary;
- d) developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

POLICY – the Group:

- will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending;
- will seek value for money for all goods and services;
- shall ensure that competitive tenders are invited for
 - the supply of goods, materials and manufactured articles;
 - the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
 - for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals.

- 13.1. The Group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the Group's Governing Body.
- 13.2. The Governing Body may only negotiate contracts on behalf of the Group, and the Group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:
 - a) the Group's Standing Orders;
 - b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and
 - c) take into account as appropriate any applicable NHS England or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.
- 13.3. In all contracts entered into, the Group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the Group.

14. COMMISSIONING

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POLICY – working in partnership with relevant national and local stakeholders, the Group will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility.

- 14.1. The Group will coordinate its work with NHS England, other clinical commissioning groups, local providers of services, local authority(ies), including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.
- 14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.
- 14.3. The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT AND INSURANCE

POLICY – the Group will put arrangements in place for evaluation and management of its risks.

- 15.1. The CCG will adopt a Risk Management Strategy that will outline the organisation's approach to managing risk. A key feature of the strategy will be the maintenance of a Risk Register that will be used to record and monitor risks. It is intended that the Risk Register will be presented to each meeting of the Integrated Governance and Quality Committee to provide on-going oversight and review.
- 15.2. An Assurance Framework will also be maintained to provide details of the assurances that will be provided to the Governing Body regarding the achievement of the organisation's Annual Objectives. The Assurance Framework will identify gaps in assurances and controls regarding the objectives, along with details of the major risks that have been identified. The Assurance Framework will also be presented to each meeting of the Integrated Governance and Quality Committee as part of the oversight and review activity.

16. PAYROLL

POLICY – the Group will put arrangements in place for an effective payroll service.

- 16.1. The Chief Finance Officer will ensure that the payroll service selected:
 - a) is supported by appropriate (i.e. contracted) terms and conditions;

- b) has adequate internal controls and audit review processes;
- c) has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll.

17. NON-PAY EXPENDITURE

POLICY – the Group will seek to obtain the best value for money goods and services received.

17.1. The Governing Body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers.

17.2. The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

- a) advise the Accountable Officer on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation;
- b) be responsible for the prompt payment of all properly authorised accounts and claims;
- c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

POLICY – the Group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place policies to secure the safe storage of the Group's fixed assets.

18.1. The Accountable Officer will:

- a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

- b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges;
- d) be responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2. The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

19. RETENTION OF RECORDS

POLICY – the Group will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance.

19.1. The Accountable Officer shall:

- a) be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance;
- b) ensure that arrangements are in place for effective responses to Freedom of Information requests;
- c) publish and maintain a Freedom of Information Publication Scheme.

20. TRUST FUNDS AND TRUSTEES

POLICY – the Group will put arrangements in place to provide for the appointment of trustees if the group holds property on trust.

20.1. The Chief Finance Officer shall ensure that each trust fund which the Group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

APPENDIX G - NOLAN PRINCIPLES

The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

- a) **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- b) **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards
- d) and benefits, holders of public office should make choices on merit.
- e) **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- f) **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- g) **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- h) **Leadership** – Holders of public office should promote and support these principles by leadership and example.

Source: *The First Report of the Committee on Standards in Public Life* (1995)⁶⁹

⁶⁹ Available at <http://www.public-standards.gov.uk/>
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APPENDIX H – SEVEN KEY PRINCIPLES OF THE NHS CONSTITUTION

The NHS Constitution sets out seven key principles that guide the NHS in all it does:

1. **the NHS provides a comprehensive service, available to all** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population
2. **access to NHS services is based on clinical need, not an individual's ability to pay** - NHS services are free of charge, except in limited circumstances sanctioned by Parliament.
3. **the NHS aspires to the highest standards of excellence and professionalism** - in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.
4. **NHS services must reflect the needs and preferences of patients, their families and their carers** - patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.
5. **the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population** - the NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being
6. **the NHS is committed to providing best value for taxpayers' money and the most cost-effective, fair and sustainable use of finite resources** - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves
7. **the NHS is accountable to the public, communities and patients that it serves** - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS

should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)⁷⁰

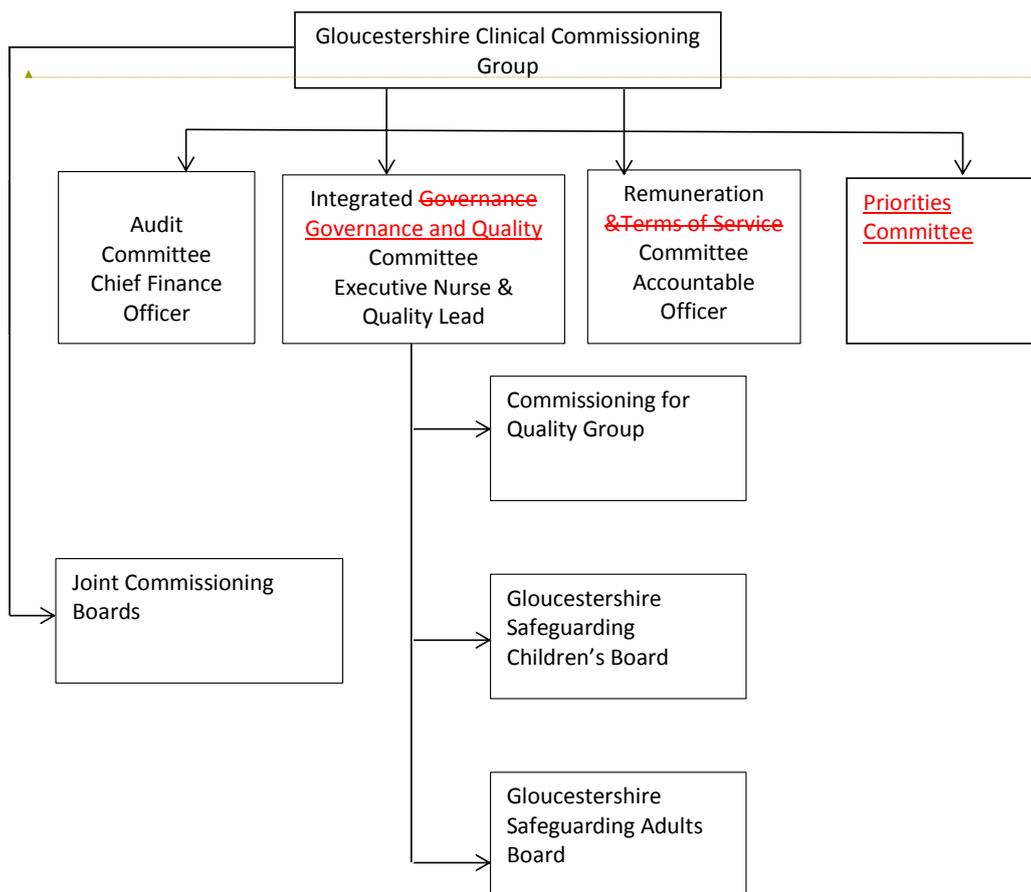
⁷⁰ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

APPENDIX I – CHECKLIST FOR A CLINICAL COMMISSIONING GROUP’S CONSTITUTION

| Essential/ Optional | Content | Included |
|------------------------|--|----------|
| Essential | <p>The constitution must specify:</p> <ul style="list-style-type: none"> • the name of the clinical commissioning group; • the members of the group; and • the area of the group <p>The name of the group must comply with such requirements as may be prescribed</p> | ✓ |
| Essential | <p>The constitution must specify the arrangements made by the clinical commissioning group for the discharge of its functions (including its functions in determining the terms and conditions of its employees)</p> | ✓ |
| Optional | <p>The arrangements may include provision:</p> <ul style="list-style-type: none"> • for the appointment of committees or sub-committees of the clinical commissioning group; and • for any such committees to consist of or include persons other than members or employees of the clinical commissioning group | ✓ |
| Optional | <p>The arrangements may include provision for any functions of the clinical commissioning group to be exercised on its behalf by:</p> <ul style="list-style-type: none"> • any of its members or employees; • its governing body; or • a committee or sub-committee of the group | ✓ |
| Essential | <p>The constitution must specify the procedure to be followed by the clinical commissioning group in making decisions</p> | ✓ |
| Essential | <p>The constitution must specify the arrangements made by the clinical commissioning group for discharging its duties in respect of registers of interest and management of conflicts of interest as specified under section 14O(1) to (4) of the 2006 Act, as inserted by section 25 of the 2012 Act</p> | ✓ |
| Essential | <p>The constitution must also specify the arrangements made by the clinical commissioning group for securing that there is transparency about the decisions of the group and the manner in which they are made</p> <p>The provisions made above must secure that there is effective participation by each member of the clinical commissioning group in the exercise of the group’s functions</p> | ✓ |
| Essential | <p>The constitution must specify the arrangements made by the clinical commissioning group for the discharge of the functions of its governing body</p> | ✓ |
| Essential | <p>The arrangements must include:</p> <ul style="list-style-type: none"> • provision for the appointment of the audit committee and remuneration committee of the governing body | ✓ |

| Essential/ Optional | Content | Included |
|------------------------|---|----------|
| Optional | The arrangements may include: <ul style="list-style-type: none"> • provision for the audit committee (but not the remuneration committee) to include individuals who are not members of the governing body • provision for the appointment of other committees or sub-committees of the governing body. These may include provision for a committee or sub-committee to include individuals who are not members of the governing body but are: <ul style="list-style-type: none"> ○ members of the clinical commissioning group, or ○ individuals of a description specified in the constitution | ✓ |
| Optional | The arrangements may include provision for any functions of the governing body to be exercised on its behalf by: <ul style="list-style-type: none"> • any committee or sub-committee of the governing body, • a member of the governing body; • a member of the clinical commissioning group who is an individual (but is not a member of the governing body); or • an individual of a description specified in the constitution | ✓ |
| Essential | The constitution must specify the procedure to be followed by the governing body in making decisions | ✓ |
| Essential | The constitution must also specify the arrangements made by the clinical commissioning group for securing that there is transparency about the decisions of the governing body and the manner in which they are made This provision must include provision for meetings of governing bodies to be open to the public, except where the clinical commissioning group considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting | ✓ |
| Essential | In its constitution, the clinical commissioning group must describe the arrangements which it has made and include a statement of the principles which it will follow in implementing those arrangements, to secure that individuals to whom health services are being or may be provided pursuant to its commissioning arrangements are involved (whether by being consulted or provided with information or in other ways): <ul style="list-style-type: none"> • in the planning of the commissioning arrangements by the group; • in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and • in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact | ✓ |

Gloucestershire Clinical Commissioning Group
Proposed Governance Structure



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NHS Gloucestershire Clinical Commissioning Group

Governing Body Audit Committee Terms of Reference

1. Introduction

- 1.1. The Audit Committee (the Committee) is established in accordance with Gloucestershire Clinical Commissioning Group's Constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

2. Membership

- 2.1. The Committee shall be appointed by the Clinical Commissioning Group as set out in the Clinical Commissioning Group's Constitution and may include individuals who are not on the Governing Body.
- 2.2. The membership of the Audit Committee shall include:-
- the lay member of the Governing Body with a lead role in overseeing key elements of governance
 - two other lay members
 - two GP Governing Body members
- 2.3. The lay member on the Governing Body, with a lead role in overseeing key elements of governance, will chair the audit committee.
- 2.4. In the event of the Chair of the Committee being unable to attend all or part of the meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.
- 2.5. The Chair of the Governing Body shall not be a member of the Audit Committee.
- 2.6. Members of the Committee shall cease to be members of the Committee if they are no longer members of the Governing Body.
- 2.7. The members from the GP members of the Governing Body shall not be in the majority.

3. Attendance

- 3.1. The Committee shall invite the Chief Finance Officer, the respective internal and external auditors and a representative of NHS Protect/Counter Fraud to attend meetings of the Committee.
- 3.2. Additionally the Committee may invite any individual to attend any or part of its meetings.
- 3.3. The Committee may invite any person to attend meetings to provide advice and/or expertise as required. Any such person shall not be a member of the Committee and shall withdraw upon request.
- 3.4. Any individual invited to attend the Committee may contribute to the proceedings and provide advice and/or guidance to the Committee as requested.
- 3.5. Notwithstanding the above provisions, external audit, internal audit and local counter fraud and security management providers will have full and unrestricted rights of access to the committee in respect of their **audit** functions.

4. Secretary

4.1. The Committee Secretary shall be the Associate Director Corporate Services.

5. Quorum

5.1. The quorum of the Committee shall be three members, two of whom must be lay members.

6. Frequency and notice of meetings

6.1. The Committee shall meet not less than four times each financial year.

6.2. The Chair of the Committee may convene additional meetings as required.

6.3. The external auditor or internal auditor may requisition a meeting of the Committee if it is deemed necessary.

6.4. Written notice of meetings and the agenda shall be provided to Committee members not less than 5 working days before the meeting.

6.5. Notice of Committee meetings and the agenda shall also be provided to the Accountable Officer, Chief Finance Officer and the Clinical Commissioning Group employee responsible for internal audit.

6.6. The Committee shall meet in private with the internal and external auditors not less than annually.

6.7. The Committee shall meet with the Accountable Officer not less than annually to discuss and consider the process for assurance that supports the Statement on Internal Control.

7. Remit and responsibilities of the Committee

7.1. The Committee shall critically review the Clinical Commissioning Group's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

7.2. The key duties of the Committee are:-

Integrated governance, risk management and internal control

7.3. The Committee shall review the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities that support the achievement of the Clinical Commissioning Group's objectives.

7.4. In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the Clinical Commissioning Group.
- the underlying assurance processes that indicate the degree of achievement of the Clinical Commissioning Group's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

7.5. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

7.6. This will be evidenced through the Committee's use of an effective assurance structure to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

7.7. The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the audit committee, Accountable Officer and the Clinical Commissioning Group. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the clinical commissioning group.
- An annual review of the effectiveness of internal audit.

External audit

7.8. The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Clinical Commissioning Group and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Clinical Commissioning Group and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

- 7.9. The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the Clinical Commissioning Group.
- 7.10. These will include, but will not be limited to, any reviews by Department of Health arms-length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

Counter fraud

- 7.11. The Committee shall satisfy itself that the Clinical Commissioning Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

Management

- 7.12. The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 7.13. The Committee may also request specific reports from individual functions within the Clinical Commissioning Group as they may be appropriate to the overall arrangements.

Financial reporting

- 7.14. The Audit Committee shall monitor the integrity of the financial statements of the Clinical Commissioning Group and any formal announcements relating to the Clinical Commissioning Group's financial performance.
- 7.15. The Committee shall ensure that the systems for financial reporting to the Clinical Commissioning Group, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Clinical Commissioning Group.
- 7.16. The Audit Committee shall review the annual report and financial statements before submission to the Clinical Commissioning Group, focusing particularly on:
- The wording in the governance statement and other disclosures relevant to the terms of reference of the committee;
 - Changes in, and compliance with, accounting policies, practices and estimation techniques;
 - Unadjusted mis-statements in the financial statements;
 - Significant judgements in preparing of the financial statements;
 - Significant adjustments resulting from the audit;
 - Letter of representation; and
 - Qualitative aspects of financial reporting.

8. Relationship with the Governing Body

Authority

- 8.1. The Committee is authorised by the Governing Body to obtain professional advice, including the appointment of external advisor and/or consultants, related to its functions as it deems fit at the expense of the Clinical Commissioning Group.
- 8.2. The Committee shall recommend appropriate action(s) should be taken by the Governing Body in allowing the Committee to fulfil its terms of reference.

Monitoring and Reporting

- 8.3. The minutes of each meeting of the Committee shall be formally recorded and retained by the Clinical Commissioning Group. The minutes shall be submitted to the Governing Body.
- 8.4. The Chair of the Committee shall report the outcome and any recommendations of the committee to the Governing Body.
- 8.5. The Committee shall report to the Governing Body annually on its work in support of the Statement of Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework process.

9. Policy and best practice

- 9.1. The Committee shall have regard to current good practice, policies and guidance issued by the NHS England, the Clinical Commissioning Group and other relevant bodies.

10. Conduct of the Committee

- 10.1. The Committee shall conduct its business in accordance with these terms of reference and the Clinical Commissioning Group's governance arrangements.

NHS Gloucestershire Clinical Commissioning Group

Governing Body Remuneration Committee Terms of Reference

1. Introduction

- 1.1 The remuneration committee (the committee) is established in accordance with NHS Gloucestershire Clinical Commissioning Group's constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the clinical commissioning group's constitution and standing orders.

2. Membership

- 2.1 The committee shall be appointed by the clinical commissioning group from amongst its governing body members. The members shall include:-
- All Lay members of the Governing Body
 - CCG Chair
 - 2 GP members of the Governing Body
- 2.2 The non-clinical Vice Chair shall be the Chair of the committee.
- 2.3 No one other than the members of the committee is entitled to be present at committee meetings. The Accountable Officer will only attend when the remuneration and terms of service of other Directors is being discussed
- 2.4 The committee may invite any person to attend meetings to provide advice and/or expertise as required. Any such person shall not be a member of the committee and shall withdraw upon request.

3. Secretary

- 3.1 The committee secretary shall be the Company Secretary

4. Quorum

- 4.1 The quorum of the committee shall be three members.

5. Frequency and notice of meetings

- 5.1 The committee shall meet not less than twice a year.
- 5.2 Written notice of the date, venue and agenda shall be circulated to all committee members not less than 5 working days before the proposed date.
- 5.3 The Chair of the committee may convene additional meetings as required.
- 5.4 The minutes of committee meetings shall be circulated as soon as is practicable after the meeting to which they relate to members of the committee and the Accountable Officer.

6. Remit and responsibilities of the committee

- 6.1 The committee shall make recommendations to the governing body on determinations about pay and remuneration for employees of the clinical commissioning group and people who provide services to the clinical commissioning group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.
- 6.2 Specifically the committee shall undertake the following:-

- 6.2.1 determine the policy regarding terms of service and remuneration of the members of the Governing Body having regard to the provisions of national arrangements where appropriate;
- 6.2.2 have delegated authority to review the performance and determine the individual remuneration arrangements including any performance related pay for members of the Governing Body;
- 6.2.3 consult with the Accountable Officer and Chair of the Governing Body in relation to their proposals relating to the remuneration of members of the Senior Management Team;
- 6.2.4 approve any changes to the standard contract of employment for members of the Governing Body, where applicable, including termination arrangements taking into account relevant guidance and current good practice;
- 6.2.5 agree terms for the termination of a contract having regard to HM Treasury guidance and current good practice;

7. Relationship with the governing body

Authority

- 7.1 The committee is authorised by the Governing Body to obtain legal advice, remuneration or other professional advice, including the appointment of external advisor and/or consultants, related to its functions as it deems fit at the expense of the clinical commissioning group.
- 7.2 The committee shall recommend appropriate action(s) should be taken by the Governing Body in allowing the committee to fulfill its terms of reference.

Monitoring and Reporting

- 7.3 The minutes of each meeting of the committee shall be formally recorded and retained by the clinical commissioning group. The minutes shall be submitted to the Governing Body.
- 7.4 The Chair of the committee shall report the outcome and any recommendations of the committee to the Governing Body.

8. Policy and best practice

- 8.1 The committee shall have regard to current good practice; policies; and guidance issued by the National Commissioning Board, the clinical commissioning group and other relevant bodies.

9. Conduct of the committee

- 9.1 The committee shall conduct its business in accordance with these terms of reference and the clinical commissioning group's governance arrangements.

NHS Gloucestershire Clinical Commissioning Group

Integrated Governance & Quality Committee Terms of Reference

1. Aims

- 1.1 The aim of the Integrated Governance and Quality Committee is to continuously improve the delivery of healthcare services to the people of Gloucestershire, so ensuring that the services are of high quality, clinically effective and safe, within available resources. This will be delivered through a culture of openness supported by sound governance arrangements. We will do this by ensuring that controls are in place and are operating efficiently and effectively to deliver the principal objectives of the Governing Body and to set in place processes to manage identified risks, minimising the Clinical Commissioning Group's exposure to corporate, financial and clinical risks. The Committee will have a pro-active approach to the management of risk and quality, ensuring the organisation learns and takes appropriate corrective action.

2. Core Membership

- 2.1 The Committee shall be appointed by the Clinical Commissioning Group from amongst its Governing Body members. The members shall include:-
- 3 Lay Members
 - Clinical Chair of the CCG
 - Accountable Officer
 - Chief Financial Officer
 - Director of Public Health
 - Registered Nurse
 - Executive Nurse & Quality Lead
 - Director of Commissioning Implementation
 - 2 Clinical Commissioning Leads
- 2.2 The Registered Nurse shall be the Chair and one of the GP Members the Vice-Chair of the Committee.
- 2.3 The Committee may require any person to attend meetings to provide advice and/or expertise as required. Any such person shall not be a member of the Committee and shall withdraw upon request.

3. Secretary

- 3.1 The Committee secretary shall be the Associate Director of Corporate Governance.

4. Quorum

- 4.1 Four members of the Committee must be present including at least one clinician member, two lay members and an executive member for the quorum to be established.

5. Frequency and notice of meetings

- 5.1 The Committee shall meet bi-monthly.

- 5.2 Written notice of the date, venue and agenda shall be circulated to all Committee members.

members not less than 5 working days before the proposed date.

- 5.3 The Chair of the Committee may convene additional meetings as required.
- 5.4 The minutes of Committee meetings shall be circulated by the Chair as soon as is practicable after the meeting to which they relate to all members of the committee.

6. Remit and responsibilities of the Committee

6.1 The Committee is responsible for the overall development of the Integrated Governance Strategy and to ensure that the appropriate governance plans and mechanisms are in place and being monitored across the following areas:-

- Corporate Governance
- Clinical Effectiveness
- Patient Experience
- Clinical Audit
- Risk Management
- Serious Incident reporting
- Infection Control
- Equality & Diversity
- Service Planning
- Performance in respect of commissioned services
- Information Governance
- Child and Adult Safeguarding
- Health and Safety
- Human Resources
- Research Governance
- Information Governance

7.2 Governance

Through the delegated authority from the Governing Body the Committee will:

- 7.2.1 Monitor and facilitate Clinical Commissioning Gloucestershire compliance against external standards, good practice guidance and legislation;
- 7.2.2 Receive assurances that the CCG responds appropriately to reports from external agencies relevant to integrated governance, e.g. Care Quality Commission, Audit Commission, NICE, Monitor, Health and Safety Executive, NHS Litigation Authority, NHS England Area Team.
- 7.2.3 Monitor the Risk Register and Board Assurance Framework ensuring that risks are appropriately prioritised and adequately controlled and that all high and extreme risks are communicated to the Governing Body;
- 7.2.4 Review the Committee arrangements to ensure that they remain structurally fit for purpose and to make recommendations for amendments to the Governing Body as appropriate and;
- 7.2.5 Receive reports from the Local Children and Adult Safeguarding Boards including serious case review reports.

8. Quality Governance

Gloucestershire Clinical Commissioning Group's Constitution

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The assurance of quality services commissioned by the CCG will be underpinned by the six dimensions of healthcare quality. We will therefore work to ensure services to the people of Gloucestershire are:

Person-centred; Safe; Effective; Efficient; Equitable and Timely.

We will do this by:

- 8.3.1 Ensuring appropriate mechanisms are in place to monitor and drive-forward the quality and safety of services commissioned by the CCG, recommending courses of action where concerns have been identified. Using measures for improvement to assure the Committee of progress in developing services to meet the patient / client's needs.
- 8.3.2 Receiving and mandating action on reports on quality in respect of the CCG's commissioned services (acute, mental health, community, independent and any willing/qualified provider); the reports will cover provider performance against CQUINs; patient experience (including complaints and compliments we receive as commissioners), patient safety and clinical performance indicators.
- 8.3.3 As part of the annual planning cycle, agree the CQUIN schedule and review implementation by providers.
- 8.3.4 Ensuring the patient voice is listened to in order to understand the diversity of the patient experience. This will include consideration of complaints and compliments received by the CCG. The Committee will also receive patient stories at their meetings and consider service delivery from a patient's perspective in undertaking their governance role.
- 8.3.5 Receiving, reviewing and scrutinising reports on serious incidents (SIs) occurring in commissioned services and monitor associated action plans. Requesting additional action / information as necessary, gaining assurance that provider organisations have learnt lessons and taken appropriate action.
- 8.3.6 Considering national quality reports and results from relevant national audits and ensuring actions are taken where necessary.
- 8.3.7 Reviewing performance against quality indicators in the NHS Outcomes Framework and receiving assurances that concerns are appropriately addressed.
- 8.3.8 Receiving assurances that appropriate systems are in place for the development and review of care pathways, clinical policies and the implementation of NICE guidance and quality standards.
- 8.3.9 Reviewing non-financial performance indicators; identifying key areas of focus e.g. infection control.
- 8.3.10 Receiving internal and external audits reports relating to quality and follow up action plans
- 8.3.11 Ensuring adequate systems are in place for the governance of research in line with the Department of Health's requirements.

8.3.12 Monitoring that arrangements are in place within the CCG relating to equality and diversity issues, ensuring compliance with statutory obligations and implementation of equality plans.

8.3.13 Annually review and critique the provider quality accounts.

9. Relationship with the governing body

Authority

9.1 The Committee is authorised to conduct its activities that provide assurance to the Governing Body in relation to the following:-

- There is an appropriate and fit for purpose range of systems, policies and procedures in place to manage all risks;
- It has fulfilled its responsibility to manage risk by providing evidence of compliance with all risk management processes
- The Assurance Framework accurately reflects the organisations objectives and that the associated risks are identified together with the measures and controls to manage these principal risks;

9.2 The Committee shall recommend appropriate action(s) should be taken by the Governing Body in allowing the Committee to fulfil its terms of reference.

Monitoring and Reporting

9.3 The minutes of each meeting of the Committee shall be formally recorded and retained by the Clinical Commissioning Group. The minutes shall be submitted to the Governing Body.

9.4 The Chair of the Committee shall report the outcome and any recommendations of the committee to the next available Governing Body.

10. Policy and best practice

10.1 The Committee shall have regard to current good practice; policies; and guidance issued by the National Commissioning Board, the Clinical Commissioning Group and other relevant bodies.

11. Conduct of the Committee

11.1 The Committee shall conduct its business in an open and responsive manner and in accordance with these terms of reference and the Clinical Commissioning Group's governance arrangements.

12. Sub-Committees

12.1 The following sub-committees will report to the Integrated Governance & Quality committee and will submit the minutes of their meetings to the Committee for review:

- Policy Review sub-committee
- Clinical Effectiveness sub-committee
- Information Governance working group

- Individual Funding Request (IFR) panel

Date Approved by Governing Body:

Date for Review:

CCG Priorities Committee

Terms of Reference

Strategic purpose

The CCG has established a prioritisation process comprising a Prioritisation Framework, a Priorities Committee and individual Funding Request panel. The purpose of the Priorities Committee is to advise the local NHS health economy as to the health care interventions and policies that should be given high or low priority. The priorities committee helps the CCG and its Localities choose how to allocate its resources to promote the health of the local community, based on the local health needs assessment.

Purpose

The purpose of the Priorities Committee is to guide and underpin the decision making processes of the CCG and it further supports a consistent approach to commissioning by:

- Providing a coherent structure for discussion, ensuring all important aspects of each issue are considered.
- Promoting fairness and consistency in decision making from meeting to meeting and with regard to different clinical topics, reducing the potential for inequity.
- Providing a means of expressing the reasons behind the decisions made.
- Reducing risk of judicial review by implementation of robust decision making processes that are based on evidence of clinical and cost effectiveness within an Ethical Framework.
- Supporting and integrating with the development of CCG Commissioning Plans.

Key responsibilities as delegated by the Governing Body:

- To set the organisational priorities within which commissioning plans are developed.
- To provide guidance to the clinical programme groups on the priority areas for their work.
- To agree programme scope and outcomes to deliver organisational priorities and deliver transformational change.
- To use a transparent prioritisation framework to agree commissioning priorities, plans and projects; this includes decisions regarding investment, service redesign and disinvestment.
- To review the robustness of the prioritisation framework annually or more frequently if necessary.
- To agree indicative resources to programmes using a programme budgeting approach.

- To supervise the development of an annual programme plan for each clinical programme group, that outlines the key priorities and makes explicit the links to the CCG overall strategic objectives, using the programme budget to understand the overall cost of the programme and support decision-making.
- To receive recommendations (programme business case) for investment, disinvestment and service redesign at least annually.
- To monitor and resolve impacts between programmes and barriers to progress that require strategic input.
- To understand the aggregate impact of all clinical programmes on key providers and ensure alignment with overall strategic objectives recommending adjustments to individual programme business cases as required.
- To ensure that localities and locality plans are sufficiently represented within the programme plans both as generators of evidence/ideas but also as stakeholders with whom the programme consults and as implementation leads.
- To seek assurance from programme leads that they have consulted with other key stakeholders including partner organisations and communities of interest for that programme and to carry out more strategic consultations through CCG representation at key events and meetings.
- To sign off the programme business cases ensuring they are resourced and deliverable within the overall organisational financial plans.
- To agree specific outputs from clinical programme groups as required e.g. new care pathways.
- To receive and review a programme plan to deliver the business case and receive reports that monitor progress against programme outcomes with quarterly programme updates that demonstrate that the programme plan is delivering.

Membership:

Chair – Clinical Commissioning Group - Chair
Vice Chair – Deputy Clinical Chair

Members (or their delegated representatives)

- CCG GP Governing Body Members
- CCG Lay Governing Body Members
- CCG Executive Governing Body Members
- CCG Healthcare Professional Governing Body Members
- Director of Public Health (GCC)
- Director of Adult Services (GCC)

Other CCG staff or representative from other organisations will be invited to attend for specific items on the agenda.

Accountability and reporting:

The CCG Priorities Committee will be accountable to Gloucestershire Clinical Commissioning Group Governing Body. The Committee will have delegated powers to make decisions on behalf of the governing body as described in the CCG Governing Body constitution.

The CCG Priorities Committee will be responsible for prioritisation across the range of programmes and healthcare services.

The Associate Director Clinical Programmes will provide routine updates to the committee on the progress with the work of the clinical programme groups (CPGs).

The CPG clinical leads will provide information and updates on individual programmes on an ad hoc basis as required.

The Associate Director of strategic Planning will provide regular updates to the committee on progress with specific projects and programmes initiated by the CCG.

Quorum

Chair or Vice Chair, 3 CCG GPs, a Governing Body Lay Member, Accountable Officer or Deputy; Chief Financial Officer or deputy; Executive Nurse or Deputy.

Frequency of CCG Priorities Committee

A minimum of 4 meetings per annum

Sub-groups

All Clinical Programme Groups will formally report to the CCG Priorities Committee.

Secretariat to be provided by

The Director of Transformation and Service Re-design team

Agenda and papers:

The agenda and papers will be circulated electronically one week prior to the meeting.

Agenda items and relevant papers should be submitted at least 1 week prior to this date.

Minutes will be circulated in draft within 5 working days of the meeting to allow members to respond.

Review:

These terms of reference will be reviewed annually

Appendix O ~~– Locality Executive Group Terms of Reference – to be agreed~~

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Locality Executive Group

TERMS OF REFERENCE

1. Purpose

To provide leadership for developing and implementing clinical commissioning plans at a locality level through the engagement of all practices and other stakeholders in the locality.

2. Objectives

- Fully engage in the clinical commissioning process.
- Work within the financial resources available each year (as set out through the indicative budget allocation)
- Ensure good communication regarding clinical commissioning between and within practices/localities, including dissemination of new care pathways and sharing of best practice.
- Work with the Gloucestershire Clinical Commissioning Group to ensure achievement of its strategic aims.
- Clearly articulate GCCG aspirations and objectives to constituent practices through locality plans.
- Work with Public Health colleagues to respond to the JSNA in order to improve outcomes and address health inequalities.
- Work with the GCCG to ensure PBC supports and enhances the quality, innovation, productivity and prevention (QIPP) agenda.
- Engage and involve patients and/or carers in GCCG developments and service redesign.
- Promote multi-professional involvement within locality clinical commissioning arrangements/structures.
- Feed into contract development to support the contract negotiations with providers e.g. quality, new care pathways.
- Lead service redesign/development and movement of services from secondary to community and primary care settings.

3. Membership

Nominated Executive GPs from constituent practices

Practice manager
AHP / other clinical representative
Patient representative

Commissioning Director/Executive team lead
Medicines Management
Finance and Information
Public Health
Other as required

4. Structure and Frequency of Meetings

The group will be chaired by a locality GP (as agreed by the GP members of the group).

The Chair will ensure that all communications relating to formal meetings are disseminated and papers / reports are circulated in a timely manner.

Agenda items should be forwarded to the Chair a minimum of one week prior to the meeting.

Formal meetings of the Executive will take place on a monthly basis.

