

Governing Body

**Meeting to be held at 2pm on Thursday 25th September 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 31 st July 2014	Chair	Approval
4	Matters Arising	Chair	
5	Public Questions	Chair	
6	Chair's Update	Chair	Information
7	Accountable Officer's Update	Mary Hutton	Information
8	Time to Change Organisational Pledge	Mark Walkingshaw	Information
9	Mental Health Crisis Review and Action Plan	Mark Walkingshaw	Approval
10	Strategy for Engagement and Experience	Marion Andrews-Evans	Approval
11	Procurement Strategy	Mark Walkingshaw	Approval
12	Performance Report	Cath Leech	Information
13	Integrated Governance and Quality Committee Minutes	Julie Clatworthy	Information
14	Audit Committee Minutes	Colin Greaves	Information
15	Any Other Business (AOB)	Chair	

Date and time of next meeting: Thursday 27th November 2014 at 2pm in Board Room at Sanger House

Questions should be sent in advance to the Associate Director of Corporate Governance: alan.potter1@nhs.net by 12 noon on Tuesday 23rd September 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 31st July 2014
in the Board Room, Sanger House, Gloucester GL3 4FE**

Present:		
Dr Helen Miller	HM	Clinical Chair
Dr Steve Alder	SA	Secondary Care Specialist
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Peter Brambleby	PB	Interim Director of Public Health
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
Cath Leech	CL	Chief Finance Officer
Ellen Rule	ER	Director of Transformation and Service Redesign
Dr Andy Seymour	AS	Deputy Clinical Chair
Valerie Webb	VW	Lay Member - Business
Mark Walkingshaw	MW	Deputy Accountable Officer
Margaret Willcox	MWi	Director of Adult Social Care, GCC
In attendance:		
Becky Parish	BP	Associate Director Patient and Public Engagement
Marian Hoyle	MHo	Head of Patient Experience
Helen Goodey	HG	Associate Director Locality Development & Engagement
Caitlin Lord	CLo	Patient Advice & Liaison Service (PALS) Advisor
Alan Potter	AP	Associate Director Corporate Governance
Emma Simpson	ES	Board Administrator
There were 6 members of the public present.		

1 Apologies for Absence

- 1.1 Apologies were received from Dr Caroline Bennett, Dr Hein Le Roux and Dr Jeremy Welch.
- 1.2 Condolences were expressed by the Chair to the family of the 2gether NHS Foundation Trust employee who died recently.

2 Declarations of Interest

- 2.1 There were no declarations of interest.

3 Minutes of the Meeting held on Thursday 29th May and Tuesday 3rd June 2014

- 3.1 The minutes of the meeting held on Thursday 29th May were approved subject to the following amendments:
 - Section 9.5 to be amended to read **84** GP practices.
 - Section 8.7 to indicate that the evaluation would include productivity measures.
 - Section 10.5 to be amended to read approval of the changes **to** NHS England.
- 3.2 The minutes of the meeting held on Tuesday 3rd June 2014 were approved subject to the following amendments.
 - It was noted that Dr Peter Brambleby was welcomed as the Interim Director of Public Health.
 - Section 3.2 the phrase '**and had**' was to be deleted.

4 Matters Arising

- 4.1 29.05.14 AI 5.4 – Patient's Story/Integrated Community Teams – Item covered on the agenda. **Complete**
- 4.2 29.05.14 AI 8.7 – Accountable Officers Report/Integrated Community Teams - Item to be discussed at the September Governing Body Meeting.
- 4.3 29.05.14 AI 11.5 – Mental Health Crisis Concordat - Item to be discussed at the September Governing Body Meeting.

5 Patient's Story

5.1 CLo presented two patient case studies which related to two couples' experiences of being managed and cared for at home in the two year period following severe strokes. The stories compared the service experiences in 2011 and 2013.

5.2 Discussion took place following the presentation. Discussions focused upon:

- The access to carers' and occupational therapy assessments. It was noted that there was investment in carers support in the county although greater awareness and signposting was required.
- It was considered that the Stroke Care Pathway needs to be made more readily available. Members were advised that the Circulatory Clinical Programme scrutinises the Stroke Care Pathway as it was not straightforward and a 'navigator' was essential as different people have different requirements. It was agreed that the system needs to be more 'outcomes focussed'. It was stated that the pathway was not clear. It was acknowledged that action was currently being taken to address this issue and that a presentation would be made to the Clinical Programme Group.
- WH, JC and Andrew Hughes would review Rehabilitation Services which included those for stroke victims.

5.3 **RESOLUTION: The Governing Body noted the presentation.**

6 Public Questions

6.1 There were no questions received from the public.

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

7.1 This report was taken as read, with a summary of key issues that arose during June and early July 2014 being highlighted by HM.

- 7.2 HM referred to the work of the Respiratory Clinical Programme Group making particular reference to the commissioning of the new Home Oxygen Assessment and Review Service and implementation of Respiratory HOT Clinics.
- 7.3 HM also referred to the NHS Gloucestershire CCG event at Cheltenham Race Course held on June 12th which was attended by 100 GPs and was felt to be a very useful event.
- 7.4 **RESOLUTION: The Governing Body noted the contents of this report.**

8 Gloucestershire Clinical Commissioning Group Accountable Officer's Report

- 8.1 The Accountable Officer introduced this report which was taken as read and provided a summary of key issues arising during June and July 2014.
- 8.2 MH drew members' attention to the ambulance demand and performance issues which were highlighted in Section 2 of the report. Demand remains high for ambulance services with activity up almost 8% in 2014/15 to date. Work was underway with SWAST in order to understand the causes of this increase. It was noted that performance across SWAST was now on target at 75.02% year to date although Gloucestershire performance was at 70.5%. Discussions had taken place with HOSC regarding this. The trialling of a double-crewed ambulance in the Cotswolds had improved performance by 0.9%.
- 8.3 MH referred to the Out of Hours Procurement and advised that a contract award recommendation paper will be presented to the Confidential Section of the Governing Body on 25th September 2014.
- 8.4 It was noted that although performance regarding the Patient Transport Service had improved against a number of the Key Performance Indicators (KPIs), Arriva Transport Solutions Limited (ATSL) was not currently meeting the required standards across all indicators in Gloucestershire. The main issues were set out in the report and it was noted that the Governing Body will be updated in the coming months.

- 8.5 MH provided an update regarding the Integrated Community Teams and advised that a case management approach had been agreed and was being trialled. Members were advised that more work was to be done to develop the high intensity and case management model and embed the service with GP colleagues. MH stated that a report will be presented to the September Governing Body Meeting.
- 8.6 It was noted that the draft Operational Resilience and Capacity Plan 2014/15 was submitted to the Area Team on the July 30th 2014. Further work was required to ensure that the investment delivers change in services provided for the winter. Delegated consent for the final sign off was given to the Integrated Governance and Quality Committee (IGQC).
- 8.7 MH advised that the CCG Strategy for Engagement and Experience was out for consultation and that this would be on the website for comment for 6 weeks from the end of July. Delegated consent was given to the IGQC to approve this prior to the September Governing Body meeting.
- 8.8 Members requested further information relating to metrics and outcomes for Right Care 2. MH
- 8.9 **RESOLUTION: The Governing Body noted the contents of this report and agreed to give delegated authority to the IGQC regarding the Operational Resilience and Capacity Plan 2014/15 and Strategy for Engagement and Experience, as set out above.**

9 Cultural Commissioning Programme

- 9.1 ER presented this report which outlined that Gloucestershire CCG had recently been selected as one of two partners to be involved in a Cultural Commissioning Programme in England.
- 9.2 It was noted that the premise is to think about how arts and cultural organisations can engage with health to provide opportunities for wider self-care initiatives such as social prescribing and in general supporting the health and well-being of our population. It is intended that this work would align with the Healthy Individuals programme group.

- 9.3 The pilot will include 35 days of external support through the partners of the national programme as listed in the paper. It was hoped that this would bring a high level of expertise.
- 9.4 A number of salient points was highlighted including the CCG's commitment in resource terms.
- 9.5 Support was acknowledged from the Public Health Department and benefits were outlined including the strong evidence base.
- 9.6 **RESOLUTION: The Governing Body supported the proposed approach to the Cultural Commissioning Programme.**

10 Locality Plans – Annual Report

- 10.1 HG introduced the paper which provided an update on the two-year development plans for the seven localities which had been shared with the Governing Body in September 2013. The paper also set out the proposed ongoing reporting arrangements.
- 10.2 Key elements of the Countywide Locality Development Work Programmes were highlighted to the Committee by HG.
- 10.3 Members discussed the social prescribing pilot where patients were referred into a hub for non-medical reasons and then referred into a voluntary organisation. It was requested that a means of measurement should be established in order to evaluate the process and facilitate learning. HG advised that overall evaluation and by locality was available. It was noted that examples of good practice and innovation would be shared before the end of the financial year.
- 10.4 **RESOLUTION: The Governing Body:**
- **noted the progress made during 2013/14 within localities;**
 - **supported the progression of the refreshed plans; and**
 - **agreed at least quarterly reporting to the CCG Development Session and six-monthly reporting to the Governing Body.**

11 CCG Annual Assurance Report

11.1 ER presented this report which provided a brief overview CCG Assurance Framework along with details of the Annual Assurance Report that the CCG had received from the Area Team. It was noted that the CCG had been 'Assured' in every domain in the Framework and had therefore received an overall assessment of 'Assured', which was the highest level of assurance that can be received.

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

12 Gloucestershire Shared Care Record Project

12.1 CL presented this report which explained that the project would allow clinicians to see relevant clinical and care information from various databases in a timely manner when needed. CL stated, however, that the project will require significant investment from the CCG. The Governing Board noted that the project will involve a procurement decision later in the year once the business case had been completed and a procurement option recommended.

12.2 **RESOLUTION: The Governing Body:**

- **approved the direction of travel for the project; and**
- **approved in principal the proposal that the CCG fund the recurrent costs of the project for a minimum of two years post implementation with partners agreeing contributions during this period based on benefits realisation subject to the business.**

13 Individual Funding Request (IFR) Policy

13.1 This policy, presented by MW, outlined the CCG's approach to Individual Funding Requests.

13.2 Members noted that access to good clinical intelligence when making decisions regarding the funding of treatment was vital. It was also recognised that in some cases there may be consequences and additional costs of not funding treatment.

13.3 Members suggested the following amendments to the draft policy:

- 'Medically qualified' to be changed to read 'clinically qualified' on page 2 of Appendix 7.
- The maximum term of panel members should be restricted to 5 years.
- NICE acronym to read 'National Institute for Health and Care Excellence' throughout the document.

13.4 **RESOLUTION: The Governing Body approved the policy, subject to the amendments above.**

14 **Equality and Health Inequalities Working Group Terms of Reference**

14.1 MAE presented the Terms of Reference of the proposed Equality and Health Inequalities Working Group and explained the Group, which would report to the IGQC, was intended to provide assurance that the CCG discharges its responsibilities in these areas.

14.2 It was recommended that every CCG has such a group.

14.3 It was agreed that the Lay Member for Business, who is also the Lead for Equality, would be the Chair of the Group and that a GP member would be identified.

14.4 It was noted that suggestions had been made by the IGQC regarding membership. It was suggested that external membership should be considered in relation to the issue of wider avoidable health inequalities.

14.5 The Governing Body also noted that although responsibility for the group sits within the organisation as a whole it would be monitored by the IGQC.

14.6 It was suggested that equality and diversity training should form part of the oversight for this group.

- 14.7 **RESOLUTION: The Governing Body:**
- agreed the establishment of the Equality and Health Inequalities Working Group;
 - agreed the terms of reference for this Group;
 - agreed that a GP member will be identified for the Group; and
 - agreed that VW would chair the Group.

15 **Performance Report**

- 15.1 CL introduced the Performance Report which provided an overview of the CCG's performance against the organisational objectives for the period ended 30th June 2014.

Clinical Excellence

- 15.2 MAE referred to South Western Ambulance Service NHS Trust (SWAST) targets and advised that, generally, national targets were being met although performance in Gloucestershire remained below standard. It was noted that activity levels in Gloucestershire had increased by 5.3% in 2013/14 and had continued to rise in 2014/15. A recovery plan had been launched that included £1million of extra investment in the Northern area.
- 15.3 MAE indicated that performance in relation to MRSA infections was rated as 'red' as there had been 4 reported cases against a target of zero. All of these cases had been classified as pre-48 hour and had not, therefore, been attributed to a specific provider.
- 15.4 MAE also referred to the performance in relation to C.Difficile infections which had been rated as 'green' as, during the year to date, there had been only 35 reported cases against a target of 51.

Finance and Efficiency

- 15.5 CL advised on the financial position and reported that the CCG was forecasting a surplus of £6.862m which was in accordance with the plan. CL advised on risks and pressures that could affect the achievement of the financial targets which include Any Qualified Provider (AQP), Continuing Healthcare and Learning Disability placements.

- 15.6 CL highlighted £2.5m slippage in the CCG's overall QIPP programme. Additional programmes were currently being reviewed to bring forward where it was believed that there was opportunity to deliver in-year savings. CL advised that the QIPP programme currently totalled £17.8m.

Better Payment Practice Code

- 15.7 CL advised that there was a national target to pay all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice. The current year to date position in the value of invoices paid was 99.8% and 95.0% by volume which was in line with the 95% target.
- 15.8 Concern was raised in relation to cancer wait times; specifically in relation to the two week wait target for urgent breast referrals. MW advised that the problem had been caused by staffing problems, including sickness absence, within a small team. It was noted that performance figures for June and July are static at 89%. MW stated that efforts were continuing to use other providers. Adverts have been circulated within primary care for a breast physician. There had been an increase in non-cancer referrals due to the breast cancer awareness campaign which had put demand on the services. It was noted that performance within Urology had improved.
- 15.9 It was noted that the NHS111 performance was below target. MW advised that the CCG was working closely with the provider, Care UK, and was receiving weekly updates on staffing arrangements. Warm transfer performance (when a call needs to be transferred to a clinician with the caller on the line) continued to be of concern. Work continues on prioritisation parameters with Care UK which was being reviewed by NHS England.
- 15.10 MW advised that increases in emergency attendances during Quarter 1 which had added pressure on the achievement of the A&E four hour target. MW assured the meeting that an extensive programme of actions was being taken within GHT and other parts of urgent care system. Additional non-recurrent resources had been allocated for operational resilience and capacity planning totalling £3.6m.

15.11 MW advised that £39.8m had been 'ring-fenced' for the Better Care Fund. Due to national considerations £10m was being held against the 4.5% target reductions in Emergency Admissions.

15.12 RESOLUTION: The Governing Body:

- noted the financial position as at June 2014;
- noted the performance against local and national targets and the actions taken to ensure that performance was at a high standard; and
- delegated authority to HM and MH to work on the resubmission in relation to the Better Care Fund.

16 West of England Academic Health Science Network (WEAHSN) Report

16.1 MH presented this item which was the fourth quarterly report produced by the West of England Academic Health Science Network.

16.2 RESOLUTION: The Governing Body noted this paper.

17 Integrated Governance and Quality Committee Minutes

17.1 The Governing Body received the minutes of the meeting of the Integrated Governance and Quality Committee held on the 24th April 2014.

17.2 RESOLUTION: The CCG Governing Body noted these minutes.

18 Audit Committee Minutes

18.1 The minutes provide a record of the Audit Committee meetings held on the 11th March and 20th May 2014.

18.2 RESOLUTION: The CCG Governing Body noted these minutes.

19 Any Other Business

19.1 There was no other business.

- 20 **The meeting closed at 15:45pm.**
- 21 **Date and Time of next meeting: Thursday 25th September 2014 at 2pm in the Board Room at Sanger House.**

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair): _____ Date: _____

DRAFT

Matters arising from previous Governing Body Meetings – July 2014

Item	Description	Response	Action with
29.05.14 Agenda Item 8.7	Accountable Officer's Report	<p>HM requested that the report being produced for the ICT Steering Group should be presented to the Governing Body to inform members of the service development and also requested that the financial model was included. MH commented that an evaluation model was currently being developed and advised that this would be reported at the July Governing Body meeting. JC requested that the evaluation model should also include productivity activity in order to have a baseline from which to progress forward from.</p> <p>This will now be presented to the September 2014 meeting of the Governing Body.</p>	<p>MH</p> <p>September 2014</p>
29.05.14 Agenda Item 11.5	Mental Health Crisis Care Concordat	<p>EON requested the opportunity to present the findings from the action plan at a future Governing Body meeting and advised that the plan would include a detailed analysis which would identify any gaps in the local system and how to progress the plan forward.</p> <p>Plan is progressing well and will come before the September Governing Body Meeting.</p>	<p>MW / Eddie O'Neil</p> <p>September 2014</p>
31.07.14 Agenda Item 8.8	Accountable Officer's Report	Members requested further information relating to metrics and outcomes for Right Care 2.	MH

Agenda Item 6

**Gloucestershire Clinical Commissioning Group
Governing Body**

Governing Body Meeting Date	Thursday 25th September 2014
Title	Gloucestershire Clinical Commissioning Group Chair's Report
Executive Summary	This report provides a summary of key issues arising during August and September 2014
Key Issues	The key issues arising include: <ul style="list-style-type: none"> • Health Press Interest • AGM • 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 August and September 2014.

2 Health Press Interest

- 2.1 There has been significant health press interest in CCG developments since the last Governing Body meeting, with several publications, including on-line, running positive editorial.
- 2.2 The Commissioning Assembly ran two on-line articles on our work to support early cancer diagnosis with Dr Sadaf Haque and a headline feature on Integrated Community Teams.
- 2.3 Other publications highlighting our work include Integrated Care Today (ICTs) and an NHSG case study is due to feature in NHS Clinical Commissioners' next milestone report (weight management referral scheme).
- 2.4 Both the Health Service Journal (HSJ local) and Primary Care Commissioning have also confirmed that they will be running articles based on our submissions. All features have been promoted via social media.
- 2.5 Further health press articles, on CCG and partner developments, are in the pipeline.

3 AGM

- 3.1 The CCG's AGM took place Thursday 18 September at Sanger House, Brockworth, Gloucester, GL3 4FE from 6-9pm.
- 3.2 The evening featured our Annual Review, presentations from each of our seven Locality Executives highlighting the work they are doing with community partners and a compilation of patient stories that reflected the impact of CCG developments.

- 3.3 Dr Jim Moore, a member of the CCG's Circulatory Clinical Programme Group and the South West Cardiovascular Strategic Clinical Network, gave a talk on improving outcomes for patients with Atrial Fibrillation.

4 Meetings Attended

- 7th August - Telephone Interview with Radio Gloucestershire
- 23 September - Attended Health & Wellbeing Board South West Chairs Network Meeting in Taunton
- 23 September - Attended Women's Leadership Network Meeting in Taunton

5 Recommendation

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

Governing Body

Governing Body Meeting Date	Thursday 25th September 2014
Title	Gloucestershire Clinical Commissioning Group Accountable Officer's Report
Executive Summary	This report provides a summary of key issues arising during August and September 2014
Key Issues	The key issues arising include: <ul style="list-style-type: none"> • Reconfiguration Report • Integrated Community Teams (ICT) Update • Urgent Care Update • Out of Hours (OOH) Update • 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 (GCCG) Accountable Officer's Report

1. Introduction

This report provides a summary of key issues arising during August and September 2014.

2. Reconfiguration Report (12 month) to the Gloucestershire County Council Health and Care Overview and Scrutiny Committee (HCOSC)

This report, which was presented to HCOSC on 8 September 2014, provides a final review of the Cheltenham and Gloucester Emergency Department (ED) reconfiguration one year since its launch in July 2013. It is based upon performance indicators and the outcome of a workshop held with clinical, managerial and lay representatives from: Gloucestershire Hospitals NHS Foundation Trust (GHFT), Gloucestershire Clinical Commissioning Group (GCCG), Healthwatch Gloucestershire and South West Ambulance Service NHS Foundation Trust (SWAST).

➤ Summary Findings

The report reviews seven key questions to assess the reconfiguration against its original intentions. It finds:

- Supervision of doctors has significantly improved as a result of the reconfiguration and the Trust is no longer at risk of losing its trainee doctors.
- The predictions of the number of patients the change would affect were broadly correct.
- Waiting times in departments have generally improved and are better than the England average. CGH performance consistently exceeds the national target. Performance at GRH has improved but does not consistently meet the target.
- Mortality appears to have reduced and there have been no adverse incidents as a result of the change.
- Patient experience has improved with less complaints and more compliments.

There has been some increase in the number of transfers and diverts of patients between sites which remains a concern and is the subject of focussed efforts to minimise unnecessary disruption. With a two site model and increased specialisation transfer between sites will be inevitable. The priority is to minimise transfers and ensure, when required, the process is safe and efficient.

➤ **Lessons learnt**

The two workshops reviewing this reconfiguration (6 and 12 month) have identified some key lessons in the event of any future change:

- The main lesson is that some residents of Gloucestershire have misunderstood the reconfiguration and believe Cheltenham General Hospital Emergency Department to have shut, which is incorrect – it remains open during the day and to patients walking in and to GP referrals overnight. There is a need for stronger communication from all organisations to ensure messages are communicated effectively.
- Clinical leadership of the change meant it was more meaningful to the public and ensured it was focussed on improving care.
- There has been good partnership working between the Council and Health and Care organisations in Gloucestershire to deliver this complicated change.

➤ **Conclusion**

This final report reviewing the reconfiguration has found it has achieved the majority of its objectives and importantly has ensured good doctor training and supervision and improved care. Key lessons from this change and the review are being taken forward by the health community. There remains a firm commitment by GHFT and GCCG that there will be a strong and vibrant future for both Cheltenham General and Gloucestershire Royal Hospitals.

3. Integrated Community Teams (ICT) Update

During the last quarter further progress has been achieved in strengthening Integrated Community Teams (ICT) in line with the requirements of the Joint Case for Change. A selection of the key actions and outputs by locality are listed below: -

- Work is ongoing to embed the new functionalities of Rapid Response and High Intensity Service(HIS) within ICT teams located in Gloucester City (Commenced January 22nd 2014) and in Cheltenham (Commenced May 7th 2014);
- Preparations for the launch of Rapid Response and HIS in Tewkesbury (Tewkesbury town, Churchdown, Brockworth, Bishops Cleeve and Winchcombe practices)are progressing and the planned commencement date (24th September 2014) remains on target;
- The proposed model of integrated ICT case management will be piloted in two ICT locality teams; Gloucester City South West ICT team and Cheltenham ICT team One. Preparations for the case management pilot are well advanced;
- During the period 1st April 2014 – 31st August 2014, 444 cases have been managed and completed by the strengthened ICT functionalities (Cheltenham ICT locality and Gloucester City ICT locality). This level of performance continues to be in line with Joint Case for Change requirements although it should be noted that the number of specific interventions are less than anticipated;
- The Evaluation Review Report of ICT in Gloucester City locality (Test and Learn period) has been considered by the ICT Steering Group on the 22nd July 2014. The report confirmed that Rapid Response functionality is working effectively and the High Intensity Service functionality is still operating at a basic level. The key recommendations in the report have been accepted by GCS who are currently working on addressing these;
- There is a renewed focus on undertaking patient case reviews seen by strengthened ICTs in order to determine the outcomes of interventions delivered. It is anticipated that the revised format will take place on a more regular basis and involve GPs, GCS staff and ICT Programme members in the process;

- A number of workshops have been planned for progressing Phase 2 of the ICT programme, which initially focusses on a test and learn in Stroud and Berkeley Vale locality. The workshops run between July and December 2014 and the first four cover: (i) Setting the scene for transformation (ii) Creating a culture for innovation and quality and developing strategy (iii) Making better decisions with data (iv) Creating a compelling public narrative. Workshops involve a range of stakeholders, with Phase 2 concentrating on mental health and wellbeing primarily in later life and integrating care by connecting with community partners.

4. Urgent Care Update

The CCG has now submitted its revised draft Resilience Plan to NHS England. This plan outlines key actions being taken by the health community to ensure we have a health system which is resilient throughout the year. It now includes and builds upon our recent diagnostic of the urgent care system. The plan includes non-recurrent investment of £3.6m. This includes investment in a new short-stay ward at Gloucester to improve flow there, more focus on avoiding the need for mental health patients to come to hospital, and a significant investment in the voluntary sector.