5. Responsibility and Accountability

GP Executive members are responsible for ensuring that constituent practices are engaged in agreement and delivery of PBC plans.

GP Executive members are responsible for ensuring communication with the GP members on the Clinical Commissioning Group Shadow Board.

Members will be responsible for ensuring that their own organisation or group is fully briefed on all key issues and decisions.

6. Governance and reporting

Governance arrangements are as set out in the PBC Agreement for 2011/12. The Executive Group is responsible for delivering the requirements of the agreement at locality level.

Reporting is to the Clinical Commissioning Group Shadow Board and onwards to NHSG Board. The Locality will report to the Clinical Commissioning Group Shadow Board quarterly.

Papers and minutes are to be shared with all constituent GPs and practice managers, and the Clinical Commissioning Group Shadow Board and be available to the public on request.

7. Review of Terms of Reference

These Terms of Reference will be reviewed annually.

Clinical Commissioning Gloucestershire and Member Practices

Memorandum of Understanding

1. Memorandum of Understanding

- 1.1 The Memorandum of Understanding is between individual member practices and CCG and clarifies the expectations and obligations of both parties. It is designed to encourage productive and supportive engagement between the CCG and its Member Practices.
- 1.2 The Memorandum of Understanding documents the commissioning agreements reached between the member practice and CCG and will be the formal mechanism for determining eligibility to any future incentive payment (currently referred to as the Quality Premium). Accordingly it will be updated on an annual basis.

2. Parties to the Agreement

- 2.1 This Memorandum of Understanding is between the following parties;
 - Clinical Commissioning Gloucestershire (CCG) and its Member Practices.

3. Mission, Values and Aims of the CCG

3.1 Mission

- 3.1.1 The mission of CCG is to commission excellent and modern health services on behalf of the NHS for all people in Gloucestershire through effective clinical leadership, with particular focus on clinical effectiveness, patient safety and continuous improvements in the patient experience.
- 3.1.2 The group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

3.2 Values and Aims

- 3.2.1 Good corporate governance arrangements are critical to achieving the group's objectives.
- 3.2.2 The values/aims that lie at the heart of the group's work are to:
 - Ensure effective communication and engagement with clinicians, patients, carers, community partners and the public.
 - Use our clinical experience to ensure high quality, safe and efficient services for the people of Gloucestershire;

- Focus on clinical benefit and health outcomes – making best use of the money and resources available;
- Use our clinical experience to lead innovation and change – right care, right place, right time;
- Be accountable and transparent in our decision making

4. Commissioning responsibilities of Member Practices Practice Representatives

4.1 Practice Representatives

4.1.1 Practice representatives represent their practice's views and act on behalf of the practice in matters relating to the group. The role of each practice is to:

- Nominate commissioning and prescribing leads to:
 - a) represent the practice at CCG/locality meetings; and
 - b) represent the needs of the practice's patient population within the CCG;
- Actively engage with CCG to help improve services within the area and support effective commissioning by contributing to the development of commissioning intentions and contract development and review.
- Share all information and data, including referral, prescribing and admissions data, as appropriate, that relates to CCG's commissioning priorities of delivering equitable quality care.
- Be familiar with the Clinical Programme Group approach, and follow the clinical pathways and referral protocols where defined and agreed by CCG (except in individual cases where there are justified clinical reasons for not doing this) which are fed back appropriately;
- Manage the practice's commissioning and prescribing budget within allocated resources within the context of the risk share agreements agreed by the CCG. Support and assistance will continue to be provided to help member practices achieve this in the form of information and analysis, management support and specialist advice and support in areas such as prescribing.
- Participate in developing, as well as delivering the clinical, quality, safety effectiveness (and cost effective) strategies agreed by CCG and GH&WB (recognising the impact of such will have been assessed by the CCG).
- Promote the establishment of a practice reference group and other means determined, to obtain the views and experiences of patients and carers;
- Work constructively with the locality sub-committee/CCG;
- Respond in a timely manner to reasonable commissioning-related information requests from CCG.

4.2 Locality Groups

4.2.1 The county-wide clinical commissioning group will comprise seven constituent localities. Each Locality will have an appointed Locality Lead and Executive team. Each Locality will also have an elected Locality Liaison Lead who will act as a conduit for the views of the locality as a part of their role as a member of the CCG Governing Body. Each locality will hold regular executive meetings as well as regular meetings involving the commissioning leads from each constituent practice. Such meetings will be in addition to other regular development sessions including Practice Learning Time and other locality-specific project groups.

4.2.2 The seven Locality groups are;

- Cheltenham;
- Forest of Dean;
- Gloucester City;
- North Cotswolds;
- South Cotswolds;
- Stroud & Berkeley Vale;
- Tewkesbury.

4.3 Structure and Frequency of Meetings

4.3.1 The group will meet regularly and be chaired by a locality GP (as agreed by the GP members of the group).

4.4 Practice Budgets

4.4.1 The full scope of the commissioning budget and detail of locality and practice level commissioning budgets and risk share agreements will be issued annually to practices for agreement.

4.5 Governance and reporting

4.5.1 Governance arrangements are as set out in the Locality Commissioning Agreement for 2012/13. Member Practices and their Executive Groups are responsible for delivering the requirements of the agreement at locality level.

4.5.2 Reporting is to the Clinical Commissioning Group Board. The locality will report to the Clinical Commissioning Group Board on a quarterly basis via their lead GP.

4.5.3 Locality group papers and minutes are to be shared with all constituent GPs and practice managers, and the Clinical Commissioning Group Board and be available to the public on request.

5. CCG responsibility to the development of a Member Organisation

5.1 A key part of CCG's commitment is to build CCG as a 'membership organisation'.

5.2 CCG membership currently comprises 85 practices from seven constituent localities. Each locality appoints GPs or other healthcare professionals in the constituent practices to lead and chair the locality. Each locality will also have an elected Locality Liaison Lead who will be a member of the Governing Body of the CCG. Each Locality Liaison Lead will hold regular meetings involving the Commissioning Leads from each constituent practice of the locality.

5.3. CCG Role will be to:

- Set a commissioning strategy and policy (which is responsive to the needs assessment and priorities for the population and reflects the views of individual localities).
- Implement a clinical strategy using a co-production approach with the localities and defining quality outcomes and best value that meets the needs of our population.
- Provide a clinical leadership role by engaging member practices and the wider clinical community.
- Establish governance arrangements that establish CCG as a membership organisation.
- Establish and lead a clinical programme-based approach to commissioning.
- Ensure transparency and accountability in its decision making processes.
- Manage the commissioning budgets devolved to it.
- Support locality inspired projects where agreed and prioritised with CCG (with financial and management support) and where appropriate hold localities and others to account for their delivery.

6. Annual Commissioning Objectives

6.1 CCG will set annual commissioning objectives and targets that are outcome based and can demonstrate an improvement in the health of the local population. These will be agreed through the development of annual commissioning objectives/targets with each locality group.

7. Review of the Agreement

7.1 The agreement will be reviewed annually by CCG; any proposed changes will go to member practices for discussion prior to agreement.

8. Signatories to the Agreement

Member Practice Name:

Member Practice signatory:

Chair of the CCG:

Date:

Clinical Commissioning Gloucestershire

Disputes Resolution Process

1 Purpose

This paper outlines the approach Clinical Commissioning Gloucestershire (CCG) will adopt to address concerns/disputes raised by member practices in any of the following areas:

- The CCG's approach to the delivery of its commissioning responsibilities;
- The commissioning responsibilities of member practices;
- The CCG's approach to delivery of its duty to support the NHS Commissioning Board in continuously improving the quality of primary care services.

2 Background

It is expected that use of the dispute resolution process will be the last resort. The CCG, its constituent localities and practices will make all efforts to resolve issues locally in conjunction with the LMC (as appropriate), and demonstrate effective processes have been engaged at all levels in the CCG. This may include the following involvement in informal resolution processes:

- Escalating the seniority of staff involved in any dispute, for example by involving the Chair/Deputy Clinical Chair or Chief Officer/Deputy Chief Officer.
- Involving third parties who could also act as advisors, conciliators or arbitrators.
- Using staff from another CCG.

Where agreement cannot be reached using informal resolution processes it will be necessary to invoke the local CCG resolution process outlined below.

3 Local Resolution Process

3.1 Stage 1 Informal Process:

Individual member practice concerns should be raised in the first instance with the CCG Locality Liaison Lead GP. This should be in writing clearly stating the basis of the dispute, including where applicable the concerns and the rationale behind the dispute.

The CCG Locality Liaison Lead GP should endeavour to find an informal resolution to the problem through discussion and mediation, involving others as necessary. The CCG Liaison Lead GP will review concerns/evidence relative to the dispute and will try to find a resolution within 14 days.

The member practice may submit evidence in support of the dispute or the CCG may request further evidence/clarification from them.

If no resolution is found within 14 days the matter is to be referred by either party for consideration by the Local Dispute Resolution Panel.

At this stage the formal process will commence.

3.2 Stage 2 The Formal Local Process:

If a member practice is not satisfied that their issues have been satisfactorily addressed through the informal process they may lodge a request for “Formal Local Dispute Resolution” in writing, including the grounds for the request, to the Deputy Clinical Chair of the CCG. Under these circumstances the CCG will set up a Local Dispute Resolution Panel (LDRP) to hear the dispute and resolve the dispute where possible.

The local dispute panel should consist of:

- Governing Body lay member (Chair).
- Deputy Clinical Chair.
- CCG Locality Liaison Lead GP from a different locality from the practice.
- Deputy Chief Officer OR Chief Financial Officer OR Director of Transformation and Service Re-Design.
- LMC Representative.

The panel may also seek advice from external bodies such as the Local Area Team of the NHS Commissioning Board.

Should any members of the LDRP find it necessary to declare an interest in a dispute that is being considered, the Chair will approach another CCG representative to secure alternative panel members from within that CCG.

In the event that this approach is unsuccessful other CCGs will be approached until a suitable alternative panel member from another CCG can be secured.

If a member practice requests a formal dispute resolution, the CCG shall acknowledge receipt of the request in writing within 2 working days. The acknowledgement will explain the procedure to be carried out by the CCG.

The Hearing

The Chair of the LDRP, on being satisfied that all attempts at local resolution have been exhausted will arrange a meeting of the LDRP to hear the dispute as soon is practically possible. All parties shall be notified of the date and time of the LDRP meeting. The hearing shall be held within 25 working days of the request being lodged (where possible) by the member practice to the CCG. The Chair of the LDRP will ensure that at least 10 working days’ notice of the date of the hearing will be given to all participants.

Documentation

All the relevant documentation, including the request for Formal Local Dispute Resolution will be passed to the chair and then to panel members before the hearing. The Chair will, where necessary, seek relevant documentation from the parties involved at least 5 working days before the hearing. Documentation that is received late will not be considered. Any documentation will be shared with all relevant panel members.

Procedure at LDRP Meeting

- The Discussions of the panel shall remain confidential.
- The Chair of the panel will ensure written record/minutes are kept of the meeting.
- All written and verbal evidence will be considered.
- Should the member practice choose to attend the LDRP they and the CCG presenting officer (generally the CCG Locality Liaison Lead GP) will be asked to present their cases and may call witnesses. Members of the panel will be given the opportunity to ask any questions relevant to the case.
- Following the presentation of their case the member practice and CCG presenting officer shall withdraw and the panel will deliberate.
- The panel will reach a decision on the case before them and notify the member practice in writing, including any recommendations within 7 working days of the hearing.
- Where appropriate the decision will be reported to a meeting of the CCG Executive Team/Governing Body for information.

3.3 Stage 3 Appeal Panel

The Appeals panel will be convened when necessary to consider appeals against LDRP decisions. The Appeals panel should consist of the following (none of whom should have been previously involved in the case)

- Clinical Chair of another CCG.
- A Clinical member of the Governing Body.
- CCG Accountable Officer or Deputy
- LMC Representative.

Process

- The member practice wishing to appeal against a LDRP decision must notify the CCG Accountable Officer of their intention, in writing, within one month of their receipt of the decision.
- The Appeals Panel will consider whether the original decision of the LDRP followed due process.
- The Appeals Panel will only consider written evidence.
- The Appeals Panel will consider if:
 - o The CCG correctly followed its own procedures (all received documentation was available and considered within a reasonable timescale) and/or
 - o All important facts were taken into account when the decision was made.
- If these criteria are met the Panel will dismiss the appeal.
- If the criteria are not met then the following actions are available:

- o If the Panel finds that some aspect of the procedure was not followed, they will assess the significance of the procedural breach and decide on the appropriate action.
- o If the Panel finds that important facts were not taken into account, they shall refer the case back to the original LDRP for re-consideration.
- If the case is referred back to the LDRP following re-consideration of the case, the LDRP decision will then be final.
- The Chair of the Appeal Panel will write to the member practice within five working days of the hearing setting out the Appeal Panel's decision.

Agenda Item 11

Governing Body

| | |
|------------------------------------|---|
| Governing Body Meeting Date | Thursday 29 th May 2014 |
| Title | Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis |
| Executive Summary | <p>This report is to provide information for the Governing Body on the introduction of the HM Government Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis.</p> <p>This report seeks Governing Body approval for the Clinical Commissioning Group as a signatory organisation to endorse the Gloucestershire Mental Health Crisis Care Declaration.</p> |
| Key Issues | <p>The Concordat expects that in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.</p> <p>The Gloucestershire Clinical Commissioning Group (GCCG) has established a multi-agency Task and Finish Group which includes representation from all the relevant key agencies involved in responding to mental health crisis care.</p> |

| | |
|--|--|
| | <p>The Task and Finish Group has developed a draft Gloucestershire Declaration document which is now being taken through the governance processes in each local signatory organisation for agreement and sign off.</p> <p>The development of the Continuous Action Plan is work in progress and once completed will set out all the objectives, actions and timescales for all agencies as signatories to the local Declaration.</p> |
| <p>Risk Issues: Original Risk Residual Risk</p> | <p>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.</p> |
| <p>Financial Impact</p> | <p>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.</p> <p>Financial impact will be established as part of the development of the Crisis Care Declaration Continuous Action Plan.</p> |
| <p>Legal Issues (including NHS Constitution)</p> | <p>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.</p> |

| | |
|--|--|
| Impact on Health Inequalities | The Concordat focuses on people who experience acute mental health crisis. It spans the health, social care and criminal justice systems, but is also relevant to other partners such as housing providers and defines the service responses expected for people of all ages suffering mental health crisis. |
| 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 | The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. A strong clinical and multi-professional focus with significant member engagement and meaningful involvement of patients, carers and the public is in place to ensure delivery of the services that meet the principles of the national concordat. |
| Recommendation | The Governing Body on behalf of the Clinical Commissioning Group as a signatory organisation is asked to endorse the Mental Health Crisis Care Declaration. |
| Author | Eddie O'Neill |
| Designation | Joint Commissioner for Mental Health |
| Sponsoring Director (if not author) | Mark Walkingshaw Deputy Accountable Officer/Director of Commissioning Implementation |

Governing Body

Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis

Thursday 29th May 2014

1. Introduction

- 1.1 The HM Government Mental Health Crisis Care Concordat (**Appendix 1**) is a joint statement, written and agreed by its signatories that describes what people experiencing mental health crisis should be able to expect of the public services that respond to their needs.
- 1.2 The Concordat focuses on people who experience acute mental health crisis. It spans the health, social care and criminal justice systems, but is also relevant to other partners such as housing providers and defines the service responses expected for people of all ages suffering mental health crisis.
- 1.3 Many local organisations want to support a local Crisis Care Declaration because of their commitment to improve mental health care and may want to make a specific contribution within the local action plan for continuous improvements.

In addition, certain organisations have a formal (statutory) responsibility and/or a professional duty of care regarding people presenting in mental health crisis – they are:

- Clinical Commissioning Group
- NHS England Local Area team
- Local Social Services Authority
- The Police Service and Police and Crime Commissioners
- The Ambulance Service
- NHS providers of acute medical services (Emergency Departments within local hospitals)
- NHS providers of mental health and/or substance misuse services

- Independent sector providers of mental health or substance misuse services (if awarded an NHS contract)

GP representative organisation as providers of primary care mental and physical health services.

2. Core Principles

2.1 People seeking urgent help with mental health conditions, and friends and family close to them will approach a range of different services – including their GP, helplines or voluntary sector groups, Emergency Departments, social care, schools, colleges, mental health trusts, and the police.

2.2 The Concordat is arranged around the following domains;

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovering, staying well and preventing future crisis.

2.3 The complexity of mental health crisis may mean that individuals need support for several aspects of their crisis. For an effective emergency mental health crisis care response system there needs to be detailed coordination between all the agencies regularly contacted by people in mental distress.

3. Gloucestershire Mental Health Crisis Care Declaration and Continuous Action Plan

3.1 Following a serious untoward incident involving an individual who had been referred to NHS crisis care services. Gloucestershire Clinical Commissioning Group put in place terms of reference for reviewing mental health crisis services and the joint working arrangements with partner agencies. This work has enabled Gloucestershire to be progressing this work as an early implementer of the Crisis Care Concordat.

3.2 The GCCG established in January 2014 a multi-agency Task and Finish Group to deliver this project. The Group has now developed a local Gloucestershire Mental Health Crisis Care

Declaration which is now being taken forward within in each organisation for sign off (**Appendices 2 and 3**).

- 3.3 The local Continuous Action Plan is work in progress and will include development of local protocols agreed by NHS commissioners, the police force, the ambulance service and social care to describe the approach to be taken when police officer's uses the powers under the Mental Health Act.

4. Recommendation

- 4.1 The Governing Body is asked to endorse the Mental Health Crisis Care Declaration as a signatory organisation.

5. Appendices

- 5.1
- Appendix 1: Mental Health Crisis Care Concordat
 - Appendix 2: Gloucestershire Mental Health Crisis Care Declaration
 - Appendix 3: Declaration Signatories



HM Government

Mental Health Crisis Care Concordat

Improving outcomes
for people experiencing
mental health crisis

Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis

Author: Department of Health and Concordat signatories

Document Purpose: Guidance

Publication date: February 2014

Target audience: Local Authority CEs, CCG CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Health and Wellbeing Boards, Directors of Public Health, Medical Directors, Directors of Nursing, Directors of Adults SSs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children’s SSs, Youth offending services, Police, NOMS and wider criminal justice system, Royal Colleges

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Mental Health Crisis Care Concordat: the joint statement

“We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.

We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery.

Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England.”

Signatories to the Concordat

Association of Ambulance Chief Executives
Association of Chief Police Officers
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Association of Police and Crime Commissioners
British Transport Police
Care Quality Commission
College of Emergency Medicine
College of Policing
The College of Social Work
Department of Health
Health Education England
Home Office
Local Government Association
Mind
NHS Confederation
NHS England
Public Health England
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists

The national organisations that are signatories to this Concordat have made a commitment to work together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England.

In addition, a number of third sector and voluntary organisations have agreed to be identified formally as **supporters** of the Concordat.

The list of supporter organisations is available at www.gov.uk

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1. Concordat statement: The vision

This Concordat is about how we, as signatories, can work together to deliver a high quality response when people – of all ages – with mental health problems urgently need help. Mental illness is a challenge for all of us. When a person's mental state leads to a crisis episode, this can be very difficult to manage, for the person in crisis, for family and friends, and for the services that respond. All may have to deal with suicidal behaviour or intention, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control, or irrational and likely to endanger the person or others.

Every day, people in mental health crisis situations find that our public services are there when they need them – the police officers who respond quickly to protect people and keep them safe; the paramedics who provide initial assessment and care; the mental health nurses and doctors who assess them and arrange for appropriate care; and the Approved Mental Health Professionals, such as social workers, who coordinate assessments and make contact with families.

These services save lives. There is much to be proud of. But we must also recognise that in too many cases people find that the same services do not respond so well. There have long been concerns about the way in which health services, social care services and police forces work together in response to mental health crises.

Where there are problems, they are often as a result of what happens at the points where these services meet, about the support that different professionals give one another, particularly at those moments when people need to transfer from one service to another.

This is a very serious issue – in the worst cases people with mental health problems who have reached a crisis point have been injured or have died when responses have been wrong. In other cases, patients have had to travel long distances when acute beds have been unavailable.

There are also particular barriers to achieving better outcomes for people in black and minority ethnic (BME) communities, such as the higher levels of detention under the Mental Health Act 1983 and the higher rates of admission to hospital that people from some BME groups experience. Where a particular group or section of society is reaching crisis point at a disproportionate rate, or accessing mental health services through involvement with the criminal justice system at a high rate, this needs to be identified and addressed by commissioners.

This Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur.

The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

This Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.

We believe this Concordat serves as an important joint statement of intent and common purpose, and of agreement and understanding about the roles and responsibilities of each service. This will help to make sure people who need immediate mental health support at a time of crisis get the right services when they need them, and get the help they need to move on and stay well.

2. “When I need urgent help...”

What people who use services should expect

What should I expect if I, or the people who depend on me, need help in a mental health crisis?

The following statements were developed by Mind, the mental health charity, with service users, families and carers in a consultation carried out for the Concordat.

- **Access to support before crisis point**

When I need urgent help to avert a crisis I, and people close to me, know who to contact at any time, 24 hours a day, seven days a week. People take me seriously and trust my judgement when I say I am close to crisis, and I get fast access to people who help me get better.

- **Urgent and emergency access to crisis care**

If I need emergency help for my mental health, this is treated with as much urgency and respect as if it were a physical health emergency. If the problems cannot be resolved where I am, I am supported to travel safely, in suitable transport, to where the right help is available.

I am seen by a mental health professional quickly. If I have to wait, it is in a place where I feel safe. I then get the right service for my needs, quickly and easily.

Every effort is made to understand and communicate with me. Staff check any relevant information that services have about me and, as far as possible, they follow my wishes and any plan that I have voluntarily agreed to.

I feel safe and am treated kindly, with respect, and in accordance with my legal rights.

If I have to be held physically (restrained), this is done safely, supportively and lawfully, by people who understand I am ill and know what they are doing.

Those closest to me are informed about my whereabouts and anyone at school, college or work who needs to know is told that I am ill. I am able to see or talk to friends, family or other people who are important to me if I so wish. I am confident that timely arrangements are made to look after any people or animals that depend on me.

- **Quality of treatment and care when in crisis**

I am treated with respect and care at all times.

I get support and treatment from people who have the right skills and who focus on my recovery, in a setting which suits me and my needs. I see the same staff members as far as possible, and if I need another service this is arranged without unnecessary assessments. If I need longer term support this is arranged.

I have support to speak for myself and make decisions about my treatment and care. My rights are clearly explained to me and I am able to have an advocate or support from family and friends if I so wish. If I do not have capacity to make decisions about my treatment and care, any wishes or preferences I express will be respected and any advance statements or decisions that I have made are checked and respected. If my expressed wishes or previously agreed plan are not followed, the reasons for this are clearly explained to me.

- **Recovery and staying well / preventing future crises**

I am given information about, and referrals to, services that will support my process of recovery and help me to stay well.

I, and people close to me, have an opportunity to reflect on the crisis, and to find better ways to manage my mental health in the future, that take account of other support I may need, around substance misuse or housing for example. I am supported to develop a plan for how I wish to be treated if I experience a crisis in the future and there is an agreed strategy for how this will be carried out.

I am offered an opportunity to feed back to services my views on my crisis experience, to help improve services for myself and others.

3. Aim, purpose and scope

Aim and purpose

This Concordat is a joint statement, written and agreed by its signatories, that describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs.

It is about how these different services can best work together, and it establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements. All the bodies and organisations that have signed up to the Concordat agree that improvements need to be made and sustained.

The Concordat has also been informed by engagement with people who have needed these services in the past and who were willing to share their experiences. This engagement has been led by voluntary organisations, principally Mind and Black Mental Health UK. With these contributions, the Concordat outlines an approach to improving services that reflects what people say they need - whether they are existing service users, carers, or other people seeking access to help, care or treatment.

The Concordat also contains an action plan. This brings together the initial commitments made by the signatories to undertake work that supports the Concordat and helps to bring about its success. Much of this work is already underway. An annual Concordat Summit will be held by signatories to review

progress and hold each other to account on the delivery of this action plan.

Making it happen – local Mental Health Crisis Declarations.

The Concordat has been agreed by a partnership of national organisations and representative bodies. But real change can only be delivered locally. The most important ambition of the Concordat is that localities all over England adopt its principles.

The signatories of the Concordat therefore expect that local partnerships between the NHS, local authorities, and criminal justice system work to embed these principles into service planning and delivery.

Just as the Concordat establishes a national agreement of principles, the ambition is for every local area to commit to agreeing and delivering their own Mental Health Crisis Declaration. This should include:

- A jointly agreed local declaration across the key agencies that mirrors the key principles of the national Concordat – establishing a commitment for local agencies to work together to continuously improve the experience of people in mental health crisis in their locality
- Development of a shared action plan and a commitment to review, monitor and track improvements
- A commitment to reduce the use of police stations as places of safety, by setting

an ambition for a fast-track assessment process for individuals whenever a police cell is used; and

- Evidence of sound local governance arrangements

The Department of Health and the Home Office, with the Concordat signatories and other partners, are planning practical ways to support and promote the development of these local agreements.

Scope and context

This Concordat focuses on people who experience acute mental health crisis. It spans the health, social care and criminal justice systems, but is also relevant to other partners such as housing providers.

It defines the service responses expected for people of all ages suffering mental health crises. It takes into account the factors that can lead to a crisis, such as physical, psychological, spiritual, educational or social problems.

Although the Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention.

Where the Concordat uses the term ‘criminal justice system’, this includes the youth justice system.

The Concordat builds on and does not replace existing guidance. Current service provision should continue while the improvements envisaged in this document are put in place.

The role of the NHS – parity of esteem

The Government has put mental health at the centre of its programme of health reform. It has therefore included a specific objective

for the NHS, in the Mandate from the Government to NHS England¹, to “put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole”.

The Mandate for 2014-15 also establishes specific objectives for the NHS to improve mental health crisis. The government expects:

- NHS England to make rapid progress, working with clinical commissioning groups (CCGs) and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services.
- NHS England to ensure there are adequate liaison psychiatry services in Emergency Departments.
- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in this Concordat

NHS England is responsible for deciding the best way to achieve these ambitions, and the others contained in the Mandate. This Concordat supports this work by setting out ways that local health commissioners, working with their partners, can make sure that people experiencing a mental health crisis get as responsive an emergency service as people needing urgent and emergency care for physical health conditions.

¹ Department of Health. The Mandate; a mandate from the Government to NHS England: April 2014 to March 2015. Department of Health, November 2013. <https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015>

We recognise that there is relatively limited information available to assess current service provision. NHS England will work with partners to carry out a robust gap analysis of current demand for these services against available service provision. The availability of psychiatric beds will form part of this analysis. This information will be used to support clinical commissioning groups to understand their baseline position, as they develop plans based on local needs and circumstances to move toward the Concordat's vision, and deliver this part of the Government's mandate to the commissioning system. NHS area teams will assure these plans, and are expected to pay particular attention to parity of esteem between mental and physical health, including that sufficient crisis services are being planned by CCGs.

The immediate commitments made by NHS England are contained in the Action Plan of this Concordat.

NHS England is also currently carrying out a full review of urgent and emergency care services. The review recognises that the NHS urgent and emergency care system must be responsive to the needs of the most vulnerable people in society who rely on it, and this includes people suffering mental health crises.

Public Health England

In 2012, the Government published the mental health strategy *No health without mental health*². The strategy's implementation

framework³ includes a commitment for Public Health England to work to reduce mental health problems by promoting improvements in mental health and wellbeing. The work led by Public Health England will seek to develop the resilience of the population throughout people's lives by addressing the individual, community and societal factors that can lead to a crisis, such as environmental, psychological, emotional or social problems. This is because what will help to reduce mental health crises in the future will be making sure people have good housing, decent income and good health. Local government now has a statutory responsibility for improving the health of their populations, and Public Health England will support them in this endeavour.

The case for change

There is growing evidence^{4,5} that it makes sense, both for the health of the population and in terms of economics, to intervene early when people may have an issue with their mental health, in order to reduce the chances of them going on to develop more serious and enduring mental health problems which are worse for the individual and harder and more expensive for the NHS to treat.

² Department of Health. No health without mental health; a cross-government mental health outcomes strategy for people of all ages. Department of Health, February 2011. <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

³ Department of Health. No health without mental health; implementation framework. Department of Health, July 2012.

<https://www.gov.uk/government/publications/mental-health-implementation-framework>

⁴ NHS Confederation, Mental Health Network. Early intervention in psychosis services. Briefing 219. NHS Confederation, May 2011

http://www.nhsconfed.org/Publications/Documents/early_interventionbriefing180511.pdf

⁵ Knapp, Martin, McDaid, David and Parsonage, Michael. Mental health promotion and mental illness prevention: the economic case. Department of Health, 2011 <http://eprints.lse.ac.uk/32311/>

An independent inquiry by Mind⁶ found that access to crisis care services varies widely across the country – in the types of crisis care available, in staffing levels, and in the range of options available for those who need a safe place to go that is not a hospital. It found that in some areas the lack of community-based options, including those that support the discharge of people who have finished their hospital treatment, meant that beds were not always available for those who needed them urgently. This had meant that some patients in need of urgent care were sent to hospitals many miles from their family and community. In particular, the inquiry found there was insufficient 24 hour mental health care provision in some areas, and criticised what it identified as a decreasing number of inpatient psychiatric beds.

Primary care teams and Emergency Departments experience wide variations across England in access to specialist mental health services.

A Criminal Use of Police Cells, the joint review by Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons and the Care Quality Commission⁷, highlighted the issue of people in crisis being detained by police officers and taken to police stations, sometimes because mental health crisis services are unable to respond,

often because of a lack of capacity in the system. Although the numbers reduced in 2012/13⁸, it still happens far too often.

The Independent Commission on Mental Health and Policing⁹ made recommendations to the Metropolitan Police and forces nationally on how to prevent serious injury and deaths when officers respond to incidents involving people with mental health conditions. It concluded that mental health was part of the core business for the police, who should be trained to be aware of the vulnerabilities people may have, because mental health issues are common in the population. The report was clear that the support of other agencies is essential because the police “cannot and indeed are not expected to deal with vulnerable groups on their own”.

Other identified issues include a lack of clarity about which service should do what and when, and the continued high levels of detention of people from BME communities, and their over-representation on inpatient wards¹⁰.

This Concordat addresses these issues, by bringing together the national leadership of those services that need to work together effectively to respond to people in mental health crisis in a coordinated and timely way.

⁶ Mind. Listening to experience: an independent inquiry into acute and crisis mental healthcare. Mind. 2011. http://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

⁷ Her Majesty's Inspectorate of Constabulary, Care Quality Commission, Her Majesty's Inspectorate of Prisons, and Healthcare Inspectorate Wales. A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs. HMIC, CQC, HMIP, HIW June, 2013 <http://www.hmic.gov.uk/media/a-criminal-use-of-police-cells-20130620.pdf>

⁸ Information Centre for Health and Social Care. Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, Annual figures, England, 2012/13. October 2013 <http://www.hscic.gov.uk/catalogue/PUB12503>

⁹ Independent Commission on Mental Health and Policing report. May 2013. <http://www.wazoku.com/independent-commission-on-mental-health-and-policing-report/>

¹⁰ Information Centre for Health and Social Care. Mental Health Bulletin: Annual report from MHMDS returns – England, 2011-12, further analysis and organisation-level data. February 2013 <http://www.hscic.gov.uk/catalogue/PUB10347>

4. Effective commissioning

Developing an effective local system that anticipates, and where possible prevents, crisis, and which ensures timely and supportive crisis care, is first and foremost a commissioning responsibility. It is at heart a leadership challenge for commissioners. Commissioners should have as their standard that they commission crisis care services that they would be content for their family or friends to use if they needed it. Local commissioners have a clear responsibility to put sufficient services in place to make sure there is 24/7 provision sufficient to meet local need.

Excellence in commissioning requires a mature multi-agency approach. Health and wellbeing boards will support this by bringing together health and social care commissioners, the local community and wider partners. Through the board, these partners will work together to develop a joint understanding of the local population's health and wellbeing needs and a shared strategy for meeting them. Central to this is the Joint Strategic Needs Assessment (JSNA) process, and the development of a Joint Health and Wellbeing Strategy (JHWS) to set out a shared set of priorities to address the identified need.

JSNAs and JHWSs together therefore provide a framework for developing the shared local understanding that each locality needs to have of the current and future health and care needs, and the partnership working to deliver it. This should include people experiencing mental health crisis.

Depending on local circumstances and the evidence in JSNAs, health and wellbeing boards might choose to review:

- Whether there are effective care pathways from police custody suites and courts to make sure individuals with co-existing mental health and drug and alcohol issues can effectively access appropriate substance misuse services.
- Whether sufficient resources are available within the crisis care pathway to ensure patient safety, enable service user and patient choice and to make sure individuals can be treated as close to home wherever possible. This could also consider the transient population that may create an otherwise hidden demand in particular areas. This might include homeless people and those vulnerable people who come to notice on the rail transport network.
- The needs of children and young people with mental health conditions, such as self-harm, suicidality, disturbed behaviour, depression or acute psychoses.

Local health and social care commissioners will also be expected to develop their own commissioning plans in line with any relevant JSNA or JHWS, and must be able to justify any parts of their plans which are not consistent with these.

Clinical commissioning groups are required, under the Crime and Disorder Act 1998¹¹, to work in partnership with the police and other local responsible authorities in Community Safety Partnerships. These partnerships make strategic assessments of crime and disorder, anti-social behaviour, and drug and alcohol misuse and develop local strategies to deal with these issues.

Excellence in commissioning also requires a clear understanding of effective service responses as described and evidenced by the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE), with a focus on recovery which is demonstrated by measuring outcomes and clearly shown in service specifications. This will ensure that service providers collect, analyse and act on a range of agreed outcomes, including patient and carer experience and satisfaction data. Commissioners will want to ensure that they have effective local safeguarding arrangements in place to prevent or reduce the risk of significant harm to people whose circumstances make them vulnerable.

Addressing these questions will enable local commissioners to realise the ambitions set out in this Concordat.

Effective commissioning ensures that the support and services reflect:

- The needs of people of all ages and all ethnic backgrounds, reflecting the diversity of local communities
- An equal relationship between physical and mental health

- The contribution of primary, community and hospital care, as well as other partners
- The inclusion of seldom-heard groups, or those that need improved early intervention and prevention.

This can be achieved through service user and carer involvement in all elements of the commissioning cycle, strategic direction, and monitoring of crisis care standards.

The next section sets out the elements of an effective system which will support local areas to plan the changes needed to strengthen and improve responses in order to best address local circumstances. It is not the role of the Concordat to set out exactly how this will be translated at the local level. There can be no single national blueprint, as local circumstances will differ.

What we can do at national level is support, inform and equip the commissioning arrangements locally. We have set out a number of interventions for strengthening the commissioning system for mental health services, including crisis care. This includes:

- The establishment of the Mental Health Information Network in 2014 to ensure that commissioners have the best possible information about the state of mental health and wellbeing in every area. This will help them make good decisions about what works in making real improvements in local services, including advice about the level and types of services needed
- Working with the Association of Directors of Adult Social Services (ADASS), the Association of Directors of Children's Services (ADCS), and the Chief Social Worker to strengthen the social care contribution to commissioning
- Support from NHS England to improve specialist leadership skills among CCGs

¹¹ Crime and Disorder Act 1998. The Stationery Office.
<http://www.legislation.gov.uk/ukpga/1998/37/contents>

- Working with those areas which have been selected to be pioneers in the integration of health care services for mental health to demonstrate best practice and evaluate models of care.

In the NHS, mental health crisis care spans local commissioning led by CCGs, and primary care and specialised commissioning – led by NHS England.

NHS England, as part of its Parity of Esteem programme, will be producing a range of tools and resources to support effective commissioning of mental health services, including crisis services.

There are important roles, both for local Healthwatch organisations and local Overview and Scrutiny Committees, to hold local commissioners to account for performance in respect of crisis care services.

It is clearly important that commissioners have the opportunity to exchange experiences and practice. NHS England will facilitate this through their Commissioning Assembly and other groups.

The National Quality Board's recent guide to nursing, midwifery and care staffing capacity and capability¹² states that appropriate levels of staffing need to be sustained 24 hours a day, 7 days a week, to maintain patient care and protect patient safety. The guide is for providers and commissioners of mental health services, NHS acute services, maternity, learning disabilities and community services.

In addition, NICE announced in November 2013¹³ that it will produce definitive guidance on safe and efficient staffing levels in a range of NHS settings, including mental health inpatient and community units.

Agencies, such as police and local government also have a key role. Close partnership between all the local commissioners and the NHS England area teams is needed to translate the models of urgent and emergency care developed by NHS England into local solutions that work for the demographic needs of their areas. In doing this, they will need to draw in contributions from other disciplines, such as housing and wider criminal justice.

Local commissioners also need to make sure primary care practitioners are fully involved in developing local plans, working in partnership with NHS England's area teams to secure this involvement. Partnership working is best supported by services working within catchment areas which are as co-terminus as possible, for example within the same area covered by local Emergency Departments and ambulance services.

¹² National Quality Board. How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability. NQB. 2013. <http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf>

¹³ National Institute for Health and Care Excellence. NICE to produce guidance on safe NHS staffing levels. NICE. November 2013. Press release. <http://www.nice.org.uk/newsroom/news/NICEToProduceGuidanceSafeNHSStaffingLevels.jsp>

Case Study

A new vision for Urgent Mental Health Care in North West London

Shaping Healthier Lives is North West London's mental health transformation strategy, 2012-15. It involves collaborative work between eight clinical commissioning groups and two mental health trusts.

The aim is to improve the experience of, and outcomes from, mental health urgent assessment and care. It provides the framework for improving mental health services across North West London, including increasing the management of the health and wellbeing of people with mental health problems in primary care. There is a need for rapid access to assessment and care for those in crisis, to be provided when and where the service user most needs it.

Initial approaches to improve crisis assessment and care include:

- Roll out and embedding of a common access and care standards policy
- A review of the local skills mix, competency and training needs of staff
- Progress to align mental health services to those in primary care- covering the period 8am – 8pm as a minimum. Extension of home visiting for crisis resolution work, providing 24/7 cover every day of the year
- Simplification of the 'way in', with a single telephone number, available 24/7 every day of the year.

Glen Monks
NWL Mental Health Programme Lead

5. Core principles and outcomes

This section sets out the principles and statutory requirements that all services involved in responding to mental health crises should follow.

It also describes improvements in services that can benefit people who depend on this support.

People seeking urgent help with mental health conditions, and friends and family close to them, will approach a range of different services – including their GP, helplines or voluntary sector groups, Emergency Departments, social services, schools, colleges, mental health trusts, and the police.

The complexity of crises may mean that individuals need support for several aspects of their crisis. This means having their mental health issues understood within the context of their family, cultural or community setting and other urgent needs, such as self-harm, alcohol or drug misuse, or pregnancy.

For there to be an effective emergency mental health response system, there should be detailed coordination arrangements in place between all the agencies regularly contacted by people in mental distress. People should be able to expect a whole system response.

People needing help should be treated with respect, compassion and dignity by the professionals they turn to.

A. Access to support before crisis point

A1 Early intervention – protecting people whose circumstances make them vulnerable

Mental health services need to intervene early to prevent distress from escalating into crisis. People with mental health problems, or their families or carers, are often aware that they are approaching crisis and may know what they need to do to avert it. They need to know who to contact in these circumstances. Services, in turn, need to trust the judgement of these ‘experts by experience’ and respond swiftly.

Early interventions can include:

- The development of a single point of access to a multi-disciplinary mental health team. These teams include staff from different professions, such as social workers and psychiatrists, and have been shown¹⁴ to simplify and improve access. This access point should be available to agencies across the statutory and voluntary sectors

¹⁴ West M, Alimo-Metcalfe B, Dawson J, El Ansari W, Glasby J, Hardy G et al. Effectiveness of multi professional team working in mental health care. Final report. NIRH Service Delivery and Organisation Programme. 2012. http://www.netscc.ac.uk/hedr/files/project/SDO_FR_08-1819-215_V01.pdf

- A joined-up response from services, for people of all ages who find themselves in crisis, with strong links between agencies, for example social care teams and substance misuse services
- Help at home services, including early intervention or crisis resolution/home treatment services
- Respite away from home or a short stay in hospital as a voluntary patient
- Peer support, including access to crisis houses or other safe places where people can receive attention and help
- Access to liaison and diversion services for people with mental health problems who have been arrested for a criminal offence, and are in police custody or going through court proceedings.

Each local area will need to decide the combination of services that best serves the particular needs of their population.

Care planning, including joint crisis care planning, for people with mental health problems is a crucial element of the preventative approach to crisis management.

Primary care, working in effective multidisciplinary teams and in partnership with a range of organisations, has an important role in supporting people experiencing mental distress or crisis.

Early intervention should be appropriate for people from vulnerable groups, including BME communities, people with learning difficulties, people with physical health conditions, people with dementia and children and young people, so they can find and stay engaged with services which keep them safe, improve their mental health and prevent further crises. People from these vulnerable groups are also at a high risk of

going missing, with an estimated four out of five adults who go missing experiencing a mental health problem at the time they disappear.¹⁵

Early intervention work can include suicide prevention. The Mandate from the Government to the NHS states that, “It is... important for the NHS to take action to identify those groups known to be at higher risk of suicide than the general population, such as people in the care of mental health services and criminal justice services”.

B. Urgent and emergency access to crisis care

B1 People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery

The NHS Mandate for 2014-15 contains an objective for the NHS to make sure that every community develops plans, based on the principles set out in this Concordat, that mean no one in crisis will be turned away.

People in mental distress should be kept safe. They should be able to find the support they need – whatever the circumstances in which they first need help, and from whoever they turn to first. As part of this, local mental health services need to be available 24 hours a day, 7 days a week.

The Concordat signatories believe responses to people in crisis should be the most community-based, closest to home, least restrictive option available, and should be the most appropriate to the particular needs of the individual.

¹⁵ Missing children and adults: A cross government strategy. Home Office, 2001. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117793/missing-persons-strategy.pdf

B2. Equal access

Commissioners and providers should be aware that the Equality Act 2010¹⁶ applies to mental health services, and requires that people should have equal, appropriate access. The Health and Social Care Act 2012 also introduced new legal duties regarding health inequalities for NHS England, stating that inequality of access to services and inequality of outcomes from them must both be reduced.

Equality is a key policy objective within England's cross government strategy for mental health, *No health without mental health*.

For some people from BME communities in particular, there is evidence that poor previous experience of services leads to a reluctance to have further engagement. There is also evidence that a lack of access contributes to situations where a crisis has to be reached, often involving contact with the police or child protection services, before a person seeks or receives support.

This Concordat supports the guidance produced by Mind on commissioning crisis care services for BME communities¹⁷. It recommends that commissioners:

- Consult and engage with BME groups early on when commissioning services – this may include the voluntary agencies that represent and support service users from BME communities

- Make sure staff are delivering person-centred care that takes cultural differences and needs into account
- Commission a range of care options that meet a diverse range of needs
- Empower people from BME groups by providing appropriate information, access to advocacy services, and ensure that they are engaged in and have control over their care and treatment.

B3 Access and new models of working for children and young people

Children and young people with mental health problems, including children in care, care leavers, and those leaving custody in the youth justice system, should feel supported and protected at all times as they are especially vulnerable. In particular, this group should have access to mental health crisis care.

For those cases where children and young people need to be admitted to hospital for mental health treatment, the Mental Health Act 2007¹⁸ introduced new provisions, that took effect in April 2010, to help ensure that patients under the age of 18 are accommodated in an environment that is suitable for their age – that is, not on an adult ward, unless their particular needs made it absolutely necessary.

For young people in the 16 to 18 years age group, who are making transitions between services and need continuity of care, there is a risk of additional distress when they first come into contact with adult services. Adult systems and processes may not offer the level of support and care that adolescents are used to. It is important that all staff who

¹⁶ Equality Act 2010. The Stationery Office. <http://www.legislation.gov.uk/ukpga/2010/15/contents>

¹⁷ Mind. Mental health crisis care: commissioning excellence for Black and minority ethnic groups: a briefing for Clinical Commissioning Groups. Mind. 2013 <http://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf>

¹⁸ Mental Health Act 2007. The Stationery Office <http://www.legislation.gov.uk/ukpga/2007/12/contents>

work to support these young people should have the appropriate skills, experience and resources to support them effectively.

Parents who have been very closely involved in the care and support of their child can also face difficulties once their child is considered to be an adult. Parents can find themselves excluded from information relating to the young person's care unless there is consent. The need for early intervention and clarity about the role of parents in the young person's care plan is critical. Staff should be willing to take the views of parents into account, as well as those of other people who are close to the young person.

To help facilitate access, there needs to be robust partnership working and communication between organisations that offer primary care to children and young people and specialist secondary care services. The focus on the interface between specialist children and adolescent mental health services (CAMHS) and primary care therefore needs to remain a central policy issue in CAMHS planning.

Other partners, such as schools and youth services, should also be fully involved in developing crisis strategies for children and young people as they may well be the first to identify the problems that a young person is facing. The best interests of the child or young person should always be a significant consideration when services respond to their needs. Children and young people should be kept informed about their care and treatment, in the same ways that adults are.

B4 All staff should have the right skills and training to respond to mental health crises appropriately

Staff whose role requires increased mental health awareness should improve their response to people in mental health distress

through training and clear line management advice and support.

Because individuals experiencing a mental health crisis often present with co-existing drug and alcohol problems, it is important that all staff are sufficiently aware of local mental health and substance misuse services and know how to engage these services appropriately.

Local shared training policies and approaches should describe and identify who needs to do what and how local systems fit together. Local agencies should all understand each other's roles in responding to mental health crises.

Each statutory agency should review its training arrangements on a regional basis and agree priority areas for joint training modules between NHS, social care and criminal justice organisations. Although it is desirable that representatives of different agencies be trained together, it is not essential. It is more important that the training ensures that staff, from all agencies, receive consistent messages about locally agreed roles and responsibilities.

B5 People in crisis should expect an appropriate response and support when they need it

People in mental health crisis who need help, need to receive it promptly.

NICE quality standards are designed to help service providers quickly and easily examine the performance of their organisation and assess improvement in standards of care they provide. They also help commissioners assess whether the services they are purchasing are high quality and cost effective and focussed on driving up quality.

Service commissioners and providers should work towards NICE quality standard QS14,

Quality standard for service user experience in adult mental health, Quality Statement 6, Access to services¹⁹.

This quality standard recommends people in crisis referred to mental health secondary care services are assessed face to face within 4 hours in a community location that best suits them; service users and GPs have access to a local 24-hour helpline staffed by mental health and social care professionals; and crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, regardless of diagnosis.

In addition:

- Hospital, step-down and community services should be commissioned at a level that allows for beds to be readily and locally available in response to a person in urgent need, as required by statute²⁰.
- Accommodation and facilities, including community based solutions, designed to be suitable for patients younger than 18 years must be commissioned at a level that ensures local provision in response to a young person in urgent need.
- If people are already known to mental health services, their crisis plan and any advance statements should be available and followed where possible. Considerations regarding data sharing are covered in **section B8**.

¹⁹ National Institute for Health and Care Excellence. Quality standard for service user experience in adult mental health: Quality statement 6, access to services. NICE. December 2011. <http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14/quality-statement-6-access-to-services>

²⁰ Mental Health Act 1983, s. 140. The Stationery Office <http://www.legislation.gov.uk/ukpga/1983/20/contents>

B6 People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the police must be supported by health services, including mental health services, ambulance services, and Emergency Departments.

The police have a power, under section 136 of the Mental Health Act,²¹ to remove from a public place any person an officer believes is suffering from mental disorder and who may cause harm to themselves or another and take them to a designated place of safety for assessment under the Act.

NHS commissioners are required by the Mental Health Act to commission health based places of safety for this purpose. These should be provided at a level that allows for around the clock availability, and that meets the needs of the local population. Arrangements should be in place to handle multiple cases.

Police officers should not have to consider using police custody as an alternative just because there is a lack of local mental health provision, or unavailability at certain times of the day or night. To support this aim, it is essential that NHS places of safety are available and equipped to meet the demand in their area. The signatories of the Concordat will work together to achieve a significant reduction in the inappropriate use of police custody suites as places of safety.

Police officers responding to people in mental health crisis should expect a response from health and social care services within locally agreed timescales, so that individuals receive the care they need at the earliest opportunity.

²¹ Mental Health Act 1983, s. 136. The Stationery Office <http://www.legislation.gov.uk/ukpga/1983/20/contents>

Street triage pilots

The Department of Health is funding pilot schemes, managed by nine police forces, in partnership with local NHS organisations. Some other forces already have schemes in operation, including Leicestershire Police, as described in the case study below. In these schemes, mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health problems. This advice can include an

opinion on a person's condition, or appropriate information sharing about a person's health history. The aim is, where possible, to help police officers make appropriate decisions, based on a clear understanding of the background to these situations. This should lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of section 136. An evaluation is planned for 2014.

Case Study

British Transport Police and NHS London – Operation Partner

In February 2013 British Transport Police (BTP) and NHS London launched a pilot scheme bringing together Psychiatric Nurses to work alongside Public Protection officers and staff. Their remit was to apply a multi-agency approach to the vulnerable people who come to the BTP's notice on the railway network, often in suicidal circumstances. The overall aim is to provide a managed, risk based approach that effectively moves people from crisis to care.

This is achieved through a joint assessment of all cases over the preceding 24 hours

and the formulation of a joint plan to reducing the risk of harm and to engage relevant care pathways. The NHS staff have access to health information systems and provide a telephone service to officers on the ground, giving information and advice so that more informed decisions can be made in the best interests of the individual concerned. At the time of writing, 689 cases have been jointly reviewed.

Mark Smith
British Transport Police

Police officers may find it helpful to follow the guidance on responding to people with mental ill health or learning disabilities²². Police officers should undertake appropriate training, to enable them to recognise risk and vulnerability and identify the need for health care. This training will support the

police to decide whether individuals should be detained under section 136, or whether they can be helped in some other way. Training should also cover the roles and responsibilities of partner agencies.

As part of local Mental Health Crisis Declarations, local areas will each be expected to make a commitment to improve performance in this area – by reducing the number of such uses, and by setting

²² Guidance on responding to people with mental ill health or learning disabilities. Association of Chief Police Officers, National Policing Improvement Agency, 2010.

an ambition for a fast-track process that either provides an assessment or arranges transfer to a health based place of safety for individuals whenever a police cell is used.

Commissioners and providers should make sure there is accurate and detailed data showing why and how often police cells are used as places of safety. Local partners should also review each individual case where a police cell has been used, to make sure the use was appropriate and to see whether there are lessons to be learned for the future.

The Department of Health will monitor the national figures on the use of section 136 and expects to see the use of police cells as places of safety falling rapidly, dropping below 50% of the 2011/12 figure by 2014/15.

Local protocols

Every area should have a local protocol²³ in place, agreed by NHS commissioners, the police force, the ambulance service, and social services. This should describe the approach to be taken when a police officer uses powers under the Mental Health Act.

These local protocols should ensure that:

- When the police make contact with health services because they have identified a person in need of emergency mental health assessment, mental health professionals take responsibility for arranging that assessment.
- Individuals in mental health crisis are taken to a health based place of safety rather

than a police station. The Mental Health Act Code of Practice states that “a police station should be used as a place of safety only on an exceptional basis”. Local protocols should set out an agreement about what constitutes a truly exceptional basis, for example seriously disturbed or aggressive behaviour. Local Mental Health Crisis Declarations should include local ambitions to reduce the use of police cells as places of safety.

- Particular reference is made to the needs of children and young people. Unless there are specific arrangements in place with Children and Adolescent Mental Health Services, a local place of safety should be used, and the fact of any such unit being attached to an adult ward should not preclude its use for this purpose, Protocols should help to ensure that police custody is never used as a place of safety for this group, except in very exceptional circumstances where a police officer makes the decision that the immediate safety of a child or young person requires it. Even in cases where police stations are used, the use of cells should be avoided, and alternatives considered wherever possible
- NHS staff, including ambulance staff, should take responsibility for the person as soon as possible, thereby allowing the officer to leave, so long as the situation is agreed to be safe for the patient and healthcare staff. There should not be an expectation that the police will remain until the assessment is completed
- Assessments under the Act are made in good time (see section B7).
- Partner organisations are clear about respective roles and responsibilities in order that responses to people in crisis are

²³ Department of Health. Code of Practice: Mental Health Act 1983. Chapter 10. The Stationery Office. 2008
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf

risk based, personalised, proportionate and safe, and that a guiding principle is to choose the least restrictive option, for example not choosing to detain someone when there is a viable alternative option.

- Arrangements are in place for escalation to more senior staff in case of disagreement.

B7 When people in crisis appear (to health or social care professionals or to the police) to need urgent assessment, the process should be prompt, efficiently organised, and carried out with respect

Commissioners and providers should ensure that people who are in distress owing to their mental health condition, and who are in need of formal assessment under the Mental Health Act, receive a prompt response from section 12 approved doctors and Approved

Case Study

THE STREET TRIAGE CAR IN LEICESTERSHIRE

“Our street triage car has reduced the section 136 detention rate by 33% on the level prior to the introduction of the car” – Leicestershire Constabulary.

Since January 2013, Leicestershire Police and Leicestershire Partnership Trust (LPT) have jointly operated a mental health triage car, which is driven by a police officer and contains a mental health nurse from the crisis service operated by LPT.

It aims to improve the service provided to the people who police encounter who may be experiencing difficulties with their mental health or learning disability; responding at the earliest opportunity and then directing people to the most appropriate service available. The car provides an initial point of contact for police officers on the beat who encounter incidents which have a mental health element, before exercising their police powers.

The mental health nurse provides the training, experience and legal powers of a registered nurse, can conduct a mental health assessment, has mobile access to mental health services and information

systems, and has experience of working practices and procedures in the NHS and in particular mental health services.

The police officer provides the training, experience and legal powers of a constable. These include powers under criminal law, the Mental Health Act and the Mental Capacity Act, has mobile access to criminal justice information systems, experience of working practices and procedures within the criminal justice system. The officer has been trained in public order and methods for gaining entry to locked or barricaded premises, and is qualified to higher driving standards, enabling emergency response if required.

The approach in Leicestershire appears to have led to a reduction in section 136 detentions of 33% of the level prior to the introduction of the car. The average time to help people when they are detained is now five hours and the car deals with 120 cases per month.

Peter Jackson
Leicestershire Police

Mental Health Professionals (AMHPs) so that arrangements for their care, support and treatment are put in place in a timely way.

Timescales should reflect the best practice set out in the Royal College of Psychiatrists guidance on commissioning services for section 136²⁴, which states that the Approved Mental Health Professional and doctor approved under section 12(2) of the Mental Health Act²⁵ should attend within three hours in all cases where there are no clinical grounds to delay assessment.

In the case of children and young people, the assessment should be made by a child and adolescent mental health services (CAMHS) consultant, or an AMHP with knowledge of the needs of this age group.

There should be no circumstances under which mental health professionals will not carry out assessments because beds are unavailable. Section 140 of the Mental Health Act states: Local health commissioners must keep those local authorities whose areas overlap informed of the hospital or hospitals where arrangements are in force to allow the reception of patients in cases of special urgency, so that AMHPs know where beds are available. Similarly, provision of dedicated AMHPs should be sufficient to meet needs, especially in out of hours periods.

When deciding upon any course of action, all professional staff should act in accordance with the Mental Health Act's principle of least restriction and to ensure that the services impose the least restriction on the person's

liberty. This includes avoiding the stigmatising appearance that a mental health crisis is a crime, for example, police forces should consider using unmarked cars to travel to a property to enforce a warrant under section 135 of the Act.

B8 People in crisis should expect that statutory services share essential 'need to know' information about their needs

All agencies, including police or ambulance staff, have a duty to share essential 'need to know' information for the good of the patient, so the professionals or service dealing with a crisis know what is needed for managing a crisis and any associated risks to the distressed person or to others²⁶. This may include:

- The name, address/contact details of the person (or a description if these cannot be ascertained)
- Details of any relative(s)/friend(s) or carer who can be contacted and, for children, family and school details
- Gender/age
- Language spoken (if not English) and any communication needs e.g. sign language
- Description of current behaviour/presentation
- Whether likely to be affected by drink or drugs
- Physical impairments and any prescribed medicines or dietary requirements
- Whether the person is already engaged with his/her GP and/or mental health

²⁴ Royal College of Psychiatrists. Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983, Position Statement PS2/2013. April 2013
http://www.rcpsych.ac.uk/pdf/PS02_2013.pdf

²⁵ Mental Health Act 1983, s. 12(2). The Stationery Office
<http://www.legislation.gov.uk/ukpga/1983/20/contents>

²⁶ Department of Health. Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services Ref 11929, Department of Health. 2009

Case Study

THE DEDICATED 136 NUMBER IN LINCOLNSHIRE

“Our central number for police has helped reduce the waiting time for people in crisis who need urgent health interventions”

– Lincolnshire Partnership Foundation Trust.

In March 2012 the section 136 working group for Lincolnshire, made up of police, Lincolnshire Partnership Foundation Trust (LPFT), the ambulance service, Approved Mental Health Professionals (AMHPs) and the Local Authority, created a joint mental health process which fully outlined operational protocols and responsibilities. Essential to this protocol was the use of a central 136 number for the police to use to enable them to access information and support from mental health professionals.

The 136 number connects officers to the mental health duty nurse at the Lincolnshire

place of safety. The police expect an immediate response and advice on incidents involving an individual having a mental health crisis. The nurse is able to offer a rapid referral to healthcare services. This supports the police and ambulance services to engage with the individual in crisis with greater understanding and confidence. Section 136 is only used when necessary, because appropriate alternatives are fully considered.

The point of contact becomes the section 136 suite duty nurse once this number has been dialled and a clear data sharing process comes into play. The information is shared allowing for quicker decisions about what happens next.

Mary Quint
The Lincolnshire Partnership Foundation Trust

services and the name of the team and any involved professional

- Whether they have a mental health crisis plan or other advance statements
- Any clinical information e.g. prescribed medication, psychological therapy
- Any presenting risk factors (for example, self-harm, suicide, physical aggression, confusion, impaired judgement, self-neglect, missing from home)
- Any relevant health information – such as the person being diabetic
- Children, dependents, pets or other factors to take into account when planning the most appropriate response

Information on patients should, through appropriate sharing protocols, follow them through the system and make sure that people known to services get the treatment they need quickly, and where applicable, the services are aware of their crisis plan and any advanced statements – no matter at what point they re-enter the mental health system.

Within the requirements of the data protection legislation, a common sense and joint working approach should guide individual professional judgements. If the same person presents to police, ambulance or Emergency Departments repeatedly, all agencies should have an interest in seeking to understand why this is happening, and how to support that person appropriately to secure the best outcome. This may include identifying whether the individual is already in treatment

Case Study

INFORMATION SHARING AND POLICE TRAINING ON VULNERABLE PEOPLE IN LONDON

“Since the Metropolitan Police Service (MPS) introduced the recording of vulnerable adult information in April 2013, there have been in excess of 20,000 reports, which show that there has been an unmet demand for a mechanism to record information on vulnerable adults” – Metropolitan Police Detective Inspector, Mental Health Team.

The MPS has been working with a range of partners to adopt a fresh approach to the way in which information is collected and shared with partners to support better outcomes for all vulnerable adults, including individuals with mental ill health. The MPS wants to reduce the incidents of crisis interventions by police and mental health services, which arise in a complex city that tends to draw vulnerable people in from across the country.

Through delivering training and guidance to all newly trained police recruits, and all front line officers and staff, the MPS is working to change the way in which vulnerable people

are identified and how that information is then shared. Concerns raised as a result can then be shared with partners, through processes such as the multi-agency safeguarding hub process, with public protection units and the community multi agency risk assessment conferences (which share information to increase the safety, health and wellbeing of all, for possible further assessment or support to be offered).

All front line officers will be trained by April 2014.

Find out more about the approach being developed by the MPS from frankie.westoby@met.pnn.police.uk

Find out more about the psychiatric public emergency assessment tool originally developed in the University of Central Lancashire by [Ivan McGlen](mailto:IMcglen@uclan.ac.uk), IMcglen@uclan.ac.uk

and/or is known to services, their GP or other community-based mental health services.

B9 People in crisis who need to be supported in a health based place of safety will not be excluded

Irrespective of other factors, such as intoxication, or a previous history of offending or violence, individuals suffering a mental health crisis and urgently needing to be detained while waiting for a mental health assessment should expect to be supported in a health based place of safety.

When a decision is made by a police officer to use their power under section 136, it is essential that the person in crisis is screened by a healthcare professional as soon as possible. In the majority of cases it will be the ambulance service that will screen the person to exclude medical causes or complicating factors and advise on the local healthcare setting to which the person should be taken.

Intoxicated people, of whatever degree, where their mental state is in question, must have an adequate mental and physical clinical assessment to determine and manage the cause of their problem. People presenting

with behaviour leading to use of section 136 but complicated by alcohol ingestion are best managed in a healthcare setting – either the locally designated place of safety or, if the level of intoxication appears to pose a medical risk, the Emergency Department. Either facility requires staff skilled to make mental health and physical health assessments, diagnosis and continued clinical monitoring, with access to investigation including scans.

When dealing with a person who is intoxicated, the paramount consideration should be to ensure their safety and the safety of others. No presumption should be made in regard to the cause of apparent intoxication until the person is in a safe environment for an adequate clinical assessment to be completed. Intoxication should not be used as a basis for exclusion from places of safety, except in locally defined and agreed circumstances, where there may be too high a risk to the safety of the individual or staff.

Similarly, a previous history of violence should not in itself lead to exclusion. Only in exceptional circumstances, in accordance with locally agreed risk management protocols, should a police custody suite be used to manage seriously disturbed and aggressive behaviour.

Currently, exclusion may also occur because local services cannot respond to the needs of people with personality disorder because of their diagnosis, gender or because they have self-harmed. Local commissioners should work towards the commissioning of local provision in line with current NICE guidance²⁷ with the aim of preventing the escalation of risk and reducing the need for crisis

management by primary care, Emergency Departments or the police.

B10 People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right ongoing support

People in mental distress often seek help from Emergency Departments – sometimes directly, if they have harmed themselves, or are experiencing a physical or mental health crisis. They may also be brought in by others because they have attempted suicide or taken a substance which has altered their mental state. They may be brought in by the police if the person requires urgent medical attention – this may be voluntarily, under arrest for an offence, or through a detention under section 136.

Whatever the circumstances of their arrival, people in mental health crisis should expect Emergency Departments to provide a place for their immediate care and adequate liaison psychiatry services to ensure that they obtain the necessary and on-going support required in a timely way.

Clear responsibilities and protocols should be in place between Emergency Departments and other agencies and parts of the acute and mental health and substance misuse service to ensure that people receive treatment on a par with standards for physical health.

The 2014-15 Mandate to the NHS contains a requirement for NHS England to ensure there are adequate liaison psychiatry services. Clinical commissioning groups should therefore ensure that there are effective liaison psychiatry services in place, to make the links between Emergency Departments and mental health services.

²⁷ NICE Pathways. Personality disorder overview. <http://pathways.nice.org.uk/pathways/personality-disorders>

Case Study

Liaison psychiatry at Department of Psychological Medicine, Hull Royal Infirmary

The A&E mental health liaison team operates seven days a week from 8am until 10pm.

It is a multidisciplinary team which includes a range of professionals who focus on people who deliberately self-harm and/or who have mental health problems within the acute care pathway.

This team therefore sees patients who have self-harmed in A&E and on the Hull Royal Infirmary and Castle Hill sites. The team will also arrange to see patients who are initially seen within the minor injuries units which are spread throughout Hull and East

Yorkshire. The latter patients are usually seen within 24 hours.

The team provide an AGELESS service to patients who have self-harmed. They offer specialist psycho-social assessment, follow up where appropriate and limited outpatient work of a more psychotherapeutic nature where there is an identified need.

From: Liaison psychiatry in the modern NHS, Centre for Mental Health and NHS Confederation Mental Health Network, 2012 http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf

There should be a local forum, such as a Local Mental Health Partnership Board, for agreement of protocols and escalation of issues, ensuring that:

- People experiencing mental health crisis, who are exhibiting suicidal behaviour, or who are self-harming, are treated safely, appropriately and with respect by Emergency Department staff
- Clinical staff identify mental health problems in people presenting with a physical health problem and refer them to a GP or specialist help where necessary
- Clinical staff are equipped to identify and intervene with people who are at risk of suicide, through on-going training in accordance with the relevant NICE guidelines, statutory and legal requirements under the mental health legislation and communicate with other services so that people who are at risk are always actively followed up
- Emergency Department staff should treat people who have self-harmed in line with the NICE guidance and work towards the NICE quality standard²⁸. Screening should determine a person's mental capacity, their willingness to remain for further psychosocial assessment, their level of distress and the possible presence of mental illness and their need for referral for appropriate psychological therapies and follow up
- Commissioners work with hospital providers to ensure that Emergency Departments, police and ambulance services agree appropriate protocols and arrangements about the security responsibilities of the hospital and the safe operation of restraint procedures on NHS premises. Emergency Departments

²⁸ National Institute for Health and Care Excellence. Quality Standard for self harm. QS 34. June 2013. <http://publications.nice.org.uk/quality-standard-for-selfharm-qs34>

should have facilities to allow for rapid tranquilisation of people in mental health crisis, if necessary, and clear protocols to safeguard the patient. This should be in accordance with NICE Guidelines²⁹. (<http://www.nice.org.uk/nicemedia/live/10964/29718/29718.pdf>)”

B11 People in crisis who access the NHS via the 999 system can expect their need to be met appropriately

The experience of people in mental health crisis accessing the NHS via the 999 system could be further improved by commissioning:

- The provision of 24/7 advice from mental health professionals, either to or within the clinical support infrastructure in each 999 ambulance control room. This would assist with the initial assessment of mental health patients and help ensure a timely and appropriate response.
- Enhanced levels of training for ambulance staff on the management of mental health patients. This could include the ability to provide more multi-agency training with other professionals to ensure a truly joined up approach
- Ambulance trusts to work flexibly across boundaries by exercising judgements in individual cases to ensure that an individual’s safety and treatment is not compromised.