Following production of this plan, the focus is very much on delivery. To ensure effective governance around this process, we have significantly revised the reporting structure for this work. The resilience plan and overall strategy for urgent care in Gloucestershire is now led by the Gloucestershire System Resilience Group which will be chaired by Dr Helen Miller and which I will sit on alongside provider Chief Executives. Reporting to this group will be a delivery group led by Directors from key organisations and tasked with driving through delivery of our high priority schemes.

5. Out of Hours (OOH) Update

The procurement process for the Primary Care Out of Hours (OOH) Service is nearing completion. Written bids from 5 OOH bidders were received on 18 July 2014 and have been evaluated by a team of evaluators against an established scoring matrix. Presentations by the bidders took place on 2 September 2014. This day supported the evaluation process and gave the evaluation panel the opportunity to raise any issues relating to the bid documents or material presented. This session also included the active involvement of the Stakeholder Engagement Group.

On completion of the evaluation and moderation a recommendation for Preferred Bidder will be made by the OOH Project Board to the GCCG Governing to the confidential section of their meeting on 25 September 2014. Following acceptance of the recommendation the successful and unsuccessful bidders will be notified.

6. Meetings attended

- 27th August – North Cots GP's, Moreton-in-Marsh
- 2nd/3rd September – Out of Hours Bidder Presentations/Review, Gloucester
- 8th September – NHSIQ Phase 2 ICT Workshop, Cheltenham
- 15th September – Better Care Fund Provider Forum, Shire Hall, Gloucester
- 18th September – CCG AGM, Gloucester
- 23rd/24th September – NHSCC Strategy Board Meeting, London

7. Recommendation

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

Agenda Item 8

Governing Body

Governing Body Meeting Date	Thursday 25th September 2014
Title	Time to Change Organisational Pledge
Executive Summary	<p>Time to Change is England's biggest programme to challenge mental health stigma and discrimination. The Clinical Commissioning Group has signed the Time to Change Pledge Wall as a commitment to take action to reduce mental health discrimination in the workplace.</p> <p>Mental Health problems are common and nearly nine out of ten people who experience them say they face stigma and discrimination. This can be worse than the symptoms themselves.</p> <p>Mental health problems like depression, anxiety, schizophrenia and bipolar disorder do not need to stop people from working. With the right support and the right job people with mental health problems perform vital roles in workplace.</p>
Key Issues	The report highlights the work Gloucestershire Clinical Commissioning Group is taking to promote a healthier workplace that is free from discrimination and the development of a support network for those staff that experience mental ill health.
Risk Issues: Original Risk Residual Risk	Failure to promote a healthier workplace that is free from discrimination.

Financial Impact	In order for the Governing Body to ensure they are making best use of our resources, it is essential that we are committed to ensuring that that we create a mentally healthy workplace to allow staff with mental ill health to stay in work.
Legal Issues (including NHS Constitution)	<p>The NHS Constitution sets out rights for patients, public and staff. It outlines the NHS commitment to staff to ensure that they are treated fairly, equally and free from discrimination.</p> <p>The Constitution also pledges to provide support and opportunities for staff to maintain their health, wellbeing and safety.</p>
Impact on Health Inequalities	The Equality Act requires employers to be flexible and make ‘reasonable adjustments’ for people with disabilities to enable them to do their jobs.
Impact on Equality and Diversity	<p>The Equality Act protects people from discrimination. It brings together the law that was found in the Disability Discrimination Act (DDA), the Race Relations Act, and the Sex Discrimination Act.</p> <p>It protects people from being discriminated against because of certain characteristics, such as gender, age or disability. A mental health condition which has a serious impact on day-to-day life over a long period might be considered a disability under this law.</p>
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	The Gloucestershire Mental Health & Wellbeing Strategy and implementation action plans have been co-produced with

	service users, carers, User-led organisations and voluntary and community sector organisations.
Recommendation	The Governing Body is asked to make a public commitment to take action to reduce mental health discrimination as part of Time to Change and to support the recommendations set out within this report.
Author	Eddie O'Neil
Designation	Joint Commissioner, Mental Health
Sponsoring Director (if not author)	Mark Walkingshaw Director of Commissioning Implementation

Governing Body

25th September 2014

Time to Change Organisational Pledge

1 Background

Mental Health problems are common and nearly nine out of ten people who experience them say they face stigma and discrimination as a result. Time to Change is England's biggest programme to challenge mental health stigma and discrimination. This is the first project in England that aims to change behaviour rather than just attitudes.¹

The campaign is run by the leading mental health charities MIND and Rethink Mental Illness and is funded by the Department of Health, Comic Relief and the Big Lottery Fund. It has also received support from Norman Lamb MP, Minister for Care and Support.

2 Action to reduce mental health discrimination

The Gloucestershire Mental Health & Wellbeing Strategy implementation plans include actions to support the objective of reducing stigma and discrimination in the workplace and these are now in the implementation phase.

The Clinical Commissioning Group wish to create a mentally healthy workplace that is free from discrimination where well-being is a priority. They have joined hundreds of organisations who have also made a pledge including BT, EON, the Premier League, Channel 4, the Church of England, Comic Relief, universities, Local Authorities and NHS Trusts.

¹ <http://www.time-to-change.org.uk/>

3 Action Plan

The Clinical Commissioning Group has made a pledge which will support an action plan which includes:

- **Participate in a Time to Change Healthcheck** : this is a tool to help the organisation review their approach to mental health and wellbeing. A Time to Change consultant with experience of mental health problems, will work with the CCG to audit policies, conduct a staff survey and talk to staff. They will produce a report with recommendations for supporting staff and reducing stigma and discrimination in the workplace.
- **Organise a Time to Change Anti-stigma event** : the Mental Health & Wellbeing Strategy sub-group 'Fewer People with experience Stigma and Discrimination' are in the process of organising a community event on 10 November. This will focus on employers and the media and will start conversations that will change attitudes and behaviours towards mental health.
- **Create a support network for staff** : Work with the Public Health team to obtain Mental Health First Aid training. Those who have undertaken the training can offer help to a person developing a mental health problem or are experiencing a mental health crisis. Many people suffer mental ill health for a long time before they seek help.
- **Sign the Mindful Employer Charter** : The Charter is a voluntary agreement which shows that the CCG has a positive and enabling attitude to employees and job applicants with mental health issues.
- **Join the Organisational Learning Peer Network** : A resource for organisations involved with Time to Change to enable sharing of good practice, learning and peer support on issues surrounding the effective management of mental health problems in the workplace.

4 Recommendation

The Governing Body is asked to make a public commitment to take action to reduce mental health discrimination as part of Time to Change and to support the recommendations set out within this report.

5 Appendix

- Time to Change Action Plan
- Time to Change Pledge artwork

time to change

let's end mental health discrimination

Pledge Action Plan

In order to continue processing your Pledge request please complete this document and upload it to our website [here](#).

We ask that you submit your plan a **minimum of six weeks** before the date of your pledge signing to allow us time to feedback on your plan and create your personalised pledge board.

If your action plan is still draft at this stage it's not a problem. You can add to and develop your plan at any stage.

When you upload your plan to the website you will need the following documents / information:

- an action plan
- the date and time of your signing
- who is signing on behalf of your organisation
- where the signing is taking place
- a copy of your logo in EPS format

If you are still unsure about what to put in your plan visit our website to find more [helpful information](#).



Pledge action plan template

Activity description	Internal lead (include contact details)	Timescale	Time to change resources. To order resources please contact the campaigns team: campaign@time-to-change.org.uk	Performance indicator (optional)
Secure Senior Sponsorship : <ul style="list-style-type: none"> ▪ CCG Core Leadership sponsorship ▪ Governing Body Signing Pledge (CCG, Gloucestershire) 	Eddie O'Neil Tel : 0300 421 1544 Eddie.o'neil@nhs.net	22 July 2014 25 September 2014		
Sign the Mindful Employer Charter	Karen Taylor 0300 421 1500 Karen.taylor29@nhs.net	By end September 2014		
Organise a media campaign <ul style="list-style-type: none"> ▪ Team Brief/Staff Meeting : 21 August 2014 ▪ Display and activity in staff Hub : End August 2014/Early September 2014 ▪ Discussion forum on CCG Internet : August 2014 ▪ Update CCG website : August 2014 ▪ Twitter : August/September 2014 	Communications Team (Claire McBride and Sophie Hopkins) Tel : 0300 421 1509/1551	Planning : July 2014 Delivery : August/September 2014	<ul style="list-style-type: none"> ▪ TTC artwork to create posters ▪ TTC advert for intranet ▪ TTC Action Pack 	



Undertake a Time to Change Healthcheck	Karen Taylor 0300 421 1500 Karen.taylor29@nhs.net	Autumn 2014	<ul style="list-style-type: none"> ▪ TTC Invitation to staff ▪ TTC flyer 	
Arrange a set of Time to Talk sessions with key employers/Chamber of Commerce in Gloucestershire for World Mental Health day	Jane Melton and Stigma & Discrimination Sub-group Tel : 01452 894269 Jane.melton@glos.nhs.uk	October 2014	<ul style="list-style-type: none"> ▪ TTC artwork to create posters ▪ TTC advert for intranet ▪ TTC Action Pack 	
Organise and hold a Stigma and Discrimination Event to start the conversations that will change attitudes and behaviours	Jane Melton and Stigma & Discrimination Sub-group Tel : 01452 894269 Jane.melton@glos.nhs.uk	10 November 2014	<ul style="list-style-type: none"> ▪ TTC artwork to create posters ▪ TTC advert for intranet ▪ TTC Event Box 	
Identify staff to undertake Mental Health First Aid training	Karen Taylor 0300 421 1500 Karen.taylor29@nhs.net	By end December 2014		
Engage and seek contribution for involvement in a Stigma & Discrimination campaign using Pop Up Shops in each of the 6 Gloucestershire localities	Sue Tomlinson and Stigma & Discrimination Sub Group Tel : 01452 317485 sue.tomlinson@independen cetrust.co.uk	February 2015		
Evaluate Action Plan	Karen Taylor 0300 421 1500 Karen.taylor29@nhs.net	April 2015		

Tell the world! Your Pledge communications

Website summary

Once you have signed the Pledge we will add your logo to our list of [organisational case studies](#) within **5 working days** of your event. Please supply us with a summary of your pledge and any activity you are planning on doing to accompany your logo. **Please note:** we may edit the text before it is published on the website.



Gloucestershire Clinical Commissioning Group (CCG) pledge to raise awareness of mental health within its workforce so that we can create a culture of mental wellbeing at work, in addition to looking out for others. In August and September, we will run a media campaign to promote mental health awareness amongst its workforce. This will include displays and activities in the staff hub, discussion forums on the intranet and using Twitter to inform followers about what we are doing to create a healthier workplace.

As part of the programme of work to support the Gloucestershire Mental Health & Wellbeing Strategy, the 'Fewer people will experience stigma and discrimination' Sub-group are organising a 'Tackling Stigma and Discrimination' engagement event on 10th November 2014 in Cheltenham. The aim of this event will to take positive action to influence attitudes towards mental health and to enable people to seek help when they need it without fear of stigma or discrimination. This will be followed by a campaign using Pop Up Shops in each of the 6 Gloucestershire localities to raise awareness of mental health stigma and discrimination with the general public.

Have you....?

- ✓ ...completed your action plan?
- ✓ ...written a website summary of your activity?
- ✓ ...got a copy of your logo in EPS format?
- ✓ ...arranged a date for your signing that is at least six weeks away?
- ✓ ...got the name of who is signing the pledge on behalf of your organisation?
- ✓ ...arranged a location for the signing?
- ✓ ..decided whether you want Time to Change representation?

If the answer to all of the above is yes, please submit this information to [our website](#)

time to change

let's end mental health discrimination



Gloucestershire

Clinical Commissioning Group

We're pledging to take action to reduce mental health discrimination as part of Time to Change.

25 September 2014



Sue Baker
Director
Time to Change



Dr Helen Miller
Chair
Gloucestershire Clinical Commissioning Group

Myth: People with mental illness can't work.
Fact: You probably work with someone with mental illness.



Funded by



www.time-to-change.org.uk

Agenda Item 9

Governing Body

Governing Body Meeting Date	Thursday 25th September 2014
Title	Mental Health Crisis Review and Action Plan
Executive Summary	<p>A Task and Finish Group was convened following a serious untoward incident which occurred in 2013, within the context of NHS England's Urgent Care Review and the publication of the '<i>Crisis Care Concordat</i>', supported by 22 national organisations and launched by the Minister for Care and Support.</p> <p>The early part of this work ran alongside and promoted the '<i>Joining up your Care</i>' consultation and the findings and conclusions set out below were timed to inform contracting timescales – specifically including service specifications with specialist mental health services and with secondary acute care.</p> <p>17 local organisations have signed up to the Gloucestershire Declaration Statement and are committed to deliver actions within the Continuous Improvement Action Plan and will hold each other to account for progress.</p>
Key Issues	<p>This paper provides a progress report on the work of the Gloucestershire Mental Health Crisis Care Declaration Task and Finish Group and focusses on the four outcomes identified by the CCG as a result of the serious untoward incident in 2013.</p> <p>During 2014 a good deal of work has been</p>

	achieved. Work is needed to sustain this momentum. The Declaration Statement and Continuous Improvement Action Plan provide the means of making real progress in practice.
Risk Issues: Original Risk Residual Risk	Non compliance with the legal framework of the Mental Health Act 1983/2007.
Financial Impact	The financial impact with implementing the new service model of crisis care set out in the plan has yet to be determined. The CCG commissioning team are currently working with ² gether Trust to quantify the resource requirement for the new model.
Legal Issues (including NHS Constitution)	Adherence with HM Government 'Mental Health Crisis Care Concordat' : Improving outcomes for people experiencing mental health crisis.
Impact on Health Inequalities	The action plan will put mental health on a par with physical health (parity of esteem) and will close the health gap between people with mental health problems and the population as a whole.
Impact on Equality and Diversity	The Equality Act protects people from discrimination because of certain characteristics such as gender, age or disability. A Due Regard Statement has been created (Appendix 3).
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	The Mental Health Crisis Care Concordat has been informed by engagement with people who have needed mental health crisis services. The Gloucestershire Mental Health Crisis

	<p>Review and Action Plan supports the Concordat and both have been co-produced by partner organisations in Gloucestershire.</p> <p>Informant interviews were undertaken including those with service users and carers.</p>
Recommendation	The Governing Body is asked to note the contents of this progress report.
Author	Eddie O'Neil
Designation	Joint Commissioner, Mental health
Sponsoring Director (if not author)	Mark Walkingshaw Director of Commissioning Implementation

GCCG Governing Body

Thursday 25th September 2014

Mental Health Crisis Review and Action Plan

1 Introduction

1.1 This paper provides a progress report on the work of the Gloucestershire Mental Health Crisis Care Declaration Task and Finish Group.

1.2 The Group met between January and July 2014. Partner organisations within the county have signed up to a joint statement (Declaration Appendix 1), produced a 'Continuous Improvement Action Plan (Appendix 2), Equalities Act Due Regard Statement (Appendix 3) and agreed a date for a first governance progress review in February 2015. The work will be launched on 30th September 2014.

1.3 Gloucestershire's 'Strengths, weaknesses, opportunities and threats' (SWOT) regarding experiences of mental health crisis was prepared for a recent workshop and provides a brief overview of the findings:

<p>STRENGTH:</p> <ul style="list-style-type: none"> <input type="checkbox"/> History & commitment of working together in Glos <input type="checkbox"/> CRHTT works very well with known people with SMI. Positive HTAS & CORE reviews <input type="checkbox"/> Psychiatric Liaison – when available <input type="checkbox"/> Recovery Colleges & peer support <input type="checkbox"/> S136 Maxwell Suite 	<p>WEAKNESS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> ‘Hand-offs’ & eligibility criteria either end of age spectrum <input type="checkbox"/> Parity (physical & MH response standards, lack of triage) <input type="checkbox"/> Carer support/engagement <input type="checkbox"/> ‘Low level’ social & community support <input type="checkbox"/> Post discharge Crisis Plans
<p>OPPORTUNITY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> To influence 2015/16 CRHTT spec <input type="checkbox"/> Potential for more operational integration e.g. co-location <input type="checkbox"/> Improved info sharing – real time & ACPs <input type="checkbox"/> Multi-agency training & awareness <input type="checkbox"/> Alternatives to hospital Care <input type="checkbox"/> Less restrictive options to S136 <input type="checkbox"/> Improved mutual understanding/alignment of expectations <p>10/09/2014</p>	<p>THREAT:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mismatch of expectations & more hand-offs <input type="checkbox"/> Growing demands & shrinking resources <input type="checkbox"/> Impact of welfare benefit changes <input type="checkbox"/> Lack of preventative focus leading to high service useage & poor outcomes for service users <input type="checkbox"/> Risk of retreat from partnerships <p>21</p>

2 Background to the Gloucestershire Declaration on improving outcomes for people who experience mental health crises

2.1 The Task and Finish Group was convened following a serious untoward incident which occurred in 2013, within the context of NHS England’s Urgent Care Review and the publication of the ‘*Crisis Care Concordat*’, supported by 22 national organisations and launched by the Minister for Care and Support.

2.2 The early part of this work ran alongside and promoted the ‘*Joining up your Care*’ consultation and the findings and conclusions set out below were timed to inform contracting timescales – specifically including service specifications with specialist mental health services and with secondary acute care.

3 Methodologies

3.1 The methodologies used for this work were:

- 5 Task and Finish Group meetings with representation from 17 Gloucestershire organisations (of which 7 with a statutory responsibility or duty of care towards people in mental health crisis or user or carer perspectives)
- The Group was co-chaired by the GCCG chair and by an Expert by Experience
- Project management (including weekly highlight progress reports to GCCG)
- 46 key informant interviews (6 GPs, 3 other specialist Doctors, 9 senior clinical staff from 2gether NHS Foundation Trust, 7 managers from 2gether NHS Foundation Trust, 12 Gloucestershire County Council/Commissioners, 3 emergency services, 6 Voluntary/Independent services, service users or carers)
- Literature searches for evidence of effective practice
- Reference to/application of relevant NICE Guidelines/publications
- Reviews of national and Gloucestershire policy and practice documentation
- Equality Act 'Due Regard' analysis and Statement
- Safeguarding Mental Health Experts workshop.

3.2 The key informant interview schedule used (Appendix 4) and sources of evidence (Appendix 5) are attached.

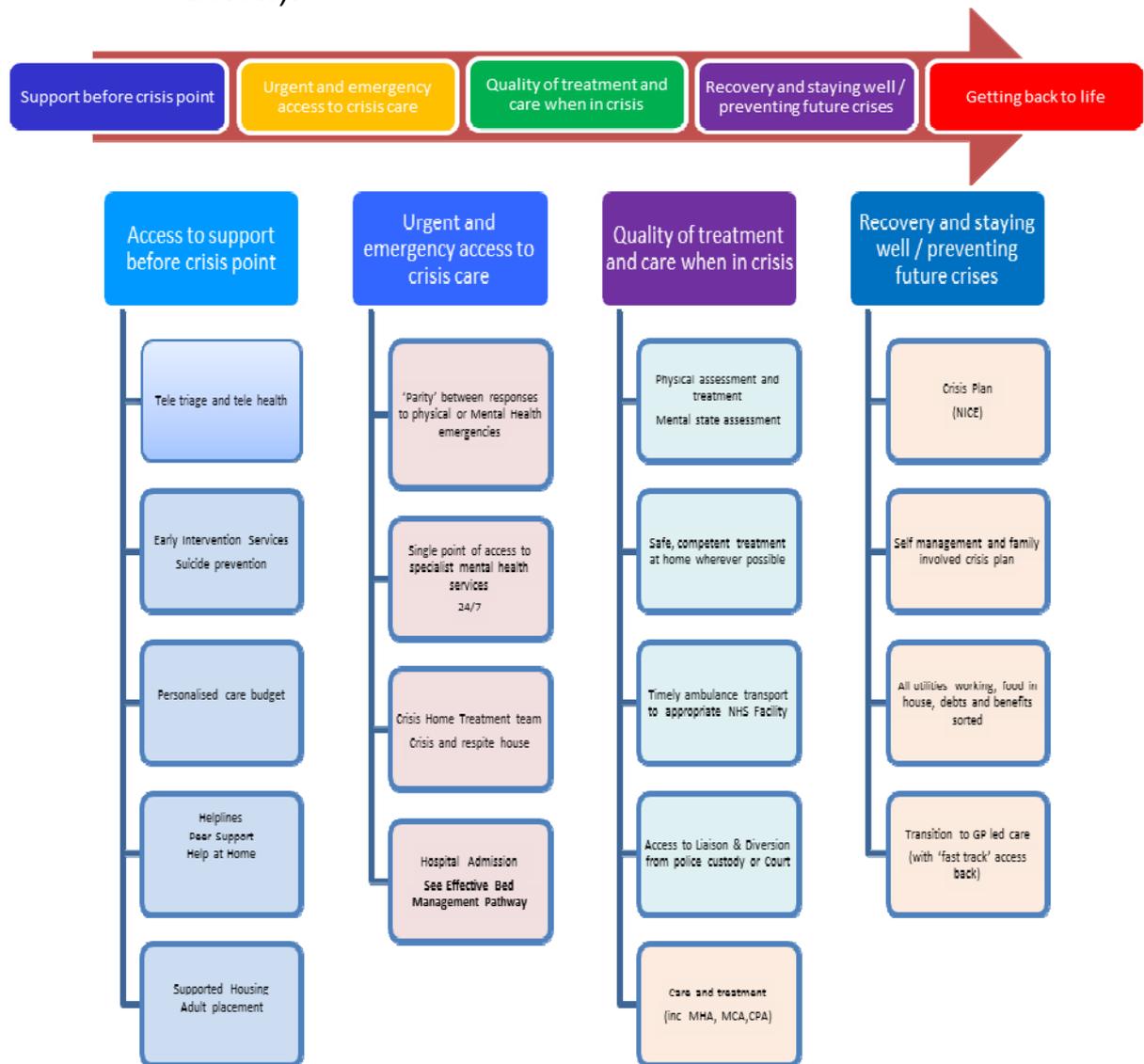
4 Findings

This section sets out the current progress of the Gloucestershire Declaration under the headings set by the GCCG terms of reference at the outset (19.12.13).

4.1 **A shared pathway for the safe support, assessment and management of people with suspected serious mental illness presenting in Crisis in Gloucestershire**

4.1.1 Gloucestershire lacks a commonly agreed and known shared pathway for mental health crisis. This is a significant gap when compared to triage systems that operate for conditions such as stroke or heart disease.

4.1.2 The Declaration work applied a theoretical pathway based upon a four stage crisis model. This is underpinned by examples from the many evidence based interventions which exist in England (see figure below):



- 4.1.3 Participants experience of access to services ranged across, for example : the Crisis and Home Treatment Teams, Psychiatric Liaison Teams, various specialist services, the NHS Section 136 Mental Health Act 1983/2007 suite, the Gloucestershire County Council (GCC) Emergency Duty Team, GCC Customer Services Centre and the ²gether NHS Foundation Trust (²GNHSFT), Contact Centre.
- 4.1.4 Service user and carer participants repeatedly reported poor understandings of how to access urgent help from health or social care services unless they were currently supported by a mental health specialist.
- 4.1.5 All participants support the production of good, accessible, information about local advice, services and agreed Gloucestershire standards which set out roles and responsibilities of organisations involved in mental health crisis care, what help and timescales can be expected - such as those set out in NICE Quality Standard Quality Standard 14 (3)¹. Additionally, people already familiar with Gloucestershire's 'Little Red Book', leaflets produced by ²gether NHS FT and various websites including NHS Choices valued these; other participants were unaware of the existence of these resources.
- 4.1.6 The most common positive findings of key informant interviews concerning access to a pathway or service were that 100% of health respondents, regardless of role or agency background, knew how to make a referral to a Crisis Resolution and Home Treatment Team (CRHTT) within Gloucestershire. However, there was not the same understanding amongst partners, service users and carers. Most interviewees stressed their appreciation of the positive attitude these teams have to working with partner organisations and GP Practices when working with patients currently known to specialist mental health services.