B12 People in crisis who need routine transport between NHS facilities, or from the community to an NHS facility, will be conveyed in a safe, appropriate and timely way

In the case of routine transfers of mental health patients, not all contracts are operated by NHS ambulance services - there are many private sector providers of routine patient transport services.

Commissioners will need to make sure that the transfer arrangements put in place by mental health trusts and acute trusts provide appropriate timely transport for these patients. For example, police vehicles should not be used to transfer patients between units within a hospital. Caged vehicles should not be routinely used.

B13 People in crisis who are detained under section 136 powers can expect that they will be conveyed by emergency transport from the community to a health based place of safety in a safe, timely and appropriate way

Where a police officer or an Approved Mental Health Professional (AMHP) requests NHS transport for a person in mental health crisis under their section 135 and 136 powers for conveyance to a health based place of safety or an Emergency Department, the vehicle should arrive within the agreed response time.

The NHS ambulance services in England are planning to introduce a single national protocol for the transportation of section 136 patients, which will provide agreed response times and a standard specification for use by clinical commissioning groups.

Police vehicles should not be used unless in exceptional circumstances, such as in cases of extreme urgency, or where there is a risk of violence. As mentioned above, caged vehicles should not be used.

²⁹ NICE Clinical Guideline 25. Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments
<http://www.nice.org.uk/nicemedia/live/10964/29718/29718.pdf>

Case Study

AN AMBULANCE SERVICE and POLICE CONVEYANCING POLICY IN THE NORTH WEST

“The policy has brought clarity to a very complex area of service. It has dispelled a few myths and unrealistic expectations held between agencies and placed the vulnerable person at the centre of day to day responses to mental ill health” – Greater Manchester Police

The North West Ambulance Service NHS Trust (NWS) and North West Regional Police Forces, under the authority of the North West Regional Mental Health Forum, have agreed a policy which provides guidance for ambulance service personnel, medical and/or other healthcare practitioners, Approved Mental Health Professionals (AMHPs) and police officers to ensure that patients with mental ill health are conveyed in a manner “which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people”, in accordance with the Mental Health Act.

The conveyance policy sets out the roles and responsibilities of each agency including the NHS trusts, the ambulance service, the police and local authorities both in and out of working hours. All parties involved in the creation of the policy use their multi-agency experience to agree effective processes and clear care pathways.

A person-centred approach is taken with the aim of ensuring that vulnerable people receive appropriate and timely care, minimising the role of the police and the use of police vehicles in the conveyance of people experiencing mental

ill health. In practical terms, the policy explains that police assistance should only be sought if there is evidence of risk of either resistance (active), aggression, violence (to self or others) or escape. The policy determines that patients are conveyed to hospital in the most humane and least threatening way, consistent with ensuring that no harm comes to the patient or to others. In order to facilitate better multi-agency working, it provides relevant telephone numbers to enable faster referrals to take place, as well as specifying the response times NWS aim to meet when requested to assist with a mental health related incident.

The policy has brought clarity to a very complex area of service. Professionals involved now ‘Think Ambulance First’. It has also enabled senior police officers to challenge requests for police involvement in conveyance when the circumstances are not appropriate and emphasised to all agencies that each has responsibilities, inside and outside of working hours, for vulnerable people.

Adele Owen
Greater Manchester Police

C. Quality of treatment and care when in crisis

C1 People in crisis should expect local mental health services to meet their needs appropriately at all times

Responses to mental health crises should be on a par with responses to physical health crises. This means that health and social care services should be equipped to deal safely and responsively with emergencies that occur at all times of day and night, every day of the year.

The dignity of any person in mental health crisis should be respected and taken into account.

C2 People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting

The Care Quality Commission (CQC) monitors and inspects many of the care services that provide a response to people experiencing a mental health crisis including acute and mental health hospitals, community based mental health services, GPs and primary medical services, NHS and independent ambulance providers and prison healthcare services. How these services respond to people experiencing a mental health crisis will form part of the regulatory judgement that leads to a rating.

The CQC is introducing changes to the way it monitors, inspects and regulates different care services, including developing a new approach which focuses on whether services are safe, effective, caring, responsive and well-led. For specialist mental health services, the CQC will put a greater emphasis on inspecting and monitoring the care that people with mental health problems receive in the community, including during a crisis.

It will develop tools and methods to ensure that consideration is given to the key issues for people experiencing a mental health crisis in the future as part of the new regulatory approach. This development work will be informed by emerging concerns relating to the quality of mental health crisis care such as:

- The accessibility and responsiveness of services to support people through crisis and prevent admission to hospital, and
- The number of people who are admitted to hospital far away from their home area because of pressures on their local acute or admission wards.

The CQC also has specific responsibilities to monitor the use of the Mental Health Act and to protect the interests of people whose rights are restricted under the Act. This will include making sure the powers of the Mental Health Act are properly used by the range of professionals involved in its operation, including AMHPs and the police. The CQC will take account of this Concordat when inspecting and monitoring the support people receive from these agencies in response to their crisis, including inter-agency working at key points in the care pathway. They will also ensure that there is evidence that the least restrictive care has been provided and that mental health legislation and codes of practice have been complied with.

In addition, service providers have the responsibility for monitoring the quality of their responses to people in crisis.

Where specific concerns are raised that relate to the criminal justice system the criminal justice inspectorates will have regard to these in developing their joint inspection programme.

C3. When restraint has to be used in health and care services it is appropriate.

Once a person is in a mental health setting, the Code of Practice requires the organisation to make sure staff are properly trained in the restraint of patients. The Code also requires adequate staffing levels.

There should be a clear local protocol about the circumstances when, very exceptionally, police may be called to manage patient behaviour within a health or care setting. In these cases, mental health professionals continue to be responsible for the health and safety of the person. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological well-being.

The Department of Health and other partners are working on a programme to ensure the use of appropriate and effective restraint in health and care services.

C4. Quality and treatment and care for children and young people in crisis

There should be clearly stated standards relating to how each service involves and informs children and young people about their care, including medication and diagnosis, to make sure it is age appropriate.

Each service should explain how they seek and respond to the views of children and young people, and how they are supported if they wish to make a complaint. It can be beneficial for children and young people who have experienced mental health services to take part in shaping services to meet their needs.

Children and young people should have access to an advocate. Mental health professionals should advise them if their circumstances give them this right, for example if they are sectioned, and make

the necessary arrangements. Young people should also be supported in maintaining contact with their families where appropriate.

If a child or young person needs treatment, the first principle should be to treat at home or in the community if possible. If treatment is needed in an inpatient bed, local accessibility is important, so that the young person is close to home, friends and school, so long as none of these is contributing to the crisis. Young people need easily accessible and age appropriate information about the facilities available on the inpatient unit, geared towards their specific needs. This includes information on their rights and how to complain. They require extra support to settle in from a single key worker who remains the same throughout their stay where possible. They should be able to phone their families and friends. The units need to be safe, warm and decorated at an appropriate age level, and not appear to be an institution. Families should have regular meetings with the ward staff.

D. Recovery and staying well / preventing future crises

As stated in **A1 Early intervention**, care planning is a key element of prevention and recovery. Following a crisis, NICE recommends³⁰ that people using mental health services who may be at risk are offered a crisis plan. This should contain:

- Possible early warning signs of a crisis and coping strategies
- Support available to help prevent hospitalisation

³⁰ National Institute for Health and Care Excellence. Quality Standard on crisis planning. <http://www.nice.org.uk/guidance/qualitystandards/service-user-experience-in-adult-mental-health/CrisisPlanning.jsp>

- Where the person would like to be admitted in the event of hospitalisation
- The practical needs of the service user if they are admitted to hospital, for example, childcare or the care of other dependants, including pets
- Details of advance statements and advance decisions made by the person to say how they would like to be treated in the event of a mental health crisis, or to explain the arrangements that are in place for them
- Whether and the degree to which families or carers are involved
- Information about 24-hour access to services
- Named contacts.

A person's transitions between primary and secondary care must be appropriately addressed. Commissioners should expect clear criteria for entry and discharge from acute care. This should include fast track access back to specialist care for people who may need this in the future, and clear protocols for how people not eligible for the Care Programme Approach (CPA) can access preventative specialist health and social care when they need it. The CPA is a particular way of assessing, planning and reviewing someone's mental health care needs.

The principles of integration of care are valuable in this respect, in making sure the pathway of services is comprehensive and is organised around the patient, particularly during transition from acute to community teams.

Meeting the needs of individuals with co-existing mental health and substance

misuse problems requires an integrated and coordinated approach across the range of health, social care and criminal justice agencies.

In terms of local leadership, directors of public health, clinical commissioning groups, NHS England and police and crime commissioners all have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways to meet the needs of people with co-existing mental health and substance misuse problems. Health and wellbeing boards offer a forum for joining up local services and could coordinate the commissioning of services for people with multiple needs.

Clinical commissioning groups and local authority commissioners should ensure that service specifications include a clear requirement for alcohol and drug services to respond flexibly and speedily where an individual in crisis presents in a state of intoxication or in need of urgent clinical intervention. Workforce development has an important role to play in ensuring that staff receive the necessary training and support to work effectively and confidently. This should be reflected in the commissioning intentions of both substance misuse and mental health services.

Joined-up support is particularly important in criminal justice settings and it is critical that the development of liaison and diversion schemes is closely tied in with existing custody based interventions, such as those for drug misusing offenders to maximise their impact on this client group.

6. Next steps – enabling improvements in crisis care to happen

Actions to enable delivery of shared goals

This Concordat sets out the principles under which statutory agencies should work together to refine and improve the services that support people with mental health problems when they need urgent help.

As a first step towards making sure that these principles are translated into improvements across the health and justice systems, the Concordat signatories have all made specific commitments, which are contained in the following annex.

These commitments cover all of the areas that this Concordat seeks to address - effective commissioning, access to support before crisis point, urgent and emergency access to crisis care, the quality of treatment and care when in crisis, and preventing future crises.

These actions represent a vital part of this Concordat. An annual Concordat Summit will be held by signatories to review progress and hold each other to account on the delivery of this action plan.

Mental Health Crisis Declarations

The local dimension is critical to success, and central to this ambition is the expectation that local areas commit to delivering their own Mental Health Crisis Declaration.

The drive to achieve this will be supported by the national Concordat signatory organisations from spring 2014, through the use of existing networks and partnerships. In particular, the Department of Health will promote a number of road show events across England that will provide health and police partners in local areas with an opportunity to come together to review local practice and agree their Declaration.

A programme to support implementation is being developed, including:

- The opportunity to register local declarations online
- An independent evaluation of the support programme. This will include convening a national steering group to oversee and assess the implementation of the Concordat and its effectiveness
- Regional events across the England and an annual summit to assess progress, the first to be hosted by the Royal College of Psychiatrists.

Annex 1

Mental Health Crisis Care Concordat – Actions to enable delivery of shared goals

1. Commissioning to allow earlier intervention and responsive crisis services

| No | Action | Timescale | Led By | Outcomes |
|---|--|--|--|--|
| Matching local need with a suitable range of services | | | | |
| 1.1 | Share good practice on the development of JSNAs, local health plans and local commissioning plans, with a focus on establishing the local need for mental health and substance misuse services, working with local partners, and signposting to safe, effective and evidence-based local alternatives to hospital admission. | Within annual commissioning cycle (review and update). | LGA. | Least restrictive, most local and effective response to crises. Reduction in out of area placements because of urgent need. |
| 1.2 | A toolkit will be developed with police forces to capture and articulate data which quantifies the demand for responses for people in mental health crisis, including local monitoring arrangements for MHA S135/136 to ensure needs related to mental disorder and intoxication. | Scoping work beginning April 2014. | Home Office, with policing partners and PHE. | Clearer evidence on which to base local commissioning. |
| 1.3 | Support, develop and improve Mental Health Clinical leads' knowledge and experience of commissioning for crisis care and physical health of people with severe mental illness. | By April 2016. | Royal College of General Practitioners. | Improved commissioning of mental health services. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|--|---|--|
| Improving mental health crisis services | | | | |
| 1.4 | Review of the availability, quality and gaps in the information needed to assess the level of local need for crisis care, develop baseline assessment of current provision and the gap analysis and monitor the effectiveness of responses to people who experience a mental health crisis including those who are assessed and detained under the Mental Health Act. | NHS England is developing its mental health intelligence programme and, from April 2014, when the data is routinely available, commissioners and providers will be able to review capacity in line with local need and agreed model. | NHS England Information Strategy and Mental Health Intelligence Network (NHS England, PHE HSCIC, CQC, NHS Benchmarking club, NHS clinical informatics network and AHSNs). | Improved national data to inform commissioning decisions. |
| 1.5 | Analysis of gap between current provision and concordat vision to inform actions. | From April 2014. | NHS England/DH/PHE. | Focus commissioning support programmes on areas needing improvement. |
| 1.6 | Programme of support to CCGs to improve mental health crisis care commissioning. | From April 2014. | NHS England. | Commissioning Development Assembly working group to consider issues around commissioning mental health services. |
| 1.7 | Consider forming an improvement collaborative to share learning and transform services. | During 2014. | NHS England to lead with partners, including PHE. | Transformation of local services. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|--------------------|--|---|
| 1.8 | To develop bespoke guidance and model service specifications to support commissioners in delivering an integrated and responsive approach to meeting the needs of individuals experiencing mental health crisis where there are also co-existing substance misuse issues. | By September 2014. | PHE/NHS England/RC Psych/RCGP. | To provide clear, updated guidance to promote commissioning practice in line with concordat expectations. |
| Ensuring the right numbers of high quality staff | | | | |
| 1.9 | <p>HEE will set up a Mental Health Advisory Group to advise on policies, strategy and planning of the future workforce for mental health. This will enable HEE to:</p> <p>Ensure sufficient numbers of psychiatrists, other clinicians and care staff are trained to meet service needs.</p> <p>Review and set out future requirements for workforce training as outlined in HEE Mandate, in particular, by rolling out the Improving Access to Psychological Therapies and dementia programmes.</p> <p>Ensure agreement on the policy, funding and implementation plan for improvements to GP training including compulsory work-based training modules in child health, and mental health, including dementia and also include understanding of working in multi- disciplinary teams to deliver good integrated care.</p> | From April 2014. | Health Education England and partners. | Staff are equipped to treat mental and physical conditions with equal priority. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|--------------|---|--|
| Improved partnership working at a local level | | | | |
| 1.10 | Development of a web portal to enable exchange of effective practice for police/health service/local authority partnerships. | Early 2014. | Home Office/ national police leads. | Spread of good practice. |
| 1.11 | NHS England mental health partnerships website, launched to support its strategic clinical networks (SCNs) to establish with partners examples of what good looks like, including in crisis services. | Mid 2014. | NHS England. | Spread of evidence based good practice. |
| 1.12 | Develop a programme of support, including online tools, to support local areas to develop their own 'Local Crisis Declarations' driven by local circumstances. | Spring 2014. | Department of Health/NHS England/Home Office. | Spread of good practice and evaluation of impact of the Concordat. |

2. Access to support before crisis point

| No | Action | Timescale | Led By | Outcomes |
|---|---|-------------------------------------|--|--|
| Improve access to support via primary care | | | | |
| 2.1 | Develop a programme of work to support primary care to work collaboratively with other services, facilitating and co-ordinating access to specialist expertise and to a range of secondary care services including crisis care mental health and substance misuse services as required. | Ongoing. | Royal College of General Practitioners (with CCG Mental Health Network). | Prevention of avoidable crises. |
| 2.2 | Support, develop and improve GPs knowledge and experience of management of severe mental illness including physical health and crisis care through the RCGP Curriculum statement for mental health and the appointment of an RCGP Mental Health Clinical Lead. | April 2015. | Royal College of General Practitioners. | Prevention of avoidable crises. |
| Improve access to and experience of mental health services | | | | |
| 2.3 | DH to work with voluntary sector organisations to understand and respond to inequalities in access to mental health services, particularly for black and minority ethnic communities. | Development work before March 2014 | DH. | Improved outcomes and experiences of black and minority ethnic communities involved with mental health services. |
| 2.4 | Work with voluntary sector providers to assess any additional gaps in provision which are specific to the needs of LGBT people and those from 'seldom heard' groups experiencing mental health crises. | Development work before March 2014. | DH/NHS England/PHE/HO. | Ensure services take account of the needs of diverse local populations when improvements are made. |

3. Urgent and emergency access to crisis care

| No | Action | Timescale | Led By | Outcomes |
|--|--|------------------------|--|---|
| Improve NHS emergency response to mental health crisis | | | | |
| 3.1 | Complete a Review of Urgent and Emergency Care, including specific reference to models of care that work for people in mental health crisis. | By October 2014. | NHS England. | Description of models and commissioning guidance by Oct 2014. |
| 3.2 | Planning process to deliver mental health crisis care objectives in 2014-15 Mandate. | Started November 2013. | NHS England. | |
| 3.3 | Audit and Review Emergency Department access to specialist mental health services across England and report back findings to NHS England and CCG networks. | September 2014 | Royal College of Psychiatrists, College of Emergency Medicine | Establish baseline for parity of urgent access standards for people experiencing mental health crises |
| 3.4 | Following NHS England Urgent and Emergency Care review, develop best clinical practice around mental health crisis. | September 2014 | Royal College of Psychiatrists (with partner agencies) | Improved commissioning of good clinical practice/quality services |
| 3.5 | Audit of mental health assessment rooms in Emergency Departments. | During 2014. | College of Emergency Medicine, through the PLAN accreditation network. | Service users experience a safe and improved environment and staff safety is improved. |

| No | Action | Timescale | Led By | Outcomes |
|--|---|----------------|--|---|
| Social services' contribution to mental health crisis services | | | | |
| 3.6 | <p>Support local social services to review their arrangements for out of hours AMHP provision:</p> <ul style="list-style-type: none"> • consider the implementation of a scheme that employs sessional AMHPs in addition to existing resources to ensure they are able to respond in a timely manner • explore potential for better integration of AMHP and EDT services with out of hours crisis provision of health and other partners • authorities who have combined the services with children's safeguarding should satisfy themselves, in consultation with the police and mental health providers, that AMHPs can be available within locally agreed response times. | By April 2014. | ADASS (with LGA and College of Social Work). | Reduction in delays experienced by service users awaiting an AMHP assessment. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|-----------------|---|--|
| 3.7 | Support local social services to review and plan contribution to local mental health crisis services including: <ul style="list-style-type: none"> • representation in local senior operational and strategic forums overseeing and developing crisis services • in collaboration with local partners to have a system of ongoing review to ensure AMHP workforce is sufficient and capable to address local needs. | By April 2014. | ADASS (and LGA with College of Social Work). | Reduction in delays experienced by service users. |
| 3.8 | CQC and DH to review effectiveness of current approach to monitoring AMHP provision and whether the Care Quality Commission requires additional powers to regulate AMHP services. | April 2014. | DH and CQC. | Service users experience improved timeliness and quality of service. |
| Improved quality of response when people are detained under section 135 and 136 of the Mental Health Act 1983 | | | | |
| 3.9 | Update guidance, first published in Jan 2013, on the use of section 136 for commissioners and providers. | September 2014. | Royal College of Psychiatrists (with partner agencies). | Improved data collection and monitoring to inform commissioning standards. |

| No | Action | Timescale | Led By | Outcomes |
|------|---|--|--|---|
| 3.10 | <p>CQC to carry out a review of health based places of safety including coverage, capacity, inclusion and exclusion criteria, staffing, arrangements for governance and multi-agency working including police support.</p> <p>Develop this approach to monitoring the quality of health based places of safety as part of future inspections.</p> | Survey completed by April 2014; monitoring approach developed by September 2014. | CQC. | Improved information made public on the availability and quality of health based places of safety. |
| 3.11 | The NHS ambulance services in England will introduce a single national protocol for the transportation of S136 patients, which provides agreed response times and a standard specification for use by clinical commissioning groups. | April 2014. | Association of Ambulance Chief Executives (AACE). | Consistent responses to S136 conveyance experienced by service users. |
| 3.12 | Model for more effective joint agency arrangements to address the safeguarding and needs of vulnerable people with complex need, including personality disorders, addictions or dependencies, who turn to emergency services for help at times of crises and are at risk of exclusion from mental health services. | By September 2014. | Royal College of Psychiatry and College of Emergency Medicine. | Reduction in repeated crises experienced by people with complex needs. |
| 3.13 | The Department of Health will monitor the national figures on the use of section 136. | By November 2015. | DH. | An expectation to see the use of police cells as places of safety falling rapidly, dropping below 50% of the 2011/12 figure by 2014/15. |

| No | Action | Timescale | Led By | Outcomes |
|------|--|--------------------|---|---|
| 3.14 | <p>Review and update local Mental Health Act protocols on mental disorder and intoxication from alcohol or drugs to include guidance for emergency services, so that:</p> <ul style="list-style-type: none"> • People who appear to be mentally disordered and so intoxicated as to represent an immediate physical health risk to themselves will be medically assessed in an Emergency Department • People intoxicated as a result of alcohol or drug misuse who have been assessed as mentally disordered or are currently being treated by a mental health service will be accepted into the designated health based place of safety • People intoxicated as a result of alcohol or drug misuse who do not appear to be mentally disordered or who are not known a mental health service will be dealt with by the police through criminal justice processes. | From January 2014. | DH through updating Mental Health Act Code of Practice Chapter 10, and Royal College of Psychiatry Interagency group. | People are dealt with by the service most able to respond to their immediate needs. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|--|---|
| Improve information and advice available to front line staff to enable better response to individuals | | | | |
| 3.15 | Support agencies sharing key information about a person, in line with current guidance – Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services Ref 11929, DH 2009. | Summer 2014. | DH through local partnership board arrangements and through Caldicott and data protection officers. | Improved management experienced by the person in crisis. |
| 3.16 | Support local mental health service providers to develop arrangements which provide real time advice and support to the police when assessing the mental health needs of a vulnerable person. | April 2014. | National Policing Lead for Mental Health /NHS Confederation Mental Health Network to provide a joint Briefing paper including examples of current best practice. | Improved quality of assessments and experience by vulnerable people with mental health needs. |
| 3.17 | Street triage pilots in nine police forces will be conducted. The Department of Health and Home Office will share the evaluation and lessons learned from the pilots widely as they progress to benefit all other triage approaches being used. | 1 year pilot programme: Autumn 2013 to Autumn 2014. | Department of Health/Home Office. | New initiatives to improve the efficiency of responses and collaboration between health partners and the police are evaluated for the benefit of other areas. |

| No | Action | Timescale | Led By | Outcomes |
|--|---|-------------------|---|---|
| Improved training and guidance for police officers | | | | |
| 3.18 | Review of curriculum available to police forces to enable officers to undertake sufficient training on mental health. The review will also survey the 'take-up' of, and adherence to, the available training, leading to recommendations for improvements to the police curriculum. | Summer 2014. | College of Policing (supported by the Home Office). | All police forces in England can realistically be able to ensure that all frontline officers (and others) who may deal with people with mental health problems, can receive sufficient training with minimal disruption to normal business. |
| 3.19 | Review of 2010 <i>Guidance on Responding to People With Mental Ill Health or Learning Disabilities</i> . | Commence in 2014. | College of Policing. | Police guidance is updated and easier to use, transferred into Authorised Professional Practice – and available to the public. |
| Improved services for those with co-existing mental health and substance misuse issues | | | | |
| 3.20 | Nationally: Public Health England, NHS England and the LGA will work together to develop resources that will support LAs and CCGs in the development of an effective framework for the commissioning of services that will meet the needs of those in mental health crisis. | April 2014. | PHE / LGA. | To drive improved service provision and encourage a consistent approach to commissioning services to individuals in crisis who present with co-existing mental health and substance misuse issues. |

4. Quality of treatment and care when in crisis

| No | Action | Timescale | Led By | Outcomes |
|---|--|--|------------|--|
| Review police powers and use of places of safety under the Mental Health Act 1983 and CQC monitoring of operation | | | | |
| 4.1 | Review of Mental Health Act 1983 Code of Practice. | Updated Code of Practice published October 2014. | DH. | Response to recommendations of HMIC/CQC report on use of police cells for s136. |
| 4.2 | Review of legislative framework for sections 135 and 136. | Spring 2014. | DH and HO. | Recommendation for any change to primary legislation to support principles of Concordat. |
| 4.3 | Carry out a thematic review of the quality, safety and responsiveness of care provided to people experiencing a mental health crisis by regulated providers and providers/agencies with responsibility for operating the Mental Health Act 1983. | October 2013 – September 2014. | CQC. | Focused assessment of regulated providers and localities in relation to mental health crisis response; inspection of multi-agency responses within a sample of localities, particularly where concerns are identified; local and national reporting to inform improvement. |

| No | Action | Timescale | Led By | Outcomes |
|---------------------------------|--|---|-------------|--|
| 4.4 | Based on the learning from CQC's thematic review, develop the approach to monitoring and inspecting providers that respond to people experiencing a mental health crisis and who are regulated by CQC so that key issues are routinely considered within the new model for regulation. | September 2013 – April 2015. | CQC. | Strengthened regulation of providers that respond to mental health crises to promote improvement in the experience and outcomes for people who use these services. |
| Patient safety and safeguarding | | | | |
| 4.5 | Positive and safe campaign on restraint practices. | Guidance published for consultation, December 2013. | RCN for DH. | Part of a wider programme to reduce the use of physical restraint in mental health services. |

| No | Action | Timescale | Led By | Outcomes |
|-----|---|--------------|------------|---|
| 4.6 | Develop resources to support safeguarding boards, specific to the circumstances and needs of, and responses to, people experiencing mental health crisis. | During 2014. | LGA/ADASS. | <p>Ensure effective planning, monitoring and review of local safeguarding arrangements.</p> <p>Support safeguarding boards to take oversight of the safeguarding implications of current arrangements between local organisations and how these might be strengthened.</p> <p>Support safeguarding boards approach to monitoring the effectiveness of safeguarding arrangements for people experiencing mental health crisis.</p> <p>Support the development of strategic plans (in advance of statutory requirement) that include the very specific needs of people experiencing mental health crisis.</p> |

| No | Action | Timescale | Led By | Outcomes |
|-----------------------|---|-------------|---|--|
| Primary care response | | | | |
| 4.7 | Improve GP Trainees' understanding of the management of severe mental illness including physical health and crisis care in the community (through the extended training proposals). | April 2015. | Royal College of General Practitioners, Health Education England. | Improve primary care response to mental health crisis. |

5. Recovery and staying well / preventing future crises

| No | Action | Timescale | Led By | Outcomes |
|---|--|--------------------|------------------------|--|
| Joint planning for prevention of crises | | | | |
| 5.1 | Information and good practice guidance about prevention and early intervention produced and disseminated. | From April 2014. | PHE. | Service users experience more appropriate and consistent responses, disseminating latest best practice evidence and disseminating emerging case studies. |
| 5.2 | Set standards for the use of Crisis Care plans, in line with Care Programme approach guidance (DH publication 2010) and NICE Clinical Guidance CG 136 (Service User Experience of adult Mental Health Services NICE 2013). | Date to be agreed. | NHS England. | Service users jointly produce contingency plans in case of relapse or crisis. |
| 5.3 | Bring to attention of Health and Social Care services vulnerable people identified in the course of day to day policing in order to contribute to management plans and develop role of Neighbourhood Policing in helping to protect vulnerable people. | Ongoing. | Police national leads. | Prevention of crises due to relapse in poor mental health experienced by a vulnerable person. |

| No | Action | Timescale | Led By | Outcomes |
|-----|--|-------------|------------------|---|
| 5.4 | Commission services so that Liaison and Diversion Services and Street Triage refer individuals with co-existing mental health and substance misuse problems to services which can address their needs. | April 2014. | PHE/NHS England. | The needs of service users with co-existing mental health and substance misuse needs are better addressed in the development of services. |

**The 2014 Gloucestershire Declaration on improving outcomes for
people experiencing mental health crisis
(Version: Proposed by Task & Finish Group for adoption; April
2014)**

We, as partner organisations in Gloucestershire, will work together to put in place the principles of the national **Concordat** to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in Gloucestershire by putting in place, reviewing and regularly updating the attached action plan.

This declaration supports ‘parity of esteem’ (see the glossary) between physical and mental health care in the following ways:

- Through everyone agreeing a shared ‘care pathway’ to safely support, assess and manage anyone who asks any of our services in Gloucestershire for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.

- Through agencies working together to improve individuals' experience (professionals, users and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's **recovery** and wellbeing.

We, the organisations listed below, support this declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in Gloucestershire.

Many local organisations want to support the Declaration because of their commitment to improve mental health care and may want to make a specific contribution within the action plan for continuous improvements.

Certain organisations have a formal (statutory) responsibility and/or a professional duty of care regarding people presenting in mental health crisis – they are:

- Clinical Commissioning Group
- NHS England Local Area team
- Local Social Services Authority
- The Police Service and Police and Crime Commissioners
- The Ambulance Service
- NHS providers of acute medical services (Emergency Departments within local hospitals)
- NHS providers of mental health and/or substance misuse services
- Independent sector providers of mental health or substance misuse services (if awarded an NHS contract)
- GP representative organisation as providers of primary care mental and physical health services.

Glossary of terms used in this declaration

| | |
|------------------|---|
| Concordat | <p>A document published by the Government.</p> <p>The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental–health crisis need help.</p> <p>It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat.</p> <p>Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis</p> <p>Author: Department of Health and Concordat signatories</p> <p>Document purpose: Guidance</p> <p>Publication date: 18th February 2014</p> <p>Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf</p> |
|------------------|---|

| | |
|-----------------------------|---|
| Mental health crisis | When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger. |
| Parity of esteem | <p>Parity of esteem is when mental health is valued equally with physical health.</p> <p>If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses.</p> <p>Further information (link) :</p> <p>http://www.england.nhs.uk/ourwork/qual-clin-lead/pe</p> |
| Recovery | <p>Recovery embraces the following meanings:</p> <ul style="list-style-type: none"> • A return to a state of wellness (e.g. following an episode of depression) • Achievement of a quality of life acceptable to the person (e.g. following an episode of psychosis) • A process or period of recovering (e.g. following trauma) • A process of gaining or restoring something (e.g. one’s sobriety) • An act of obtaining usable resources from apparently unusable sources (e.g. in prolonged psychosis) • Recovering an optimum quality and satisfaction with life in disconnected circumstances (e.g. dementia) • Recovery can therefore be defined as “<i>a personal process of overcoming the negative impact of</i> |

diagnosed mental illness/distress despite its continued presence.”