¹ <http://www.nice.org.uk/guidance/QS14/chapter/List-of-statements>

- 4.1.7 For patients not currently known to secondary mental health services, gaps in access to appropriate and timely help in a crisis were commonly reported – with particular lack of clarity at both ends of the age ranges concerning children and young people and older adults with dementia.
- 4.1.8 The most common concerns were that respondents who did not encounter serious and urgent mental health crises very often reported a lack of clarity over what help could be expected, variability in their experiences of asking for help or intervention from specialists and a lack of clarity over eligibility criteria. Outside of urgent care situations, which often occur “out of hours”, the ²GNHSFT Contact Centre was reported as an effective resource. However, “hand offs” and a lack of flexibility by mental health specialists were consistent criticisms from GPs, GCC staff and user and carer participants who reported being passed from one service to another in situations where any sort of complexity existed.
- 4.1.9 Clinical participants from both primary care teams and specialist mental health services felt that there are understandably differing thresholds of judging risk and urgency from each of these perspectives. Safe, shared pathway development is seen as requiring flexibility between professionals, clarity over referral guidance, easy access to consultation/advice and information sharing and appropriate levels of training or access to other professional development for non-mental health specialists.
- 4.1.10 Some interviewees had experience of the Liaison Psychiatry teams based within the two Emergency Departments. These services are consistently highly valued “when available”. Out of the hours of the teams operation, services were reported to be less able to respond. Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) has produced data on peak times of patient presentations in order to identify the reported gap between need and provision.

- 4.1.11 The operation of the Maxwell Suite (NHS Mental Health Act 1983/2007 designated 'Place of Safety') was consistently reported in a positive way. Updated data on the impact and operation of this facility is available and due for publication in the near future.
- 4.1.12 Interviews and Task and Finish Group meetings suggest that certain groups are less likely to seek help early or to use urgent or crisis mental health services in Gloucestershire. These include some people with early onset of dementia, minority communities including some Asian and some Chinese communities and Travellers. Conversely interviewees reported a significant increase in self-harming young people seeking help in a range of different agencies.
- 4.1.13 Some people appear overrepresented in their use of crisis services, even allowing for local demographics. They are very intoxicated people, some people from Black and Minority Ethnic Communities (BME), people with complex needs or a 'dual diagnosis' such as substance misuse and mental illness or learning disabilities and people understood to have a Personality Disorder. However, current CRHTT data shows that teams do work with some people in each of these groups. ²GNHSFT and Turning Point have implemented and will audit a '*Dual Diagnosis pathway for as substance misuse and mental illness*'.
- 4.1.14 Clearly, ²GNHSFT Children and Young People's services are highly valued, though a number of participants felt these need to be expanded and require further investment generally, and specifically in order to prevent and respond to mental health crises.
- 4.1.15 In summary, the development of a definitive pathway – agreed between all partners within the system - for people with suspected serious mental illness which takes account of the issues described above is work in progress. This can be taken forward through the Continuous Improvement Action Plan which follows from the Gloucestershire Declaration and through the

CCG's Commissioning specification to ²GNHSFT for 2015/16. The latter includes a service model for mental health crisis advice, triage and response based upon learning from other NHS services. A final care pathway/directory of services should set out the locally agreed arrangements for a 24/7 single point of access, map preventative options, primary care community services, specialist mental health services with standard referral routes and guidance, treatment options including crisis services and hospital admissions where these are needed and aftercare, relapse prevention and recovery support.

5 Improved individual experience (professionals, users and carers), interagency working and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.

5.1 All interviewees were clear about what people in Gloucestershire want and need in a mental health crisis – the consensus is that they seek or need to be made safe, have timely assessments or interventions from competent professional staff, be kept informed and listened to, be treated respectfully and with kindness. This is similar to the findings of a national Mind survey undertaken for the Concordat. Some service users wanted to record their appreciation of professionals who had listened, understood their distress and helped them.

5.2 Information sharing and managing confidentiality between agencies and professionals is a key issue for improving the experiences of all involved in a mental health crisis and reducing the likelihood of harm.

5.3 A range of medico-legal and ethical issues apply, but the principles of information sharing are that good care plans or relapse prevention plans should be co-produced between professional staff and the individual they are supporting, that consent to share information should be sought, and that services should know how to access information that is available to manage a

crisis presentation. Urgent circumstances, where there is a high level of clinical risk to the individual or to other people will continue to require individual professional judgements to be made concerning disclosure of risk factors including the person's medical condition. Staff need to be clear about their good reasons for disclosing information without obtaining consent or for overriding consent in order to share personal information in a proportionate and justifiable way.

- 5.4 There is a vast amount of advice and guidance available on this topic, including a comprehensive Toolkit produced by the British Medical Association² (). The Gloucestershire Action Plan recommends the development of a '*Specific Information Sharing Agreement*' (SEIA) – a model that works well for other vulnerable groups locally – specifically for mental health crisis, to be adopted by all Declaration Statement signatories in order to provide an explicit framework for the guidance of all professionals within the county.
- 5.5 Staff from emergency, urgent care service primary care, social care and across sectors frequently reported their commitment to multi-agency training and felt that this would improve the prevention or management of mental health crises. ²GNHSFT mental health awareness training provided to the police is greatly valued and improves individual experience through both content and increased confidence in working with people who have mental health needs.
- 5.6 Some informants are concerned that disproportionate amounts of staff time can be taken up with people who are '*frequent attendees*'. This concern was reported in relation to the Emergency Departments (where a limited amount of clinical time is available for follow up of this group).

² <http://bma.org.uk/practical-support-at-work/ethics/mental-capacity-tool-kit>

- 5.7 The same issue applies to the Maxwell Suite (where it also appears that less than half of the people assessed require psychiatric or psychological follow up). For the first three months of 2014 there have been 20 people who have been detained on S136 MHA who have used the facility before. In total there have been 94 detentions this calendar year of which more than 50% have been created by this group of 20. 31% of the 94 referrals have been created by 4 people, each with more than 6 detentions. Of the 20, 10 individuals have used it once this year. 7 females with a diagnosis of personality disorder have been detained more than 3 times this year; of those, 4 people have been detained by police more than 6 times. These are people known to services and have a care co-ordinator. They are all subject to multi-disciplinary meetings and have reviews set up. Evidence from other parts of England indicates that Crisis Resolution and Home Treatment Teams with flexibility to respond more quickly can prevent S136 arrests by the police.
- 5.8 In each case above, '*frequent attendance*' indicates a poor individual experience for service users and staff in addition to a pressure upon limited staffing resources.
- 5.9 Within the primary care setting, access to ²gether NHS FT Recovery Colleges with peer support, to Improving Access to Psychological Therapies (IAPT) workers and to mental health nurses where they work closely with the primary care team are each valued as early interventions and as ways of improving individual experiences. These services are felt to provide less stigmatising and more socially inclusive alternatives to hospital. A number of informants recommended that there should be more listening services and "low key support" available for people with long term mental health conditions.

- 5.10 NHS Protect has recently provided updated guidance and resources for 'lone working', which has been received and disseminated by NHS Gloucestershire³.
- 5.11 From a carer and families perspective, issues based upon individual experiences included slow responses from professionals or mental health services when they have sought help as a crisis is developing (to the extent that they contacted 999 or the police), lack of feedback on their family members care or treatment, problems over confidentiality and consent, lack of awareness of role of young carers, lack of support with post medication management, confusion over their role as a carer and feeling stigma about mental illness. One carers organisation reported that carers can be included within care plans as part of the support system without their knowledge or consent.
- 5.12 The Gloucestershire Continuous Improvement Action Plan addresses these issues through the use of technology ('Apps') or emergency cards, increasing advance care planning, considering alternatives to the use of S136 MHA, developing a service specification to include telephone advice and support, improved access between primary and specialist care in urgent situations and specific training for carers. The Samaritans and Carers Gloucestershire, as signatories, intend to spread the reach of existing services and to develop 'Carers Response to 'Crisis Plans' to improve the individual experiences outlined above.
- 5.13 A safeguarding expert workshop was held to explore the main implications of mental health crisis situations. Agreed actions include the following:

³ NHS Protect re : Lone workers, Summer 2014:
http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/20140724_loneworker_newsletter_edit.pdf

- 5.13.1 Scope audit of safeguarding referrals where the primary issue was wider mental health problems.
- 5.13.2 As part of commissioning of the revised contract for the CRHTT ensure ²GNHSFT expertise and advise is available 24/7 for partner colleagues dealing with safeguarding situations for all situations for all ages and whether the case is 'known' or 'not known'.
- 5.13.3 Ensure ²GNHSFT CRHTT staff and managers are fully aware of their safeguarding responsibilities in crisis situations.
- 5.14 Follow up discussions are being held with both Gloucestershire Safeguarding Boards.

6 The provision of a safe and effective CRHTT service with clear agreed operational policies and protocols in place in relation to access and referral to the service

- 6.1 NICE Guidance⁴ sets out expectations that:
- Health and social care providers should ensure that CRHTTs are accessible 24 hours a day, 7 days a week and available to service users in crisis regardless of their diagnosis
 - Health and social care providers should ensure that service users can routinely receive care and treatment from a single multidisciplinary community team. That they are not passed from one team to another and do not undergo multiple assessments unnecessarily

⁴ <http://www.nice.org.uk/guidance/CG136/>

- Ensure timely access to psychological, psychosocial and pharmacological interventions recommended for their mental health problem.

The NICE Guideline specifically recommends that all GPs should have access to a 24 hour helpline staffed by health and social care professionals.

- 6.2 A strong consensus from key informants, each of whom had personal experience of Gloucestershire CRHTTs is that they work well with known patients within the context of a relatively low bed base. Standards of one hour for responses and four hours for assessments where these are indicated are met. The service for children and young people consistently received positive feedback – within the limits of its resources - from informants who knew them.
- 6.3 At the time of interviews being undertaken and Task and Finish meetings, there was clear confusion about how GP referrals are made in crisis to specialist mental health services and whether a primary assessment by a GP was needed. Following an amendment made to the GCC contract specification in 2013, self referrals can be accepted. Together NHS FT has given the CCG assurance that this agreement is being implemented and that website and leaflet information for referrers and the public is being updated.
- 6.4 Two recent objective assessments of local CRHTTs have been undertaken. Firstly, by the University College London '*Crisis Team Optimisation and Relapse*' (CORE) study, funded by National Institute for Health Research. This independent research assessed the performance of 75 Crisis Resolution and Home Treatment teams - including the Gloucester City Team - to gauge their effectiveness by applying a fidelity scale to measure adherence to best practice.

The CORE team are developing online resources to support teams making service improvements based upon this evidence. This is to be published and made available to the NHS in 2015. Secondly, the Royal College of Psychiatrists run standards based accreditation scheme for Crisis Resolution and Home Treatment teams (HTAS). Accreditation is intended to assure staff, service users and carers, commissioners and regulators of the quality of the service being provided.

- 6.5 These indicate that Gloucestershire services operate at a level which is just above the national average (overall CORE score of 129 compared to 124 for England), which indicates fair to good fidelity to the standard model for this service. All teams are currently HTAS accredited and scored highly on the criteria for effectiveness which is used by this professional peer network.
- 6.6 HTAS reported that the Gloucestershire teams met their criteria for 'gate keeping' of referrals for inpatient care, which is a core function of the Crisis Resolution and Home Treatment model. The CORE study surprisingly gives one participant team from the county a low score (1:5) for this function for reasons which relate to data capture and quality rather than the team's actual service delivery. Extended roles of the team in responding to Maxwell Suite assessments and to Emergency Departments during the hours that the Psychiatric Liaison Teams being unavailable are beyond the traditional model. Crisis Teams are less able to provide the continuity of service and speed of response as hospital based liaison teams working with Emergency Departments.

- 6.7 The CORE study has questioned the deployment of Crisis Resolution and Home Treatment Team staff to undertake assessments within the Maxwell Suite, but all local participants – including the police - report that this arrangement works well within Gloucestershire and fosters the creation of alternatives to hospitalisation.
- 6.8 Care Programme Approach Guidance requires that patients treated by specialist mental health services have a crisis plan, which should be accessible on provider and GP records. Taken together, the evidence from interviews, CORE and HTAS suggests that current areas for improvement include systematic access to advance care plans/crisis plans and delivery of these plans when patients are discharged from the wards as part of home treatment. This also forms part of the CQC standard for quality and safety and Regulation 24 of the Health and Social Care Act 2008.
- 6.9 The ‘National Audit of Homicides and Suicides’ (July 2014) emphasises the period of two weeks following hospital discharge as a high risk period where planned aftercare support is needed as part of suicide prevention practice. This research shows that 3,225 known mental health patients died by suicide in the UK within the first three months of their discharge from hospital – 18% of all patient suicides, between 2002-2012. 526 patients died within the first week after hospital discharge, which is the peak time of risk in England. This National Audit recommendation is that careful and effective care planning is needed including for patients before they are discharged and for those who self-discharge. Potentially, measurable quality improvement in the availability of crisis plans could form part of a local commissioning CQUIN within 2015/16.

6.10 In summary, the main gap within the county has been in the lack of a clear pathway for people not currently known to mental health services, who present in crisis. The amendment to CRHTT specification and updated operational policy ('draft' August 2014) which allows for assessments to be made without prior screening from a GP or other clinician provides an important improvement. Further opportunities for improvements in line with the NICE Standard and Gloucestershire Declaration ambition that no one presenting to publically funded services in a mental health crisis will be turned away, include:

- greater integration between health and social care provision for people needing urgent advice, assessment or treatment
- further development of alternatives to hospital
- the negotiation of updated service specifications for 2015/16.

7 All relevant organisations work together accepting their organisational responsibilities in order to reduce the likelihood of future harm to health and social care practitioners, carers, patients and service users

7.1 17 local organisations have signed up to the Gloucestershire Declaration Statement (Appendix 1), committed to deliver actions set out within the Continuous Improvement Action Plan and will hold each other to account for progress though shared governance at a first review in February 2015.

8 Commissioning implications and specifications for 2015/16

8.1 The commissioning of a new Crisis Resolution and Home Treatment service model from 2gether NHSFT will be set out in a new contract service specification which is planned to commence from April 2015. The new service model specification is currently being developed by a CCG and 2gether NHS FT joint project team. This work is taking account the key findings from the local review in which a number of gaps in the crisis service and care pathway have been identified. The development of the new crisis service model is also informed from the learning from crisis care pathways and responses which have been developed elsewhere within in England these include significant features such as:

- A single point of access which responds to mental health crisis 24/7 response to urgent telephone requests for help from people of all ages and conditions
- Triage and routing/signposting to appropriate services within Gloucestershire
- Separation of rapid response initial assessment and home treatment service functions
- 24 hours a day phone line with calls are managed by trained handlers
- Qualified mental health staff providing a first point of contact for the public, service users, carers and referrers

8.2 Localities which have reconfigured service models report improved outcomes⁵, including:

⁵ <http://mentalhealthpartnerships.com/project/sunderland-and-south-of-tyne-initial-response-team/>

- Improved response times (average 30 minutes from call to door)
- Improved telephone access (average 9 second pick-up)
- Equality of access to urgent mental health services
- Improved service user, carer and referrer experiences
- Reduced avoidable harm - no “bounced referrals” (these are routed to the most appropriate service)
- Reduced assistance required

8.3 The commissioning of a new service model that will achieve the aims of the Crisis Care Concordat will potentially require additional investment from the CCG. The CCG Commissioning team are currently working on the analysis of crisis care activity across the system in order to understand the economic impact and the business case to inform future commissioning decisions and any further investment requirements.

9 Conclusions and support required

9.1 External evaluations indicate Gloucestershire CRHTTs are working reasonably effectively within limits of the service specification, but a lot more is needed to meet aspirations of the Concordat. While partnership working in Gloucestershire is generally good and well established there remains scope for joining up care further at the interfaces between teams and organisations. The common value base is to ensure that meeting the needs of people in mental health crisis and their carers is at the centre of care and treatment.

9.2 Gloucestershire are one of four sites being evaluated nationally, funded by the Department of Health, to assess the impact of the work to improve outcomes for people experiencing a mental health crisis.

9.3 In summary, during 2014 a good deal of work has been achieved. Work is needed to sustain this momentum. The Declaration Statement and Continuous Improvement Action Plan provide the means of making real progress in practice.

10 Recommendation

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

11 Appendices

- Appendix 1 - Gloucestershire Declaration Statement
- Appendix 2 - Gloucestershire Declaration Action Plan for Continuous Improvement
- Appendix 3 - Equalities Act Due Regard Statement
- Appendix 4 - Key informant interview schedule
- Appendix 5 - Evidence sources for effective practice in mental health crisis

Appendix 1

The 2014 Gloucestershire Declaration on improving outcomes for people experiencing mental health crisis

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.

Gloucestershire Clinical Commissioning Group
Gloucestershire Care Services NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
2gether NHS Foundation Trust
NHS England
South Western Ambulance Service NHS Foundation Trust
Gloucestershire County Council
Gloucestershire Constabulary
Gloucestershire Police and Crime Commissioner
The Samaritans
Healthwatch Gloucestershire
Turning Point
County Community Projects
Rethink
Carers Gloucestershire
Independence Trust
National Probation Service

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 Author: Department of Health and Concordat signatories Document purpose: Guidance 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	<p>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.</p>

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) : 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 diagnosed mental illness/distress despite its continued presence.</i>" <p>Department of Health (2004), <i>Emerging Best practice in Mental Health Recovery.</i></p>

2014 CONTINUOUS ACTION PLAN TO ENABLE DELIVERY

OF SHARED GOALS

OF THE MENTAL HEALTH CRISIS CARE CONCORDAT

WITHIN GLOUCESTERSHIRE

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NO	ACTION	TIMESCALE	LED BY	OUTCOMES
1.	EQUALITY ACT 2010 DUE REGARD ACTIONS (see attached Due Regard Statement, July 2014)			

1.1	<p>Data:</p> <ul style="list-style-type: none"> ▪ Commence data collection on 'Protected Characteristics' not currently collected ▪ Review quality of existing data ▪ Improve collection of qualitative data around experience of patients from BME community 	<p>October 2014 On-going</p> <p>October 2014 On-going</p> <p>October 2014 On-going</p>	<p>Les Trewin 2gether NHSFT Steve Bean Gloucestershire Constabulary</p> <p>2gether NHSFT</p> <p>2gether NHSFT</p>	<ul style="list-style-type: none"> ▪ Improved demographic data on the people using crisis services to inform service development ▪ Improved understanding of how patients from the BME community experience crisis services ▪ Better more sensitive services for people who belong to 'protected characteristic' groups
1.2	<p>Independent Mental Health Advocacy contract monitoring meetings to focus on Protected Characteristic Groups with a specific focus on the in-patient community</p>	<p>6 monthly</p>	<p>Karl Gluck Gloucestershire County Council</p>	<ul style="list-style-type: none"> ▪ The Independent Mental Health Advocacy service is more accessible to members of 'protected characteristic groups' both in-patients and people living in the community ▪ A more sensitive Independent Mental Health Advocacy service for people who belong to 'protected characteristic groups'
1.3	<p>County Community Projects to develop interface with Crisis Resolution Home Treatment Team and explore with users of the Teams if they see a need for an Independent Mental Health Advocacy in this context</p>	<p>October 2014</p>	<p>Leonie Seebourne County Community Projects Karl Gluck Gloucestershire County Council</p>	<ul style="list-style-type: none"> ▪ An understanding of the relevance of the Independent Mental Health Advocacy service to people in contact with the Crisis Resolution Home Treatment Team ▪ Improved access if service agreed to be relevant
1.4	<p>Implement MIND guidance on commissioning crisis care services for</p>	<p>By April 2015</p>	<p>Eddie O'Neil Clinical Commissioning</p>	<ul style="list-style-type: none"> ▪ Commissioning of more culturally sensitive services

	<p>BME communities:</p> <ul style="list-style-type: none"> ▪ consult and engage with BME groups early on when commissioning services ▪ Ensure staff are delivering person-centred care that takes cultural needs into account ▪ Commission a range of services ▪ Empower people from BME groups by providing appropriate information, access to advocacy services etc. 		Group	<ul style="list-style-type: none"> ▪ BME community empowered to influence the nature of the local mental health services
1.5	All partners to consider making <i>'reasonable adjustments'</i> to enable people who may be marginalised to articulate what they want	December 2014 and on-going	All partners to the local Declaration	<ul style="list-style-type: none"> ▪ All partner services are more sensitive to the particular needs of members of 'protected characteristic' groups & make 'reasonable adjustments' where required
1.6	2 ^{gether} NHSFT Crisis Resolution Home Treatment Team's and other specialists teams to engage with their local BME communities through developing their outreach capacity e.g. visit local Mosques, invite local Imam into the Crisis Resolution Home Treatment Team etc	December 2014 and on-going	Martin Griffiths 2 ^{gether} NHSFT	<ul style="list-style-type: none"> ▪ Crisis Resolution Home Treatment Team's have a better understanding of any specific mental health needs of their local BME community ▪ BME communities have a better of understanding of what their local Crisis Resolution Home Treatment Team can offer the community ▪ The Crisis Resolution Home Treatment Team is more accessible and sensitive to the needs of its local BME communities ▪ Earlier intervention preventing situations developing into crisis & subsequent admission
1.7	Development of the cultural competency of Crisis Resolution	April 2015	Martin Griffiths 2 ^{gether} NHSFT	<ul style="list-style-type: none"> ▪ Crisis Resolution Home Treatment Teams have a better understanding of any specific mental

	Home Treatment Team staff at a clinical level through a rolling programme of training			<p>health needs of their local BME community</p> <ul style="list-style-type: none"> ▪ The Crisis Resolution Home Treatment Team is more accessible and sensitive to the needs of its local BME communities
1.8	Development of the Sheffield 'Crisis Support Centre' type model within the Gloucester Friendship Cafe, a base for networking with specialist Mental Health services	April 2015	Les Trewin and 2gether NHSFT Social Inclusion Staff	<ul style="list-style-type: none"> ▪ The Crisis Resolution Home Treatment Team is more accessible and sensitive to the needs of its local BME communities through the development of a base within the community ▪ Improved communication & mutual understanding between the BME community and the Crisis Resolution Home Treatment Team ▪ Earlier intervention preventing situations developing into crisis & subsequent admission
1.9	Partner agency staff, particularly GPs aware of vulnerability and needs of people from transgender community	October 2014	All partners	<ul style="list-style-type: none"> ▪ A more sensitive mental health service to members of the transgender community, recognition of mental health needs ▪ Earlier intervention preventing situations developing into crisis & subsequent admission ▪ Transgender identity is not confused with a mental health problem
1.10	Update the Joint Strategic Needs Assessment (JSNA) to include more information on mental health and specifically data on mental health crisis	Dec 2014	Eddie Parsons Senior Research Analyst and Joe Green Senior Data Analyst, Strategy and Challenge Group, GCC	<ul style="list-style-type: none"> ▪ Improved useable data at a local level ▪ Improved mental health intelligence around which to plan, commission & provide mental health services & specifically crisis services ▪ Implementation of mental health metrics devised by NHS England for 2014/15
2. COMMISSIONING TO ALLOW EARLIER INTERVENTION AND RESPONSIVE CRISIS SERVICES				
Matching local need with a suitable range of services				