Department of Health (2004), *Emerging Best practice in Mental Health Recovery.*

Appendix 3

Gloucestershire Mental Health Crisis Care Declaration Organisations/Signatories

Gloucestershire Healthwatch

County Community Projects

Gloucestershire NHS Hospitals Foundation Trust

Samaritans

2gether NHS Foundation Trust

Gloucestershire County Council

NHS Gloucestershire Care Services

Gloucestershire Police

General Practitioners - Local Medical Committee

South West Ambulance Service Trust

Gloucestershire Probation Service

Carers Gloucestershire

Office of the Police and Crime Commissioner Gloucestershire

Turning Point

Rethink

NHS England

Agenda Item 12

Governing Body

| | |
|---|--|
| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | Co-commissioning of Primary Care |
| Executive Summary | <p>NHS England announced on 1st May 2014 the opportunity for CCGs to express an interest in co-commissioning Primary Care services.</p> <p>The CCG will be discussing this announcement at the CCG Development Session on the 22nd May 2014, before preparing an expression of interest.</p> <p>The deadline date for applications is the 20th June 2014, to coincide with submission of five year plans.</p> <p>This paper seeks to obtain delegated authority from the Governing Body for the GCCG Executive Directors and Audit Committee Chair to compile and submit an expression of interest as set out within this summary document.</p> |
| Key Issues | The deadline date for submission is so soon after the announcement, constraining the opportunity for the Governing Body to see the proposal prior to submission, hence the request for delegated authority. |
| Risk Issues: Original Risk Residual Risk | If delegated authority is not given, the CCG will be unable to register an expression of interest by the deadline date, preventing the opportunity to co-commission Primary Care at this stage. This would delay the delivery of our five year strategy, <i>Joining Up Your Care</i> , as we have identified Primary Care as the hub of our out-of-hospital care system; if NHS England Area Team continues to commission, it will impair the speed we are able to deliver and implement our Primary Care Strategy that is the key enabler to our plans. |

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|--|---|
| Financial Impact | <p>This is to be determined, but due diligence will be undertaken prior to the submission of the expression of interest to ensure a full understanding of any financial impact.</p> <p>However, it is likely that there will be a financial impact on running costs as some functions will need to be absorbed within the CCG's running costs.</p> |
| Legal Issues (including NHS Constitution) | <p>In March 2014, following consultation, the Department of Health published a draft Legislative Reform Order (LRO) to amend the NHS Act 2006 to allow formation of joint committees between NHS England and CCGs. This is progressing through parliamentary procedures for approval and will be supportive to co-commissioning arrangements.</p> <p>GCCG will ensure it continues to meet its legal commitments within the NHS Constitution and other national guidance.</p> |
| Impact on Health Inequalities | <p>GCCG are seeking to make a positive impact on health inequalities within Gloucestershire as part of our five year plan. Co-commissioning of Primary Care is an enabler to development and delivery of our Primary Care Strategy.</p> |
| Impact on Equality and Diversity | <p>No</p> |
| Impact on Sustainable Development | <p>There are no direct sustainability implications contained within this paper.</p> |
| Patient and Public Involvement | <p>No</p> |
| Recommendation | <p>The Governing Body is asked to approve the request for delegated authority.</p> |
| Author | <p>Helen Goodey</p> |
| Designation | <p>Associate Director Locality Development and Engagement</p> |
| Sponsoring Director (if not author) | <p>Andy Seymour Deputy Clinical Chair</p> |

Governing Body

Thursday 29th May 2014

Co-commissioning of Primary Care

1 NHS England's Offer

- 1.1 Simon Stevens wrote to all CCGs on 1st May 2014 announcing the opportunity for CCGs to co-commission Primary Care medical services in partnership with NHS England
- 1.2 Further detail was sent on 9th May, outlining the powers and responsibilities that CCGs could express an interest to provide. Management of the Performers List, revalidation and appraisal fall outside the scope of any co-commissioning arrangements, as does Pharmacy, Dental and Ophthalmic services.
- 1.3 Applications need to describe the form that CCGs would like co-commissioning to take and how they would like this to evolve, including the proposed relationship with any current or proposed joint commissioning with local authorities.
- 1.4 CCGs are also expected to ensure that proposals take advantage of synergies with existing areas of CCG activity and enable functions to be discharged within existing CCG running costs as far as possible.
- 1.5 NHS England will test applications against a set of criteria, such as raising standards, advancing care integration, and reducing health inequalities while demonstrating transparency, fair governance and alignment with our five year plan.
- 1.6 Applications are required by 20th June 2014 to coincide with the submission of five year plans.

2 GCCG Response

- 2.1 GCCG's ambitions set out within the five year plan can best be delivered through the commissioning of whole pathways of care.
- 2.2 Primary Care handles 90% of all patient contacts, and is the cornerstone of our patient relationships as well as gatekeepers to all our services. They are integral to our vision, ambitions and plans and key stakeholders in delivering our out of hospital care aspirations.
- 2.3 The current commissioning architecture has proved challenging to both providers and commissioners, resulting in fragmentation, confusion and duplication. We need to agree solutions between the NHS England Area Team and GCCG that minimises these frustrations, providing more time to focus on delivering the desired outcomes for patients.
- 2.4 The current pressures across Primary Care require urgent action. Co-commissioning is vital for delivery of a local Primary Care Strategy, which allows us to tackle the priorities and investment required to enable sustainable services; supporting new ways of working that deliver our hospital plans detailed in the five year plan, *Joining Up Your Care*.
- 2.5 GCCG are therefore working with key stakeholders to develop an expression of interest that is reflective of our strategic needs in relation to Primary Care commissioning.

3 Recommendation(s)

- 3.1 The Governing Body are asked to agree the approach outlined in this paper.
- 3.2 The Governing Body are asked for delegated authority for the GCCG Executive Directors and Audit Committee Chair to progress this proposal in order to meet the submission deadline for expressions of interest to NHS England.

Governing Body

| | |
|--|--|
| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | West of England Academic Health Science Network Report and Plan |
| Executive Summary | The attached document is the third quarterly report produced by the West of England Academic Health Science Network. Also attached is the organisation's Business Plan for 2014/15. |
| Key Issues | The following key issues are referred to in the report: <ul style="list-style-type: none"> • Sir Bruce Keogh's visit to the WEAHSN • Adoption of Spread and Innovation • Enterprise and Translation • WEAHSN Conference 2014 |
| 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 and plan which is provided for information. |

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| 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, 05 March 2014

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. This report includes a one page summary of our Business Plan for 2014/15.

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

2. Sir Bruce Keogh, Medical Director, NHS England Visit to West of England AHSN

The Chair reported that Sir Bruce Keogh had visited the West of England AHSN on 21 February. This was Sir Bruce's first visit to an AHSN and he met Board members and clinicians who are leading our work across the West of England. A short film has been made of the visit www.youtube.com/watch?v=gftizLhXiwY. Member organisations are invited to use it on their websites.

3. Progress Report and Business Plan for 2014/15

At Sir Bruce Keogh's visit, we highlighted the key areas of focus during our first year and these are being built on within our Business Plan for 2014/15 which will come to all member organisations to confirm their support. In line with the NHS England "Licence for AHSNs", our programme is under the following headings:

Focus on Patients and Populations

- **Patient Safety Programme** – we are continuing to support Safer Care South West which is the Patient Safety programme headed by James Scott, Chief Executive, RUH Bath and Shaun Clee, Chief Executive of 2Gether Mental Health Trust. We already have a vibrant core programme in patient safety which is well supported by clinical "faculty" across the West of England and which we intend to develop to draw in all member organisations as fully as possible.

The Mental Health programme extends across the whole of the South of England and we expect this to continue. During 2014/15, the West of England will lead a bid to establish a Patient Safety Collaborative as part of which we will pilot a Patient Safety in Primary Care programme which is currently being

developed under the leadership of North Somerset Clinical Commissioning Group, working with the BNSSSG Area Team.

- **Connecting Data for Patient Benefit** – during 2013/14, we have had discussions across the West of England about how best to connect data at individual patient level across GP practices, NHS Trusts and Social Enterprises and our local authorities. We have now agreed to support a feasibility, or proof of concept, study in each of Gloucestershire, BaNES and Swindon/Wiltshire. This will include all organisations including those who cover several health communities, such as Mental Health Trusts and the South West Ambulance Services.

“Connecting Care”, the BNSSSG programme for Connecting Data for Patient Benefit is now live and is showing great potential for improving patient safety, system-wide efficiencies and more holistic management of a person’s care to avoid hospital admission. During 2014/15, this programme will offer “e-Discharge” to the GP practices of all patients discharged from hospital.

Adoption of Spread and Innovation

- **Evidence into Practice** – we have now selected and are at Project Initiation stage of three schemes which will be rolled out during 2014/15. They are:
 - Preventing Cerebral Palsy in pre-term babies – women who go into labour early can be given Magnesium Sulphate which is protective against Cerebral Palsy. The strength of this evidence has been verified by the Cochrane Collaboration and will be adopted initially by Gloucestershire Hospitals, University Hospitals Bristol and North Bristol Trust.
 - Proving outcomes in hip replacement – this evidence from the National Joint Registry confirms that cemented hip replacements results in better outcomes for people who are over 70. The programme will start with presentation and discussion of the evidence by clinicians in each NHS Trust which offers hip replacements.
 - Stroke Prevention in Atrial Fibrillation. This is NICE guidance and a priority of the Cardiovascular Strategy Clinical Network in the South West. It is being addressed with advice from Dr Martin James, Clinical Lead for the Cardiovascular Network, and will be implemented jointly with the seven Clinical Commissioning Groups in the West of England.
- **Commissioning Evidence-Based Care** – this programme was launched on 29 January 2014 with a training event for commissioners on interpreting, presenting and using evidence. This event included all Clinical Commissioning Groups and was well attended and well evaluated. It is the first of a series of initiatives in which we plan to support commissioners and help them build capability and capacity for commissioning evidence-based care.

Enterprise and Translation

This programme established three themes during 2013/14 which are being strengthened in 2014/15:

- **Articulating Key Challenges for Clinicians or the NHS** – inviting companies to work in partnership with us to develop responses. The national Small Business Research Initiative programme has supported a specification we crafted with the Patient Safety Faculty around the deteriorating patient. Three

companies were selected and we will now work with them as they develop their proposals. We will use this model for a series of local West of England challenges in 2014/15.

- **Developing a 'Translator Network'** – we have over 40 people in the West of England who have a role in innovation within their Trust, Clinical Commissioning Group or Social Enterprise. We will fill in the gaps and build this network during 2014/15.
- **Mapping Health Related Companies** – we now have over 250 companies on our database and we will work with the three Local Enterprise Partnerships for Gloucestershire, Avon and Swindon/Wiltshire to offer outreach events and build on areas of strength.

4. West of England AHSN Conference 2014

Our conference this year will be on Thursday 16 October 2014 at the University of the West of England Conference Centre.

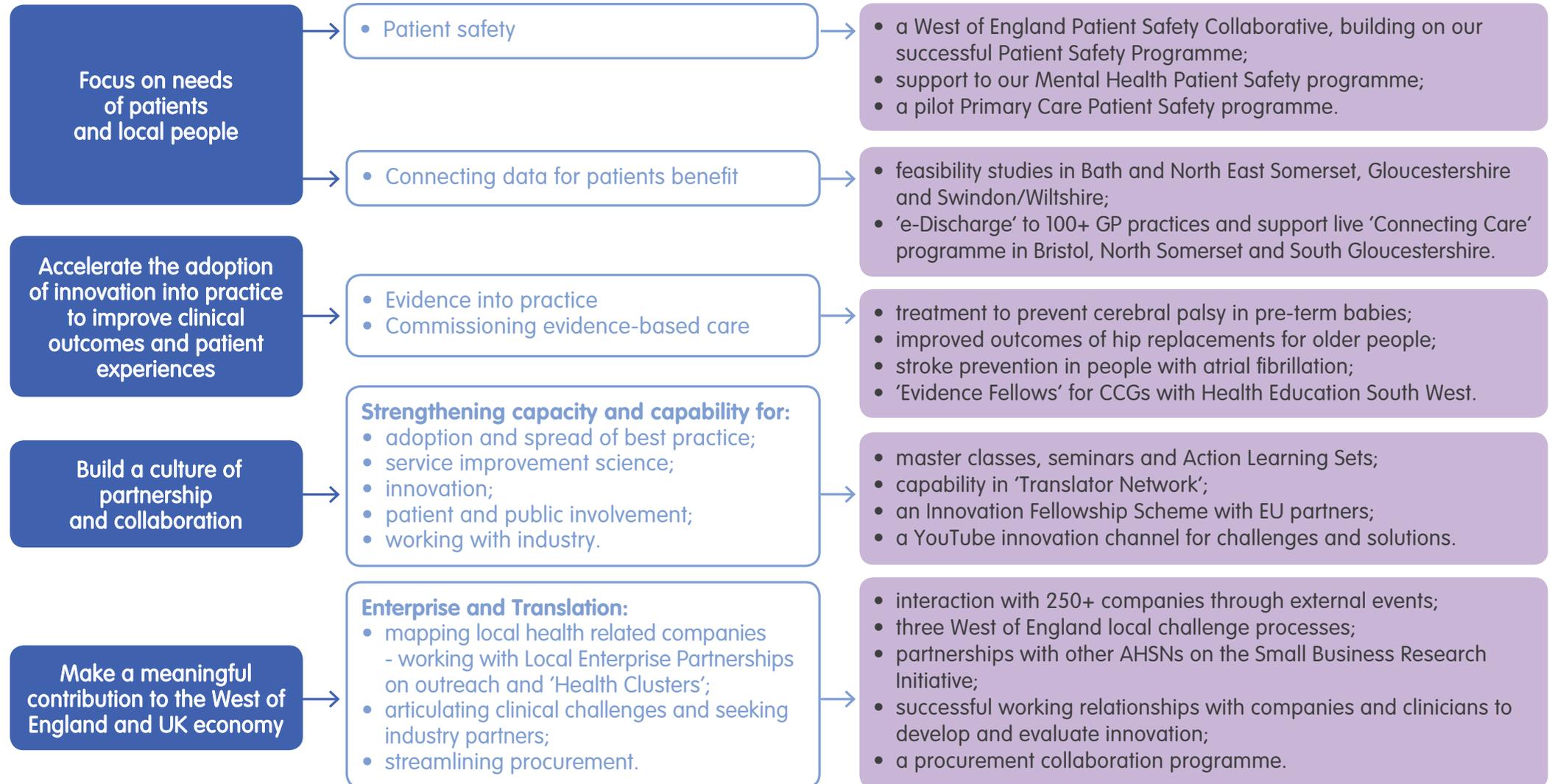
We are holding it jointly with the West of England Local Clinical Research Network.

Deborah Evans
March 2014

NHS ENGLAND LICENCE FOR AHSNs

WEST OF ENGLAND BUSINESS PLAN KEY THEMES

WE WILL DELIVER





West of England
Academic Health
Science Network

WEST OF ENGLAND
ACADEMIC HEALTH
SCIENCE NETWORK
BUSINESS PLAN 2014/15

Contents

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1. Introduction

The West of England Academic Health Science Network has developed a clear work programme which reflects the big challenges facing the NHS, the priorities of our member organisations and the profile of health needs across the West of England. We are beginning to develop powerful ways of articulating clinical problems and challenges and supporting partners from industry to develop innovative responses. In developing our enterprise and translation work we are working with the Local Enterprise Partnerships covering Gloucestershire, Avon and Swindon and Wiltshire to map health related activity, bring companies together through an outreach programme and develop areas of particular local strength and focus. For the West of England much of this activity relates to small and medium sized enterprises and focusses around medical technologies and digital communications.

The work programme for 2014/15 is presented graphically as a “Plan on a Page” (Appendix 2) in which are key programmes are:

Patient Safety

We will continue to develop our Patient Safety Programme across all our acute, mental health and community health service providers. We will pilot a primary care patient safety programme which is currently in development.

Connecting Data for Patient Benefit

During 2014/15 the AHSN will support three feasibility studies and one live programme on connecting individual patient data across all health and social care providers.

This programme has significant potential for further rollout to support urgent care and integrated care systems.

Evidence into Practice - initial schemes are:

- Preventing cerebral palsy in pre-term babies
- Better outcomes in hip replacement
- Preventing strokes

Commissioning Evidence Based Care

This is a programme to support commissioners and in 2014/2015 will provide further training and capacity building in Commissioning Evidence Based Care

Enterprise and Translation

- Small business research initiative – three themes
- West of England local challenges
- Working with Local Economic Partnerships.

Building the partnerships with CLAHRCWest and West of England Local Clinical Research Network.

2. Strategic Context

The West of England Academic Health Science Network services a population of 2.4 million people and is a “membership organisation” comprising:

| | |
|--|--|
| 3 Universities: | University of Bath University of Bristol University of the West of England |
| 7 Clinical Commissioning Groups | Bath & North East Somerset Bristol Gloucestershire North Somerset South Gloucestershire Swindon Wiltshire |
| 2 Mental Health NHS Trusts | Avon & Wiltshire Partnership NHS Trust 2Gether NHS Foundation Trust |
| 6 Acute NHS Trusts | Gloucestershire Hospitals NHS Foundation Trust Great Western Hospitals NHS Foundation Trust, Swindon North Bristol NHS Trust Royal United Hospital Bath NHS Trust University Hospitals Bristol NHS Foundation Trust Weston Area Health NHS Trust |
| 5 Providers of Community Health and Social Care | Bristol Community Health Gloucestershire Care Services North Somerset Community Partnership SEQOL, Swindon Sirona Care and Health CIC |
| 1 Ambulance Service | South West Ambulance Service NHS Foundation Trust |

Our AHSN received an allocation of £2.4 million for 2013/14 and expects to receive a similar amount in 2014/15.

We remain committed to our vision...

“A vibrant and diverse network of partners committed to equality and excellence, which will accelerate the spread of innovative, evidence based practice to improve health and care quality.”

... and to our strategic goals as described in our prospectus: which match those highlighted in the NHS England licence for AHSNs:

- To deliver measurable gains in health and wellbeing across the West of England focusing on the needs of our patients and local population.
- To make a meaningful contribution to the West of England and UK economy.
- To build a learning and delivery network to accelerate the adoption and spread of innovation and improvement of clinical outcomes and patient experience.
- To build a culture of partnership and collaboration.

This Business Plan for 2014/15 builds on our original Business Plan submitted to NHS England in August 2013 and responds to the NHS England 'Licence' for AHSNs which guides our priority setting.

3. Programmes

The AHSN is working on four broad programme areas which correspond to the four objectives in the NHS England Licence for Academic Health Science Networks. These are:

3.1 Focus on needs of patients and local population

In 2014/15 the AHSN will continue to develop its two cross-cutting programmes which connect all the settings of health care delivery have the potential to transform care and which fully support the NHS "Call to Action".

- **Patient safety**

West of England Academic Health Science Network has hosted the South West Patient Safety Programme "Safer Care South West" during 2013/14 and is now progressing to lead a new patient safety collaborative for the West of England. This programme has an existing track record of delivering improvement in patient safety and is supported by a well-established clinical faculty. Our aims for 2014/15 will be to consolidate and build engagement.

We are committed to supporting our mental health trusts in their leadership of and commitment to a South of England wide mental health patient safety collaborative.

We are in the process of developing a primary care work stream within our patient safety programme which will be piloted in two clinical commissioning groups.

We will continue to support the strong specific work streams we have such as critical care, perioperative care whilst developing further those themes such as medicines safety, pressure ulcers, venous thrombo embolism (VTE), and the deteriorating patient which address interface issues and are not setting specific. Six

workshops are scheduled to take place in Quarter 1 and 2 offering 210 places for clinical staff on these thematic areas.

Health Education South West have undertaken a baseline review of patient safety within all undergraduate curricula and post graduate training. In partnership with Health Education South West, South West AHSN, we will offer a South West wide programme on 'Human Factors in Patient Safety' during 2014/15 and will work together on strengthening patient safety education and training where needed.

- **Connecting data for patient benefit**

The AHSN is working with each health community across the West of England to accelerate progress in testing and developing approaches which connect data at individual patient level between all organisations in health and social care. During 2014/15 feasibility studies will take place in Gloucestershire, Swindon and Wiltshire, and Bath and North East Somerset. The "Connecting Care" programme which is live in Bristol, North Somerset and South Gloucestershire provides an exemplar of the real time benefits which exist for patients when their clinician can see every aspect of their care. During 2014/15 this programme will deliver "e discharge" to GP practices which will also be visible to other partners such as social care for every person discharged from hospital.

3.2 Evidence into Practice/Commissioning Evidence Based Care

These sister programmes are established and priorities have been agreed across the West of England for 2014/15.

There are three evidence into practice schemes which are:

- **Preventing cerebral palsy in pre-term babies**

The evidence from a Cochrane Review on the effectiveness of magnesium sulphate in protecting against cerebral palsy in pre-term babies will be implemented during 2014/15 starting with Gloucestershire Hospitals, University Hospitals Bristol and North Bristol Trust.

- **Better outcomes in hip replacement**

This work demonstrated through the National Joint Registry will be taken forward across the West of England in 2014/15 starting with engagement events with orthopaedic surgeons at each NHS Trust.

Gloucestershire Hospitals is the first West of England Trust to adopt this evidence which has been implemented at North Bristol Trust who have achieved 95% of cemented hip replacements in the target over 70s age group.

- **Anticoagulation for atrial fibrillation and stroke prevention**
This South West Strategic Clinical Network priority is being taken forward with Clinical Commissioning Groups and is part of our partnership agreement with NICE. It will run over two years and will extend to 200 GP practices serving a population of 1.5 million people starting in Bath & North East Somerset, Gloucestershire, Bristol and North Somerset.

3.3 Partnerships and Collaboration

The AHSN is achieving strong and growing engagement across all its member organisations which include formal reporting back to all boards after each AHSN Board meeting and quarterly West of England leaders meetings.

This business plan has been developed in partnership with all member organisations and will be owned by them as part of our distributed leadership model. The AHSN is developing extensive and productive working relationships with a wide range of partners and stakeholders which is an essential feature of its network role.

Specific examples include:

- A clear arrangement for how the AHSN works with the South West Strategic Clinical Networks supporting particular network priorities, avoiding duplication and adding value.
- Collaboration with the NHS Leadership Academy to support its September 2014 TEDMED Leadership Event.
- Cross representation with Health Education South West at board level and a programme of joint activity.
- Shared functions with CLAHRCWest and the West of England Local Clinical Research Network with strong leadership engagement between all three.
- Regular dialogue with the seven local authority Directors of Public Health and Public Health England.
- Dialogue and partnership working with the two NHS England Area Teams, NHS England South and the central AHSN team at NHS England.
- A joint AHSN and West of England Local Clinical Research Network Conference in October 2014.

3.4 Enterprise and Translation

Our enterprise and translation operational plan will build on the strong momentum we have achieved in 2013/14 including:

- Small Business Research Initiative – we will continue to work with the three companies supported through this national programme who are working on innovations around patient safety and the deteriorating patient. We will also co-develop two or three other clinical themes with other AHSNs and select promising responses for development.

- The West of England will issue a number of local clinical challenges to companies and work with the successful ones to develop and test them in the West of England. The first one will be about mobile health (MHealth) within a commissioned health care pathway and will be launched in Quarter 1.
- Local economic activity – we now have a database of over 250 companies who are active in health related fields and during 2014/15 will work with Local Enterprise Partnerships, hold outreach activities and build up locality specific strengths (see profile at Appendix 3).
- We will create a You Tube innovation channel where companies with innovative ideas can pitch their solutions to the NHS. This is in partnership with SETSquared (University partners).
- The AHSN will continue to work with the Gloucestershire, Avon, and Swindon and Wiltshire Local Enterprise Partnerships, holding outreach events and identifying key local strengths such as robotics and biosensors which may attract national or EU funding.
- We will continue to work with NHS England on developing an approach to wealth creation across all 15 AHSNs.

4. Patient and Public Involvement

The Academic Health Science Network is developing a joint patient and public involvement and empowerment programme with CLAHRCWest and the Local Clinical Research Network. During 2013/14 the Academic Health Science Network has held a number of patient and public stakeholder events to guide our development and this lead to patient safety being adopted as our flagship programme. We have also built patient and public perspectives into each of our work streams.

The West of England is already recognised as having built strong public and patient perspectives into its research activities through INVOLVE South West.

5. Building Capacity and Capability

The West of England leadership group of Chairs, Chief Executives, Pro-Vice Chancellors and Clinical Commissioning Group Leaders has recognised the added value which the AHSN can bring to building capability in the areas of:

- Change management and improvement science
- Evidence into practice/Commissioning evidence based care
- Innovation and business skills
- Patient safety

We will be working with Health Education South West, the NHS Leadership Academy and our member organisations to implement approaches which add value, encourage collaboration across the West of England and capitalise on the unique aspects of the AHSN's contribution.

We have developed a programme for 2014/15 which will include learning sets on service improvement/evidence into practice, working with industry, bid writing and using evidence for commissioners.

6. Ensuring that we deliver

The Academic Health Science Network has developed a robust programme management approach internally and is developing specific metrics which will support each programme.

We have resources available to support evaluation and understanding the evidence on best practice both internally and from CLAHRCWest.

We have commissioned an overall evaluation of the AHSN which is being led by Professor Christine Harland at Cardiff University and which involves each of our three Universities.

Each individual programme adopted within the AHSN Business Plan will also include evaluation.

Appendix 1 - References

The West of England Academic Health Science Network Board papers which include details of our Strategic and Operational Plans are all published on the AHSN website: <http://www.weahsn.net/about-us/board-papers/>

The following may be of particular interest:

- West of England AHSN Business Plan (September 2013):
<http://www.weahsn.net/wp/wp-content/uploads/2013/10/WE-AHSN-Business-Plan-from-GF-23Aug2013.pdf>
- Evidence into Practice Task and Finish Group:
http://www.weahsn.net/wp/wp-content/uploads/2013/12/05.4b-Reseach_Evidence_into_PracticeTFGroup_reportrecommendations-appendix-1JTv1.0_26Nov20131_PB.pdf
- Informatics Strategy (December 2013):
<http://www.weahsn.net/wp/wp-content/uploads/2013/12/06.2-131210-Informatics-FINAL-2dec13.pdf>
- Enterprise and Translation Strategy (December 2013):
<http://www.weahsn.net/wp/wp-content/uploads/2013/10/04.5b-adoptstrat+reportWealth-Creationapp1JT15Sept2013.pdf>
- Enterprise and Translation Operational Plan:
http://www.weahsn.net/wp/wp-content/uploads/2013/12/06.3b-Outline_operational_plan_ET_Workstream_Q4_2013-LS-V0.4-de-2-dec13.pdf

The AHSN uses a crowd sourcing tool "Ideas Spotlight":

<https://westofenglandahsn.wazoku.com>

Agenda Item 14

**Gloucestershire Clinical Commissioning Group
Governing Body**

| | |
|--|--|
| Governing Body Meeting Date | Thursday 29th May 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 March 2014. |
| 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 | The CCG achieved its planned surplus for the year |
| Legal Issues (including NHS Constitution) | These are set out in the main body of the report |
| Impact on Health Inequalities | Not Applicable. |
| Impact on Equality and Diversity | There are no direct health and equality implications contained within this report |
| Impact on Sustainable Development | There are no direct sustainability implications contained within this report |
| Patient and Public Involvement | These are set out in the main body of the report. |

| | |
|--|--|
| Recommendation | The Governing Body is asked to: <ul style="list-style-type: none">• Note the financial position as at March 2014• 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 |

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 March 2014. 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
- Patient Experience
- Partnerships
- Staff

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 March 2014

| 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 up to 31st March 2014

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

| 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 |
| Support the CPGs to develop high level quality outcomes measures, based on the 6 dimensions of quality to be incorporated into a Quality Assurance Framework in order to provide assurance to CCG | | A |
| 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 (CPG) and the localities ensuring that quality and patient safety is at the heart of their work (Green).

Following the development of the Quality Strategy, there is an expectation that each Clinical programme group (CPG) will develop a Quality Assurance Framework for their clinical programme areas. The CCG has engaged with a senior lecturer with an interest in methodological development, in the faculty of Health and Applied Sciences, from University West of England. This work will focus on the research and development of system wide quality measures to contribute to individual CPG quality assurance frameworks as well as organisational level measures.

As part of the work on the clinical effectiveness group knowledge management has been discussed and how a systematic way of horizon scanning can be applied across all sources of clinical information to support CPGs. This work will continue and an agreed approach put in place.

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).

All applicable NICE TAs are available from our main acute services provider and appear on the joint formulary.

| NICE TECHNOLOGY APPRAISALS (TAs) | Q1 (April - Jun 13) | Q2 (July- Sept 13) | Q3 (Oct- Dec 13) | Q4 (Jan -Mar 14) to date | Cumulative to date |
|----------------------------------|------------------------|-----------------------|---------------------|-----------------------------|-----------------------|
| Number issued | 14 | 5 | 6 | 6 | 31 |
| Number relevant to GCCG | 8 | 3 | 3 | 4 | 18 |

As a method of reassurance the CCG Quality Team chair a Clinical Quality Review Group (CQRG) on a quarterly basis for all main providers. These groups work to a standard agenda to monitor the quality requirements with additional agenda items added to review any exception reporting in the previous quarter, which includes patient safety, patient experience and clinical effectiveness. Any actions arising from these meetings are reviewed for implementation and evaluation of effectiveness.

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:

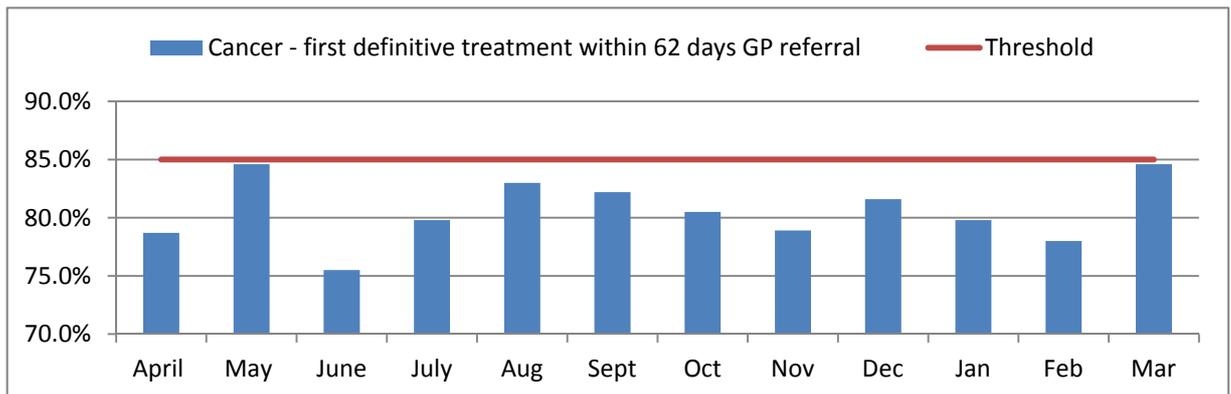
- Overall reduction in the number of over 30 minute handover delays
- Achievement of all cancer 31 day targets

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.

| 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% | Mar | 99.1% | 99.3% | |
| Cancer - subsequent treatment for cancer within 31 days - surgery | 94% | Mar | 100.0% | 99.1% | |
| Cancer - subsequent treatment for cancer within 31 days - Drug Regime | 98% | Mar | 100.0% | 99.7% | |
| Cancer - subsequent treatment for cancer within 31 days - Radiotherapy | 94 | Mar | 100.0% | 100% | |
| Cancer - first definitive treatment within 62 days GP referral | 85% | Mar | 84.6% | 80.7% | |
| Cancer - first definitive treatment within 62 days screening service | 90% | Mar | 92.3% | 97.2% | |
| Cancer - first definitive treatment within 62 days upgrade | 90% | Mar | 100.0% | 93.6% | |
| Patients Access to unscheduled care | | | | | |
| Cat A RED 1 Ambulance incidents | 75% | Mar | 71.9% | 69.9% | |
| Cat A RED 2 Ambulance incidents | 75% | Mar | 72.6% | 72.3% | |
| Cat A 19 min response Ambulance | 95% | Mar | 95.0% | 94.9% | |
| Over 30 minute ambulance handover delays (GHNHSFT) | <2012/13 | Mar | 117 | 1151 | |
| Over 1 hour ambulance handover delays (GHNHSFT) | <2012/13 | Mar | 16 | 207 | |
| Crew clear up delays of over 30 minutes | <2012/13 | Mar | 17 | 201 | |
| Crew clear up delays of over 1 hour | <2012/13 | Mar | 4 | 43 | |
| 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% | Mar | 86.0% | 83.1% | |
| Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours | 60% | Feb | 69.4% | 71.3% | |
| Treating and caring for people in a safe environment & protecting them from avoidable harm | | | | | |
| Number of MRSA infections (Health Community) | 0 | Mar | 0 | 8 | |
| Number of MRSA infections (GHNHSFT) | 0 | Mar | 0 | 2 | |
| Number of C.diff infections (Health Community) | 162 | Mar | 21 | 210 | |
| Number of C.diff infections (GHNHSFT) | 52 | Mar | 8 | 60 | |
| Number of Never Events | 0 | Mar | 0 | 4 | |

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-end performance was Amber rated 80.7% 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.

February’s performance was 78.0% (24 breaches), March’s performance improved to 84.6% (19 breaches)

Actions have been taken to address capacity issues within certain specialties and work has also been undertaken to review patient pathways.

Following review the CCG and GHNHSFT are focusing upon the diagnostic delays within patient pathways. Key themes in the revised action plan include reducing time the amount of time it takes for radiology and pathology tests to be completed.

GHNHSFT have sourced additional diagnostic capacity and additional consultants have been recruited.

The actions put in place to reduce backlogs from March onwards are being reviewed during weekly performance meetings.

Cat A RED Ambulance incidents (SWAST North division)

Cat A 8 min response - The percentage of Category A RED 1 & 2 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.

Year-end performance was Red rated for both Red 1 & 2 targets:

Red 1 - 69.9%

Red 2 - 72.3%

Threshold – at least 75% of incidents requiring an emergency response should be arrived at within 8 minutes.

Performance improved during quarter 4; the breakdown of 8 minute response in March was; Red 1 71.9% and Red 2 performance 72.6%.

Overall activity has increased during 2013/14 (5.7% increase compared to 2012/13); as of the end of March 2014 SWAST North division activity was 3.7% above contracted levels.

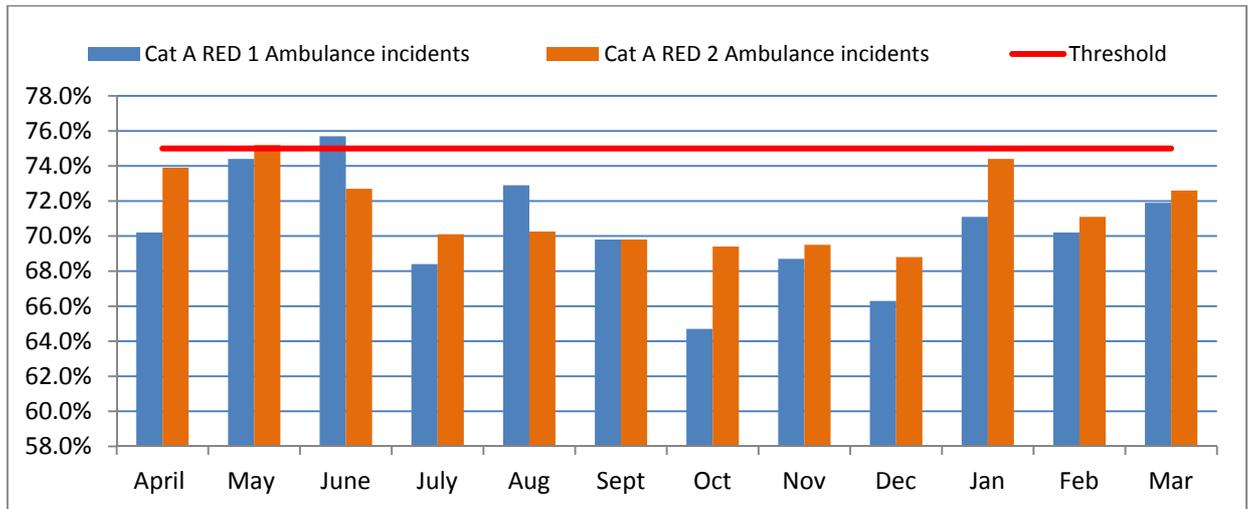
SWAST performance is being reviewed regionally by all constituent CCGs, action plans and trajectories have been reviewed and implemented. SWAST have conducted an internal review and in January implemented a number of actions to improve performance. These included additional vehicles and crews, along with strengthened performance management arrangements in the North patch. Actions are in place to improve overall performance in 2014/15 and also to improve areas where there is differential performance.

A19 Ambulance incidents (SWAST north division)

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.

Year-end performance was Amber rated. 94.9% against a threshold of 95%.

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

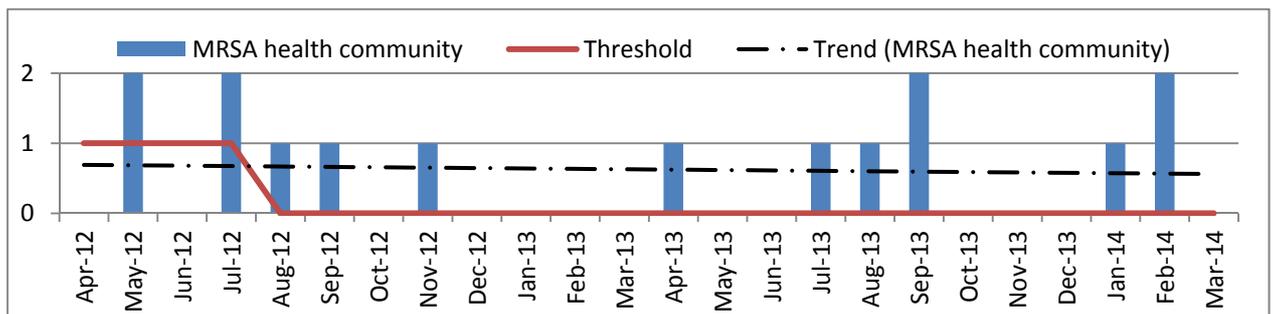


Number of MRSA infections (Health Community)

Number of MRSA infections (Health Community) – Year-end performance was Red rated. 8 cases against a target of zero.

6 cases were pre 48 hour and therefore have not been attributed to acute providers. Two post 48 hour infections have been reported, one at Great Western and one at GHNHSFT.

GCCG are investigating the two cases reported in February; for CCG actions please see GCCG Quality report to the Integrated Governance Quality committee (IGQC).



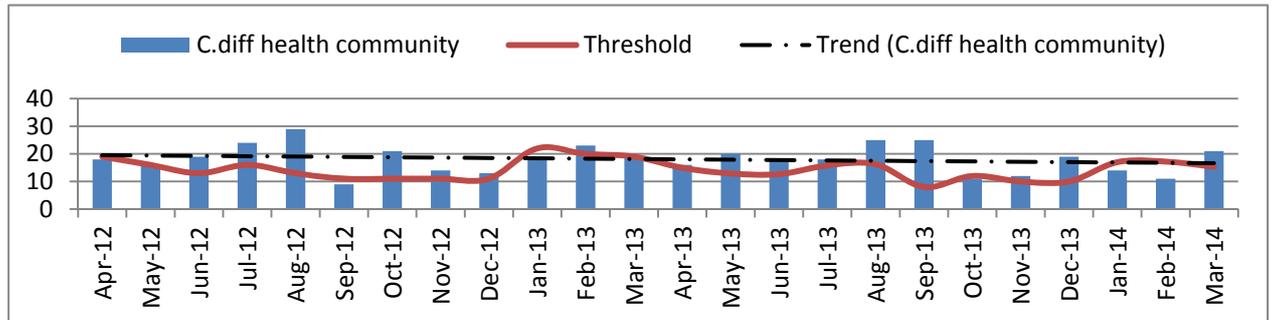
Number of total C. diff infections (Health Community)

Number of C. diff infections (Health Community) – Year-end performance was red rated. 210 cases against a target of 162.

In Q4 there were a cumulative total of 46 episodes of clostridium difficile infection against a cumulative target of 43 cases.

Overall there has been a reduction in the number of MRSA and C.diff infections compared to 2012/13.

The threshold for 2014/15 has increased from 162 to 201 cases.



Number of Never Events

Red rated due to 4 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.

A wrong site dental extraction has been reported at an out of hour's dentist. An investigation has been conducted and full report received (attributed to GCS).

3.1 Perspective 2. Finance and Efficiency

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

3.1.1 Finance and efficiency – Period to 31st March 2014

Summary:

- The CCG has achieved a surplus of £6.806m (in excess of the plan of £6.757m).
- The reported position is fully inclusive of all risks and pressures.
- The QIPP programme reported an under-performance against the plan during the financial year.
- The better payment practice code performance for the year (for non-NHS invoices by volume) is 92.6% which was below the targeted figure.
- A negotiated settlement was agreed with GHFT and this is reflected within the outturn position.

Based on the outturn position, as has been the case for the majority of the year, the overall assessment for the finance and efficiency perspective is amber.

3.2 Resources

The CCG's end of year resource limit (see Appendix 2) remains at £678.89m in March which is the same as the previous month.

3.3 Expenditure

The financial summary as at 31st March 2014 shows an outturn surplus of £6.806m (in excess of the plan of £6.757m) and further detail is shown at Appendix 3. Key budget areas with forecast outturn variance are highlighted below:

| <u>Key</u> | Trend | Outturn Over/ (Under) Spend £'000 |
|---|---|---|
|  Indicates a favourable movement in the month | | |
|  Indicates an adverse movement in the month | | |
| Gloucestershire Hospitals NHS FT | | |
| A year end agreement was reached following extensive discussions across both organisations. The outturn position acknowledges the estimated year end over-performance highlighted through received monthly monitoring and includes all agreed developments and some non-recurrent pressures, particularly within urgent care. |  | £14,638.7 |
| Winfield Hospital | | |
| The overspend reflects the continued over-performance in Orthopaedics which has been highlighted in previous monthly reports. The recurrent impact of the overperformance has been included in the 2014/15 contracting round. |  | £1,033.5 |
| University Hospital Bristol | | |
| The contract performance follows the trend shown in previous months and includes of any changes in Specialist Commissioning responsibilities. |  | (£605.4) |
| Great Western Hospital | | |
| The reported position is consistent with last month; the majority of the over-performance relating to emergency inpatients and critical care and this is offset by under-performance in elective inpatient activity. |  | £482.8 |
| Any Qualified Provider (AQP) | | |
| AQP providers have shown an over-performance throughout the year and this has been included in planning for 2014/15. |  | £548.5 |
| | | |

| | | |
|--|---|----------|
| Non Contracted Activity (NCA) | | |
| The CCG has analysed trends by provider and compared them with expenditure incurred in previous years; allowing for changes in Specialist Commissioning responsibilities. This work has informed the 2014/15 budget setting process. | ↑ | £774.0 |
| | | |
| Continuing Health Care | | |
| The reported position primarily relate to slippages on staff appointments and underspends on Funded Nursing Care. | ↑ | (£616.0) |
| | | |
| Community Services | | |
| The outturn position includes an overspend against the Gloucestershire County Council managed integrated equipment pool together with non-recurrent adjustments on the Gloucestershire Care Services contract. | ↓ | £316.2 |
| | | |
| Oxygen | | |
| The rate of overspend on this budget has reduced and continues to reduce following the introduction of the GCS managed assessment service; the recurrent impact has been included within 2014/15 budget setting. | ↑ | £264.2 |
| | | |
| GP Prescribing | | |
| The prescribing data received to February 2014 highlights a marginal deterioration in the previous forecast outturn position. | ↓ | £274.3 |
| | | |
| Local Enhanced Services | | |
| The 2013/14 outturn position is consistent with that previously reported. New year plans are based on the agreements reached following decisions made in following the review of enhanced services. | ↑ | (£175.6) |
| | | |
| Running Costs | | |
| As has been the case across the financial year, the pay underspend is due to slippage in staff appointments; this fully committed from 2014/15 onwards. | ↓ | (£948.4) |
| | | |

3.4

QIPP

There have been no changes in achievement reported against the QIPP plan in the month. Appendix 4 shows the outturn against programme areas. Appendix 5 shows each scheme and its RAG rating in terms of implementation, in year savings and also its

forecast financial impact in 2014/15. All slippage and associated financial risk is reflected in each budget line within the reported outturn position.

3.5 Cash (Appendix 6)

The CCG received a revised maximum cash drawdown (MCD) figure for 2013/14 which was based on a NHSE submission made in February. The CCG successfully managed its payments and receipts within this cash envelope.

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 no significant change in the value of invoices paid (from 97.5% to 97.3%) although this is still above the 95% target. The year to date achievement by volume at 92.6%, although a marginal increase on the previous month, remained below target. However, in February alone the position improved to 95.7%.

3.7 Statement of Financial Position (Appendix 8)

The position shown includes the impact of transfers of legacy assets and partially completed spells from Gloucestershire PCT as at 31/3/13. Legacy provisions remained on the balance sheet of NHS England in 2013/14. However, those claims not previously recognised have been provided for by the CCG in 2013/14 (at a level of £870k). The payment of retrospective CHC claims from 1/4/14 will be financed under a national risk pooling scheme although full details of this scheme are yet to be received from NHS England.

3.8 Financial Risk

All financial risks previously reported have been included within the outturn position and those considered to be of an ongoing nature have been addressed within the 2014/15 budget setting process.

Recommendations:

The Governing Body is asked to

- Note the financial position which formed the basis of the CCG's 2013/14 unaudited Annual Accounts.

4.1 Perspective 3. Patient experience

4.1.1 Patient Experience – Period to 31st March 2014

| 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 | | G |
| 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 | | G |
| 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 | | G |
| 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 | | A |
| 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 | | A |
| 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.

The GHT FFT target to the end of quarter 4 was to achieve a Trust-wide response rate of 15%, which was met by the end of quarter 3. Collated data for quarter 4 has not yet been published and will be summarised in the May paper.

FFT response rates for maternity services vary across the four stages that are surveyed, and only the response rate for Question 2 (Labour) is meeting the validity criterion of 15%.

A Patient Experience CQUIN has been developed which includes reference to FFT outcomes (for patients and staff). Revised national guidance, to include Primary Care, Community Services and Mental Health is due to be published by NHS England at the end of June 2014. Each provider’s individual FFT CQUIN schedule allows for consideration of the new guidance.

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

The GCCG Patient and Public Engagement (PPE) objective to establish a system for GCCG for to share their experiences and make suggestions so that the CCG has been achieved. However, the system is not well used it may be that a different approach needs to be considered.

The CCG have reviewed the processes for Serious Incidents and Never Events (which are a sub-set of Serious Incidents) and have implemented a processes to identify themes and lessons learned. Feedback is provided via the IGQC Quality Report which is readily available. Serious incidents are reported by the providers and the CCG liaises with them regarding reports, progress of action plans.

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

Measures to develop and embed the culture of learning from patient experience and promote an approach that values staff feedback have been outlined in an Action Plan, developed to support the GCCG Quality Strategy, submitted to the Integrated Quality and Governance Committee (IGQC) in

April 2014. The plan also includes measures to support the development of patient experience information and the promotion of shared decision making with patients and carers.

GCCG has recently concluded the Joining up Your Care engagement with the public, the feedback received has been used to inform GCCG's two-year operational plan and five-year strategic plan.

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% | Mar | 91.0% | 92.3% | |
| % of non - admitted pathways treated within 18 Weeks | 95% | Mar | 96.2% | 97.1% | |
| % of incomplete Pathways that have waited less than 18 Weeks | 92% | Mar | 92.1% | 94.1% | |
| Zero RTT pathways greater than 52 weeks (incomplete pathways) | 0 | Mar | 5 | 14 | |
| % of patients seen within 2 weeks of GP referral for suspected cancer | 93% | Mar | 94.7% | 94.1% | |
| % of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected | 93% | Mar | 93.0% | 89.0% | |
| % of patients waiting more than 6 weeks diagnostic test | 1% | Mar | 0.43% | 0.76% | |
| % of patients waiting more than 6 weeks for a Planned/ Surveillance diagnostic test from their to be seen date – Endoscopy procedures only | 1% | Mar | 22 | 22 | |
| Patients access to community care | | | | | |
| % referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks | 95% | Mar | 97.0% | 99.0% | |
| % referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks | 95% | Mar | 100.0% | 98.8% | |
| % referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks | 95% | Mar | 98.5% | 98.3% | |
| % referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks | 95% | Mar | 100.0% | 99.9% | |
| % referred to the Podiatry Service who are treated within 8 Weeks | 95% | Mar | 100.0% | 98.0% | |
| % referred to the Adult Occupational Therapy Service who are treated within 8 Weeks | 95% | Mar | 100.0% | 99.9% | |
| % referred to the Adult Physiotherapy Service who are treated within 8 Weeks | 95% | Mar | 98.0% | 97.0% | |
| % referred to the Parkinson Nursing Service who are treated within 8 Weeks | 95% | Mar | 100.0% | 100.0% | |
| % referred to the Diabetic Nursing Service who are treated within 8 Weeks | 95% | Mar | 100.0% | 99.0% | |

| Patients Access to unscheduled care | Threshold | Month | Performance | YTD performance | Trend |
|---|-----------|-------|-------------|-----------------|-------|
| 4-hour A&E target GHNHSFT | 95% | Mar | 91.7% | 93.9% | |
| 4-hour A&E target GCS MIU | 95% | Mar | 100.0% | 99.9% | |
| 12 hour trolley waits | 0 | Mar | 0 | 0 | |
| Positive patient experience of secondary care | | | | | |
| Mixed-sexed accommodation breaches | 0 | Mar | 0 | 52 | |
| Cancelled operations - 28 day breaches | 0 | Mar | 5 | 49 | |
| Urgent operations cancelled for a second | 0 | Mar | 1 | 1 | |
| Positive patient experience of mental health services | | | | | |
| Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days | 95% | Q4 | 99.0% | 99.0% | |
| The proportion of people who have depression and or anxiety disorders who receive psychological therapies | 13% | Q4 | 13.7% | 13.7% | |
| The proportion of people who complete therapy who are moving towards recovery | 50% | Q4 | 51.0% | 51.0% | |

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.

March's performance was 91.7% making year the final year end position 93.9% compared to a target of 95%. Threshold – at least 95% of patients should be transferred, admitted or discharged within 4 hours.

Focus on making improvements across the USC system ensuring patients are seen at the right time and right place. GCCG has promoted system wide initiatives focusing on patient flow and timely discharge.

Continued work will focus on managing demand at the front door of A&E, in conjunction with an increased impact of ICT (rapid response and high intensity service), further development of SWAST “see and treat” and NHS 111 enhanced clinical advice service. Other schemes in implementation include, OPAL, increased investment in integrated discharge team, ‘hot clinics’ and extension of AEC.

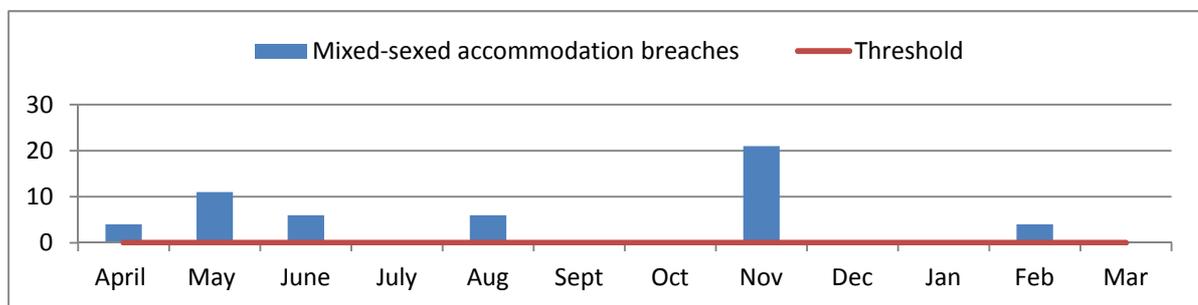
It is recognised that 4 hour performance has been impacted significantly by bed availability and a number of schemes are underway to positively affect LOS.

Eliminate mixed-sexed accommodation breaches at all providers sites

During 2013/14, 52 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 was one breach in February affecting 4 patients; there were no breaches in March.

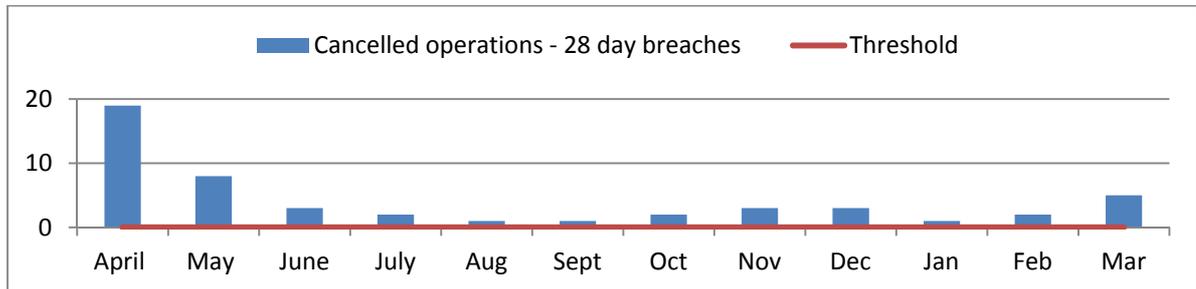


Cancelled operations - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days.

The year-end position for GHNHSFT shows a total of 49 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 49 breaches 30 occurred in Q1 where significant pressure was experienced within the unscheduled care system. In Q4 8 patients at GHNHSFT were cancelled and not provided another date within 28 days. GHNHSFT also reported an urgent operation cancelled for a second time in February 2014.



Number RTT pathways greater than 52 weeks

During 2013/14 a total of 14 breaches of the 52 week standard for incomplete pathways occurred. 12 of the 14 were reported in Q4, 2 were at GHNHSFT with the other 12 at out of county providers.

A full root cause analysis has been undertaken for all breaches to ensure lessons are learned.

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

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

Cancer waiting times – 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-end performance was Amber rated at 89% 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 performance has improved.

5.1 Perspective 4. Partnerships

5.1.1 Partnerships – Period to 31st March 2014:

| | | |
|---|---------------------|---------------------------------|
| 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 |
| <i>Key performance indicators</i> | | |
| Signed off Better care fund (BCF) plan | | G |
| 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 health & social care, independent and voluntary sector | | G |
| Success criteria 2: Delivery of the Health & Well Being plan | | Under development |
| <i>Key performance indicators</i> | | |
| 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 |
| <i>Key performance indicators</i> | | |
| 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.

Final plans for the BCF have been developed and were submitted on the 4th April 2014. The submitted plans were drawn up by the Gloucestershire Health Community and signed off by the Health and Well Being Board

The submission combines the shared direction of travel, the ambitions identified in Your Health Your Care, GCCGs commissioning intentions, GCCGs local operating and service planning with our developing 5 year vision - Joining Up Your Care.

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.

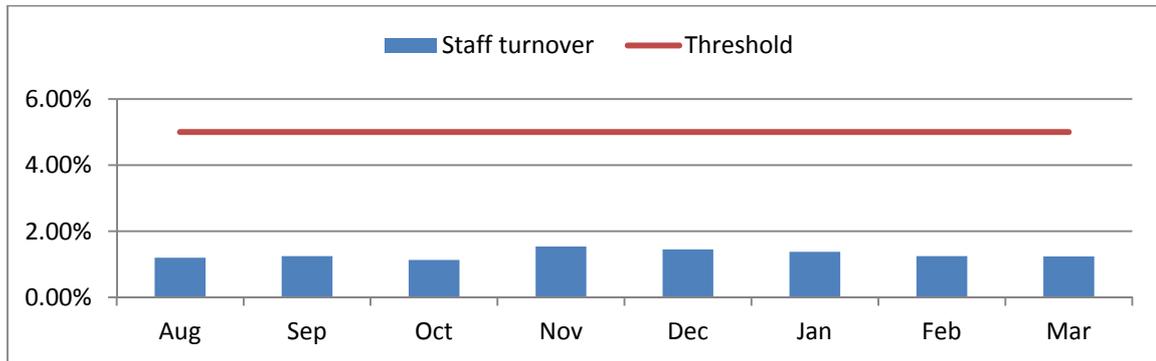
6.1 Perspective 5. Staff

6.1.1 Staff – Period to 31st March 2014:

| | | |
|--|--------------|---------------------------------------|
| PERSPECTIVE 5 | Staff | Green |
| Success criteria 1: Attracting and retaining high quality staff aligned to the CCGs vision and values | | G |
| <i>Key performance indicators</i> | | |
| Turnover - % of employees leaving the organisation | | 1.24% |
| Number of current Vacancies in structure | | 11 |
| Success criteria 2: Personal development processes that are linked to the strategic plan | | Collating results from October |
| <i>Key performance indicators</i> | | |
| 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 |
| <i>Key performance indicators</i> | | |
| Staff sickness levels | | 1.83% |
| 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 1.25% to 1.24% per month. The number of leavers since April 2013 is 28 (3 in March).



There are 5 jobs live on NHS Jobs and 6 are in the recruitment process.

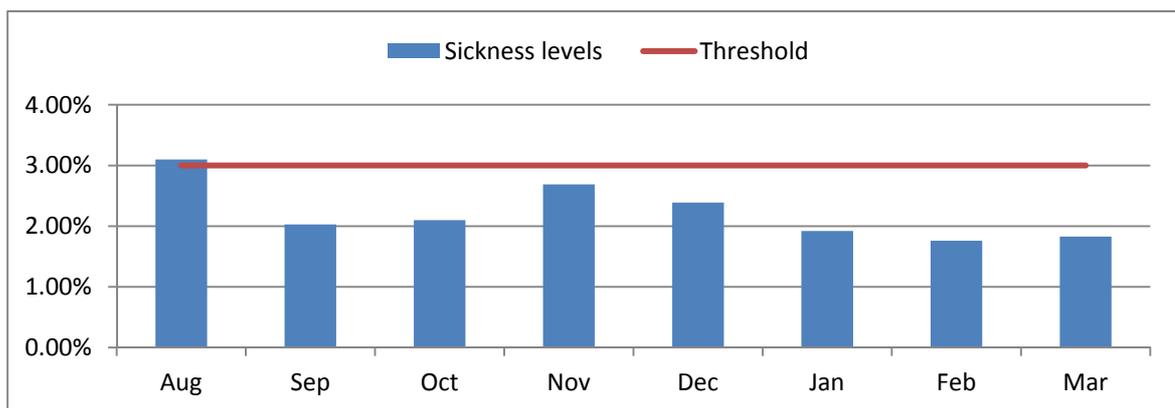
6.1.3 Personal development processes (PDP) that are linked to the strategic plan

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 March have been 1.83% which is below the GCCG target of less than 3%, but higher than the level reported in February. 1.83% equates to 1236.4 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.



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 |

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. |

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 | 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% | C | |
| | | GRH | 94.5% | 91.4% | 91.9% | 93.7% | 95.5% | 93.7% | 94.4% | 94.4% | 93.3% | 93.8% | 93.2% | 90.7% | 89.3% | | 93.0% |
| | | CGH | 95.0% | 89.9% | 93.1% | 95.4% | 93.4% | 97.2% | 97.9% | 98.2% | 97.3% | 97.5% | 95.9% | 94.4% | 95.6% | | 95.4% |
| | | GHNHSFT total | 94.7% | 90.8% | 92.4% | 94.4% | 94.7% | 95.0% | 95.7% | 95.8% | 94.7% | 95.1% | 94.2% | 92.0% | 91.7% | | 93.9% |
| | | GCS - MIU | 99.9% | 99.95% | 99.88% | 99.91% | 99.9% | 99.9% | 99.95% | 99.96% | 99.87% | 99.9% | 99.8% | 99.9% | 99.95% | | 99.91% |
| CB_S9 | 12 hour trolley waits (no A&E attender should wait more than 12 hours from the decision to admit to admission) | Target | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | C | |
| | | GRH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | CGH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | GHNHSFT total | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | GCS - MIU | 0 | 0 | 0 | 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% | C | |
| | | SWASFT | n/a | 70.2% | 74.4% | 75.7% | 68.4% | 72.9% | 69.8% | 64.7% | 68.7% | 66.3% | 71.1% | 70.2% | 71.9% | | 69.9% |
| | | Glos only | n/a | 69.9% | 70.1% | 73.6% | 67.3% | 78.7% | 76.4% | 63.8% | 66.9% | 62.2% | 65.4% | 70.1% | 69.0% | | 69.1% |
| 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% | C | |
| | | SWASFT | n/a | 73.9% | 75.2% | 72.7% | 70.1% | 70.3% | 69.8% | 69.4% | 69.5% | 68.8% | 74.4% | 71.1% | 72.6% | | 72.3% |
| | | Glos only | n/a | 74.7% | 74.8% | 72.7% | 72.8% | 70.2% | 69.2% | 70.2% | 68.1% | 67.1% | 71.7% | 70.0% | 70.4% | | 71.9% |
| 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% | C | |
| | | SWASFT | 95.5% | 95.2% | 95.9% | 95.2% | 94.6% | 95.0% | 94.1% | 94.6% | 94.3% | 94.2% | 95.0% | 94.6% | 95.0% | | 94.9% |
| | | Glos only | 95.0% | 95.7% | 95.2% | 94.1% | 95.1% | 94.8% | 93.6% | 95.0% | 94.4% | 92.9% | 93.7% | 93.0% | 94.1% | | 94.4% |
| CB_S7 | Over 30 minute ambulance handover delays (GHNHSFT) | Actual | 2,473 | 136 | 86 | 77 | 78 | 98 | 76 | 100 | 106 | 75 | 114 | 88 | 117 | 1151 | C |
| CB_S7 | Over 1 hour ambulance handover delays (GHNHSFT) | Actual | 731 | 71 | 10 | 18 | 19 | 10 | 13 | 13 | 9 | 12 | 6 | 10 | 16 | 207 | |
| CB_S8 | Clear up delays of over 30 minutes | Actual | n/a | 12 | 14 | 6 | 16 | 19 | 24 | 15 | 22 | 14 | 20 | 22 | 17 | 201 | C |
| CB_S8 | Clear up delays of over 1 hour | Actual | n/a | 5 | 3 | 7 | 4 | 0 | 2 | 2 | 2 | 4 | 5 | 5 | 4 | 43 | |
| Delayed Transfers of Care (DTC) | | | | | | | | | | | | | | | | | |
| 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 | C | |
| | | GHNHSFT actual | | 14.8 | 16.6 | 9.8 | 10.5 | 9.8 | 8 | 11.2 | 13.3 | 6.0 | 8.8 | 12.3 | 8.5 | | 10.8 |
| Local | Reimbursable Days for Acute DTCs (Attributable to Social Services) | GHNHSFT | | 0 | 0 | 0 | 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 | M | |
| | | GCS actual | | 5.5 | 8 | 5.5 | 5.3 | 4.6 | 5 | 7.8 | 10 | 4.5 | 2.6 | 2.0 | 2.8 | | 5.3 |
| 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% | M | |
| | | Actual | | 73.9% | 89.5% | 95.7% | 96.6% | 97.9% | 96.1% | 98.7% | 97.9% | 96.8% | 98.4% | 98.5% | 96.3% | | 94.7% |
| 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% | M | |
| | | Actual | | 4.4% | 3.1% | 1.3% | 2.4% | 0.4% | 0.7% | 0.4% | 0.3% | 0.5% | 0.4% | 0.2% | 0.7% | | 1.2% |
| 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% | M | |
| | | Actual | | 77.3% | 75.6% | 74.8% | 74.0% | 74.7% | 79.3% | 79.8% | 80.3% | 82.9% | 81.1% | 78.5% | 77.9% | | 78.0% |
| 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% | M | |
| | | Actual | | - | 49.3% | 44.4% | 55.7% | 76.4% | 77.2% | 82.7% | 74.8% | 66.4% | 74.6% | 69.0% | 68.4% | | 67.2% |
| 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 | M | |
| | | 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 | 00:06:22 | 00:03:53 | 00:26:07 | | |
| 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 | M | |
| | | 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 | 00:19:38 | 00:09:45 | 00:02:59 | | |
| 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% | C | |
| | | Actual | | 93.6% | 92.8% | 93.2% | 94.2% | 93.7% | 91.3% | 91.2% | 90.9% | 93.6% | 91.3% | 91.0% | 91.0% | | 92.3% |
| CB_S6 | Number of completed admitted pathways greater than 52 weeks | Target | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | C | |
| | | Actual | | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 3 | | 6 |
| Local | Number of specialties where admitted standard was not delivered | Actual | | 2 | 7 | 5 | 3 | 4 | 6 | 6 | 2 | 7 | 6 | 3 | 6 | 5 | |
| 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% | C | |
| | | Actual | | 98.0% | 97.9% | 97.9% | 97.6% | 97.1% | 97.2% | 97.1% | 97.3% | 96.7% | 95.7% | 96.8% | 96.2% | | 97.1% |
| 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 | C | |
| | | Actual | | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | 2 |