2.1	<p>Explore funding possibilities to:</p> <ul style="list-style-type: none"> ▪ Develop Positive Caring mental health specific courses to include different mental health conditions/strategies for coping with crisis provider information and input to Carer Support Groups about dealing with crisis ▪ Provide 1:1 peer mentoring support to carers to enable locally based non-judgemental support 	October 2014	Tim Poole Carers Gloucestershire	<p>Carers better able to:</p> <ul style="list-style-type: none"> ▪ Recognise and deal with the onset of a crisis through having a greater understanding of the conditions affecting the person they care for. ▪ Respond to changes in the person's condition, knowing what is normal to expect and when to alert others. ▪ Flag up changes leading to crisis earlier ▪ Ask questions that might otherwise not be able to ask
2.2	<p>Following review, commission a new model of Crisis and Home Treatment Service ensuring services and pathways are designed across the age transitions from under 16s through to adulthood and recognising the needs and rights of young carers</p>	April 2015	<p>Eddie O'Neil Clinical Commissioning Group Simon Bilous Gloucestershire County Council Les Trewin 2gether NHSFT with Mandy Bell Gloucestershire Young Carers</p>	<ul style="list-style-type: none"> ▪ New Crisis Resolution Home Treatment Team service specification agreed and incorporated in 2gether NHSFT contract to commence delivery from April 2015 ▪ Agreed performance indicators and reporting for new service ▪ Well planned and managed transition ▪ Clarity over criteria/ thresholds and ways to overcome them ▪ Outcomes-led/ needs-led approach ▪ Age removed as a barrier to accessing appropriate support ▪ Young carers are recognised and listened to ▪ Prevention of some crisis through listening to young carer and recognition of warning signs ▪ Young carer needs are met
2.3	<p>Deliver a new model of Crisis Service in line with commissioning</p>	April 2015	<p>Les Trewin 2gether NHSFT</p>	<ul style="list-style-type: none"> ▪ Single point of access ▪ Equitable crisis provision for all ages and

	expectations and specifications and exploring options for co-location with other emergency services, to include a review of the skill mix and qualifications/competencies of workforce to work with u18s		Simon Bilous Gloucestershire County Council	<p>mental health issues</p> <ul style="list-style-type: none"> ▪ A minimum of an initial response to all crises as defined by the person experiencing the crisis/carer and referring agency ▪ Clear and concise pathways of care without 'hand offs' ▪ Standard response times, referral processes and quality standards to mental health crises delivered in response to Gloucestershire commissioning specification for 2015/16 ▪ Skilled, competent and confident workforce ▪ Reduced staff absence
2.4	Undertake an options appraisal and benefits realisation of telecare/ telehealth for improving responses to people in mental health crisis	April 2015	Eddie O'Neil Clinical Commissioning Group	<ul style="list-style-type: none"> ▪ Speedier response to people in mental health crisis in their own environment
2.5	Investigate the need for a safe place for care/containment and subsequent mental health assessment for people who are too intoxicated to be interviewed	April 2015	Eddie O'Neil Clinical Commissioning Group Steve O'Neil Public Health	<ul style="list-style-type: none"> ▪ Reduction in inappropriate use of S136 suite and Emergency Dept, improved assessments ▪ Vulnerable people are assessed in a safe place ▪ Reduction in resources wasted by partner agencies 'containing' very intoxicated individuals ▪ Improved response to people lacking capacity with MH needs, but not needing the ED
2.6	Ensure availability of the Mental Health Voice Service User Group and	On-going	County Community Projects Advocacy	<ul style="list-style-type: none"> ▪ Inclusion of service users in consultation around review of services and service

	the Voices in Recovery (Substance Misuse) Group to commissioners		Service Karl Gluck Gloucestershire County Council	improvement initiatives
2.7	Implement training resources to support action learning within the pathway	April 2015	Clinical Commissioning Group	<ul style="list-style-type: none"> ▪ Staff from all agencies who encounter mental health crises will develop an evidence based understanding of mental health crisis from the perspective of patients, carers and families
2.8	Review the Psychiatric Liaison Service to consider all age approach and current gaps including hours required within the Mental Health Liaison team to best meet patient need	Scoping by September 2014 (via Psychiatric Liaison Group)	Eddie O'Neil Clinical Commissioning Group Simon Bilous Gloucestershire County Council Maggie Arnold/ Delia Parnham-Cope Gloucestershire Hospitals NHSFT	<ul style="list-style-type: none"> ▪ Age no longer a barrier to accessing appropriate support ▪ Crises responded to within standardised timescales and quality standards and with better outcomes ▪ Fewer admissions – to GRH, Tier 4 inpatient care, Maxwell Suite
2.9	Following introduction of new Crisis Resolution Home Treatment Team (CRHTT) model in 2015/16 police to produce up-dated guidance to officers to include: <ul style="list-style-type: none"> ▪ Consideration of the involvement of the CRHTT as an alternative to use of S136 powers ▪ Standardised recording and reporting of cases where police 	March 2015	Steve Bean Gloucestershire Constabulary	<ul style="list-style-type: none"> ▪ Less restrictive alternative for people in mental health crisis and reduction in numbers subject to S146 ▪ Reduction in stigma for people in mental health crisis ▪ Improved data collection and monitoring to inform monitoring/outcomes of service ▪ Improved understanding of use of place of safety

	<p>cells are used as a POS including any refusals by the Maxwell Suite</p> <ul style="list-style-type: none"> ▪ Use of Gloucestershire-wide S136/135 data set Consider use of unmarked cars/plain clothes etc in mental health situations (could include turning off police care blue lights and ear piece transmitters that can exacerbate distress in people with paranoia) 			
2.10	Improve mental health awareness training for Police Officers and police response	April 2015	Steve Bean Gloucestershire Constabulary	<ul style="list-style-type: none"> ▪ Police Officers provide an informed and sensitive approach to people in mental health crisis
2.11	Scope the need for the provision of a commissioned ward for patients with psychiatric/general care needs	Scope by April 2015	Gloucestershire Hospitals NHSFT ² Gether NHSFT Clinical Commissioning Group (Psychiatric Liaison Group)	<ul style="list-style-type: none"> ▪ Scoping exercise completed ▪ Pending the results of the scoping exercise, make recommendations to Commissioners ▪ Resent actions, depending outcome of the Scoping Exercise ▪ 'Shared care' model for patients with co-conditions of mental health and general
2.12	Scope the gap between needs and current provision of children and young people services (including those with behavioural problems) within GHNHSFT inpatient care and paediatric wards with Commissioners and ² GNHSFT	October 2014	Maggie Arnold/ Delia Parnham-Cope/ Vivien Mortimore Gloucestershire Hospitals NHSFT John Trevains ² Gether NHSFT Eddie O'Neil Clinical Commissioning	<ul style="list-style-type: none"> ▪ Scoping exercise complete ▪ Recommendations made to Commissioning bodies ▪ Review of, and suggestion of improved provision for children and young people with 'behavioural issues' ▪ Better inpatient provision for Children and Young People

			Group (Psychiatric Liaison Group) Simon Bilous Gloucestershire County Council	
2.13	Scope the availability of the Liaison Health Visitor post, so that all children and young people who attend ED are reviewed.	March 2015	Vivienne Mortimore Gloucestershire Hospitals NHSFT Candace Plouffe Gloucestershire Care Services Clinical Commissioning Group	<ul style="list-style-type: none"> ▪ Review the current provision of HV liaison support to the Emergency Departments ▪ Consider resourcing the post to allow the scrutiny of all Children and Young People admitted to the Emergency Departments, particularly of those in emotional/ mental health crisis ▪ 'Safety net' of review of all children and young people attending
2.14	To undertake a needs analysis of potential service models for alternative to hospital admissions	December 2014	Eddie O'Neil Clinical Commissioning Group Karl Gluck Gloucestershire County Council	<ul style="list-style-type: none"> ▪ Reduction in hospital admissions ▪ Better experiences for people experiencing mental health crisis as evidenced through satisfaction surveys
2.15	Pilot and evaluate use of a free helpline number available in mental health crisis 24/7	December 2014	Eddie O'Neil Clinical Commissioning Group	<ul style="list-style-type: none"> ▪ Improved access to support for people experiencing mental health crisis
2.16	Further evaluate the scope for NHS 111 responding to mental health needs	December 2014	Maria Metherall Clinical Commissioning Group	<ul style="list-style-type: none"> ▪ Improved access to support for people experiencing mental health crisis
2.17	Include Triangle of Care standards in all MH provider contracts	April 2014	Eddie O'Neil Clinical Commissioning	<ul style="list-style-type: none"> ▪ Carers and the essential role they play are identified at first contact or as soon as possible

			Group Karl Gluck Gloucestershire County Council	thereafter <ul style="list-style-type: none"> ▪ All staff are 'carer aware' and trained in carer engagement strategies ▪ Policy and practice protocols re confidentiality and sharing information are in place ▪ A range of carer support services are in place
Ensuring the right numbers of high quality staff				
2.18	Ensure access to, and benefits of Rethink Mental Illness Self Harm Telephone helpline in Gloucestershire as a means of supporting management and reducing incidence of self harm and suicide are widely promoted to the population through a range of means including via workshops, posters, distribution of Coping Strategies booklet, attendance and publicity at events around the county, website information, information in different formats including Braille, Easy Read and community languages besides English, evidenced through increased uptake of helpline support and reduction in reports of self harm and suicide attempts	From June 2014	Rethink Mental Illness working with commissioners and the Gloucestershire Suicide Prevention Partnership Forum	<ul style="list-style-type: none"> ▪ Higher levels of community awareness recorded through event and activity information presented in reports to service commissioners ▪ Reduced incidence of self harm and / or suicide related admissions to hospital as evidenced by data provided by ²gether NHSFT NHS MHFT, police service and ambulance service
2.19	Increase early help-seeking behaviour of young people as a result	From July 2014	Rethink Mental Illness working with	<ul style="list-style-type: none"> ▪ Increase in use of the Rethink Mental Illness self harm helpline by younger people of 14-16

	<p>of participation in specially developed workshops in 36 schools in the county by:</p> <ul style="list-style-type: none"> ❖ Developing a plan for equipping the helpline staff with the knowledge and skills required ❖ Reviewing staffing of the helpline in order to support the increase in calls 		commissioners and local schools	<p>years old as evidenced by service statistics shared with commissioners</p> <ul style="list-style-type: none"> ▪ Use of self harm helpline documented as an integrated pathway of support in young people's care plans ▪ Reduction in admissions from 14-16 year olds for self harm and / or suicide attempts, as evidenced by data provided by 2gether NHSFT NHS MHFT, police service and ambulance service
2.20	Commitment to participate in any future rolling programme of multi-agency, multi-professional mental health crisis pathway training	April 2015	Steve Bean Gloucestershire Constabulary	<ul style="list-style-type: none"> ▪ Increased awareness of mental health issues for police officers leading to a more personalised and sensitive responses ▪ Improved understanding between operational staff in partner agencies leading to more joined up responses and less 'hand off's ▪ Direction and consistency of all aspects of policing and mental health via Mental Health Strategic Tasking and Co-ordinating Group
2.21	Provide 'Crisis' training as part of MH awareness training to GLOSSE providers (Gloucestershire Safe and Social Environments) which include café's, museums, garden centres, libraries etc	October 2014	Jack Beech Independence Trust with GLOSSE providers	<ul style="list-style-type: none"> ▪ GLOSSE providers will know what to do and who to contact when a person presents with a crisis or a crisis is suspected.
2.22	Review skills mix, competency and training needs of staff, volunteers	October 2014	Jack Beech Independence Trust	<ul style="list-style-type: none"> ▪ Ensure there is a consistent approach to Crisis across the organisation

	and peers within Wellbeing Plus, Occupation Plus, Community Health Trainers, Families First. Develop guidance and access to specialist training to ensure we excel in Crisis			
Improved partnership working in Gloucestershire				
2.23	Pilot and review outcome for Gloucestershire Shared Care Records approach	April 2015	Eddie O'Neil Clinical Commissioning Group Commissioning Support Unit	<ul style="list-style-type: none"> ▪ Better information sharing across the partner organisations ▪ Fewer A&E attendances ▪ Fewer emergency admissions ▪ Improved medication management
2.24	Work with the NHS to produce a local mental health information sharing/ triage system between the Police and NHS in order that the service/ professional dealing with a crisis knows what is needed to manage the crisis/associated risks to the distressed person or to others	April 2015	Steve Bean Gloucestershire Constabulary Eddie O'Neil Clinical Commissioning Group	<ul style="list-style-type: none"> ▪ Information sharing enable people known to services to get the treatment they need quickly and where applicable, services are aware of their crisis plan and any advance statements no matter at what point they re-enter the mental health system ▪ Improved quality of assessments
2.25	Rethink Mental Illness will offer to work with the Gloucestershire Constabulary to deliver two workshops to control room staff to support improved understanding of self harm and suicide and how best to support the person affected and their family	From July 2014	Rethink	<ul style="list-style-type: none"> ▪ Better experiences of emergency response in relation to calls about self harm or suicide reported as recorded by people who have been supported ▪ Increased confidence and competence of police officers attending self harm or suicide related incidents evidenced through course feedback
2.26	Explore opportunities presented by the new centralised Custody Suite at	November 2014	Steve Bean Gloucestershire	<ul style="list-style-type: none"> ▪ Improved and more sensitive less stigmatising service to mentally ill people in contact with

	Quedgeley to improve the service to mentally ill people in crisis on the explicit understanding the Maxwell Suite remains the Place of Safety of choice for the overwhelming majority of S136 detainees		Constabulary	<p>the Criminal Justice Service</p> <ul style="list-style-type: none"> Healthcare professional available to assist with initial assessment and triage of anyone presenting with healthcare issues.
2.27	Critical review/analysis of partner agencies mental health crisis related policies, procedures and protocols	February 2014	<p>Jim Symington Symington-Tinto Health and Social Care Consultancy David Pugh Independent Consultant</p>	<ul style="list-style-type: none"> Reflects best practice as evidenced by analysis of national documentation including NICE guidance Evidence of a personalised approach Involvement of carers/friends and 'protected characteristic groups' Consistent with service specifications
2.28	Amend current contract specification to include standardised response times, from Psychiatrists to referrals for inpatients with mental health crisis	By April 2015	<p>Maggie Arnold Gloucestershire Hospitals NHSFT Eddie O'Neil Clinical Commissioning Group ²Gether NHSFT</p>	<ul style="list-style-type: none"> Scoping exercise completed Pending outcome of scoping exercise, arrange meeting with ²Gether NHSFT, Contracting and Commission to agree the Service Level Agreement An agreed response time to requests for consultant review
3. ACCESS TO SUPPORT BEFORE CRISIS POINT				
3.1	Ensure simple access to Samaritans by systematic availability of Gloucestershire Samaritans Referral Form by Declaration signatories especially GPs, Emergency Department, Police, Ambulance Services and ² gether NHSFT	From September 2014	<p>Garth Barnes Samaritans Eddie O'Neil Clinical Commissioning Group</p>	<ul style="list-style-type: none"> Improved early access to listening service
3.2	Extend the work of Samaritan Volunteers within identified	From September 2014	<p>Garth Barnes Samaritans</p>	<ul style="list-style-type: none"> Additional support to the Suicide and self-harm strategy through early intervention.

	vulnerable areas and/or Deliberate Self Harm helpline as area (to explore further)		Deliberate Self Harm Helpline Anne Kendal NSF Sola Aruna Gloucestershire County Council	
3.3	Review information provision and pathway for patients who attend following self-harm, who are not admitted	September 2014	Delia Parnham-Cope, Gloucestershire Hospitals NHSFT Jon Burford 2gether NHSFT	<ul style="list-style-type: none"> ▪ Pathway reconsidered ▪ Ensuring that patients are identified, and managed to prevent crisis and attendance at Emergency Department
3.4	Establish a Gloucestershire link with the British Transport Police to involve them in prevention projects to tackle mental health and suicidal behaviour challenges	December 2014	David Pugh Independent Consultant	<ul style="list-style-type: none"> ▪ Prevention of people seeking to harm themselves on the railway
Improve access to and experience of mental health services				
3.5	Develop interface with Crisis Resolution Home Treatment Team and explore users of the Teams if they see the need for an Independent Mental Health Advocacy in this context	October 2014	Leonie Seabourne, County Community Projects Independent Mental Health Advocacy Service Karl Gluck Gloucestershire County Council	<ul style="list-style-type: none"> ▪ Clarity of relevance of statutory advocacy to users of Crisis Resolution Home Treatment Team ▪ Subject to above, service users empowered through access to appropriate advocacy in crisis
3.6	Report findings based on Wellbeing client's experience of being in crisis,	July 2014	Jack Beech Independence Trust	<ul style="list-style-type: none"> ▪ Contribution to the client voice element of the review of the Mental Health Crisis Service in

	what works well, what could be improved			Gloucestershire.
4. URGENT AND EMERGENCY CARE ACCESS TO CARE				
Improve NHS emergency response to mental health crisis				
4.1	Introduce the use of an appropriate vehicle in the event of conveyance being required in a mental health emergency	From September 2014	Sammer Tang South Western Ambulance Service NHSFT	<ul style="list-style-type: none"> Reduction in stigma/improved response times/safe transport at point of crisis.
4.2	Local implementation of the Association of Ambulance Chief Executive national S136 guideline for transportation of people under Section 136 detention	From April 2014	Sammer Tang South Western Ambulance Service NHSFT	<ul style="list-style-type: none"> All Section 136 requests for ambulance transportation would be categorised as a Green 2 (30 minutes emergency response).
4.3	Create multi-agency 'Standards for mental health Assessment' leaflet/information sheet	Dec 2014	Karl Gluck Gloucestershire County Council	<ul style="list-style-type: none"> A set of multi-agency standards around MH assessment Shared understanding between key stakeholders Users/carers know what they can expect from key agencies in a MH assessment A timely and efficient assessment process
4.4	Creation of a set of evidence based actions that will improve Mental Health safeguarding responses in a mental health crisis including:	Nov 2014	All Declaration Partners facilitated by Alison Feher Safeguarding Lead 2gether NHSFT	<ul style="list-style-type: none"> All key stakeholders are aware of their safeguarding responsibilities Effective responses to all safeguarding situations for people whose circumstances make them vulnerable Effective sharing of information MH crisis responses aligned to Gloucestershire Safeguarding strategy and systems
	<ul style="list-style-type: none"> Develop the MH Crisis Specific Information Exchange Agreement 	February 2015	Eddie O'Neil Clinical Commissioning	<ul style="list-style-type: none"> Information is appropriately shared in mental health crisis safeguarding situations

	<p>(SIEA) or equivalent addresses safeguarding concerns</p> <ul style="list-style-type: none"> ▪ Scope possibility of audit of Safeguarding referrals where the primary issue was wider mental health problems including carers ▪ As part of the commissioning of the revised contract for the Crisis Home Treatment Service ensure 2gether mental health expertise & advise is available 24/7 for partner colleagues dealing with safeguarding situations for all ages and whether the case is 'known' or 'not known' ▪ 2gether Crisis Resolution Home Treatment Team staff and managers are fully aware of their safeguarding responsibilities in all crisis situations ▪ Presentation to Adult & Children's Safeguarding Boards 	<p>April 2015</p> <p>March 2015</p> <p>September 2015</p> <p>November 2014</p>	<p>Group, Police, Council and Glos Health Community</p> <p>Safeguarding Board Audit Committee via Sarah Warne</p> <p>Eddie O'Neil Clinical Commissioning Group</p> <p>Les Trewin 2gether NHSFT</p> <p>Jim Symington/ David Pugh</p>	<ul style="list-style-type: none"> ▪ Improved understanding of mental health safeguarding situations ▪ Safeguarding assessments are informed by the best possible background mental health information and expertise ▪ Improved safeguarding decisions ▪ The needs of vulnerable adults and children/young people in mental health crisis situations are always taken into account ▪ Both Boards aware of work of mental health Crisis Task & Finish Group ▪ Any relevant synergies established
4.5	Ensure as part of estate development, consideration is given	Ongoing – when opportunity	E Gatling/A. Chandran/ Space Utilisation Group	<ul style="list-style-type: none"> ▪ Ensure parity of the provision of an appropriate space provision

	to create an appropriate mental health assessment room at Cheltenham General Hospital (CGH)	arises for redevelopment of CGH	Gloucestershire Hospitals NHSFT	
4.6	Review current model for 'specialing' to ensure it best meet the patient's needs at all ages	By September 2014	Sue Milloy/ Jon Burford Gloucestershire Hospitals NHSFT ² Gether NHSFT	<ul style="list-style-type: none"> ▪ Closer observation of patient, best meets their clinical needs. ▪ Resource allocation is better managed
Social services' contribution to mental health crisis services				
Approved Mental Health Professional sufficiency and competency				
4.7	Develop, agree and implement an All Age Approved Mental Health Professional Joint Workforce Strategy	October 2014 onwards	Karl Gluck Gloucestershire County Council Sarah Bennion/ Jane Hutchinson ² gether NHSFT	<ul style="list-style-type: none"> ▪ Sufficient number of trained and competent Approved Mental Health Professionals ▪ Approved Mental Health Professionals integrated with health colleagues in the mental health system ▪ Approved Mental Health Professionals well managed and led ▪ Resources used efficiently and effectively
4.8	Ensure all Approved Mental Health Professionals maintain competence through an agreed Continuing Professional Development programme (annual report)	April – onwards Annual report May 2015	Jane Hutchison/ Sarah Bennion ² gether NHSFT	<ul style="list-style-type: none"> ▪ All Approved Mental Health Professionals meet the legal competency requirements
4.9	Ensure all Approved Mental Health Professional reports are of sufficient quality (audit)	Jan-Mar 2015	Les Trewin ² gether NHSFT Karl Gluck Gloucestershire County Council	<ul style="list-style-type: none"> ▪ All Approved Mental Health Professionals meet the legal competency requirements
4.10	Review interface between daytime Approved Mental Health Professional	End of October 2014	Karl Gluck/Louise West Gloucestershire County	<ul style="list-style-type: none"> ▪ Ensure that Mental Health Act assessments are undertaken in a timely fashion in accordance

	and EDT (to include planned OOH Mental Health Act assessments)		Council	with the legislation/Code of Practice
4.11	Review role of single contact (adult helpdesk) in conjunction with ² GNHSFT Contact Centre for Mental Health Act assessment requests Review Adult helpdesk Approved Mental Health Professional protocols	End of October 2014	Karl Gluck Gloucestershire County Council Les Trewin ² gether NHSFT	<ul style="list-style-type: none"> ▪ Clear guidance for Health and Social Care staff on how and when to request a Mental Health Act assessment
4.12	Review role of Approved Mental Health Professional within Crisis Resolution and Home Treatment Teams	January 2015	Karl Gluck Gloucestershire County Council Sarah Bannion ² gether NHSFT	<ul style="list-style-type: none"> ▪ Options appraisal for commissioners on best practice
4.13	Review multi-agency conveyance guidance for individuals detained under the Mental Health Act	January 2015	Karl Gluck Gloucestershire County Council Interagency Monitoring Group	<ul style="list-style-type: none"> ▪ Revised multi-agency policy and implementation plan
4.14	Review multi-agency Police assistance for Approved Mental Health Professionals policy	January 2015	Karl Gluck Gloucestershire County Council Interagency Monitoring Group	<ul style="list-style-type: none"> ▪ Revised multi-agency policy and implementation plan
4.15	Establish emergency specialist foster care arrangements available in emergency	November 2015	Delia Amos Gloucestershire County Council	<ul style="list-style-type: none"> ▪ Skilled, competent, confident workforce ▪ Quicker 'step down' arrangements
4.16	Review housing and accommodation needs as part of crisis pathways for	December 2014	District Councils	<ul style="list-style-type: none"> ▪ Appropriate access to settled accommodation

	people with mental health long terms conditions			
Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983				
4.17	Review and combine s135(1) and s135(2) policies	Within 3 months of publication of revised Mental Health Act Code of Practice	Karl Gluck Gloucestershire County Council Interagency Monitoring Group	<ul style="list-style-type: none"> Revised multi-agency policy and implementation plan that reflects best practice.
4.18	Review of Gloucestershire multiagency S136 Policy, Procedure and Guidance following the legislative outcome of the current review of 2007 Mental Capacity Act Code of Practice. This should include management of intoxicated detainees	Within 3 months of publication of revised Mental Health Act Code of Practice	Karl Gluck Gloucestershire County Council and Inter Agency Monitoring Group	<ul style="list-style-type: none"> An improved common framework for operation of Section 136 where partner agencies roles and responsibilities are clearly understood and reflects best practice along with alignment of partner expectations
4.19	Audit of experience of subjects of S136 of the Maxwell Suite	December 2015	Dr Jim Laidlaw 2gether NHSFT David Pugh Independent Consultant	<ul style="list-style-type: none"> Detainee experience of Maxwell Suite established (note: research of Laidlaw, Pugh et al focussed exclusively on detainee experience of police stations) Opportunity to improve experience of S136 detainees
Improved information and advice available to front line staff to enable better response to individuals				
4.20	Independent Mental Health Advocacy service information material to front line staff	6 months	County Community Projects Independent Mental Health Advocacy Service	<ul style="list-style-type: none"> Improved awareness and understanding of the IMHA role. Increase in referrals for clients to the IMHA service ensuring service user involvement in decisions affecting their lives.
4.21	Campaign to raise awareness of services and approaches available to	March 2015	Kevin Elliott NHS England	<ul style="list-style-type: none"> Primary care services know how to support their patients at time of mental health crisis

	people in mental health crisis			
Improved training and guidance for police officers				
4.22	Ensure all officers undertake mental health training within the context of a rolling programme to be agreed by the staff of the development unit	September 2014	Steve Bean Gloucestershire Constabulary	<ul style="list-style-type: none"> Increased awareness of mental health issues for police officers leading to more personalised and sensitive responses
Improved services for those with co-existing mental health and substance misuse issues				
4.23	Establish a partnership between Mental Health Voice and Voices in Recovery Service User Groups and Carers	December 2014 (note in progress)	Leonie Seabourne, County Community Projects Core Group led by Advocacy Service	<ul style="list-style-type: none"> Ensuring a voice for service users To encourage and support service users for consultation towards improving services and shared needs for those with co-existing mental health and substance misuse issues
4.24	Strengthen pathway and communication channels with Recovery Team and Crisis team to ensure joint crisis planning	December 2014	Jack Beech Independence Trust	<ul style="list-style-type: none"> Wellbeing Staff are less likely to get stuck 'holding' a person in a crisis Knowledge/interventions and trust built with client will be formally recognised as part of a crisis plan Clients will have a fast track access back to secondary care rather than via GP
4.25	<ul style="list-style-type: none"> Undertake Clinical Audits (audit, review and report outcomes to all Gloucestershire Declaration partners) Turning Point and ²gether NHSFT monitoring of all known referrals 	April 2014 to March 2015 (Review)	Dr Sarah Welch Turning Point Dr Karen Williams ² gether NHSFT	<p>Improved access to:</p> <ul style="list-style-type: none"> Engagement/assessment/treatment/services for people with mental illness and drug or alcohol problems (Outcome/success criteria to be developed)

	to/from Crisis Resolution Home Treatment teams and Turning Point			
	<ul style="list-style-type: none"> Turning Point and ²gether NHSFT monitoring audit of 'information transfers' within the 2014 Dual Diagnoses pathway 			
5. QUALITY OF TREATMENT AND CARE WHEN IN CRISIS				
Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring				
Service User/Patient safety and safeguarding				
5.1	Review existing work of patient pathways in place for frequent attenders with mental health at Emergency Department and extend provision	April 2015	Delia Parnham-Cope Gloucestershire Hospitals NHSFT John Trevains ² gether NHSFT	<ul style="list-style-type: none"> Continue existing work with partners reviewing frequent attendee and developing pathway plans for better management to prevent attendance
Staff Safety				
5.2	Review Datix incidents where Emergency Department has been used as a place of safety	By April 2015	Gloucestershire Hospitals NHSFT (Psychiatry Liaison Group) Steve Bean Gloucestershire Constabulary	<ul style="list-style-type: none"> List of incidents (via Datix) available for consideration, and to contribute to further discussions on use of S136 etc
Primary Care Response				
5.3	Implement the recommendations	By April 2015	Eddie O'Neil/	<ul style="list-style-type: none"> Improved GP awareness, evidence and

	from the <i>Strengthening mental health commissioning in primary care: Learning from experience¹</i> via the CPD Programme for 2015		Martin Gibbs Clinical Commissioning Group	response to patients with mental health needs at risk of crises/relapses.
6. RECOVERY AND STAYING WELL/PREVENTING FUTURE CRISES				
Joint Planning for prevention of crises				
6.1	Information pack for the Independent Mental Health Advocacy service and the Mental Health Voice Service User Group	Now available for distribution. On-going action.	County Community Projects Advocacy Service and Mental Health Voice Service User Group	<ul style="list-style-type: none"> ▪ Opportunities to engage with other service users and play an active role in the forum, contributing in consultations etc., raising their awareness of existing or alternative services, increasing their choices and improving their knowledge of their rights
6.2	Work with carers to draw up and implement 'Carer Response to Crisis' plans bringing together relevant contact details, specific coping strategies etc. which are easily accessible when carer in the heat of the crisis and under stress	September 2014	Tim Poole Carers Gloucestershire	<p>Carers better able to:</p> <ul style="list-style-type: none"> ▪ Cope with a crisis at home without involving emergency services and escalating issue. ▪ Respond in a calm way helping to reduce the stress for the service user
6.3	Develop and deliver specific training to carers on managing challenging	December 2014	Tim Poole Carers Gloucestershire	<p>Carers better able to:</p> <ul style="list-style-type: none"> ▪ Cope with more crises at home without

¹ <http://www.slcsn.nhs.uk/scn/mental-health/london-mh-scn-primary-care-commiss-072014.pdf>

	behaviours specifically related to MH including exploring the potential for DVD/CBT training materials to better support carers			<p>involvement of emergency services.</p> <ul style="list-style-type: none"> ▪ Handle situation reducing the risk of injury to themselves and/or the person experiencing carers the crisis. ▪ Deploy strategies that help them remain calm which will help person remain calmer
6.4	Develop a system similar to the Carers Emergency Card level 1- a person with long term mental health issues who has crisis episodes could have the option of carrying a card linked to Linkline call centre with details of a carer to contact in event of crisis	December 2014	Tim Poole Carers Gloucestershire	<p>In a crisis away from home:</p> <ul style="list-style-type: none"> ▪ Carer can be notified about the crisis to reassure them about what has happened, to attend if appropriate and/or give advice/information about the person ▪ Carer experiences less anxiety which may enable them to cope for longer ▪ Person experiencing crisis may take comfort in knowing that carer is aware and potentially on their way to help ▪ Better information available to police and others in managing the crisis
6.5	Provide coping with crisis and developing plans workshops through our A-Z recovery college options/prospectus <i>“What do you do in a crisis?”</i>	September 2014	Jack Beech Independence Trust Tim Poole Carers Gloucestershire	<ul style="list-style-type: none"> ▪ All Wellbeing Plus clients will be able to attend workshops to develop their own personal plans (or review existing ones) and share strategies and techniques with other clients
6.6	Provide a 24 hour response telecare service for clients which is linked to	September 2014	Jack Beech Independence Trust	<ul style="list-style-type: none"> ▪ Wellbeing Plus Clients, carers and concerned others can contact the 24 hour helpline

	crisis plans and advance statements			<ul style="list-style-type: none"> ▪ Responder staff can access plans and determine next steps through a series of trigger questions (software reassurance in place)
6.7	Promote and extend the use of Advance Care Plans, Crisis Plans Decisions and Advance Decisions for mental health patients including Children and Young People and people with dementia	By end October 2014	Paul Winterbottom with Clinical Directors 2gether NHSFT Gloucestershire Hospitals NHSFT	<ul style="list-style-type: none"> ▪ All known service users will have a future crisis plan that lessens the likelihood of a repeat crisis and ensures the wishes of the service user are taken into consideration ▪ Evidence that these plans are routinely part of the CPA process ▪ Clinical audit programme evidence that the plans exist are accessible 24/7 and that they are acted upon
6.8	Audit current use of Crisis Care Plans	By end October 2014	Paul Winterbottom with Clinical Directors 2gether NHSFT	<ul style="list-style-type: none"> ▪ Establish current practice and standards related to crisis plans ▪ Establish what learning is required and promote a standardised approach to crisis plans

Appendix 3

Due Regard Statement – Final Version (15.07.14).

Introduction:

This Due Regard Statement has been created by the Mental Health Crisis Task & Finish Group & key stakeholders. It is based on a template created by Gloucestershire county Council (GCC). It has been used to inform the Mental Health Crisis Continuous Improvement Action Plan. This draft is the current version of what is an on-going iterative process.

Please use this statement to evidence how 'due regard to' the three aims of the public sector equality duty has been made (section 149 of the Equality Act 2010) during the development of the 'policy'.¹

- Eliminate discrimination, harassment & victimisation & any other conduct prohibited by the ACT;;
- Advance equality of opportunity between people who share a protected characteristic & people who do not share it; &
- Foster good relations between people who share a protected characteristic

Name of the 'policy':	Review of Gloucestershire Mental Health Crisis Pathway
Person(s) responsible for completing this statement	David Pugh on behalf of the CCG led Mental Health Crisis Pathway Task & Finish Group

¹ For 'policy': any new & existing policy, strategy, services, functions, work programme, project, practice & activity. This includes decisions about budgets, procurement, commissioning or de-commissioning services, service design & implementation.

<p>Briefly describe the activity being considered including aims & expected outcomes</p>	<p>To review of the Mental Health Crisis Pathway in order to achieve the following CCG specified outcomes:</p> <ol style="list-style-type: none">1. That there will be a shared pathway for the safe support, assessment & management of people with suspected serious mental illness presenting in crisis in Gloucestershire.2. This will improve individual experience (professionals, users & carers), interagency working & reduce the likelihood of harm to the health & wellbeing of patients, carers & professionals.3. The provision of a safe & effective Crisis Resolution & Home Treatment Team (CRHTT) service with clear agreed operational policies & protocols in place in relation to access & referral to the service.4. All relevant organisations work together accepting their organisational responsibilities in order to reduce the likelihood of future harm to health & social care practitioners, carers, patients & service users.
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Documenting use of sufficient information

Please document below the data & information sources that you have used to understand the needs, participation & experiences of each protected group. Evidence must be gathered as the policy is developed & used to inform decisions.

Service user data

Service user data is an important source of evidence & should be collated as part of routine monitoring of in- house or external services. If service user data is not available record 'not known' & use the action plan to identify what improvement actions will be used to gather data going forward.

[Service user diversity reports](#) are available on our website & give an indication of service user participation across commissioning areas, for example adult residential services & youth services. It does not include participation data at individual service level.

Needs analysis

[Gloucestershire population demographics](#) data is available to understand the representation of different protected groups across the county & help with needs analysis. Data like this may also be also useful for benchmarking to identify under or over representation of a service by any of the protected groups. For example, a service is open to all residents & from monitoring you know that 2% of service users are disabled: However, demographic data indicate that 16.7% of Gloucestershire residents report having a disability or long term limiting illness. This finding can be used to explore if there are barriers to participation by residents with disabilities & how this can be addressed as part of the development of your 'policy'.

Data gaps

You may find that you have more information about some of the protected groups for example, gender, age, disability & less about others, for example, sexual orientation & religion &/or belief. If data is not available & you intend to start collating data about a protected characteristic please use the action plan to outline how this data will be collated. You can find equality monitoring guidance on our [website](#) including an equality monitoring template.

If you have no plans to start collating data about a protected characteristic please state the rational why.

Service information (if applicable) or Needs analysis (if applicable)

Who is responsible for delivering the service?	Whilst 2gether NHSFT provide three CRHTTs Teams which provide a specialist rapid response & access to the acute care pathway for adults with mental illness across Gloucestershire other statutory & non-statutory partners contribute to the pathway. This includes the following: Health (including primary & specialist services, Emergency Department, Ambulance Service), Social Care commissioners & providers & Criminal Justice agencies (primarily Police, Liaison & Diversion & Probation Services). The non-statutory sector also contributes to the pathway & there is scope to develop this further. Non-statutory
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	<p>partners include CCP, Rethink, Samaritans & Glos Age UK.</p> <p>'The Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis' highlights 'Equal access' under B2 of the Concordat commenting that '<i>Equality is a key policy objective within England's cross government strategy for mental health 'No heath without mental health'</i>'.</p> <p>www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf www.gov.uk/government/publications/the-mental-health-strategy-for-England</p> <p>The Concordat Action Plan has commissioned the Mental Health Provider Forum & the Race Equality Foundation to develop a structured map of better practice to improve outcomes for BME groups. Also the Mental Health Equality Working Group (EWG) has been set up to lead & support the improvement of equality across the range of protected characteristics.</p> <p>The BMA report '<i>Recognising the importance of physical health in mental health & intellectual disability</i>' (2014) concludes that 'equality of access to mental health & intellectual disability services must be made a reality:</p> <ul style="list-style-type: none">• Healthcare providers must ensure that they are compliant with their duties under the Equality Act 2010' (p.69). <p>The Home Treatment Accreditation Scheme (HTAS) produced by the Royal College of Psychiatrists (RCP 2013) have a standard on 'quality & diversity' 4.1 – 4.5. Their 2014 Pilot Report commented that '<i>Whilst all 17 pilot teams take into account the diversity of each service user & have 24 hour access to translation services, one of the 17 teams was not using ethnicity monitoring forms & only 11 of the 17 teams monitor the quality of experience & service received by people from equality target groups</i>'. The three Gloucestershire CRHTT were subject to HTAS accreditation & all but Cheltenham were fully accredited in terms of meeting the 'Equality & diversity' standards (Sec 4.1 – 4.4).</p> <p>The DH CORE CRHTT fidelity item 35 states that 'The CRT takes account of equality & diversity in all aspects of service provision'. On 25.02.14 the Gloucester CRHTT was subject to a review by CORE.</p>
<p>Service user data/Needs analysis information. The following data in red is taken from the GCC Gloucestershire Equality Profile 2014 & it is against this data that comparisons are made with what is known about protected characteristic groups access to the MH Crisis Pathway. It is based on the 2011 Census. Comments in blue are from the 45 interviews carried out as part of the</p>	

<p>Pathway Review & data in black is locally sourced data. For more detail on sources of data see p.9/10.</p>	
<p>Age</p>	<p>Gloucestershire: 22.8% are aged 0-19 years, 57.8% aged 20-64 & 19.4% aged 65 years & older. The proportion of people aged 65+ exceeds the national average.</p> <p>Sec 136: Data from Laidlaw, Pugh et al showed the mean age from heath data for subjects of Sec 136 MHA 1983/2007 was 37 years. The most frequent age band for police data was 35 – 44 yrs (33%). Data for the Maxwell Suite (Feb 2009 – Jan 2013) showed the most frequent age band was 35 – 44 (21.5%). The majority of detainees were aged between 25 – 54 years (64%). Only a minority were at the extremes of age 6.1% under 18 years & 3.4% over 56 years.</p> <p>CRHTT & Sec 136 Data (2013): 89% between 16 – 64 years, & 97% for Sec 136 detainees. The most frequent age band across CRHTT & Sec 136 was 45 – 54 years (23%). During 2009 – 2013 1.3% of Maxwell Suite detainees were 16 years or under. This is monitored closely by 2gether and a Children & Young Person Consultant was involved in the majority of assessments. Prior to 2009 all would have been assessed in a police POS. Out of 24 under 18s detained under section 136; 10 had to be admitted to adult wards as there was nowhere else to hold them, a ‘Never Event’.</p> <p>Interviews: Noted that the CRHTT criteria exclude older people with dementia and young people, so the response of the Team is age dependent. No parallel services for these groups.</p> <ul style="list-style-type: none"> ➤ <i>‘appears to exclude younger & older people with dementia’</i> ➤ <i>‘there is a gap in urgent & emergency care for people with dementia’</i> ➤ <i>‘people with dementia, although a different type of crisis to that of a WAA or O/P with a functional illness. The risk is usually focused on the person rather than a risk to others...& the crisis can often be a crisis for the person caring for the person with dementia..it also tends to be seen as more of a ‘social problem’..</i>
<p>Disability</p>	<p>Gloucestershire: 16.7% of Gloucestershire residents reported having a long term limiting health problem, which was below the national average. Dementia is one of the major causes of disability along with learning disability. Estimates suggests 8,667 people aged 65+ are living with dementia in Glos & 2,563 people aged 65+ with a</p>

	<p>learning disability.</p> <p>Interviews: Comments from some interviews about a lack of parity of care for people with physical, learning disability & mental health problems. With both of the latter the focus is seen as on the physical or learning disability. Comment that the 2gether Trust sometimes finds it difficult to make <i>'reasonable adjustments'</i> as required by the Equality Act, failing to provide access to the specialist skills of the CRHTT service...'</p> <ul style="list-style-type: none"> • <i>'People with LD seen as outside the remit of the CRHTT, requiring a dedicated specialist service.'</i> • <i>'Young people with LD not formally excluded, but a lot more difficult to access appropriate services for them.'</i>
<p>Sex</p>	<p>Gloucestershire: The overall gender split in Gloucestershire is slightly skewed towards females, with males making up 49.0% of the population & females account for 51.0%. For people aged 85+ females accounting for 67.3% of the total population.</p> <p>Sec 136: Data from Laidlaw et al showed 55% were male from health data & 61% were male from police data. Recent data discussed in the IAMG indicated a very high proportion of repeat detainees within the last quarter were female. Data for the Maxwell Suite showed 55.7 % were male.</p> <p>CRHTT Data (2013): 56% were women.</p>
<p>Race (including Gypsy & Traveller)</p>	<p>Gloucestershire: 95.4% of Gloucestershire's population is white. Black or Ethnic Minorities make up the remaining 4.6% of the population, which is considerably lower than the 14.6% reported for England as a whole. Asian/Asian British account for the largest proportion of Black or Ethnic Minorities in Gloucestershire, following the national trend. Gloucester has the highest proportion of people from a Black or Ethnic Minority, at 10.9% of the total population.</p> <p><i>Part B2 of the Crisis Concordat comments that '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...before a person seeks or receives help'. The Concordat supports the guidance produced by Mind on commissioning crisis care services for BME communities.</i></p> <p>CQCs annual report on monitoring the MHA for 2012/13 continues to show people from all black & minority</p>

ethnic groups can be over-represented within in-patient (I/P) services and higher rates of detention under the Act, particularly for 'Black Caribbean' & 'Other Black' people. However, the 2013 AMEND study found '*There is no evidence for that amongst those assessed under the MHA, ethnicity has an independent effect on the odds of being detained*' (Psychological Medicine (2014), 44, 997–1004). Hospitalisation rates as informal patients were lower than expected for patients from a number of black & minority ethnic groups (p.24). For 2012-13 the rate of detention for people from BME groups was 250.3 people per 100,000 of the population. This was around 3 times higher than for the White ethnic group (62.9) per 100,000 of the population (Source: Health & Social Care Information Centre). Interestingly information from a Rethink Director on their 'Step Down' accommodation which all residents enter voluntarily showed an average of 20% of residents were from BME backgrounds.

Sec 136 data from Laidlaw et al (2010) for health Places of Safety between 2002 - 2004 showed 95% of subjects were white & 4% Black/Afro Caribbean/Chinese/Asian. Police data for 2003 – 2006 showed 93% were white & 4% Black/Asian. There is a possible very slight over-representation of Afro-Caribbean males. The 2001 Census showed Glos's non-white ethnic minority population was 2.8%.

Police data for Feb 2013 – Jan 2014 showed that out of 82 detainees 4 were from a BME background (4.5%). Data for the Maxwell Suite (Feb 2009 – Jan 2013) showed 4.4% were from Black/African/Caribbean/Black British/Mixed/Multiple ethnic groups & Asian/Asian British. **IMHA** data for 01.10.2013 – 31.03.14 demonstrated only one person seen from a CRHTT. For in-patients (I/P) out of a total of 266 cases 10 (3.7%) were from BME backgrounds. The BME I/P population for Jan – Dec 2013 was 19 (5.7%).

CRHTT/Sec 136 Data (2013): 3% from BME community although 12% not known & 73% White British. Sec 136 data for this period indicated 5.7% BME & 68% White British although 15% not known. For CRHTTs the figures are as follows:

- CRHTT Cheltenham: 1.3% (13)
- CRHTT Gloucester: 6.3% (65)
- CRHTT Stroud: 0.7% (8)

However, 'not known' figures are very high for all three Teams.

The **CORE** review concluded that the Gloucester CRHTT could access interpreters to attend in person/video conference within 24 hours & by phone within 4 hours for .90% of service users for whom this is needed. It also found that the CRHTT monitored demographic characteristics of service users referred & accepted for CRHTT support. However, it also concluded that '*The CRT was not able to demonstrate at least one active attempt*

	<p>during the last 12 mths relevant to the local population to make the CRT service more appropriate for a minority group'. Overall the Team scored 4 out of 5 which equals good fidelity to the standard.</p> <p>Travellers: The GCC Principal Traveller Services Officer commented that mental health issues are not uncommon in Travelling communities & can be aggravated by both genetic & environmental factors that are specific to that community. There is also a deep rooted belief in <i>'looking after their own'</i> so <i>that most care is delivered within the family...there is still a sense of shame associated with mental health & families will not always as for help from outside bodies in the first instance. However, in my experience once they seek help then they seem to have the same access to services & receive the same quality of service as non-Travellers'</i>.</p> <p>Interviews:</p> <ul style="list-style-type: none"> ➤ <i>'African Caribbean & Asian communities excluded due to cultural issues/different belief systems which may not medicalise mental health issues or may feel stigma'</i>. ➤ <i>'problematic & difficult for some BME communities to access the CRHTT because of a lack of awareness, GP awareness & stigma', plus 'lack of interpreters & culturally sensitive advocacy...'</i>. ➤ <i>'there appear to be an increasing number of people from South Asian backgrounds with mental health problems some of which develop into crisis situations, but not reflected in referrals to CRHTT'</i> ➤ <i>'It feels like the Chinese community & Asian Community present to services at a 'disproportionately low rate'.</i> ➤ <i>'little is seen to work well for the BME community unless you are a 'known' client of a mental health Team'</i> ➤ <i>'BME communities don't feel sufficient regard is given to meeting their particular needs. BME families are often unable to articulate their mental health problem'</i> ➤ <i>'Assumptions made about the 'community looking after its own', the myth of 'extended family support'</i> ➤ <i>'Risk within BME community of deviance from cultural norms being interpreted as signs of mental illness'.</i>
<p>Gender reassignment</p>	<p>Gloucestershire: Gender reassignment is defined by the Equality Act 2010 as a person proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning their sex by changing physiological or other attributes of sex. Estimates of gender reassignment suggest between 0.6% &</p>

	<p>1% of the UK's adult population have undergone gender reassignment.</p> <p>The 'Trans Mental Health & Emotional Well Being Study 2012' highlights anecdotal evidence that transgender people experience high levels of depression, anxiety, self-harm & suicide ideation related to transphobic discrimination experiences & lack of appropriate health service provision. Over half of the respondents of the reports study felt they had been so distressed at some point that they needed to seek help or support urgently. Such support was sought from friends followed by their GP or partner. This was reinforced through local comments, plus an additional comment that there still exists a misapprehension that transgender issues are mental health issues. However, whilst they are not mental health issues in themselves there is said to be a higher risk of mental breakdown due to the stress of being in the transgender community than in most other communities.</p>
<p>Marriage & civil partnership</p>	<p>Gloucestershire: 30.5% are single, 50.2% are married & 0.3% are in a registered same-sex civil partnership. Gloucestershire has a lower proportion of people who are single or separated when compared to the national average. In contrast the proportion of people who are married, divorced or widowed exceeds the national average.</p> <p>CRHTT/Sec 136 Data (2013): 13% married & 38% single, but difficult to draw any conclusions as 25% a 'null' return. For subjects of Sec 136 only 0.6% were married & 41% single, but 33% null.</p>
<p>Pregnancy & maternity</p>	<p>Gloucestershire: There were 6,880 live births in Gloucestershire in 2012. The largest number of live births was among the 25-34 year old age group, continuing the trend of later motherhood.</p> <p>No local data available.</p>
<p>Religion or Belief</p>	<p>Gloucestershire: According to the 2011 Census, 63.5% of residents in Gloucestershire are Christian, making it the most common religion. This is followed by no religion which accounts for 26.7% of the total population.</p> <p>CRHTT/Sec 136 Data (2013): With 60% 'null' it is not possible to draw any meaningful conclusions.</p>

Sexual Orientation	<p>Gloucestershire: Estimates used by the Government Treasury, & quoted by Stonewall, suggest around 5-7% of the population aged 16 years + are Lesbian, Gay or Bisexual. This would mean somewhere between 24,700 & 34,600 people in Gloucestershire are Lesbian, Gay or Bisexual. However, a more recent estimate from the ONS Integrated Household Survey suggests that nationally Lesbian, Gay & Bisexuals represent 1.5% of people aged 16 over, 7400 in Gloucestershire. These groups have repeatedly demonstrated higher levels of health risk behaviours, such as smoking & drug & alcohol use, as well as higher levels of self-harm.</p> <p>I understand from the GCC Equalities Manager & a Public Health Manager that the issues around higher levels of self harm are reflected locally.</p>
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Other information

<p>GCC Performance & Needs Group were involved in the development of this statement & provided data on population statistics based on the 2011 Census. The document 'Gloucestershire Equality Profile 2014' shows the make up of the population in Gloucestershire & its districts, broken down by each of the nine characteristics. The data is stronger on characteristics such as age, gender, race which were collected before the introduction of the Equality Act, but weaker on characteristics such as pregnancy, & maternity, gender re-assignment. This data is formatted in red.</p> <p>The Gloucestershire Joint Strategic Needs Assessment (JSNA) is rather light information on mental health crisis & it has been agreed it should be bolstered including data on mental health crisis. Data for mental health emergency hospital admissions shows 134.39 per 100,000 population compared with 137.00 for the South West & 216.93 for England.</p> <p>2gether NHSFT provided information on the CRHTT (demographics of staffing & service user data), the in-patient unit & the local health based Sec 136 Place of Safety (POS) the Maxwell Suite at Wotton Lawn Gloucester. This was for the period Jan 01 – December 312013. This data was aggregated across all three CRHTTs, plus the Sec 136 POS which is staffed by the CRHTT. This data was disaggregated for some protected characteristic groups. The Sec 136 research referred to by Laidlaw, Pugh et al was published in <i>Medicine, Science & the Law</i> 2010; 50, 29-33 under the title '<i>The use of Sec 136 (MHA 1983) in Gloucestershire</i>'.</p>

Data from the Maxwell Suite is for the period February 2009 – January 2013. In addition the police provided data on people taken to police station POS & detainees who transfer to the Maxwell Suite.