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 | Perf. Measured |
|--|--|-----------------|----------|----------|--------------|----------|----------|---------------|----------|----------|--------------|----------|----------|--------------|------------------------|----------------|
| Local | Number of specialties where non-admitted standard was not delivered | Actual | 1 | 2 | 2 | 5 | 5 | 5 | 7 | 4 | 5 | 8 | 4 | 4 | 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% | |
| | | Actual | 95.6% | 95.7% | 95.9% | 95.8% | 95.2% | 95.3% | 94.9% | 94.7% | 93.1% | 92.0% | 92.0% | 92.1% | 94.1% | |
| CB_S6 | Number of incomplete pathways greater than 52 weeks | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | Actual | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 5 | 5 | 14 |
| Local | Number of specialties where incomplete standard was not delivered | Actual | 4 | 4 | 4 | 4 | 4 | 5 | 4 | 2 | 7 | 7 | 10 | 6 | 5 | |
| 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 | |
| | | Actual | 19 | 8 | 3 | 2 | 1 | 1 | 2 | 3 | 2 | 1 | 2 | 5 | 5 | |
| 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 | |
| | | Actual | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | |
| 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% |
| | | Actual breaches | 68 | 68 | 41 | 60 | 57 | 44 | 62 | 88 | 40 | 42 | 37 | 33 | 640 | |
| | | Actual Perf | 0.98% | 0.94% | 0.60% | 0.84% | 0.83% | 0.62% | 0.84% | 1.3% | 0.6% | 0.5% | 0.5% | 0.4% | 0.75% | |
| Local | Percentage of patients who have waited 6 weeks longer than their due date for a planned diagnostic surveillance 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% | |
| | | Actual | 522 | 483 | 413 | 89 | 39 | 5 | 16 | 7 | 16 | 7 | 6 | 22 | | |
| 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% | |
| | | Actual breaches | 67 | 38 | 48 | 51 | 121 | 89 | 50 | 60 | 49 | 80 | 66 | 62 | 781 | |
| | | Actual Perf | 93.8% | 96.1% | 95.2% | 95.2% | 88.8% | 92.0% | 95.7% | 94.1% | 95.7% | 93.3% | 94.1% | 94.7% | 94.1% | |
| 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% | |
| | | Actual breaches | 4 | 5 | 2 | 15 | 117 | 63 | 4 | 15 | 8 | 7 | 5 | 13 | 258 | |
| | | Actual Perf | 97.7% | 97.7% | 99.0% | 92.8% | 46.6% | 73.0% | 97.7% | 92.5% | 95.5% | 96.4% | 96.9% | 93.0% | 89.0% | |
| 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% | |
| | | Actual breaches | 4 | 0 | 0 | 3 | 2 | 3 | 0 | 0 | 1 | 3 | 2 | 2 | 20 | |
| | | Actual Perf | 98.2% | 100.0% | 100.0% | 98.7% | 99.1% | 98.9% | 100.0% | 100.0% | 99.6% | 98.9% | 99.1% | 99.1% | 99.3% | |
| 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% | |
| | | Actual breaches | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 4 | |
| | | Actual Perf | 97.7% | 97.9% | 100.0% | 97.8% | 100.0% | 100.0% | 100.0% | 97.5% | 100.0% | 100.0% | 100.0% | 100.0% | 99.1% | |
| 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% | |
| | | Actual breaches | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | |
| | | Actual Perf | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.7% | |
| 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% | |
| | | Actual breaches | 0 | 0 | 0 | 0 | 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% | 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% | |
| | | Actual breaches | 20 | 18 | 25 | 22 | 17 | 23 | 24 | 23 | 19 | 23 | 24 | 19 | 257 | |
| | | Actual Perf | 78.7% | 84.6% | 75.5% | 79.8% | 83.0% | 82.2% | 80.5% | 78.9% | 81.2% | 79.8% | 78.0% | 84.6% | 80.7% | |
| 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% | |
| | | Actual breaches | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 2 | 1 | 7 | |
| | | Actual Perf | 100.0% | 96.4% | 100.0% | 100.0% | 95.0% | 95.7% | 100.0% | 100.0% | 94.7% | 100.0% | 90.0% | 92.3% | 97.2% | |
| 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% | |
| | | Actual breaches | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | |
| | | Actual Perf | 66.7% | 75.0% | 100.0% | 100.0% | 83.3% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 93.6% | |
| 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 (GHT Only) | Target | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | |
| | | Glos | 75.0% | 81.1% | 82.4% | 93.3% | 79.6% | 68.3% | 83.6% | 87.8% | 88.9% | 83.3% | 88.1% | 86.0% | | |
| EC | Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (GHT Only) | Target | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | 60.0% | |
| | | Glos | 73.3% | 66.7% | 89.5% | 59.6% | 81.6% | 78.9% | 45.8% | 61.5% | 82.4% | 75.6% | 69.4% | | | |
| CB_A9 | Dementia diagnosis rate (Annual) | Target | | | | | | | | | | | | | | |
| | | Glos | | | | | | | | | | | | | | |
| Community Care Referral to Treatment (GLOUCESTERSHIRE only) | | | | | | | | | | | | | | | | |

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 | Perf. Measured | |
|---|--|----------------------|----------|----------|--------------|----------|----------|---------------|----------|----------|--------------|----------|----------|--------------|------------------------|----------------|-----|
| 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% | C |
| | | Actual | 100.0% | 100.0% | 99.5% | 99.3% | 98.9% | 100.0% | 96.0% | 95.5% | 96.7% | 100.0% | 100.0% | 97.0% | 99.0% | | |
| Local | Percentage of patients referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks | Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | C |
| | | Actual | 100.0% | 100.0% | 94.8% | 96.0% | 100.0% | 97.0% | 100.0% | 100.0% | 98.0% | 100.0% | 100.0% | 100.0% | 98.8% | | |
| Local | Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks | Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | C |
| | | Actual | 98.8% | 99.3% | 97.0% | 98.9% | 99.3% | 100.0% | 98.2% | 99.0% | 99.2% | 95.9% | 96.0% | 98.5% | 98.3% | | |
| 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% | C |
| | | Actual | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.0% | 100.0% | 100.0% | 100.0% | 99.0% | 100.0% | 100.0% | 99.9% | | |
| Local | Percentage of patients referred to the Podiatry Service who are treated within 8 Weeks | Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | C |
| | | Actual | 99.0% | 99.0% | 99.0% | 99.0% | 98.0% | 97.0% | 98.0% | 98.0% | 98.0% | 95.0% | 96.0% | 100.0% | 98.0% | | |
| Local | Percentage of patients referred to the Adult Occupational Therapy Service who are treated within 8 Weeks | Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | C |
| | | Actual | 99.6% | 100.0% | 100.0% | 99.6% | 100.0% | 100.0% | 99.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.9% | | |
| Local | Percentage of patients referred to the Adult Physiotherapy Service who are treated within 8 Weeks | Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | C |
| | | Actual | 100.0% | 100.0% | 98.0% | 96.0% | 95.7% | 95.2% | 96.0% | 97.0% | 97.0% | 96.0% | 99.0% | 98.0% | 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% | C |
| | | Actual | 100.0% | 100.0% | 100.0% | 100.0% | 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% | C |
| | | Actual | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 96.0% | 97.0% | 100.0% | 99.0% | |
| 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% | C | |
| | | Glos | | | 100.0% | | | 99.5% | | | 97.4% | | | 98.5% | 98.9% | | |
| 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% | | C | |
| | | Glos actual | | | 3.4% | | | 6.6% | | | 9.8% | | | 13.7% | 13.7% | | |
| 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% | C | |
| | | Glos actual | | | 50.4% | | | 50.6% | | | 50.8% | | | 51.0% | 51.0% | | |
| Quality | | | | | | | | | | | | | | | | | |
| Quality Indicators | | | | | | | | | | | | | | | | | |
| CB_B17 | Eliminate mixed-sexed accommodation breaches at all providers sites | GHT | | 4 | 10 | 6 | 0 | 6 | 0 | 0 | 4 | 0 | 0 | 1 | 0 | 31 | C |
| | | GCS | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 2gether | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Number of Never Events | | GHT | | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 3 | C |
| | | Care Services Actual | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 2gether | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | SWAST | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | Ramsay Healthcare | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 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 | C |
| | | Glos HC actual | | 1 | 0 | 0 | 1 | 1 | 2 | 0 | 0 | 0 | 1 | 2 | 0 | 8 | |
| 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 | C | |
| | GHNHSFT actual | | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 4 | | |
| 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 | C | |
| | | Glos HC actual | | 16 | 20 | 18 | 18 | 25 | 25 | 11 | 12 | 19 | 14 | 11 | 21 | | 210 |
| Number of post 48 hour C Diff infections (Acute Trust) | GHNHSFT target | | 6 | 5 | 4 | 5 | 6 | 2 | 4 | 4 | 4 | 4 | 4 | 5 | C | | |
| | GHNHSFT actual | | 4 | 8 | 5 | 1 | 8 | 9 | 3 | 4 | 3 | 3 | 4 | 8 | | 60 | |

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position as at 31st March (Month 12)

| AS AT Month 12 2013/14 | 2013/14 | | <u>TOTAL</u> £000 | <u>Cash</u> <u>Limit</u> £000 |
|--|------------------|-------------------|----------------------|-------------------------------------|
| | <u>R</u> £000 | <u>NR</u> £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 adjustment to prior year surplus | (12,839) | 23 | (12,839) | (12,839) |
| 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) |
| Ambulance Winter Pressures | | 422 | 422 | 422 |
| Transfers to SCG re: GHFT/UHB/GWH/RUH | | (3,102) | (3,102) | (3,102) |
| NHS111 improved DOS | | 5 | 5 | 5 |
| Other Adjustments | | 25 | 25 | 25 |
| Community Equipment Capital Grant | | 4,450 | 4,450 | 4,450 |
| Last month total | 668,628 | 10,262 | 678,890 | 678,890 |
| Adjustments in month | | | | |
| Maximum Cash Drawdown exercise | | | | (42,770) |
| Adjustments actioned in month | | | | (42,770) |
| TOTAL NATIONALLY REPORTED LIMIT | 668,628 | 10,262 | 678,890 | 636,120 |

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Summary Financial PositionOverall financial position as at 31st March 2014 (Month 12)

| | 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) | 322,615 | 332,210 | 9,595 | 322,615 | 332,210 | 9,595 |
| Acute contracts - Other providers | 9,156 | 16,062 | 6,906 | 9,156 | 16,062 | 6,906 |
| Acute - NCAs | 7,835 | 8,609 | 774 | 7,835 | 8,609 | 774 |
| Pass-through payments | | | | | | |
| Sub-total Acute services | 339,606 | 356,881 | 17,275 | 339,606 | 356,881 | 17,275 |
| Mental Health Services | | | | | | |
| MH contracts - NHS | 75,324 | 76,850 | 1,526 | 75,324 | 76,850 | 1,526 |
| MH contracts - Other providers | 2,682 | 894 | (1,788) | 2,682 | 894 | (1,788) |
| Sub-total MH services | 78,006 | 77,744 | (262) | 78,006 | 77,744 | (262) |
| Community Health Services | | | | | | |
| CH Contracts - NHS | 85,130 | 85,519 | 389 | 85,130 | 85,519 | 389 |
| CH Contracts - Other providers | (122) | (194) | (72) | (122) | (194) | (72) |
| CH - Other | | | | | | |
| Sub-total Community services | 85,008 | 85,325 | 317 | 85,008 | 85,325 | 317 |
| Continuing Care Services | | | | | | |
| Continuing Care Services (All Care Groups) | 18,530 | 18,197 | (333) | 18,530 | 18,197 | (333) |
| Local Authority / Joint Services | 5,050 | 4,963 | (87) | 5,050 | 4,963 | (87) |
| Free Nursing Care | 8,822 | 8,626 | (196) | 8,822 | 8,626 | (196) |
| Sub-total Continuing Care services | 32,402 | 31,786 | (616) | 32,402 | 31,786 | (616) |
| Primary Care services | | | | | | |
| Prescribing | 89,254 | 89,133 | (121) | 89,254 | 89,133 | (121) |
| Enhanced services | 4,268 | 4,092 | (176) | 4,268 | 4,092 | (176) |
| Other | 4,886 | 5,150 | 264 | 4,886 | 5,150 | 264 |
| Sub-total Primary Care services | 98,408 | 98,375 | (33) | 98,408 | 98,375 | (33) |
| Other Programme services | | | | | | |
| Re-ablement funding | 2,062 | 2,092 | 30 | 2,062 | 2,092 | 30 |
| Other | 5,791 | 5,741 | (50) | 5,791 | 5,741 | (50) |
| Sub-total Other Programme services | 7,853 | 7,833 | (20) | 7,853 | 7,833 | (20) |
| Total - Commissioned services | 641,283 | 657,944 | 16,661 | 641,283 | 657,944 | 16,661 |
| Specific Commissioning Reserves (Inc headroom and Contingency) | 15,760 | | (15,760) | 15,760 | | (15,760) |
| Total - Programme Costs (excl Surplus) | 657,043 | 657,944 | 901 | 657,043 | 657,944 | 901 |
| Running Costs (incl reserves) | 15,090 | 14,140 | (950) | 15,090 | 14,140 | (950) |
| Total - Programme Costs (excl Surplus) | 15,090 | 14,140 | (950) | 15,090 | 14,140 | (950) |
| Surplus | 6,757 | | (6,757) | 6,757 | | (6,757) |
| Total Application of Funds | 678,890 | 672,084 | (6,806) | 678,890 | 672,084 | (6,806) |

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

QIPP Programme 2013/14 as at 31st March (Month 12)

| Theme | Planned Gross Savings 2013/14 £'000 | Forecast £'000 | Variance £'000 |
|--|-------------------------------------|----------------|----------------|
| Unscheduled Care / Long Term Conditions | 2,720 | 2,695 | -25 |
| Planned Care | 2,384 | 1,970 | -414 |
| Community Care | 3,521 | 1,271 | -2,250 |
| Prescribing | 4,087 | 4,000 | -87 |
| Mental Health | 495 | 370 | -125 |
| Learning Difficulties | 982 | 982 | 0 |
| Continuing Health Care | 1,756 | 1,756 | 0 |
| Transactional QIPP | 2,000 | 2,000 | 0 |
| Other - GHFT | 255 | 255 | 0 |
| Grand Total | 18,200 | 15,299 | -2,901 |
| Additional Schemes - increased usage of the ISTC | | 500 | 500 |
| Additional QIPP schemes / Slippage / Contingent resources / Application of QIPP rule | | 2,401 | 2,401 |
| Grand Total | 18,200 | 18,200 | 0 |

| Theme RAG | Savings RAG | Recurrent / Trend RAG |
|-----------|-------------|-----------------------|
| A | G | A |
| A | A | R |
| A | R | A |
| G | G | G |
| A | A | G |
| G | G | G |
| G | G | G |
| A | G | A |
| R | G | R |

| | | |
|---|---|---|
| A | A | A |
|---|---|---|

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP
QIPP Programme 2013/14 as at 31st March (Month 12)

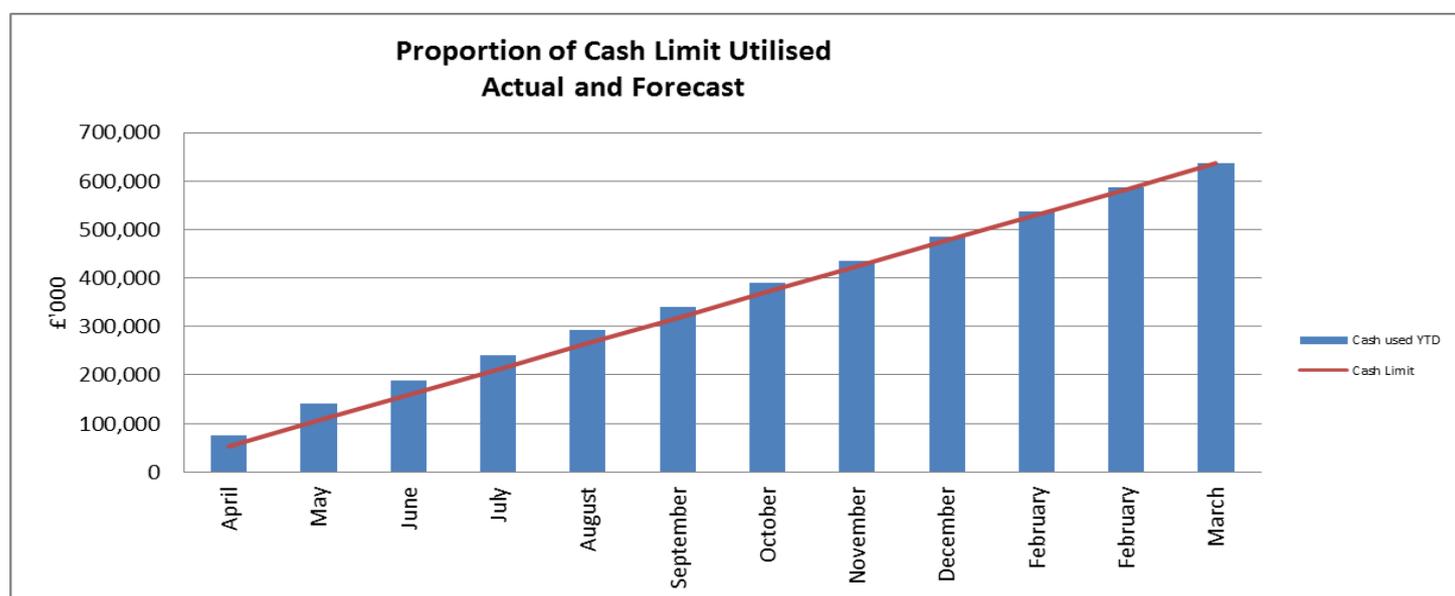
| Theme | Work Programme | Component Projects | Comments | Project RAG | Savings RAG | Recurrent / Trend RAG |
|--|--------------------------------------|--|--|--|-------------|-----------------------|
| Unscheduled Care / Long Term Conditions | Frail Elderley | OPAL | Locum now recruited to backfill 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 | G | G |
| | Access | ADU / AEC | Interim service implemented GRH Sept 13. CGH service commenced Jan 14. 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 GCGG - pathway redesign and integrated care model to be developed as part of ICT. | A | G | G |
| | | 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 to April 2014 implementation | R | G |
| 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 |
| Ophthalmology CPG | | Ophthalmology: 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 | R |
| Demand Management | | Peer Review | Continuation of Referral Peer Review project - full year effect. Further practice sign-up achieved. Referrals 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 Community 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. Launched in Gloucester City Jan '14, Cheltenham locality due to launch May '14. | 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 until full ICT services are operational. | 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 20x 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 | OOO Placements | On-going management to bring OOO 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 Unidentified | (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 | A |

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 31st March 2014 (Month 12)

| Month | Status | Actual/Forecast Charges in Month Advance | | | | YTD TOTAL | CASH LIMIT | Mth end Balance | Cash Limit Drawn | Ratio of Bal/Cash Limit |
|-----------|--------|--|-------------|-------------|----------------|-----------|------------|-----------------|------------------|-------------------------|
| | | Drawn | Prescribing | Home Oxygen | Drugs Payments | | | | | |
| | | £000 | £000 | £000 | £000 | £000 | £000 | £000 | % | % |
| April | Act | 75,000 | | | | 75,000 | 53,010 | 12,285 | 11.79% | 1.93% |
| May | Act | 66,000 | | 130 | | 66,130 | 106,020 | 7,608 | 22.19% | 1.20% |
| June | Act | 42,000 | 6,506 | 135 | (208) | 48,433 | 159,030 | 2,067 | 29.80% | 0.32% |
| July | Act | 45,000 | 6,622 | 129 | 122 | 51,873 | 212,040 | 5,997 | 37.95% | 0.94% |
| August | Act | 44,000 | 6,218 | 132 | 192 | 50,542 | 291,978 | 8,526 | 45.90% | 1.34% |
| September | Act | 41,000 | 6,782 | 131 | (114) | 47,799 | 339,777 | 6,084 | 53.41% | 0.96% |
| October | Act | 43,000 | 6,531 | 132 | (37) | 49,626 | 389,403 | 6,503 | 61.22% | 1.02% |
| November | Act | 39,000 | 6,371 | 135 | 47 | 45,553 | 434,956 | 84 | 68.38% | 0.01% |
| December | Act | 43,000 | 6,605 | 128 | 171 | 49,904 | 484,860 | 6,616 | 76.22% | 1.04% |
| January | Act | 46,590 | 6,420 | 129 | (114) | 53,025 | 537,885 | (19) | 84.56% | 0.00% |
| February | Act | 41,167 | 6,676 | 123 | (10) | 47,956 | 585,841 | 5,643 | 92.10% | 0.89% |
| March | Act | 43,545 | 6,642 | 92 | | 50,279 | 636,120 | | 100.00% | 0.00% |

**Overview of current position**

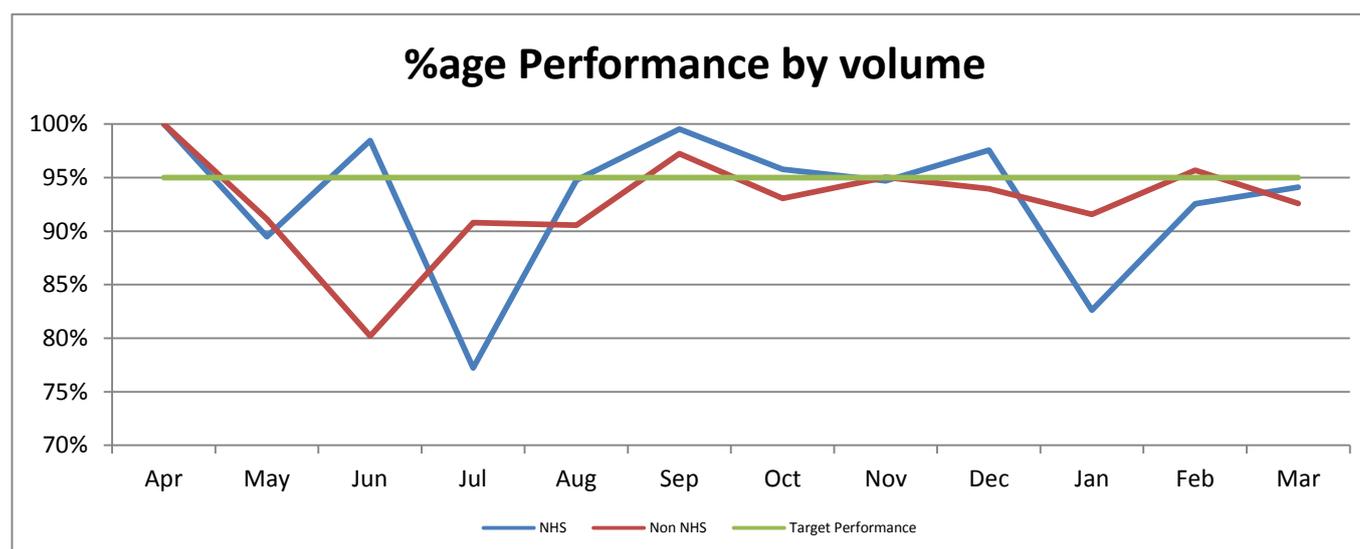
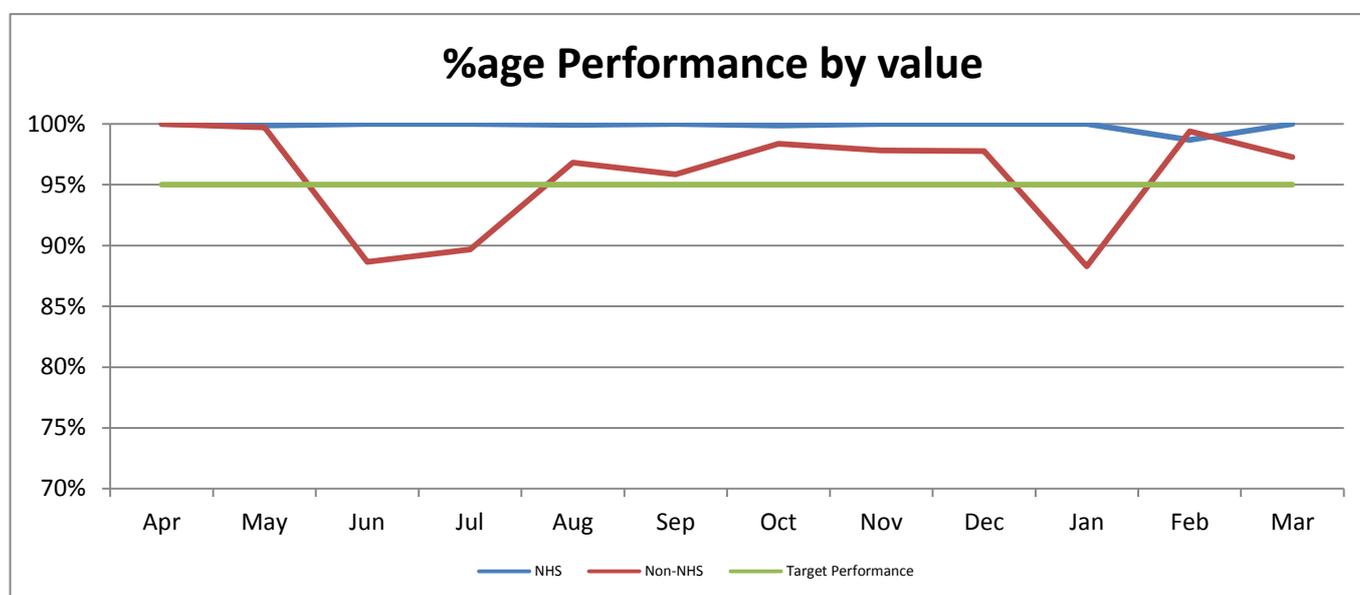
The CCG is currently undergoing a national exercise to establish its cash limit but has an estimated maximum cash limit of £636m in 2013/14. At the end of March £636m has been drawn down (100%) of the anticipated cash limit.

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Performance against better payment practice codeAs at 31st March 2014 (Month 12)

| | In Month | | Year to Date | |
|--------------------------------|---------------|--------------|---------------|--------------|
| | NHS | Non NHS | NHS | Non NHS |
| By volume | | | | |
| Total number of invoices | 2,556 | 5,291 | 2,556 | 5,291 |
| Number paid within target | 2,405 | 4,899 | 2,405 | 4,899 |
| Performance | 94.1% | 92.6% | 94.1% | 92.6% |
| By value | | | | |
| Total value of invoices (£'M) | 504 | 73.40 | 503.80 | 73.40 |
| Value paid within target (£'M) | 504 | 71.40 | 503.80 | 71.40 |
| Performance | 100.0% | 97.3% | 100.0% | 97.3% |

The target performance level is 95%



NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Statement of Financial PositionAs at 31st March 2014 (Month 12)

| | Current Month end Position £000 | Forecast Position as at 31 March 2014 £000 |
|--|--|---|
| Non-current assets: | | |
| Premises, Plant, Fixtures & Fittings | 61 | 61 |
| IM&T | 0 | 0 |
| Other | 0 | 0 |
| Long Term Receivables | 0 | 0 |
| Total non-current assets | 61 | 61 |
| Current assets: | | |
| Inventories | 0 | 0 |
| Trade and other receivables | 8,350 | 8,350 |
| Cash and cash equivalents | 30 | 30 |
| Total current assets | 8,380 | 8,380 |
| | | |
| Total assets | 8,441 | 8,441 |
| Current liabilities | | |
| Payables | (42,948) | (42,948) |
| Provisions | (870) | (870) |
| Borrowings | 0 | 0 |
| Total current liabilities | (43,819) | (43,819) |
| | | |
| Non-current assets plus/less net current assets/liabilities | (35,378) | (35,378) |
| Non-current liabilities | | |
| Trade and other payables | 0 | 0 |
| Other Liabilities | 0 | 0 |
| Provisions | 0 | 0 |
| Borrowings | 0 | 0 |
| Total non-current liabilities | 0 | 0 |
| | | |
| Total Assets Employed: | (35,378) | (35,378) |
| Financed by taxpayers' equity: | | |
| General fund | (35,378) | (35,378) |
| Revaluation reserve | | |
| Other reserves | | |
| Total taxpayers' equity: | (35,378) | (35,378) |

Governing Body

| | |
|--|--|
| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | 2013/14 Assurance Framework |
| Executive Summary | <p>The attached Assurance Framework for 2013/14 provides details of the assurances provided to the Governing Body regarding the achievement of the CCG's Annual Objectives for 2103/14.</p> <p>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.</p> |
| Key Issues | A number of risks identified in relation to the 2013/14 objectives remain relevant at the year-end. Action plans have, however, been devised and 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 identified and addressed. |
| Original Risk | 8 (2x4) |
| Residual Risk | 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 |

Governing Body

Thursday 29th May 2014

2013/14 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.
- 2.2 The document outlines the principal risks, control systems and assurances that have been provided to the Governing Body regarding the achievement of each summary objective. Details of the action plans to address the residual 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 and the Governing Body. The attached document, incorporates final 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. Recommendation

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

4. 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 April 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 | 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. | | Supporting Local Protected Learning Time Events. (June 2014) |
| Q1 | Insufficient clinical engagement from secondary care clinicians. | Marion Andrews-Evans, Justine Rawlings. | 12 (3x4) | 12 (3x4) | ↑ | 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. | | Implementation of the Clinical Programme Development Plan and Clinical Programme Plan. (June 2013) |
| Q3 | Specialised Commissioning transferring to the Area Team with lack of timely and appropriate specialised services for children and young people with mental health problems. | Helen Chrystal | 12 (3x4) | 12 (3x4) | ↔ | Monitoring service provision with local providers and provide feedback to the Area Team. | Assurance from Area Team | | Raise the concerns with the Area Team and get feedback to ensure the lead commissioner is involved in this specific area. (March 2014) |
| 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 | | Locality and Primary Care Development Manager to be appointed to support the Primary Care Strategy for Gloucestershire and ensure that strategic priorities are embedded within the Localities. (February 2014) |
| Objective 2: Work with patients, carers and the public to inform decision making. | | | | | | | | | |
| N/A | No significant risks remain regarding this objective. | N/A | N/A | N/A | ↓ | N/A | N/A | N/A | N/A |
| 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. | | | | | | | | | |

| Risk No | Principal Risks | Risk Owners | Original Risk Ratings (LxC) | Current Risk Ratings (LxC) | Change since April IGC | Key Controls | Sources of Assurance | Gaps in Controls or Assurance | Action Plan and Target Date |
|---------|---|------------------|-----------------------------|----------------------------|------------------------|---|---|--|--|
| 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 financial estimates may be exceeded. | Mary Morgan | 8 (2x4) | 8 (2x4) | ↔ | National directives and guidance. | Financial Reports based on findings to date. 20 cases have been randomly allocated across team for assessment to provide further assurance regarding our financial forecasts. | Currently all PUPoC data is held on a separate spreadsheet and should be included in overall CHC information to mitigate risks associated with running two systems . | Of the 697 applicants it is likely 15 – 20 % will be eligible for reimbursement which may result in payouts between £2 to 3m. This estimate is about to be tested as 20 random cases have been allocated for assessment and then review of financial forecasts based on findings. (March 2015) |
| 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 | | Work plans agreed with KPIs and links to localities. (May 2014) |
| 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. | Governing Body Report | Revised guidance anticipated from NHS England in February 2014. Revised Contestability Framework will be developed on receipt of guidance. | Revised CCG contestability framework will be drafted for Governing Body approval following publication of NHS England guidance on the application of the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations. (February 2014) |
| C27 | Non-Emergency Patient Transport Service. Variance in predicted activity levels and operational issues which could impact on delivery of KPIs and patient experience. | Gill Bridgland | 12 (3x4) | 9 (3x3) | ↓ | Risk to be managed consistently across Gloucestershire, Swindon, Wiltshire and B&NES CCGs | Performance Reports and dashboards | | Commissioners to identify potential service gaps and work with provider to ensure continuity and quality of service. (March 2014) |

| Risk No | Principal Risks | Risk Owners | Original Risk Ratings (LxC) | Current Risk Ratings (LxC) | Change since April IGC | Key Controls | Sources of Assurance | Gaps in Controls or Assurance | Action Plan and Target Date |
|---------|--|-----------------|-----------------------------|----------------------------|------------------------|---|--|-------------------------------|--|
| C5 | Inability to shorten length of stay within acute trust affecting patient flow within the health community. | Maria Metherall | 12 (3x4) | 9 (3x3) | ↓ | Weekly Executive level discharge meeting since Sept. WEF : Feb 14 fortnightly Executive level discharge meetings with weekly Task & Finish group commencing . | Performance Reports and dashboards, critical milestones reviewed, regular programme stock take | | Fortnightly senior meetings, weekly Task and Finish Group. Two new staff members to be appointed. (June 2014) |
| C6 | A&E 4 hour targets may not be delivered. | Maria Metherall | 12 (3x4) | 12 (3x4) | ↔ | Urgent Care Working Group, weekly executive meeting. | Performance Reports, weekly situation report, daily escalation matrix | | Monthly progress review plus weekly monitoring with GHT. (March 2014) |
| C8 | Anticipated whole system benefit from NHS 111 may not be achieved. | Maria Metherall | 16 (4x4) | 9 (3x3) | ↓ | Urgent Care Network Board, NHS 111 Contract Board, Governance Group. | Performance Reports, weekly situation report | | Well constructed DoS and strong local buy-in of providers and developing process. (March 2014) |
| C9 | Winter Plan may not deliver the planned improvements in the urgent care system. | Maria Metherall | 12 (3x4) | 12 (3x4) | ↔ | Urgent Care Networking Board, weekly executive meeting. | Performance Reports, DEM, WS | | Development of winter plan and escalation, with supported schemes. (March 2014) |
| C10 | Delays in implementing Planned Care QIPP schemes, due to multiple reasons, such as non-compliance with pathways, reduced utilisation of services, new services increasing system demand, and tender and/or tariff negotiation with providers, variable ability to track direct effect of project, 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 projects to have clear baseline monitoring with agreed KPIs. Monthly project monitoring with focus on schemes at risk of non-delivery, with agreement on remedial action. (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 2014) |

| Risk No | Principal Risks | Risk Owners | Original Risk Ratings (LxC) | Current Risk Ratings (LxC) | Change since April IGC | Key Controls | Sources of Assurance | Gaps in Controls or Assurance | Action Plan and Target Date |
|---------|---|-------------------------|-----------------------------|----------------------------|------------------------|--|--|-------------------------------|--|
| 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) |
| 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 | | Work with GHNHSFT and specialised commissioners to understand the areas of concern. (April 2014) |
| 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. | | Test and learn before full roll out, shared QIPP schedule, controlled recruitment, assurance review of model, interim specification. (July 2014) |
| C28 | Non delivery of the SWAST red 1/2 urgent 999 performance target. | Maria Metherall | 20 (5x4) | 12 (3x4) | New Risk | Internal performance report, contract board, UCWG, Sitreps, escalation monitoring. | Governing Body Performance Report | | Ongoing development of SWAST recovery plan. (July 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. (Finance & Informatics) | Cath Leech | 12 (3x4) | 8 (2x4) | ↓ | Contract/service level agreement signed between the CCG and CSU specifying the services to be delivered. | Monthly meetings between the CCG and the CSU to review service delivery. CCG service leads meet with their counterparts in the CSU to review more detailed aspects of delivery. | | Monitoring meetings schedule to be set up. (May 2014) |
|----|---|------------|----------|---------|---|--|---|--|---|

| Risk No | Principal Risks | Risk Owners | Original Risk Ratings (LxC) | Current Risk Ratings (LxC) | Change since April IGC | Key Controls | Sources of Assurance | Gaps in Controls or Assurance | Action Plan and Target Date |
|---------|--|---|-----------------------------|----------------------------|------------------------|--|---|-------------------------------|--|
| 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) | 8 (2x4) | ↔ | Contract/service level agreement signed between the CCG and CSU specifying the services to be delivered. | Monthly meetings between the CCG and the CSU to review service delivery. CCG service leads meet with their counterparts in the CSU to review more detailed aspects of delivery. | | 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) |
| 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. | | 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) | ↔ | 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. |
| 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 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. | Approval of GCCG Communications and Engagement Strategy (June 2014) |

| Risk No | Principal Risks | Risk Owners | Original Risk Ratings (LxC) | Current Risk Ratings (LxC) | Change since April IGC | Key Controls | Sources of Assurance | Gaps in Controls or Assurance | Action Plan and Target Date |
|---------|---|--|-----------------------------|----------------------------|------------------------|---|---|---|--|
| 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. | Approval of GCCG Communications and Engagement Strategy (June 2014) |
| L4 | Fragmentation of payments to practices across the Area Team, CCG and Public Health around enhanced services across three 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. (March 2014) In process of moving budgets from Area Team so this will be managed by CCG. (Feb 2014) |
| Q7 | Lack of compliance with national targets for <i>C.difficile</i> and MRSA could result in a lower quality of care for some patients. | Teresa Middleton, Karyn Probert | 12 (4x3) | 12 (4x3) | ↓ | Countywide HCAI action plan. Monthly monitoring of incidents of <i>C.difficile</i> and MRSA. | Performance reports. | | Bi-monthly Strategic Countywide Healthcare Acquired Infections (HCAIs) Group. Ribotyping all <i>C.difficile</i> cases. Annual review of Countywide Antibiotic Formulary. Bimonthly CCG <i>C.difficile</i> Working Group. Regular communications with all Prescribers. (March 2014) |