IMHA data was available for the 6 months 01.10.13 – 31.03.14.

Locally in terms of the experience of the local black & minority ethnic community Haroon Kadodia (GCC Deputy Team Manager) & Zain Patel (2gether NHSFT) were interviewed as part of the general interview process. Two of the interview questions specifically focussed on whether the Pathway excluded any groups & whether any group was reaching crisis at a disproportionate ate. These comments are formatted in **blue**. Paul Kenyon Principal Traveller Services Officer at GCC was contacted re the experience of travellers & Gill Oxley Community & Equalities Manager GCC raised the issue as part of a meeting with the transgender community on 28.04.14. Information was also sought from the Director of Public Health on gender re-assignment. The 'Trans Mental Health & Emotional Well Being Study 2012' (partnership report instigated by the Scottish Transgender Alliance) was obtained through the former link.

The **CQC annual report** 'Monitoring the MHA in 2012/13' provides data on ethnicity, but only in relation to in-patients.

Finally, the following **national organisations** were invited to provide information to contribute to the assessment:

- Stonewall
- Runnymede Trust
- MIND
- Rethink
- Fawcett Society
- Health & Social Care Information Service (the latter commented that they do not currently collect this data & have agreed to consider doing so in the future).

Workforce data

Please document details of staff only if they will be affected by the proposed activity. This could include GCC staff transferring under TUPE to a new service provider, relocating, employment at risk. **GCC [Workforce diversity reports](#)** are available on our website. The data in **red at the start of each sub-heading** is taken from the Gloucestershire Equality Profile 2014 (GGC) & it is against this data that comparisons are made with the composition of the three Gloucestershire Crisis Resolution & Home Treatment Teams (CRHTT). One interviewee from a lived experience perspective commented that he believed the teams were essentially white middle class & not reflective of the make up of the community. However the **CORE** review of the Gloucester Team stated that '*The CRHTT broadly reflects the demographics of the local population*'.

If the proposed activity does not affect staff, please state 'Not affected below'.

<p>Total number of staff affected</p>	<p>At this stage in the review there is no direct impact on the staff of the three CRHTTs. For this reason a commentary is only made in relation to how reflective the Teams are of the composition of their local communities. Data is aggregated for in-patient and CRHTTs. This will need to be revisited if at any stage during the review & subsequent implementation of the Action Plan there is a direct impact on staff.</p>
<p>Age</p>	<p>Gloucestershire: 22.8% are aged 0-19 years, 57.8% aged 20-64 & 19.4% aged 65 years & older. The proportion of people aged 65+ exceeds the national average. <i>22.8% are aged 0-19 years, 57.8% aged 20-64 & 19.4% aged 65 years & older. The proportion of people aged 65+ exceeds the national average.</i> 83% of I/P/CRHTT are aged between 25 – 54 years of age. The age profile differs between the 3 Teams with West Glos having the highest proportion of both 25-34 & 55 – 64 year olds.</p>
<p>Disability</p>	<p>Gloucestershire: 16.7% of Gloucestershire residents reported having a long term limiting health problem, which was below the national average. Dementia is one of the major causes of disability along with learning disability. Estimates suggests 8,667 people aged 65+ are living with dementia in Glos & 2,563 people aged 65+ with a learning disability. 78% have no disability, but 18% undefined.</p>
<p>Sex</p>	<p>Gloucestershire: The overall gender split in Gloucestershire is slightly skewed towards females, with males making up 49.0% of the population & females account for 51.0%. For people aged 85+ females accounting for 67.3% of the total population.</p>

	72% female. The figure for Cotswolds & Vale is only 59%.
Race (including Gypsy & Traveller)	<p>Gloucestershire: 95.4% of Gloucestershire's population is white. Black or Ethnic Minorities make up the remaining 4.6% of the population, which is considerably lower than the 14.6% reported for England as a whole. Asian/Asian British account for the largest proportion of Black or Ethnic Minorities in Gloucestershire, following the national trend. Gloucester has the highest proportion of people from a Black or Ethnic Minority, at 10.9% of the total population.</p> <p>81% are White British (note 4% 'not stated'). Broken down by CRHTT the figure is 87% White British in Chelt & Tewk, 92% White British in West Glos & 100% in the Cotswolds & Vale.</p>
Gender reassignment	<p>Gloucestershire: Gender reassignment is defined by the Equality Act 2010 as a person proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning their sex by changing physiological or other attributes of sex. Estimates of gender reassignment suggest between 0.6% & 1% of the UK's adult population have undergone gender reassignment.</p> <p>No local data available.</p>
Marriage & civil partnership	<p>Gloucestershire: 30.5% are single, 50.2% are married & 0.3% are in a registered same-sex civil partnership. Gloucestershire has a lower proportion of people who are single or separated when compared to the national average. In contrast the proportion of people who are married, divorced or widowed exceeds the national average.</p> <p>41% are married & 28% single.</p>
Pregnancy & maternity	<p>Gloucestershire: There were 6,880 live births in Gloucestershire in 2012. The largest number of live births was among the 25-34 year old age group, continuing the trend of later motherhood.</p> <p>No local data available.</p>
Religion or Belief	<p>Gloucestershire: According to the 2011 Census, 63.5% of residents in Gloucestershire are Christian, making it the most common religion. This is followed by no religion which accounts for 26.7% of the total population. 39% Christian & 8% Atheist.</p>

Sexual Orientation	<p>Gloucestershire: Estimates used by the Government Treasury, & quoted by Stonewall, suggest around 5-7% of the population aged 16 years + Lesbian, Gay or Bisexual. This would mean somewhere between 24,700 & 34,600 people in Gloucestershire are Lesbian, Gay or Bisexual. However, a more recent estimate from the ONS Integrated Household Survey suggests that nationally Lesbian, Gay & Bisexuals represent 1.5% of people aged 16 over, 7400 in Gloucestershire. These groups have repeatedly demonstrated higher levels of health risk behaviours, such as smoking & drug & alcohol use, as well as higher levels of self-harm.</p> <p>63% heterosexual & 1.39% gay, but 21% undefined.</p>

Consultation & engagement

List all types of consultation that has taken place during the development of this activity. Include on-line consultations, events, meetings with stakeholders, community events, employee consultation exercises etc

Service users	<p>The Review methodology has included extensive interviews (currently 45) with all stakeholders who contribute to the Mental Health Crisis Pathway including people with lived experience of mental health crisis, carers & staff from statutory & non-statutory organisations. The co-chair of the Task & Finish Group has lived experience of mental health crisis.</p>
Workforce	<p>The Review methodology has included extensive interviews with all stakeholders who work within the Mental Health Crisis Pathway.</p>
Partners	<p>The Review methodology has included extensive interviews with all key partners from both statutory & non-statutory organisations.</p>
External providers of services	<p>There are no significant external providers of services within the mental health crisis pathway.</p>

Equality analysis: Summary of what the evidence shows & how has it been used

This section will allow you to outline how the evidence has been used to show ‘due regard’ to the three aims of the general equality duty. It is important that this consideration is thorough & based on sufficient information. Consideration should be relevant & proportionate.

- Eliminate discrimination
- Advance equality of opportunity
- Promote good relations.

Protected group	Challenge or opportunity considered & what we did This section will be subject of continuous review. Noted the Cheltenham CR/HT didn't meet CORE criteria 4.2 namely that the team 'monitor quality & experience received by people from equality target groups'.
Age(A)	<p>✚ The current structure of CRHTT largely excludes younger people & older people with dementia. In relation to Sec 136 only a minority have been at either end of the age spectrum although this should be constantly monitored. There is a major issue around suitable placements for young people aged 17 years & under who need in-patient treatment with 10 having to be admitted to adult wards last year, an NHS 'Never Event'. This will be addressed as part of the local Continuous Improvement Action Plan.</p>
Disability (D)	<p>✚ Evidence people with dual disabilities do not have their mental health needs met people with learning disabilities (LD) struggle to access the service. More emphasis needed on making '<i>reasonable adjustments</i>' to the service.</p>
Sex (S)	<p>✚ Men are slightly over represented in Sec 136 data, although there is significant over representation of women in parts of the service & particularly women subject to repeat Sec 136 detentions. The reasons for this need to be explored. Within the CRHTT women are slightly over represented at 56%.</p>
Race (including Gypsy & Traveller)(R)	<p>✚ Mixed data quality makes drawing definitive conclusions difficult – data available in different categories & for different periods of time, no common cross agency approach to data collection. Cheltenham didn't meet criteria 4.2 of the HTAS review namely that the</p>

	<p>team <i>'monitor quality & experience received by people from equality target groups'</i>.</p> <ul style="list-style-type: none"> ✚ A mixed picture about representation within crisis services. Most data points towards under-representation within CRHTT particularly from the Chinese & Asian community. It is noted that late referrals can exacerbate crisis as can inappropriate pathways. The experience of racism is likely to make people distrustful & reluctant to seek help at the appropriate time. The over representation of people from the BME community detained under Sec 136 in other parts of the country particularly is to a very small degree reflected in Gloucestershire = 5.7% against 4.6% for the County as a whole. However data for police POS for the same period was only 4.5%. There is minor under representation in the White community & Asian/Asian British. ✚ IMHA access to BME patients on Wards slightly under-represented. ✚ There was a strong view from some BME professionals/managers that CRHTT are not as accessible and culturally sensitive as they could be. The CORE review stated that <i>'The CRT was not able to demonstrate at least one active attempt during the last 12 mths relevant to the local population to make the CRT service more appropriate for a minority group'</i>. ✚ The CRHTT have a higher proportion of BME staff than the community as a whole but representation is unevenly distributed. ✚ BME groups make up 5.2% of in-patient wards & white British 81.7% representing a slight over-representation of BME groups & under representation of the white community.
<p>Gender reassignment (GR)</p>	<ul style="list-style-type: none"> ✚ Anecdotal evidence this group have significant mental health issues & are at a higher risk of mental breakdown because of discrimination & stigma. Implication of need for increased awareness of this risk status amongst health professionals in order to respond in a timely fashion.
<p>Marriage & civil partnership (MCP)</p>	<ul style="list-style-type: none"> ✚ The number of people subject to Sec 136 who are married is very low (0.6%) although the 'null' figure was very high (33%). This could indicate a lack of support & means to access to

	services enjoyed by people with stronger family/friend networks.
Pregnancy & maternity (PM)	✚ No data available.
Religion &/or Belief (RAOB)	✚ No meaningful patient data evidence available.
Sexual Orientation(SO)	✚ Nationally there are issues as identified on page 8 but it is unclear whether these are replicated locally.

Strengthening actions: Planning for further improvements

Please outline here what actions are required for further improvements to address challenges or opportunities, for example:

- Arrangements for continued/new engagement with stakeholders, staff, service users
- Plans to close data gaps across any of the protected characteristics through reviewed contract management arrangements
- Identify other plans already underway to address the challenges or opportunities identified in this statement
- Share findings with partner organisations.

If none, state 'none' below.

Action Plan

Action	Who is accountable	Time frame
Data: 1. Commence data collection on 'Protected Characteristics' not	2gether NHSFT & Gloucestershire Police	October 2014. On-going

<p>currently collated.</p> <p>1.2 Review quality of existing data.</p> <p>1.3 Improve collection of qualitative data around experience of patients from BME community.</p>	<p>“</p> <p>2gether NHSFT</p>	<p>“</p> <p>“</p>
<p>2. IMHA contract monitoring meetings to focus on Protected Characteristic Groups with a specific focus on the in-patient community.</p>	<p>Outcomes Manager, Mental Health</p>	<p>6 monthly</p>
<p>3. CCP to develop interface with CRHTT & explore with users of the Teams if they see a need for an IMHA in this context.</p>	<p>IMHA Lead Manager, CCP & Outcomes Manager, Mental Health</p>	<p>October 2014</p>
<p>4. Implement Mind guidance on commissioning crisis care services for BME communities; i) consult & engage with BME groups early on when commissioning services ii) ensure staff are delivering person-centred care that takes cultural needs into account iii) commission a range of services & iv) empower people from BME groups by providing appropriate information, access to advocacy services etc</p>	<p>Lead Commissioner Mental Health</p>	<p>October 2014</p>
<p>5. All partners to give more consideration to making <i>'reasonable adjustments'</i> to enable people who may be marginalised to articulate what they want?</p>	<p>All partners to the local Declaration</p>	<p>December 2014 & on-going</p>
<p>6. 2gether CRHTTs & other specialists teams to engage with their local BME communities through developing their outreach capacity e.g. visit local Mosques, invite local IMANs into the CRHTT etc</p>	<p>CRHTTs</p>	<p>December 2014 & on-going</p>

7. Development of the cultural competency of CRHTT staff at a clinical level through a rolling programme of training.	2gether/partner agencies	2015
8. Development of the Sheffield 'Crisis Support Centre' model http://www.nursingtimes.net/Journals/2012/08/17/g/i/i/080101DevBME.pdf within the Gloucester Friendship Cafe, base for networking with specialist Mental Health services.	2gether Social Inclusion Staff	2015
9. Partner agency staff, particularly GPs aware of vulnerability & needs of people from transgender community.	All partners	October 2014
10. Update the Joint Strategic Needs Assessment (JSNA) to include more information on mental health & specifically data on mental health crisis.	Eddie Parsons Senior Research Analyst & Joe Green Senior Data Analyst, Strategy & Challenge Group, GCC	Dec 2014

Monitoring & Review

Please indicate what processes/actions will be put in place to keep this 'activity' under review. For example will progress be monitored/ reported to a board, scrutiny committee, project board etc

This Statement will be initially considered by the Mental Health Crisis Task & Finish Group whose joint chair is the Clinical Lead for the CCG. The findings in the Statement will inform the Continuous Action Improvement Plan & all reports based on the latter. This will be circulated to the relevant Governance Groups of all partners to the local Mental Health Crisis Declaration.

Sign off & Scrutiny

By signing this statement off as complete you are confirming that 'you' have examined sufficient information across all the protected groups & used that information to show due regard to the three aims of the general duty. This has informed the development of the activity

Senior level sign off: Chairs of Mental Health Task & Finish Group	Date:
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I am in agreement that sufficient information & analysis has been used to inform the development of this 'activity' & that any proposed improvement actions are appropriate & I confirm that I as the decision maker have been able to show due regard to the needs set out in section 149 of the Equality Act 2010.

Name of relevant CCG Board Member:	
Signed by Portfolio Holder/Cabinet Member:	Date:

Publication

This statement accompanies the Mental Health Crisis Declaration & Continuous Improvement Action Plan & is published on the CCG website alongside partner websites.

Appendix 4 – Key informant interview schedule

General questions:

1. What works well in terms of the Glos response to people with SMI in crisis?
2. What gets in the way of effective working?
3. What policies/procedures/protocols/guidelines/care pathways do you use in these situations?
4. What would you most like to change/3 wishes?
5. What would be a quick win to improve the response people in mental health crisis receive in Gloucestershire?

A. Access to support before crisis point

6. What information is available about your service for people in mental health crisis for the public, patients & professionals and what format is this information in?
7. What do you believe are the criteria for CRHTT engagement?
8. Do you differentiate between a MHA assessment and a general mental health assessment? Do you know how to go instigating these assessments?
9. Do you feel the mental health pathways excludes any groups ?who ?

B. Urgent and emergency access to crisis care

10. Are you clear about the Mental Health crisis care pathway; who to contact, how and in what situations?
11. Do you have any evidence that any particular group or section of society is reaching crisis point at a disproportionate rate?
12. Do you believe anything further could be done to prevent people's distress escalating into crisis?

C. Quality of treatment and care when in crisis

13. What do you see as the role and responsibility of your organisation in the mental health crisis pathway?
14. What are your expectations of partner agencies (Police/ AMHPS, CRHTT/LASWs/Social Care/ SWASFT, Turning Point/Probation/GHNHSFT/Primary Care/Samaritans)?

D. Recovery and staying well / preventing future crises

15. Do you believe anything further should be done to help people stay well after a crisis & prevent future crisis?

16. What do you believe people with a serious mental illness want in a crisis?

Training/partnerships/performance management

17. What training/workforce development is available/can your staff access? Is there any particular training you would like to see developed?

18. What opportunities do you have for partnership working e.g. regular multi-agency meetings, service development opportunities with partners, input into service evaluation of partner services?

19. Do you have any views on what would be suitable performance indicators for this care pathway both for your own organisation and partner organisations?

D A Pugh

13.02.14.

Appendix 5 – Evidence Sources for Effective Practice in Mental Health Crisis

1. Commissioning to allow earlier intervention and responsive crisis services:

A commissioner's guide to Primary care mental health, July 2014

<http://www.slcsn.nhs.uk/scn/mental-health/london-mh-scn-primary-care-commiss-072014.pdf>

Alcohol Concern - Alcohol Harm Map, Gloucestershire:

<http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map>

Atlas of Variation: Identifying unwarranted variation across mental health and wellbeing indicators in England, July 2014:

<http://www.rightcare.nhs.uk/index.php/2014/07/identifying-unwarranted-variation-across-mental-health-and-wellbeing-indicators-in-England/>

Chief Medical Officer (CMO) annual report: Public Mental Health, September 9, 2014.

<https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health>

DH 'Closing the Gap: Priorities for essential change in mental health' (national action plan) published 20.1.14 (see Ch. 15 re : MH Crises):

<https://www.gov.uk/government/publications/mental-health-priorities-for-change>

ENOUGH IS ENOUGH - A report on child protection and mental health services for children and young people, June 2014:

<http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/enough.pdf>

Hansard (Mental health beds/How many declarations in place?), 29 July 2014

<http://www.publications.parliament.uk/pa/ld201415/ldhansrd/text/140729-0001.htm>

Health Select Committee are interested in crisis and CAMHS (which is a theme in the local interviews):

<http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cmh-2014/>

Mental health care severely underfunded, 25 July 2014:

<http://rt.com/uk/175524-mental-health-nhs-funding/>

Press: Mental health patients forced to travel miles for care, 6 May 2014:

<http://www.bbc.co.uk/news/uk-27285555>

Range of media follow up Guardian/Community Care, 24 February 2014:

http://www.communitycare.co.uk/2014/02/24/need-innovate-reduce-pressure-mental-health-teams-nhs-england-qa/#.Uw3Nm_I_t0o?cmpid=NLC|SCSC|SCNEW-2014-0226/R5Live/other

MH Crisis Concordat published on 18.02.14:

<https://www.gov.uk/government/news/better-care-for-mental-health-crisis/END>
<https://www.gov.uk/government/publications/mental-health-crisis-care-agreement>

Mind's election manifesto:

<http://www.mind.org.uk/media/958931/Mind-Manifesto-Jun14-FINAL-Amend-lo-res-v2.pdf>

National Concordat website now open:

www.crisiscareconcordat.org.uk

NHS England : Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report 10 July 2014 (Numerous references re: Crisis Responses):

<http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

NHSE intention for five year strategy, 15 August 2014:

<https://www.england.nhs.uk/2014/08/15/5yfv/>

Mental Health Cop support for Concordat, 22 February 2014:

<http://mentalhealthcop.wordpress.com/2014/02/22/crisis-care-concordat/>

Ministerial messages for reference:

<http://youtu.be/SJi19QMUJQc>

<https://www.dropbox.com/s/vqyh4bbekt1xpay/Norman%20Lamb%20Crisis%20Concordat%202nd%20July.m4v>

Letter from DH Director General to Concordat signatories (see PDF).

<http://www.local.gov.uk/documents/10180/12137/Progress+report+NHS+England++DH+Winterbourne+View+Concordat++Programme+of+Action/8a32b5a8-8b58-4f53-b167-541d2aa80d8e>

2. Access to support before crisis point:

European Code of Practice for Telehealth Services:

www.telehealthcode.eu

New website launched to help people to devise their own mental health strategy.

(Note potential fit with Cambridge 'SUN' app), July 2014:

<http://www.mentalhealthtoday.co.uk/new-website-launched-to-help-people-to-devise-their-own-mental-health-strategy.aspx> or <http://www.wheelofwellbeing.org/Support>
Tool Update: MH/Physical health, 2014 update:
<http://www.rcpsych.ac.uk/pdf/Lester%20update%20June%202014%20FINAL.pdf>

3. Urgent and emergency access to crisis care:

Bristol CCG investment, July 2014:

<https://www.bristolccg.nhs.uk/news/innovative-mental-health-sanctuary-open-bristol/>

NHS National Institute for Health Research (NIHR): mixed-methods study exploring therapeutic relationships and their association with service user satisfaction in acute psychiatric wards and crisis residential alternatives, July 2014:

http://www.journalslibrary.nihr.ac.uk/_data/assets/pdf_file/0004/122737/FullReport-hsdr02220.pdf

NHS Protect re : Lone workers, Summer 2014:

http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/20140724_loneworker_newsletter_edit.pdf

4. Quality of treatment and care when in crisis:

BBC report on increasing number of under-18s with MH problems being treated in adult psychiatric wards, February 2014:

www.bbc.co.uk/news/education-26255533

Stronger Code: Better Care Consultation on proposed changes to the Code of Practice: Mental Health Act 1983, July 2014 - Consultation will end: 12 September 2014:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/327653/Doh_Consultation_for_web.pdf

BMA publication : Recognising the importance of physical health in mental health and intellectual disability, May 2014:

<http://bma.org.uk/working-for-change/doctors-in-the-nhs/mental-health-parity-report>

CQC doc: Monitoring the MHA 2013/14, published (Ch 5 Access to care during mental health and MHA crises and CQC commitment to Concordat):

http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.

CQC launch MH Crisis themed review with call for people's experience of MH crisis (19.02.14):

<http://www.cqc.org.uk/content/tell-us-your-experience-mental-health-crisis-care>

CQC report on the inspection of hospital services for children and young people (mental health reference page 40), 4 August 2014:

<http://www.networks.nhs.uk/networks/news/getting-inspections-right-for-children-and-young-people>

Crisis Resolution Teams – how are they performing? (Mental Health Today, May/June 2014):

http://www.mentalhealthtoday.co.uk/crisis_resolution_teams_how_are_they_performing_2576813430.aspx

West of England Academic Health Science Network: Patient Safety:

<http://www.weahsn.net/our-work/patient-safety/>

5. Recovery and staying well / preventing future crises:

Joseph Rowntree Foundation: Can a Neighbourhood Approach To Loneliness Contribute To People's Well-Being? July 2014:

<http://www.jrf.org.uk/publications/loneliness-evaluation>

H&SCIC Reports summary, 20 May 2014:

<http://www.hscic.gov.uk/catalogue/PUB14125>

Linked HES-MHMDS Date Report (July 2014):

<http://www.hscic.gov.uk/catalogue/PUB14392>

Manchester fire service (MH and fires – one third of fire fatalities known to Mental Health Trust):

<http://www.firebrake.org/uploads/attachments/paula.pdf>

Mental health patients are at their highest risk of dying by suicide in the first two weeks after leaving hospital, 16 July 2014:

http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/report_press_release_2014.pdf

National confidential inquiry into suicide and homicide by people with mental illness: annual report 2014 – England, Northern Ireland, Scotland and Wales, 16 July 2014:

<http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/>

NOTE : Numerous additional references are posted on the Mental Health Crisis

Concordat website, alongside examples of positive practice :
www.crisiscareconcordat.org.uk

Jim Symington
David Pugh
10.09.14

Agenda Item 10

Governing Body

Governing Body Meeting Date	Thursday 25th September 2014
Title	Our open culture: a strategy for engagement and experience
Executive Summary	<p>This Strategy describes ‘Our Open Culture’ Framework setting out three guiding principles and three methods of delivery.</p> <p>The Strategy promotes ‘Equality’ and working in ‘Partnership’ and the desire to enable ‘Anyone and Everyone’ to have a voice. To achieve this we must provide ‘Information and good Communication’, focus on ‘Experience’ feedback and undertake good ‘Engagement and Consultation’.</p> <p>This Strategy’s aim is to ensure that the CCG: achieves the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual’s experience of care is a driver for quality and service improvement.</p>
Key Issues	<p>Gloucestershire Clinical Commissioning Group wants to ensure that ‘quiet voices’ are heard and that we are recognised as ‘commissioners on the ground’. This Strategy describes how using a simple Framework, underpinned by three enabling principles and three methods of delivery, we achieve this.</p>
Risk Issues: Original Risk Residual Risk	

Financial Impact	
Legal Issues (including NHS Constitution)	This strategy address the CCG's requirement to meets its legal duty to involve the public in the commissioning process as set out in the NHS Act 2006, amended in the Health and Social Care Act 2012 and the NHS Constitution 2010.
Impact on Health Inequalities	Not acceptable to say Yes or No. This must be described in more detail and an Equality Impact Assessment completed.
Impact on Equality and Diversity	An Equality Impact Analysis has been completed on this Strategy. This can be found at Appendix 10.
Impact on Sustainable Development	
Patient and Public Involvement	This Strategy sets out our approach to engagement and experience.
Recommendation	Paper for information and approval.
Author	Becky Parish
Designation	Associate Director Engagement and Experience
Sponsoring Director (if not author)	Marion Andrews-Evans Executive Nurse and Quality Lead

Governing Body

25th September 2014

**Our open culture:
a strategy for engagement and experience**

1 Introduction

- 1.1 This Strategy describes 'Our Open Culture' Framework setting out three guiding principles and three methods of delivery.

The Strategy promotes 'Equality' and working in 'Partnership' and the desire to enable 'Anyone and Everyone' to have a voice. To achieve this we must provide 'Information and good Communication', focus on 'Experience' feedback and undertake good 'Engagement and Consultation'.

- 1.2 This Strategy's aim is to ensure that the CCG: achieves the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual's experience of care is a driver for quality and service improvement.

2 Recommendation(s)

- 2.1 This Paper is for information and approval.

3 Appendices

Appendix 1a: Other GCCG Strategies, policies, guidance and procedure documents which should be read in conjunction with the Strategy (a-z)

Appendix 1b: GCCG's Mission, Values and Aims as set out in our Constitution (revised version 2014)

Appendix 2a: Recommended content to be included in the next version of the GCCG Constitution 2014)

Appendix 2b: Recommended additional content to be included in the next version of the GCCG Procurement Strategy

Appendix 3: Our Shared Vision (2014)

Appendix 4: Legislation and Policy

Appendix 5: How can we hear what the experience of care feels like?

Appendix 6: Who are our strategic partners?

Appendix 7: Which key resources have influenced our thinking?

Appendix 8: Is there is a business case for engagement?

Appendix 9: What are the governance and accountability arrangements to ensure we achieve good engagement and experience?

Appendix 10: Equality Impact Analysis

Appendix 11: Feedback summary (consultation on draft Engagement and Experience Strategy August/September 2014)

**We want to hear the ‘quiet voices’ and be
‘commissioners on the ground’.**

Dr Helen Miller, Clinical Chair and Mary Hutton, Accountable Officer



Our open culture: a strategy for engagement and experience

Introduction to us and our open culture

The NHS is one of the most recognised brands in the world. Belief in the NHS and its principles remains high among the population of the UK.

Gloucestershire Clinical Commissioning Group (the CCG) wants to play its part in maintaining the NHS' reputation locally.

To do this we believe that our culture must be open so that our decisions are informed by feedback from you.

We want to: *'ensure effective communication and engagement with patients, carers, community partners, the public and clinicians'* and be *'accountable and transparent in our decision making'*.

The CCG inherited a 10 year Engagement Strategy from its predecessor, NHS Gloucestershire Primary Care Trust. 'Our open culture' Strategy has been developed during the first year of the CCG's operation in response to what we have learned. As the culture of our organisation has evolved, so too has our approach to engagement and experience.

How should we address you?

We do not want to 'label' people, as we believe this is disempowering. People are first and foremost individuals. Some of the time they might be patients or service users, but for the majority of people, for most of the time, they are not.

As an NHS organisation it is difficult to avoid the use of the word 'patient'. Often when we use the word patient we mean anyone who experiences care, but we want this Strategy to encompass not only patients receiving treatment today or tomorrow but their carers, family members, friends, staff, volunteers, in fact anyone who has an experience of the local health and care system.

In response to your feedback, we are going to address **'you'**.

Feedback from you

You have told us that they would prefer us to be honest and clear about the limitations of the potential for your feedback to influence our decisions and to explain the practical limitations facing us too, such as finite resources and national directives. On a practical note,

you have said that you want to know how you will be involved and we have provided an example later to illustrate this.

You want us to share the challenges and opportunities facing the local health and care community openly with you, so that more local people obtain a greater understanding of why change is often necessary and how change has been part of the evolution of the NHS since its establishment in 1948.

Finally, we all know that some conversations about healthcare will be easy, others will not. Our aim is to create shared knowledge, understanding and agreement and, where this is not possible, we will lead open local debate, designed to inform and reach the most appropriate solutions to support the delivery of our Mission Statement, which 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 patient experience.

‘Our Open Culture’

Our Clinical Chair and Accountable Officer have said that we want to ensure that ‘quiet voices’ are heard and that we are recognised as ‘commissioners on the ground’. This Strategy describes how using a simple Framework, underpinned by three enabling principles and three methods of delivery, we achieve this.

‘Our Open Culture’ Framework promotes ‘**Equality**’ and working in ‘**Partnership**’ and the desire to enable ‘**Anyone and Everyone**’ to have a voice. To achieve this we provide ‘**Information and good Communication**’, focus on ‘**Experience**’ feedback and undertake good ‘**Engagement and Consultation**’.

This Strategy’s aim is to ensure that the CCG: *achieves the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual’s experience of care is a driver for quality and service improvement.*¹

Who is this Strategy for?

To achieve this Strategy’s aim we have an organisational objective to ensure that ‘*engagement and experience*’ is a crucial infrastructure function of the CCG’s core business across all constituent parts.

¹ Often ‘Patient Experience’ is referred to in the context of performance measures, such as 18 week referral to treatment (RTT). This Strategy does not focus on quantitative performance monitoring. The approach we set out focusses on the qualitative experience of the individuals rather than the quantitative measures. We recognise both are important.

The CCG has created an Engagement and Experience Team, which is our infrastructure. The Team: *Acts as a catalyst for change within the CCG, promoting through its actions, the adoption of an organisational culture which values working with patients, carers and the public to inform decision making* and *Promotes the rights and responsibilities set out in the NHS Constitution within the CCG and the wider community*.

The Engagement and Experience Team members are crucial to the successful delivery of this Strategy. It is through their skills and experience, and their influence and involvement with other CCG staff that we demonstrate 'Our open culture.' This Strategy informs their work.

However, ultimately the target audience for this strategy is you – the people who live and work in Gloucestershire. This includes the majority of our own GP Members and staff, as well as staff and volunteers providing health and care services in the county.

Not everyone will notice the impact of our engagement and experience activities but our aim is that the services you experience have benefitted from them.

Legal requirements

There are several 'must dos' in the field of engagement and experience. These are set out in national legislation and guidance. The key requirements and mechanisms we must work with are described within three key pieces of legislation: Health and Social Care Act 2012, The Equality Act 2010 and The NHS Constitution 2010. Details of these requirements can be found at Appendix 4. Delivering this Strategy ensures the CCG meets these legal responsibilities.

Our first year

From April 2013, NHS Gloucestershire Clinical Commissioning Group took on responsibility for commissioning (buying) local NHS services, such as emergency care services, operations or treatments that can be planned in advance and mental health services. These services are provided by a range of 'provider' healthcare organisations, such as NHS Trusts. We have a Governing Body, seven localities and we are a membership organisation (all local GP practices are Members).

It is vital that the CCG's corporate strategies and approaches are underpinned by values and aims, which are declared openly and, more importantly, are demonstrated in our behaviours and actions. In our first year of operation we have developed the following key strategic documents and approaches, all of which inform our organisational culture.

'Joining up your care': Our commissioning strategy (2 and 5 years) 'Joining up your care' and our one year commissioning intentions were informed by a comprehensive community engagement exercise earlier in 2014. It used individual case studies to describe how local services, statutory, community and voluntary services, can, and are, starting to focus in a joined up way on the individual at the centre of the community, within which health and care services are a component part.

'Our Shared Vision': We instigated and led discussions with key partners to develop a shared vision for Gloucestershire: *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.* A full copy of 'Our Shared Vision' can be found at Appendix 3.

Clinical Programme Approach: Experiences of care and feedback from engagement are an integral part of our Clinical Programme Approach. This includes: project planning, locality priority setting and procurement activities.

'Our Journey for Quality': Patient experience and staff satisfaction are key components of 'Our Journey for Quality 2014 -19', our Quality Strategy. Key amongst the objectives it identifies are:

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

Experience-led commissioning: we will develop a range of patient experience information to be used to influence the commissioning cycle and to inform the redesign of healthcare services using CQUINs (Clinical Quality Indicators) and the NHS contract.

Experiences of care and feedback from engagement

Your voices are heard, alongside those of clinicians and managers, when we are planning, developing, procuring, evaluating and monitoring services. We aim to be clear about what you can and cannot influence, explain where there is scope for local decision making, or where we must follow actions mandated by others.

We bring our knowledge of your care to look at how services are planned and how your journey through care can be improved. Combining this clinical knowledge with your first-hand insights and those of communities in Gloucestershire, provides a unique collaboration. We believe that the combination of this local clinical knowledge, together with the knowledge you have regarding your own experiences, and communities have about their particular circumstances, will lead to evidence and experience based commissioning and design of services.

We have learned that investing the time and effort in building strong and sustainable relationships and engaging in open conversations can avoid surprises, builds trust, confidence and credibility and engenders mutual respect. This provides firm foundations for the development of better future services.

Ensuring that we hear from as many people and communities in Gloucestershire as possible, requires us to understand that the way we seek your feedback and views influences who gets involved. The design of our experience and engagement processes addresses this.

In our first year we have been establishing relationships with our partners; from individuals who experience care and the staff who deliver it, to those who represent us all in Parliament and local councils and with local communities who have specific needs and interests. The purpose is simple: improving local services together and your experiences of care.

It is clear that the leadership and involvement of clinicians in conversations with you is recognised by others, as well as ourselves, as having the potential to make a significant contribution to open debate with local population and something we should build upon.

Shared Expectations

We have a legal duty to make arrangements to ensure you are involved in the commissioning decisions we make. Maintaining and building upon the approach set out in this Strategy will facilitate an informed, ongoing dialogue with you, which is both reactive and proactive.

For us engagement consists of three levels of engagement, which describe a continuum from activities associated with responding to an individual's experience of care through to

formal public consultation. Our approach recognises that some individual's engagement with us will not extend beyond the receipt of treatment and care, but for others it will be an important element of their lives. We respect the fact that each individual's wish to be involved will depend on their own circumstances, which may change at any time.

We have a range of opportunities for involvement in place, which are responsive to individuals' changing circumstances. These recognise the differences in circumstances between particular individuals and groups and we tailor our approach accordingly.

This Strategy is underpinned by an on-line resource to support experience and engagement activities. Key resources include: *'The Engagement Cycle'*, *'The Excellence Framework for Patient Experience'* and *'Transforming Participation in Health and Care: The NHS belongs to us all'*.

Being responsive to the feedback we receive is important, not just in terms of reporting the outcome of engagement, but also in being clear how any changes we wish to take forward are evaluated and how outcomes will be shared and monitored.

Our open culture approach expands the opportunities for working with partners in communities to help us to hear, in the words of our Clinical Chair, Dr Helen Miller, the *'quiet voices'*.

We value the relationship developing between ourselves and those who experience the care we commission on their behalf - the Gloucestershire population. We want, in the words of our Accountable Officer, Mary Hutton, to be *'commissioners on the ground.'*

'Our open culture' – Our Framework for delivering this Strategy

This Strategy is supported by 'Our open culture' Framework, which describes three guiding principles and three methods of delivery.

Principles: Three enabling principles support the delivery of this Strategy (a, b, c)

a) Equality

We want to ensure that we hear from all people and communities living and working in Gloucestershire. We understand that the way we seek people's feedback and views influences who gets involved; so our experience and engagement processes are designed with this in mind – it's a cliché, but one size does not fit all. We use Equality Impact Analysis (EIA) to inform our thinking and activities and equality monitoring to assess the representativeness of the feedback and views we receive. Where there are gaps we adapt and make new plans to address them. We acknowledge the crucial benefit of working with partners in other agencies and across the voluntary and community sector to achieve this.

Our legal duty to be compliant with the Equality Act 2010 is set out in 'Legal Responsibilities' at Appendix 4. However, our commitment is not only to our legal duties. We are committed to having open and honest conversations, which we believe will help to build strong relationships with communities, with 'protected'² groups and within 'communities of interest and place' (These are defined in Appendix 5).

b) Partnership

We want to develop our partnerships across the county, from encouraging people to become partners in their own care, to working with communities and with strategic partners such as district councils, to promote healthy lifestyles. The CCG has good working relationships within the third sector locally, in particular with Healthwatch Gloucestershire and the Gloucestershire Voluntary and Community Sector (VCS) Alliance. We will continue to build upon these in future. Details of our strategic partners are set out in Appendix 6.

To work in partnership is more challenging for some than others. This may be as a consequence of skills, resources, capacity, inclination or confidence. We seek to establish mutual trust with partners, established and new. We believe this can be done through a common commitment to the future of the health and care in this area. We are realistic, we know that mutual trust takes time to build and can be damaged quickly without practicing openness and transparency.

c) Anyone and Everyone - you

You are 'Anyone and Everyone'. Anyone and everyone is any individual who lives or works in Gloucestershire. Sometimes you might also be someone who lives or works close to Gloucestershire, or who comes into the county to access services.

To support wider engagement, we want to ensure that you, if you wish to participate, it is your choice, can be individually or collectively involved in the decisions that are made by us.

We continue to build upon existing mechanisms for engagement and establish new ones, which allow everyone who has a stake in healthcare services to have the opportunity to have a voice. This can range from the information we publish, to the activities we invite you to take part in. We can't force you to participate, but we can make getting involved more valued as a meaningful option for greater numbers of people locally. We can do this by the manner in which we make it possible for you to participate and the recognition involvement provides to you. The CCG is developing a Reward and Recognition Policy, which will detail this approach. We wish to achieve parity in this area with our other NHS partners in county and will be pursuing joint working on this later this year.

² The following characteristics are protected characteristics: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation
<http://www.legislation.gov.uk/ukpga/2010/15/section/4>

Methods of delivery: There are three levels of activity which support the delivery of this Strategy (d,e,f).

d) Information and Communication

How we inform and communicate with people are the first two building blocks for good engagement. You should feel that you get the right information, in the right way, at the right place and the right time for you. We communicate clearly developments in local services using a range of media, often using case studies to illustrate how new services will be delivered. We recently received positive feedback on the use of animations during the 'Joining up you Care' engagement, which brought to life new care pathways.

We are fortunate to have access to a mobile resource, The Information Bus, which is used to bring information to all areas of the county and is a valuable mobile venue for engagement and a visible presence in the community

We are increasingly using new media, regularly tweeting and updating our Facebook page. We have increasing numbers of 'followers'. Our website is a valuable communications tool, which we use to provide information and as a platform for online surveys.

We aim to improve 'health literacy' amongst the population of Gloucestershire. Health Literacy is the level of knowledge and understanding you have about how to prevent ill health or to be involved in decisions and actions affecting your health. Actions which increase healthy literacy, such as providing information and training, enable you to make informed choices about your lifestyle and, when you need to, to know which support or services to access. Increased health literacy supports people with long term conditions to participate more in decisions about their treatment and care, sharing control with their clinicians.

e) Experience (of care)

Patient experience is a core component of quality in the NHS, identified as one of three quality areas or 'domains' (Safety, Experience, Clinical Effectiveness). Our role is to ensure care is safe; ensure care is effective and ensure individuals have the most positive experience possible. We do this through contract setting and monitoring, by considering information in Care Quality Commission³ reports, audits, incidents and serious incidents notifications, NICE standards, professional body standards, complaints, surveys (staff and

³ The Care Quality Commission's (CQC) role is to check whether hospitals, care homes, GPs, dentists and services in your home are meeting national standards. The CQC does this by inspecting services and publishing its findings, helping people to make choices about the care they receive.

patient and public), service reviews, Healthwatch feedback, NHS England Area Team, NHS Choices website, and the Friends and Family Test.

In the context of this Strategy, 'experience' is what the process of care feels like for you.

Experience can be defined as feedback from individuals about: *'what actually happened in the course of receiving care or treatment, both objective facts and their subjective views of it'* (Dr Foster, The Intelligent Board 2010). Although an individual may have received appropriate clinically effective interventions along a care pathway, if these have not been delivered on time, in poor clinical environments, or not communicated in a clear manner, the individual may view this as a disappointing experience.

We receive experience feedback in many ways, for instance through our Experience Team (PALS and Complaints) or via our providers. We also collect feedback on our Information Bus. Healthwatch Gloucestershire prepares quarterly reports setting out comments received. Appendix 5 sets out in more details ways in which we hear about your experiences.

The experience feedback we collect helps us to understand how you feel about the services we commission, what we may need to consider changing and signals areas for improvement. Often suggestions are put forward by carers and family members or friends who sometimes have a different view of what an experience has been like than the individual receiving care. We also hear from those who deliver services, the staff and, often volunteers, within communities. The feedback we receive is used to build an evidence base to inform future commissioning intentions, service changes, procurements (when required) and the monitoring of existing services. Our Experience Team analyses the experience information gathered, providing relevant data to support the work of CCG groups or projects as required.

f) Engagement and Consultation

Engagement can be defined as the active participation of the public, patients, including children and young people, carers and community representatives, in the development of health services. Engagement gives you a say in how services are planned, commissioned (purchased/procured), delivered and reviewed. It is important to recognise who we involve through our engagement activity and we are keen to ensure that we provide opportunities for individual, group and collective engagement.

More formal engagement, for instance with the a Local Authority Health and Care Overview and Scrutiny Committee (HCOSC) and the wider general public, relating to proposals for a 'substantial development' of the health service in the area, or a 'substantial variation' in the provision of services, such as a changing where a service is provided from, is referred to as 'consultation'.

We facilitate engagement in many ways including: hosting public events, drop-ins, stakeholder workshops and presentations and targeted focus groups. We commission community volunteer activities, undertake telephone structured interviews and skype debates, we also frequently attend partner events, produce on-line and freepost surveys and we are exploring opportunities to use social media more, we plan to initiate more 'twitter' discussions.

The accompanying online guidance to support the delivery of this strategy provides links to a range of tried and tested experience and engagement techniques. This is a 'living' resource, frequently refreshed to take account of new ways of thinking in relation to engagement and experience work.

'Our open culture' – how we know this Strategy is working

You asked us to show how our approach works on practices. To test this, below is an example of how we might engage or consult you and how your experiences inform our decision making and our commissioning of services. In the example below, you can see how 'Our open culture' Framework principles and methods are applied in practice.

It is necessary to refer to the Appendices as groups and terminology referred to in the example are explained in full there.

We use the 'Engagement Cycle' to drive our decision making process so that the individuals who experiences care and the communities they belong to have a voice at every stage. 'The Engagement Cycle' is explained in detail in the supporting on-line resources, in short it helps commissioning organisations, such as ours, to identify opportunities for engagement with you.

Example: developing a different service for people with asthma.

The example below illustrates where there are opportunities for engagement and for your experiences to influence at all stages of 'The Engagement Cycle'.

Note: Not all changes to services require procurement, not all procurements include changes to services and not all service changes require wider public consultation. It depends on the significance of the variation from the existing service. Unfortunately, the degree of 'significance' required to trigger a consultation is not defined in the legislation. However, we work closely with HCOSC and Healthwatch Gloucestershire to reach a decision about this locally when required.

Analysis and planning

Working with you to identify needs and aspirations for asthma services in Gloucestershire

We think, based on what we know about current services, that asthma services might need to change. What information do we base this on?

Gathering 'Experience' information

Methods used might include:

- Checking the Joint Strategic Needs Assessment (JSNA⁴) current data about asthma rates in the county. Checking whether there are any health inequalities identified.
- Identifying particular communities or groups who experience current services: such as British Lung Foundation Breath Easy Support Groups and asking them: What is working well? What could be improved? What innovations could be introduced? What are the limitations?
- Checking feedback about asthma services received via PALS contacts, complaints and Healthwatch Gloucestershire.
- Reviewing the feedback from NHS Choices, relevant survey results.
- Requesting information about current asthma services from partners: this includes our Member GP practices, hospitals and social care providers; The local authority; Health and Care Overview and Scrutiny Committee; Health and Wellbeing Board; other statutory partners, such as councils, housing agencies, schools, emergency services and criminal justice agencies; the community and voluntary sector and local employers.
- Checking for new national or local guidance which needs to be taken into account.

If there is sufficient information gathered to suggest that changes could be made to improve the quality or efficiency of the service, a Project is established.

Working with you to Plan changes to the current local asthma services

A project group is set up to oversee the development of proposals for change, their

⁴ Joint Strategic Needs Assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas.

procurement (if required), implementation and evaluation and monitoring.

The project group includes lay representation, usually one of our Lay Workers or a Healthwatch Gloucestershire representative or both, working alongside commissioners from the CCG and clinical providers of the service from hospitals and the community. Where voluntary sector providers are also involved in the services, they are invited to join the project group. Consideration is given to confidentiality, if appropriate, confidentiality agreements are signed. This usually applies if there are commercial sensitivities or any possible changes to a service are likely to be considered controversial, which means the timing of announcements requires careful coordination.

Depending on the scope of the project, a dedicated Lay Reference Group is established, usually chaired by a CCG Lay Worker and supported by a member of the CCG Engagement and Experience Team. Membership of a Lay Reference Group is decided by creating a stakeholder map of individuals and local groups most appropriate to inform the project. Once again, consideration is given to confidentiality, and if appropriate, confidentiality agreements would be signed by members of the Lay Reference Group.

Identifying gaps in the information we have

The Lay Reference Group can help to identify gaps in information and identify what targeted work is needed to fill the gaps.

- Checking to make sure we have information from those most affected i.e. people with asthma, their carers and families, and those likely to be at risk of developing asthma. If we don't have this carry out targeted engagement activities. Examples include:
 - Attending events, making presentations and having question and answer sessions, holding workshops or focus groups, carrying out telephone surveys.
- Checking to make sure we have feedback from across Gloucestershire and that 'quiet voices' have been heard.
 - Targeting activities e.g. visiting key local employers to talk to employees who don't access health services on a regular basis. Working with school nurses and pupils to record their experiences.

A Lay Reference Group supports the project through to evaluation and monitoring of the changed service.

Designing pathways

Working with you to improve quality and safety of asthma services

It is important to plan new services with you and to retain this focus through to procurement and monitoring, so that contracts reflect what you say you want.

Methods we use might use to design pathways include:

- Developing Patient Stories illustrating an individual's current experiences and identifying learning to inform the changed services. If you have asthma you could be invited to share your story.
- Hosting Experience Based Design events – with clinicians and Lay Reference Group

Members working together at the same time to redesign the services you need.

- Facilitating Focus groups with targeted groups.

Any proposals developed through the process above for medium to large scale change are presented to members of the NHS Reference Group (representatives from Gloucestershire County Council's Health and Care Overview and Scrutiny Committee [HCOSC] and Healthwatch) at the earliest opportunity for their comments.