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. | All directors | 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. (March 2014) |
| | | | | | | | | Appraisal process needs to be developed to fit the organisation's needs. | Senior Manager's Group developing an appraisal process. (March 2014) |

Gloucestershire Clinical Commissioning Group

Governing Body

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|--|--|
| Meeting Date | Thursday 29 th May 2014 |
| Title | Audit Committee Annual Report 2013/14 |
| Executive Summary | This report outlines the activities of the Audit Committee during the financial year 2013/14. |
| Key Issues | The report provides details of the areas considered by the Committee at the five meetings held during the year and summarises the reports received from the Counter Fraud Team and the Internal and External Auditors. |
| Risk Issues: | The absence of an Audit Committee Annual Report could result in the Governing Body being insufficiently aware of the role and activities of the Committee. |
| Original Risk: | 6 (2x3) |
| Residual Risk | 3 (1x3) |
| Financial Impact | None |
| Legal Issues (including NHS Constitution) | None |
| Impact on Health Inequalities | N/A |
| Impact on Equality and Diversity | None |
| Impact on Sustainable Development | None |

| | |
|--|---|
| Patient and Public Involvement | N/A |
| Recommendation | The Governing Body is asked to accept this report on the work of the Audit Committee as part of its overall governance and assurance programme for 2013/14. |
| Author | Colin Greaves |
| Designation | Audit Committee Chair |
| Sponsoring Director (if not author) | |

Governing Body

29th May 2014

Audit Committee Annual Report 2013/14

1. Introduction

- 1.1 The Health and Social Care Act 2012 set out the requirement for Clinical Commissioning Groups (CCGs) to establish an Audit Committee. This report to the Governing Body covers the work of the Audit Committee for the financial year 2013/14.

2. Membership

- 2.1 The membership of the Audit Committee during the year was as follows:
- Colin Greaves Chair – Lay Member Governance;
 - Alan Elkin – Lay Member Patient Public Engagement;
 - Valerie Webb – Lay Member Business;
 - Dr Andrew Seymour – Deputy Clinical Chair;
 - Dr Hein Le Roux – GP Stroud Locality.

3. The Function of the Audit Committee

- 3.1 The role of the Committee is to critically review the CCG's financial reporting and internal control principles and ensure an appropriate relationship is maintained with both internal and external auditors.
- 3.2 The Audit Committee's Terms of Reference were ratified by the Governing Body on 2 April 2013. The Audit Committee reviewed the Terms of Reference at the 4 July 13 meeting and recommended some minor changes; these changes were approved by the Governing Body at the 28 November 2013 meeting.

4. Meetings

4.1 The Audit Committee met on the following dates:

- 2 May 2013;
- 4 July 2013;
- 1 October 2013;
- 10 December 2013;
- 11 March 2014.

4.2 At the inaugural meeting on 2 May 2013 the Audit Committee were briefed on the PCT accounts, which had been submitted to the Department of Health on 22 April 2013. Colin Greaves attended the two remaining Audit Committee meetings for the PCT as an observer. The Audit Committee and the Executive also benefitted from having sight of a lessons learnt paper from the NHS South of England Audit Committee.

4.3 The external and internal auditors attended all meetings. The Local Counter Fraud Service attended four of the meetings and provided an update report at each meeting. The Finance Department was represented at all meetings by either the Chief Financial Officer or her deputy. The Associate Director of Corporate Governance attended all meetings. A breakdown of meeting attendance is at Appendix 1.

4.4 The Accountable Officer had an open invitation to attend all meetings.

4.5 The Committee had a private meeting with the internal auditors on 25 March 2014. The only area of concern raised was over the monitoring and performance of the CSU; however, the internal auditors were complimentary about the plans that the Executive had proposed to rectify the situation. The internal auditors also praised the attitude and approach of the Finance Department staff.

4.6 There was an open invitation to the internal and external audit and the Local Counter Fraud officer to make contact with the Chair of the Committee if they had any concerns.

4.7 The confirmed minutes of all the Audit Committee meetings were considered at the Governing Body meetings.

5. Review of the Committee's Work

5.1 The Committee has an annual work plan that structures the agendas for each meeting. The draft work plan for 2013/14 was considered at the 2 May 2013 Audit Committee meeting and has been updated during the year as additional issues have been identified.

5.2 The Committee has developed a process of self-assessment. The self-assessment is planned to be completed at the Audit Committee meeting on 20 May 2014. Following the self-assessment, a plan will be developed to take forward areas identified for improvement.

6. Internal Audit

6.1 PricewaterhouseCoopers provide the Internal Audit services for the CCG. The work of Internal Audit has focused on Risk Management and Organisational Controls and was part of an agreed plan for the year, which had been based on a risk assessment for the organisation.

6.2 The audits undertaken with their associated assessments are as follows:

- Procurement – low risk;
- Service Level Agreements – The overall assessment was medium risk but this included one high risk finding, which related to a number of unsigned contracts inherited from the PCT;
- Risk Management and Governance – low risk;
- QIPP – low risk;
- Commissioning Support Unit (contract monitoring and performance) – The overall assessment was high risk

and this included two high risk findings relating to lack of clarity in service line specifications and that CSU payments are not linked to performance. The management had identified significant performance issues with three of the service lines and determined that effort should be focused on these areas as they represented risks to the organisation's business. In terms of the specific recommendation, there is an action plan and this is being progressed as part of contract renegotiation.

- Core Financial Systems and Budgetary Control – medium risk;
- Information Governance arrangements – The overall assessment was medium risk but this included one high risk, which related to the CCG's overall progress against the requirements of the Information Governance Toolkit. The toolkit has been submitted and the CCG achieved level two in the majority of areas. Six of the areas identified as level one and there is an action plan in place to achieve level two in all areas.
- Continuing Health Care – work is still to be completed

6.3 A risk-based work plan for internal audit for 2014/15 was considered at the Audit Committee meeting on 11 March 2014.

6.4 The external auditors continue to place reliance on the work of the internal audit service to assist with their assessment of the CCG.

7. External Audit

7.1 The Audit Commission, whose responsibility it is, appointed Grant Thornton as the external auditors to the CCG for 2013/14.

7.2 The role of external audit is to give an opinion on the financial statements and issue a value for money conclusion.

7.3 Grant Thornton has provided update reports against the agreed work plan and their assessments are due to be presented to the Audit Committee at the meeting on 3 June 2014. Grant Thornton has also provided reports on emerging issues and developments; this has proved most helpful to both the Committee and the Executive.

8. Counter Fraud

8.1 The CCG is committed to developing and maintaining a counter fraud culture. A counter fraud service is provided by the Gloucestershire Hospital Foundation Trust and covers the following areas: preventing and detecting fraud; investigating fraud; and the creation of an anti-fraud culture. The annual plan was created following a risk assessment of the CCG. The Committee has received reports and reviewed work against the agreed plan for 2013/14 in all the above areas.

9. Other Assurance Functions

9.1 Through the receipt of regular reports the Audit Committee reviewed the management of the following:

- Procurement decisions;
- Procurement Waiver of Standing Orders;
- Aged Debts;
- Debts Proposed for Write-off;
- Losses and Special Payments.

The Committee is satisfied that these areas are being appropriately managed. Any concerns on individual items were raised at the time and appropriate responses have been received.

10. Governance

10.1 The responsibility for integrated governance sits with the Integrated Governance and Quality Committee (IGQC). The IGQC ensures that the appropriate governance plans and mechanisms are in place for all areas other than financial governance, which is the responsibility of the Audit

Committee.

11. Annual Governance Statement

11.1 The Draft Annual Governance Statement was reviewed by the Audit Committee at the 11 March 2014 meeting. The Annual Governance Statement will be considered by the Governing Body prior to submission to the Department of Health in June 2014.

12. Annual Accounts

12.1 The Committee reviewed the programme for the production and presentation of the CCG's accounts, annual report and supporting papers for 2013/14 at its meeting on 11 March 2014.

12.2 The plan for sign off of the year-end reports and accounts is that the final reports and accounts will be considered by the Audit Committee on 3 June 2014 before being recommended for approval to the Governing Body at an extraordinary meeting on the same day. This will ensure that the Department of Health final date of 6 June 2014 (noon) is met.

13. Co-operation

13.1 The Committee is grateful to the CCG staff, the CSU staff, Gloucestershire Local Counter Fraud Service, Grant Thornton; and PricewaterhouseCoopers for their positive and constructive approach in discussions and reporting.

14. Conclusion

14.1 The Audit Committee can confirm the following:

- The risk management systems in the CCG are adequate and allow the Governing Body to understand the appropriate management of those risks.
- There are no areas of significant duplication or omission in the systems of governance in the CCG that have come to the Committee's attention.

- The draft Annual Governance Statement is consistent with the Committee's views on the CCG's system of internal control and that it supports the Governing Body's approval of the Statement.

The basis for the above opinion is drawn from evidence highlighted in paragraphs 5 to 11 and from discussion and debate in the Audit Committee.

15. Recommendation(s)

- 15.1 The Governing Body is asked to accept this report on the work of the Audit Committee as part of its overall governance and assurance programme for 2013/14.

16. Appendices

Audit Committee Attendance

APPENDIX 1

AUDIT COMMITTEE ATTENDANCE

| | | May | Jul | Oct | Dec | Mar |
|-----------------|--------------------|-----|-----|-----|-----|-----|
| Colin Greaves | Lay Member | X | X | X | X | X |
| Alan Elkin | Lay Member | X | X | X | X | X |
| Valerie Webb | Lay Member | X | X | X | X | X |
| Dr Andy Seymour | Dep Clinical Chair | X | X | | X | |
| Dr Hein Le Roux | GP Stroud Locality | | | X | X | |
| | | | | | | |
| Paul Dalton | PwC | X | X | X | X | |
| Lyn Pamment | PwC | X | X | | X | X |
| Liz Cave | Grant Thornton | | | | X | |
| Peter Smith | Grant Thornton | X | X | X | X | X |
| Sallie Cheung | Counter Fraud Off | X | X | X | | X |
| Lee Sheridan | Counter Fraud Off | | | | | X |
| Cath Leech | CFO | X | | X | X | X |
| Andrew Beard | Dep CFO | | X | | | X |
| Alan Potter | Assoc Dir Corp Gov | X | X | X | X | X |
| | | | | | | |

In accordance with the Audit Committee's Terms of Reference other members of CCG staff attended on an as required basis.

Governing Body

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|--|--|
| Governing Body Meeting Date | Thursday 29th May 2014 |
| Title | Integrated Governance and Quality Committee (IGQC) minutes. |
| Executive Summary | The attached minutes provide a record of the IGQC meeting held on the 20 th February 2014. |
| Key Issues | <p>The following issues were discussed:</p> <ul style="list-style-type: none"> • End of Life Care • Quality Strategy • Quality Report • Child Death Overview Panel Annual Report • Quality Accounts • Impact of Planning Guidance on the Quality Agenda • Policies Working Group Terms of Reference • IT Policies • HR Report • CCG Governance Structure • Risk Register • Assurance Framework • Clinical Effectiveness Group • Information Governance |
| 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 CCG

Integrated Governance and Quality Committee (IGQC)

**Minutes of the meeting held on
Thursday 20th February 2014, Board Room, Sanger House**

| Present: | | |
|----------------------|-----|--|
| Julie Clatworthy | JC | Chair |
| Marion Andrews-Evans | MAE | Executive Nurse and Quality Lead |
| Dr Caroline Bennett | CBe | GP - North Cotswolds Locality |
| Dr Charles Buckley | CBu | GP – Stroud 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 |
| Cath Leech | CL | Chief Finance Officer |
| Mark Walkingshaw | MW | Deputy Accountable Officer |
| Alice Walsh | AW | Interim Director of Public Health |
| Valerie Webb | VW | Lay Member - Business |
| Steve Alder | SA | Secondary Care Specialist |

| In Attendance: | | |
|-----------------------|----|---|
| Gina King | GK | Commissioning Manager, End of Life Care (for Agenda Item 5) |
| Kate Roberts | KR | HR Business Partner, CSU (for Agenda Item 7) |
| Richard Haynes | RH | Senior IM&T Project Manager, CSCSU (for Agenda Item 8) |
| Teresa Middleton | TM | Deputy Director of Quality |
| Alan Potter | AP | Associate Director Corporate Governance |
| Karen Taylor | KT | Board Administrator (temporary) |

1. Apologies for Absence

1.1 Apologies were received from Dr Helen Miller.

2. Declarations of Interest

2.1 There were no declarations of interest.

3. Minutes of the meeting held on the 19th December 2013

3.1 The minutes of the meeting were accepted as a true and correct record, subject to the following amendment:

3.2 Section 5.2, bullet point 3 of the minutes to read: 'JC noted that the NHS Leadership Model and the Leadership Model for Improvement are used in the NHS'.

4. Matters Arising

4.1 JC reminded members that items on the 'Matters Arising' list should not be closed until the item has been discussed at the Committee meeting and members agreed it should be closed once satisfied the outstanding work was concluded.

4.2 **IGQC3 – Serious Incidents.** Item to remain open until AP has provided an update on falls at the next meeting. AP

4.3 **IGQC4 – Incident Report Analysis –** MG_i and MAE had met to agree a process which would link Datix, Serious Incidents and Complaints. An external consultant had been identified to take forward this piece of work including the provision of clear desk top instructions in terms of process and actions. Feedback will be provided on the Datix project plan to the Committee in April. MG_i

4.4 **IGQC7 – Any Other Business –** A development session to discuss the governance systems will be held in April 2014.

4.5 **IGQC9 – Terms of Reference –** The structure chart detailing all CCG committees and sub committees was not available for the meeting today but the first draft had been discussed by Execs at Core Team. Outstanding item. AP

- 4.6 **IGQC11 – Quality Report** – VW referred to the second meeting she had had with the Multi-agency Safeguarding Group and referred to a document setting out the safeguarding work within the county which she had forwarded to JC and would be circulated to members of the Committee. Members were asked to ensure this document remained confidential. VW
- 4.7 **IGQC19 – Policies for Approval** – Re: Research Governance Policy: MAE reported that contact had been made with the Gloucestershire Research Support Service and the CCG had been invited to attend the Gloucestershire Research Consortium. A number of countywide policies covering research governance safeguarding and ethics will be presented to the Committee for approval in due course. MAE
- 4.8 **IGQC23 – HR Policies** – MAE reported that the Policy Group had yet to meet to consider a number of policies.
- 4.9 **IGQC25 – Quality Strategy** – This item is on the agenda.
- 4.10 **IGQC33 – Policy for Continuing Healthcare and Funded Nursing Care** – The Committee were satisfied that no further action is required once the policy has been amended to reflect the comments made. **Item Closed.**
- 5. End of Life Care Presentation**
- 5.1 Gina King (GK), Commissioning Manager for End of Life Care, provided an overview of the project to implement a Care Record for the last days of life. This had resulted following Julia Neuberger’s independent report “Review of the Liverpool Care Pathway” published in July 2013.
- 5.2 The Care Record launched in January 2014, had resulted from consultation with key stakeholders in

Gloucestershire, and advice from Dr Bee Wee, National Clinical Director for End of Life Care for NHS England. It will be piloted for 6 months

5.3 In addition, a support leaflet for carers who are looking after someone at the end of their life and guidance for symptom control in end of life care have also been devised.

5.4 The Care Record contains an audit/feedback form which professionals will complete, the results of which will be collated to inform the outcome of the pilot.

5.5 GK reported that Gloucestershire had taken forward this work ahead of national guidance, which was no longer expected.

5.6 The Committee commended GK and colleagues on this important work and provided advice regarding a communications plan.

5.7 RECOMMENDATION: The Committee noted the presentation.

6. Our Journey for Quality 2014 to 2019 – Progress Update

6.1 MAE introduced the summary of progress against '*Our Journey for Quality*' which sets out the strategy for NHS Gloucestershire to assure quality is at the centre of the organisation, through the three components of quality: patient experience, patient safety and clinical effectiveness and which was agreed by the Governing Body on 30 January 2014.

6.2 The Strategy is compiled of three sections: MAE summary, reference document and implementation plan. The summary had been shared with key stakeholders and the finalised implementation plan would be presented to the IGQC in April 2014. The reference document is also expected to come back

in April 2014.

- 6.3 MAE described the work of the Quality Team in relation to further developing the Implementation Plan.
- 6.4 SA expressed concern regarding discussions at the Governing Body meeting in terms of the direction of travel for both the strategy and implementation plan. SA believed that the focus should be on projections for the next five years.
- 6.5 CBu commented on the need to ensure the focus is on the organisation as commissioners rather than providers.
- 6.6 AE suggested that emphasis should be placed on gathering real time data about services being delivered.
- 6.7 JC referred to the previous suggestion of holding a separate development workshop, although it was acknowledged this would inevitably delay the launch of the strategy
- 6.8 MW referred to the challenges and timescales MAE faced by the Executives over the next few weeks in terms of their availability and suggested a future CCG development session could be used for this discussion, and to take stock of the CCG's approach to quality. MAE agreed to identify a suitable date which would ensure attendance by members of the Committee.
- 6.9 **RECOMMENDATION: The Committee noted the summary of progress made on the Quality Strategy and supported the suggestion of a further development session to take the work forward.**
- **ACTION: To review the Quality reference document (April 2014)**
 - **To formally review progress against the**

implementation plan once approved every six months.

7. Quality Report

- 7.1 MAE introduced this report which provided assurance to the Committee and Governing Body that quality and patient safety issues are given the appropriate priority and that there are clear actions to address them. The report covered the period from the 30th September to the 29th December 2013.
- 7.2 MAE reported that the Clinical Audit Network Forum will be encouraged to share audit executive summaries and any concerns with the Committee.
- 7.3 MAE confirmed that NICE TAs were to be included in provider contracts and therefore, implementation plans could be monitored to understand any potential financial implications.
- 7.4 The results of the Ofsted thematic inspection of 'Early Help' arrangements for Gloucestershire Childrens Social Care (January 2014) were positive and the findings recognised the development of a Multi-agency Safeguarding Hub as good practice. However MH referred to the problems in Gloucestershire where children with no medical conditions were placed in the acute trust until safeguarding arrangements had been made.
- 7.5 The CCG had given approval and funding to proceed with the health contribution to the Multi-agency Safeguarding Hub. Gloucestershire Care Services NHS Trust had been commissioned to provide this element of the service.
- 7.6 AP reported on the 30% overall increase of incidents reported compared to December 2012.
- 7.7 JC asked that future reports should include the AP themes relating to incidents, particularly those

reported by GP practices.

- 7.8 MAE referred to the intention to share the Quality Report at Locality Group meetings, and that shared learning points and statistical information will continue to be shared via the CCG intranet site and weekly GP bulletin. MAE
- 7.9 AP and MAE provided detail regarding two Never Events, one relating to the out of hours dental service and another in a nursing home. MAE confirmed that the CQC had been contacted to ascertain reporting mechanisms, particularly in relation to the nursing home event. MAE
- 7.10 MAE outlined the process for monitoring incidents and events through regular meetings with Providers and bi-monthly Clinical Quality Review Groups.
- 7.11 CBu referred to the trend in serious incidents relating to histopathology results which is presently being reviewed. Following discussion regarding the process for obtaining results, CBe agreed to check the possibility of PAS access in GP surgeries. CBe
- 7.12 The first CQC Intelligent Monitoring Report was published in October 2013 and GHFT has scored 4 on the report. This related to the elevated risk of maternal puerperal sepsis. GHFT have indicated this is a data issue linked to the incorrect recording of post-delivery temperatures. Further assurance is awaited. MAE
- 7.13 MAE referred to CQUINs around Patient Experience and Patient Flow/Discharge respectively, which will entail 7 day working. It will be essential that nursing staff have the appropriate skills to ensure achievement of these CQUINs.
- 7.14 Copies of the draft quality schedules will be circulated to the Committee via email and these will ultimately signed off as part of the main provider MAE

- contract by the Governing Body and monitored through Contract Boards.
- 7.15 The Committee requested further details of the Patient Deaths by *C.diff*. MAE reported that targets for *C.diff* were set nationally but agreed with CG's suggestion to set local initiatives. TM
- 7.16 MAE referred to the high levels of Norovirus at GHFT and the Committee noted that there are no isolation rooms available in the ED at Cheltenham General Hospital. An Outbreak Management Group had been convened by the CCG and they would look at Public Health data, review evidence and pull together an action plan. There were suggestions for providers to report norovirus cases and related bed closures. MAE
- 7.17 The Committee asked for a further update on Norovirus at their next meeting, along with data for MRSA and E.coli. TM
- 7.18 MAE referred to the increase in the numbers of complaints, particularly those resulting from the new patient transport contract and retrospective claims for Continuing Health Care. CG commented on the performance of the patient transport provider and suggested they had underestimated the resources required to deliver the contract. An improvement was expected next month due to additional vehicles being allocated.
- 7.19 The Patient Experience (PE) team had previously tabled a discussion paper outlining the points for consideration in selecting, presenting and responding to patient stories. JC asked members to email any comments and she would provide a response to the PE team. ALL/
JC
- 7.20 MAE reported that the Patient Experience and Patient and Public Engagement Teams are merging with the Quality Directorate on 1 March 2014, recognising the close relationship between

patient experience and patient and public engagement with other aspects of quality, safety and clinical effectiveness. Committee members asked how the patient experience information was systemised and fed into contract negotiations to ensure improvements made.

7.21 RECOMMENDATION: The Committee noted the contents of this report

8. Child Death Overview Panel (CDOP) Annual Report

8.1 The Committee commended the work undertaken by Dr Imelda Bennett (IB) and colleagues and found the report a valuable insight to the subject.

8.2 Concern was expressed regarding the length of time taken to review child deaths but the Committee recognised the complexities involved. MAE agreed to feedback to IB.

8.3 AW commented on the comparative boroughs data set out on page 14 and suggested that district data may have been more useful.

8.4 AW also commented that Roger Clayton had been contacted as it was not felt to be an appropriate use of time for the new Public Health Consultant to chair the newly formed Business Meeting.

8.5 RECOMMENDATION: The Committee noted the contents of the CDOP Annual Report.

9. Arrangements for Quality Accounts (Verbal Update)

9.1 MAE referred to the historical process for agreeing quality accounts which previously GPs had contributed to.

9.2 Timescales for formally responding to this year's Quality Accounts are challenging and therefore, MAE

MAE suggested these would be circulated electronically to members of the Committee for comment.

9.3 RECOMMENDATION: The Committee noted the verbal update.

10. Impact of Planning Guidance 14/15 on Quality Agenda (Verbal Update)

10.1 It was noted that this year planning guidance had a key focus on service quality. This has been reflected in the development of the 5 year plan, which the quality team had contributed to.

10.2 RECOMMENDATION: The Committee noted the verbal update.

11. Policies Working Group Terms of Reference

11.1 A separate working group of the IGQC was yet to be established to consider draft policies in detail, prior to submission to the Committee for formal approval.

11.2 The terms of reference had been circulated and membership was discussed. It was agreed that a GP member would be invited to meetings when required. In addition other members of the IGQC would be invited as required. AP will amend the terms of reference to reflect these changes. AP

11.3 VW agreed to be the Lay Member on the group.

11.4 RECOMMENDATION: Subject to the amendments agreed, the Committee approved the Terms of Reference for the Policy Working Group.

12. IT Policies

12.1 CL presented two policies, updated following feedback from the previous Committee meeting.

- 12.2 **Email policy : paragraph 3.6** – Amended to read:
... The only exceptions to this are for Lay Members and/or GP members of the Governing Body who are unable to receive NHS Mail on their personal mobile devices or in an emergency situation.
- 12.3 **Email policy: paragraph 3.11.1** - List of secure email address amended to include @glos.nhs.uk and @ glos-care.nhs.uk.
- 12.4 **Telephone & Mobile Communications Policy** – The CCG has a statutory duty to safeguard voice and data information from whatever source or device that is not in the public domain. CL introduced the policy covering the use of own devices to transfer sensitive and confidential information.
- 12.5 JC referred to paragraph 7.1 Staff Telephony Cost Reimbursements and CL commented this should only be done in exceptional circumstances with prior authorisation by the relevant manager.
- 12.6 JC sought clarification regarding the term ‘in-patient’ in paragraph 8.6 and it was agreed this should read ‘... telecommunications within own sites and assurance around provider sites’.
- 12.7 VW asked how policy implementation is undertaken within the CCG and CL confirmed that all Managers have the responsibility to communicate this to staff. In addition details would be available on the CCG intranet and team brief.
- 12.8 **RECOMMENDATION: Subject to the amendments agreed, the Committee approved the Email and Telephone & Mobile Communication Policies.**
13. **HR Report**

- 13.1 MW presented the quarter 3 Workforce Report prepared by the Central Southern Commissioning Support Unit, which set out key workforce measures and activities. The document was recognised as a starting point for the organisation and would be developed in the future.
- 13.2 KR stated that the report was based on information from the Electronic Staff Record system and asked members to note that the data profiling may not be accurate at present. The next report would contain data for the full year.
- 13.3 A summary of compliance on the e-learning core/mandatory training packages was detailed within the report as at 31 December 2013. Although disappointing, it was recognised that uptake had improved during January.
- 13.4 MW reported that the appraisal process and paperwork had been agreed and implemented and staff were in the process of having their 6 monthly appraisals based on previously agreed objectives and Personal Development Plans.
- 13.5 AE commented that the report was helpful and that he believed emphasis should be placed on skills within the organisation now and in the future. KB referred to the forthcoming staff survey, the results of which would link to talent management and succession planning. MW commented on the competitive employment environment and the need to become an attractive employer to ensure the CCG retains staff.
- 13.6 Discussions continue in terms of developing an induction programme which will be introduced in April 2014. MW/KB
- 13.7 MAE referred to the ongoing work around Equality and Diversity and that staff were in the process of undertaking Equality Impact Assessment training.

13.8 It was recognised that e-learning packages were useful but that some GPs were experiencing duplication in terms of the training required for appraisal

13.9 RECOMMENDATION: The Committee noted the contents of the report.

14. CCG Governance Structure

14.1 MAE confirmed that a draft structure chart detailing all of the CCG's committees and sub-committees had been drawn up and discussed at Core Leadership Team. Further work and discussion by the Team would take place as a matter of urgency, to ensure that clear reporting and governance arrangements are in place.

14.2 The final document would be circulated to MAE Committee members in order that they can recommend for approval by the Committee at their April meeting.

14.3 ACTION: CCG Governance structure to April meeting. MAE/AP

15. Risk Register

15.1 AP presented the Risk Register which provided details of those risks identified by the responsible managers, that currently face the CCG and which could affect the achievement of the objectives detailed within the Annual Operating Plan.

15.2 AP confirmed that details of all risks to be removed from the Risk Register had been provided at Appendix 2, as agreed at the previous meeting. Following discussion, it was agreed that Risk No's C16 and C22 would remain in the short term and AP would discuss with MW. AP/MW

15.3 The register had also been reviewed with directorate risk leads to provide greater clarity

regarding the individual risk ratings and subsequent action plans. JC commended the work which had taken place. It was noted that some risks were past their completion date and the register needed to be updated by Directorates to make sure they are correct.

15.4 JC pointed out the 'typo' relating to Adult Cystic Fibrosis at Risk No. T9.

15.5 RECOMMENDATION: The Committee noted this paper and the attached Risk Register. The Committee approved the closure of risks as detailed in Appendix 2 with the exception of Risk No's C16 and C22.

16. Assurance Framework

16.1 AP presented the Assurance Framework for 2013/14 which provided details of the assurances that will be provided to the Governing Body regarding the achievement of the CCG's Annual Objectives. AP explained that the Assurance Framework identified gaps in assurances and controls regarding the objectives along with details of the principal risks that have been identified by lead managers.

16.2 AP commented that the document had been updated with the appropriate directorate risk leads, following comments received at the last meeting.

16.3 Members noted the new Risk No. T11 (page 2).

16.4 Risk No. F10 (page 6) had been reviewed as at 31st January 2014.

16.5 MAE provided clarity regarding Risk No. Q3 which referred specifically to the provision of children and young people with mental health problems.

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

17. Clinical Effectiveness Group Verbal Update

17.1 CBu reported on progress against the work programme for the Group and confirmed he would continue to update the Committee as work progresses. CBu

17.2 A CCG event has been arranged on 12 June to review best evidence in practise and how to replicate across the system.

17.3 RECOMMENDATION: The Committee noted the verbal update.

18. Information Governance Update

18.1 CL presented the paper providing an update on the organisation's information governance arrangements.

18.2 To date 126 members of staff have completed the e-learning out of 175. Further reminders have been sent to staff and Directors are checking progress. The toolkit requirements are being progressed and the CCG is on track to submit the IG toolkit in March.

18.3 The Freedom of Information (Fol) process has been subject to refinement and improvements made. The Committee asked for detailed information regarding the numbers of nature of Fols for discussion at future meetings. CL

18.4 A full review of the information being collected, and audits undertaken by PCCAG is being carried out and assurance is being sought to ensure data sharing agreements are in place.

**18.5 RECOMMENDATION:
The Committee noted the minutes from the Information Steering Group and the contents of the report.**

19. Any Other Business

19.1 Skin Cancer Audit Report

CBu referred to the results from the Dermatology Group Cancer Peer Review and in particular to the assurance provided that Gloucestershire GPs were managing cancerous lesions appropriately, which was not conclusive from the audit. CBU would circulate the report electronically.

CBu

19.2 RECOMMENDATION: The Committee noted the assurance provided in the verbal update.

The meeting closed at 12.30 pm.

Date and time of next meeting: Thursday 24th April in the Board Room at 9am.