If a major service change is proposed, a Clinical Senate may also be involved, being invited to review a proposal against the clinical evidence base.

Up to this point the activity is called '**Engagement**'.

If the change proposal is considered to be 'significant', then it requires '**Consultation**' with the public, which usually last for twelve weeks.

The project group then further develops the proposal, which is tested with the public during a period of consultation.

Information is produced and made available via the traditional media, social media, our website, via partners' networks, the Information Bus and drop-in events. An on-line survey might be produced to collect feedback in a structured way, with the same survey questions included in any printed information produced. Surveys provide the opportunity to collect demographic information, completion of this is always optional. Freepost is always available and information about access information in other formats is always included. Where targeted engagement is needed to ensure the 'quiet voices' are heard, this is arranged, often this involves working directly with communities and using their networks.

At the end of the consultation period, an Outcome of Consultation Report is prepared, and proposals are amended in response as appropriate. The HCOSC is required to consider whether the consultation has been adequate in relation to content or time allowed. If it is not considered to have been adequate, further consultation may be required or the proposal may be referred by HCOSC to the Gloucestershire County Council Full Council for consideration for referral to the Secretary of State.

If we have engaged and consulted with the public as described here, such a situation should not arise and the implementation goes ahead (with any recommendations from HCOSC, such as requirements to report on progress of the changes after a period of time).

Communication materials to promote the changed service are then produced and tested with the Lay Reference Group before making available to the wider public.

Specifying and procuring services

We take the learning from service design and pathway improvement work above to set outcomes for service delivery. This learning is used when designing contracts. When designing a new contract or specification, an existing Lay Reference Group might be

involved or a new one may be established. This group always includes representation from Healthwatch Gloucestershire.

Lay Reference Groups provide insight to inform:

- what engagement activities providers should undertake
- what experience data providers should be collecting
- how they should be reporting it
- how they can take action in response to that data.

Lay Reference Groups are involved in procurement processes in the development of specifications, evaluation of bids and as attendees at procurement panel presentations.

There is clarity about lay representation on panels; the role, terms of reference, confidentiality matters and any support and training required is agreed and provided.

The wider public are informed, holding briefing events to share information about proposals being developed and we provide updates to HCOSC and at our Governing Body Meetings in public. *Commercially sensitive material cannot be presented in the public domain.

Delivering, improving and evaluating services

The design of services and contracts will already have been informed by experience and engagement or consultation.

Contracts include clauses which describe:

- the engagement activities providers should undertake
- the patient experience data they should be collecting, how they should be reporting it and how they can take action in response to that data.

Our contracts (which specify outcomes and quality) are followed up by systematic methods to gather and use this data about patient experience in order to monitor and performance manage providers.

We work with Healthwatch Gloucestershire to ensure that data they have collected is incorporated into our monitoring processes.

Where there are concerns about a service, we work with the provider to agree action plans for improvement, which are monitored and reported at meetings in public.

What does delivering this Strategy achieve?

Following 'Our open culture' approach ensures that:

- 'quiet voices' are heard
- we are an open organisation, which is flexible in its approach to change and is willing to share power i.e. open to influences on decision making.
- the views of local people are sought in a variety of ways, tailored and adapted to the needs of individuals who experience care and to local communities.
- the needs and the views of the population of Gloucestershire inform the decisions of the CCG throughout the stages of the commissioning cycle using the 'Engagement Cycle'.
- that where there are health inequalities in Gloucestershire we tailor our approach to experience and engagement to support their reduction.
- we have mutually beneficial trusting relationships with individuals, groups, 'anyone and everyone' and our strategic partners.
- 'health literacy', shared decision making and co-production are increased.
- our Member GP practices are more involved.
- levels of understanding of the challenges facing the NHS locally amongst Gloucestershire's residents are increased.
- the NHS's reputation locally is maintained.
- the CCG meets its legal duty to involve the public in the commissioning process as set out in the NHS Act 2006, amended in the Health and Social Care Act 2012 and the NHS Constitution 2010.
- opportunities are available for all to be engaged, either directly or indirectly, if they choose to be, and these are promoted.
- we are delivering our statutory and good practice obligations under the Equalities Act 2010, endeavouring to work with a wide cross-section of the people who use or may use NHS funded services locally.
- we are being '*commissioners on the ground*'.

Action Plan

An action plan has been developed to support the delivery of this Strategy. The objectives and actions correspond to actions set out in *Our Journey to Quality, Implementation Plan* as well as the CCG's Engagement and Experience Team objectives. This Action Plan will be regularly reviewed and progress reported to the CCG Integrated Governance and Quality Committee.

Supporting documents

This Strategy is supported by an online Engagement and Experience Resource divided into four key areas: Relevant legislation, Practical resources to support engagement and experience activities, Useful links and NHS Complaints Handling. This online resource will be refreshed regularly as required. The online Engagement and Experience Resource can be found at: <http://www.gloucestershireccg.nhs.uk/feedback/gccg-engagement-and-experience-strategy/>

There are also extensive appendices supporting this Strategy:

Appendix 1a: Other GCCG Strategies, policies, guidance and procedure documents which should be read in conjunction with the Strategy (a-z)

Appendix 1b: GCCG's Mission, Values and Aims as set out in our Constitution (revised version 2014)

Appendix 2a: Recommended content to be included in the next version of the GCCG Constitution 2014)

Appendix 2b: Recommended additional content to be included in the next version of the GCCG Procurement Strategy

Appendix 3: Our Shared Vision (2014)

Appendix 4: Legislation and Policy

Appendix 5: How can we hear what the experience of care feels like?

Appendix 6: Who are our strategic partners?

Appendix 7: Which key resources have influenced our thinking?

Appendix 8: Is there is a business case for engagement?

Appendix 9: What are the governance and accountability arrangements to ensure we achieve good engagement and experience?

Appendix 10: Equality Impact Analysis

Appendix 11: Feedback summary (consultation on draft Engagement and Experience Strategy August/September 2014)

Co-design – How have local people shaped this Strategy?

This Strategy has been informed by feedback received regarding engagement activities undertaken during our first year. In particular the 'Joining up your care' – 5 year commissioning strategy engagement exercise. The CCG also took part in and NHS England Ipsos MORI 360 degree feedback survey, which provided partners with the opportunity to comment on our first year of operation as a commissioning organisation. We have also provided Evaluation Forms at our engagement events.

A four week consultation, from 14 August to 11 September 2014, provided an opportunity for comment on the original draft of this Strategy and its Action Plan. This final version of the Strategy has benefitted greatly from your feedback in terms of content, structure and length.

To discuss receiving this information in large print or Braille please ring 0800 0151 548.

To discuss receiving this information in other formats please contact:

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如需以其他格式接收此信息，请联系

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FREEPOST RRYY-KSGT-AGBR,

PALS, NHS Gloucestershire Clinical Commissioning Group, Sanger House,
5220 Valiant Court, Gloucester Business Park Gloucester GL3 4FE

How will this Strategy be kept up to date?

This Strategy will be reviewed and refreshed on an annual basis and updated as required in response to local feedback and to meet any new legal requirements and duties and national and local guidance.



A strategy for engagement and experience

Produced by Gloucestershire Clinical Commissioning Group

September 2014

Appendices



Appendix 1a

Other GCCG Strategies, policies, guidance and procedure documents which should be read in conjunction with the Strategy (a-z)⁵

Complaints Policy (4Cs Policy under review August 2014)

Equality and Diversity Strategy

Joining up your Care 2014-2019

Our Journey for Quality 2014 -19

Appendix 1b

GCCG's Mission, Values and Aims as set out in our Constitution (revised version 2014)

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. The Group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

Values and Aims

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.

⁵ This is not an exhaustive list. GCCG Strategies can be found on the GCCG website at: <http://www.gloucestershireccg.nhs.uk>

Recommended content to be included in the next version of the GCCG Constitution

GCCG approach to engagement and experience

'Ensuring effective communication and engagement with patients, carers, community partners, the public and clinicians' and *'accountable and transparent in our decision making'* are two of the stated values and aims of Gloucestershire Clinical Commissioning Group (GCCG). Ours is a culture which values the relationship between GCCG and those who experience the care we commission on their behalf. The population of Gloucestershire.

The information we hear from people's experience of care and our engagement activities will be used to understand what people are saying and how they feel about the services we commission. This will be recorded and reported and used to inform GCCG decision making.

GCCG will carry out its responsibilities with respect to Experience, Engagement and Equality as set out in legislation: The NHS Act 2006, Health and Social Care Act 2012, Equalities Act 2010 and The NHS Constitution 2010.

GCCG has an Engagement and Experience Strategy supported by an online Engagement and Experience resource.

Health and Social Care Act 2012

The White Paper, 'Equity and Excellence: Liberating the NHS', and subsequent Health and Social Care Act 2012, set out the Coalition Government's plans for the future of the NHS. Built upon the principles of the NHS – a comprehensive service, available to all, free at the point of use, based on need, not ability to pay, the 2012 Act places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution, and awareness of the NHS Constitution. The requirements in the 2012 Act specifically associated with engagement (Section 14Z2) updated the previous Section (s) 242 of the consolidated NHS Act of 2006.

CCGs (and NHS England) general duties under the NHS Act 2006

The NHS Act 2006 (including as amended by the Health and Social Care Act 2012) sets out the range of general duties on clinical commissioning groups and NHS England.

Commissioners' general duties are largely set out at s13C to s13Q and s14P to s14Z2 of the NHS Act 2006, and also s116B of the Local Government and Public Involvement in Health Act 2007.

- Duty to promote the NHS Constitution (13C and 14P)
- Quality (13E and 14R)
- Inequality (13G and 14T)
- Promotion of patient choice (13I and 14V)
- Promotion of integration (13K and 14Z1)

- Public involvement (13Q and 14Z2)
- Innovation (13k and 14X)
- Research (13L and 14Y)
- Obtaining advice (13J and 14 W)
- The duty to have regard to joint strategic needs assessments and joint health and wellbeing strategies (116B of the Local Government and Public Involvement in Health Act 2007)

Commissioners should also ensure they are familiar with s244 of the NHS Act 2006 regarding the duty to consult the relevant local authority in its health scrutiny capacity.

Of particular relevance to engagement and experience is s14Z2 of the 2012 Act, which states that CCGs must involve and consult patients and the public:

- in their planning of commissioning arrangements;
- in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which services are delivered to the individuals or the range of health services available to them; and
- in decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The Act also updates s244 of the consolidated NHS Act 2006, which requires NHS organisations to consult relevant Local Authority Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine 'protected characteristics' are described in the 2010 Act: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations. GCCG has developed an Equality and Diversity Strategy, which details our approach locally and includes guidance regarding the undertaking of Equality Impact Analysis (EIA) to support GCCG activities including engagement and consultation.

The Public Sector Equality Duty requires public bodies such as NHS commissioners to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out their activities. The Equality Duty supports good decision making. It encourages public bodies to understand how different people will be affected by their activities, so policies and services are appropriate and accessible to all and meet different people's needs.

The NHS Constitution 2010

The NHS Constitution was established in law in section 1 of the Health Act in 2009 and came into force in January 2010. The NHS Constitution places statutory duties on NHS bodies and

sets out a number of patient rights, which are a legal entitlement protected by law. It also sets out individual personal responsibilities. One of the rights relevant to engagement is the right to be involved directly or through representatives:

- in the planning of healthcare services;
- the development and consideration of proposals for changes in the way those services are provided; and
- in the decisions to be made affecting the operation of those services.

The Engagement Cycle

The Engagement Cycle a key component of the GCCG online Engagement and Experience resource. The Engagement Cycle (Copyright © 2013 InHealth Associates. All rights reserved) is highlighted in NHS England's guide to involving patients and carers in decisions relating to their care and treatment and the public in commissioning processes and decisions: *'Transforming Participation in Health and Care' 2013* is also included in our online resource.

The Engagement Cycle is a tried and tested, practical resource, used by dozens of Clinical Commissioning Groups to plan, design and deliver services for, and with, local people, supporting public participation in the commissioning cycle.

Our approach locally is to take the commissioning cycle and overlay it with the Engagement Cycle to support public engagement to drive our decision making process.



The Engagement Cycle:

- Serves as the foundation for an engagement culture – where working with patients, carers and the public becomes part of everyday behaviours, and effective relationships between professionals and patients is the norm
- Provides the basis for developing sustainable systems and processes in order to turn engagement into everyday practice
- Sets out what is required when engaging patients, carers and the public at each stage of the commissioning process
- Supports the development of effective engagement strategies and plans that embed engagement in decision-making – ensuring that 'nothing about us without us' is more than rhetoric

- Outlines, who needs to do what at each stage of the commissioning cycle, to ensure meaningful engagement for maximum impact

Recommended additional content to be included in the next version of the GCCG Procurement Strategy

Include recommended wording at Appendix 2a above plus the following:

Engagement

Of particular reference to the Procurement Strategy is Stage 4 of the Engagement Cycle 'specify and procure'. <http://engagementcycle.org/working-patients-public-procure-services/>

Commissioners should take the learning from service design and pathway improvement work to set standards and outcomes for service delivery. This learning can be used within contracts and service level agreements.

Contracts should specify what engagement activities providers should undertake

- what patient experience data providers should be collecting
- how they should be reporting it
- how they can take action in response to that data.

If patients, carers and the public are engaged in the procurement process it can lead to traditional commissioning procedures being 'opened up' and injected with intelligence that comes straight from patients.

Involve people in different aspects of procurement

People can be involved in ensuring that patients and the public inform the development of tenders and identify providers who better meet the needs of patients, scanning for innovation and identifying potential providers, participating in decision-making panels and making resource decisions.

The benefits include increasing public confidence in, and better relationships with, providers of services. It also paves the way to improved monitoring and performance management, particularly if patients are also part of those monitoring processes.

Use what you already know

Ensure evidence of what matters to patients derived from service redesign work is part of standards, outcome indicators and specifications within contracts.

Identify social innovation

Engage patients and the public in identifying providers who can deliver innovative solutions (e.g. voluntary sector, social entrepreneurs, social enterprises):

- Consider creative methods in procurement decisions.
- Consider participatory budgeting approaches that allow enhanced public decision making over resources.

Build capacity for people to be involved

Engage and support patients and public in procurement processes – in developing tenders and as part of procurement panels:

- Make sure there is clarity about patient representation on panels – their role, terms of reference and support and training.
- Keep the wider public informed. Hold briefing events so that the wider public find out what is going on and about proposals being developed.

Our Shared Vision (2014)

Our Shared Vision

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

Our Shared 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.

* 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.

This vision is illustrated in the following diagram:



We have agreed a set of shared 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 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.

Legislation and Policy

Health and Social Care Act 2012

<https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets>

The White Paper, 'Equity and Excellence: Liberating the NHS', and subsequent Health and Social Care Act 2012, set out the Coalition Government's plans for the future of the NHS. Built upon the principles of the NHS – a comprehensive service, available to all, free at the point of use, based on need, not ability to pay, the 2012 Act places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution, and awareness of the NHS Constitution. The requirements in the 2012 Act specifically associated with engagement updated the previous Section 242 of the consolidated NHS Act of 2006.

CCGs (and NHS England) general duties under the NHS Act 2006

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Commissioners' general duties are largely set out at sections 13C to 13Q and 14P to 14Z2 of the NHS Act 2006, and also section 116B of the Local Government and Public Involvement in Health Act 2007.

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- The duty to have regard to joint strategic needs assessments and joint health and wellbeing strategies (116B of the Local Government and Public Involvement in Health Act 2007)

Commissioners should also ensure they are familiar with s244 of the NHS Act 2006 regarding the duty to consult the relevant local authority in is health scrutiny capacity.

Of particular relevance to this Strategy, Section 14Z2 of the 2012 Act states that CCGs must involve and consult patients and the public:

- in their planning of commissioning arrangements;
- in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which services are delivered to the individuals or the range of health services available to them; and
- in decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Local Authority Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

The Act also establishes Healthwatch England and local Health Watch organisations. It sets out the role and powers of Healthwatch England and local Healthwatch organisations. For detail visit:

<http://www.legislation.gov.uk/ukpga/2012/7/part/5/chapter/1/crossheading/local-healthwatch-organisations/enacted>

The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine ‘protected characteristics’ are described in the 2010 Act: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance ‘Equality of Opportunity’, and c) foster good relations. GCCG has developed an Equality and Diversity Strategy, which details our approach locally and includes guidance regarding the undertaking of Equality Impact Analysis (EIA) to support GCCG activities including engagement and consultation.

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- in the planning of healthcare services;
- the development and consideration of proposals for changes in the way those services are provided; and
- in the decisions to be made affecting the operation of those services.

The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012

<http://www.legislation.gov.uk/uksi/2012/3094/contents/made>

PART 6 LOCAL HEALTHWATCH

Welsh Border protocol, 2013

<http://www.england.nhs.uk/wp-content/uploads/2013/03/england-wales-protocol.pdf>

Clinical Senate Review Process (*from 1 September 2014*)

<http://www.swsenate.org.uk/wp/wp-content/uploads/2014/07/Clinical-Senate-Single-Operating-Framework-2014-15v3-July2014.pdf>

<http://www.swsenate.org.uk/wp/wp-content/uploads/2014/07/Clinical-Senate-review-process-guidance-note-final-July2014.pdf>

What does Clinical Senate Review mean?

NHS England has a role to support and assure the development of proposals for service change by commissioners via the NHS England Assurance Process. One step in this process is to review major service change proposals against the clinical evidence base for it – it is this role that NCAT delivered previously and which Senates will now take on.

There are other elements of service change which are reviewed (patient engagement, patient choice, quality benefits, fit with best practice etc.). Clinical Senates will only be involved in the review of the clinical evidence base.

What is the expected process?

- Request for clinical review will come from either sponsoring commissioner or local area team of NHS England (with 3 months notice)
- Terms of reference (timescale, scope etc.) for review agreed and signed off by Clinical Senate Council
- Review Team developed (minimum 8 weeks notice)
- Commissioner provides information (options appraisal etc.)
- Review of data, interviews and meetings led by Review Team
- Report written to be signed off by Clinical Senate Council (determining strength of evidence base)

How can we hear what the experience of care feels like?

People's Voices (individual and collective)

We want to hear from as many voices as we can. As well as engaging through our key strategic partners and their extended networks, we want to listen to the views of local people and communities from all walks of life across Gloucestershire. One local resident described it as nurturing a 'mixed market' for engagement and experience.

It is important that we get the basics right for you and provide opportunities for you to be heard, listened to, responded to so that you can be assured that we have learned from your feedback and acted on it appropriately.

Local experience feedback – Reactive

Experience feedback is gathered both proactively and received reactively. Both elements are equally valuable. Proactive activity is described later in this Strategy. Reactive activity is described below.

The CCG Experience Team act as a catalyst for change, echoing the voices of individuals who have provided feedback about their experiences of care to us. The following channels are examples of routes for individuals to provide such feedback:

GCCG Patient Advice and Liaison Service (PALS) and Complaints handling

It is important that we maintain an 'open' door so that the direct experience of people using services commissioned by the CCG can be received and channelled through our Experience Team, which provides a commissioner public-facing experience (PALS and Complaints) service. The experiences these staff hear and raise awareness of within the organisation help them to improve services for the future. The Experience Team provides the following functions:

- 1:1 help with health related enquiries, usually over the telephone;
- help to resolve concerns or problems for people using NHS services;
- accepts compliments for services where experience has been positive and passes these to staff and managers;
- information about the NHS Complaints procedure and how to obtain independent advocacy support;
- handling of GCCG complaints process and, as required coordination of multi-agency complaints responses and reviews of NHS provider complaint investigations;
- liaison with the Public Service Ombudsman regarding referred complaints;

- signposting to Healthwatch Gloucestershire and other organisations as appropriate for information about services available locally;
- recording of all contacts, with outcomes, reporting these to the CCG Integrated Governance and Quality Committee, CCG CPGs, provider Clinical Quality Review Groups and other CCG or partner projects, such as procurement projects, as requested; and finally
- act as an early warning system to identify common problems or trends, reporting these within the organisation for escalation.

Healthwatch Gloucestershire (HWG) – Master Comments

Healthwatch Gloucestershire collects, collates and reports experience feedback to the CCG on a quarterly basis on all aspects of commissioned services (health and social care). All comments collected by Healthwatch Gloucestershire are collated by Healthwatch Gloucestershire on a spreadsheet (Master Comments) and identified by topics such as provider of care, type of care e.g. primary, secondary. This experience intelligence is a valuable source of public feedback, which the CCG regularly refers to in order to inform projects and programmes.

Lay Workers

The CCG is a membership organisation. However, its Members are the GP practices in Gloucestershire, so they cannot be described as ‘lay’. Therefore, to support the Lay Members on the CCG Governing Body, who do not have the capacity to contribute to the discussions at as many CCG groups and projects as they might like, the CCG has a group of CCG Lay Workers. Lay Workers are employed by the CCG to provide lay input into various CCG groups and projects. Lay Workers are local residents, whose experience equips them to present a ‘lay’ perspective.

For instance they chair Appeal Panels for Individual Funding Requests and, of particular relevance here, operate as Lay Champions within CPGs.

Lay Champions

Each CPG has been allocated a ‘Lay Champions’ within the CPG. Healthwatch Gloucestershire has also been invited to be represented on each CPG.

The role of the Lay Champion within CPGs is twofold. Firstly, they, together with all CPG members, receive Patient Experience and Patient and Public Engagement and Consultation feedback data. The role of the Lay Champion in particular is to consider this data and to ensure that this is presented and discussed appropriately during CPG meetings, ensuring the impact of such feedback is maximised. Secondly, as CPGs develop their work plans, Lay Champions are working with the CCG’s Experience and Engagement Teams to establish Lay

Reference Groups and short-life lay working groups to inform CPG activities. Such groups include representation from a range of local groups and individuals.

It is important to note that the role of the CPG Lay Champions is not to 'represent' patients and the public; this is the role of Healthwatch; instead it is to 'present' experience and engagement feedback, ensuring it informs CCG decision making.

To become '*commissioners on the ground*', our CPGs are reviewing the delivery of services through the introduction of 'care pathway walk-about', which will involve our Lay Champions and Healthwatch Gloucestershire.

NHS Choices

NHS Choices provides a web-based platform for the public to share their stories and experiences of healthcare services. Anyone can post an opinion on the website. We routinely search NHS Choices to find out what people are saying about local NHS funded services. There are other web-based feedback mechanisms such as Patient Opinion, currently Gloucestershire Care Services NHS Trust and South West Service NHS Foundation Trust locally subscribe to this service.

National and local surveys

National and local surveys take place across the year, covering acute, community and primary care services. The results of surveys and subsequent action plans are shared by providers with us. The CCG has the facility to develop, publish and analyse our own surveys as required to inform commissioning projects and to support engagement and experience activities.

Friends and Family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. All providers of NHS funded services will be required to implement the FFT by April 2015. National CQuINs are in place relating to the FFT. We believe the real potential of the FFT approach is the opportunity it provides to obtain qualitative feedback at the same time as asking the FFT question.

Patient Stories

We have been developing the concept of using 'patient stories' to promote learning from individuals' experiences of care during 2014. Patient Stories are now regularly presented to CCG Integrated Governance and Quality Committee and CCG Governing Body meetings. To date individuals have been identified to share their stories from cases self-referred to PALS or identified by NHS providers at our request, in order to target feedback regarding specific services commissioned by the CCG. Locally providers are also developing patient stories and

it is our intention to promote joint working to share learning from these experiences of care. We are exploring options for creating a local 'library' of stories.

Involvement in research and audit

The CCG is keen to promote opportunities for individual and communities to become more involved in research and audit activities. We will be working with the South West Academic Health Science Network (AHSNs) in future to achieve this. AHSNs align education, clinical research, informatics, innovation, training and education and healthcare delivery. Their goal is to improve patient and population health outcomes by translating research into practice, and developing and implementing integrated health care services.

Local engagement feedback – Proactive

In order to gather feedback from individuals and groups from all walks of life, proactive targeted engagement is required. Specific methodologies available to the CCG are signposted through the online resource. The Information Bus is a useful mobile resource to raise awareness and seek views from communities across Gloucestershire. Engagement events, discussion groups, surveys and media campaigns are all methodologies frequently employed to seek feedback from local people.

Consideration of equality issues must influence the decisions we reach, such as: how we act as employers, how we develop and review policy, how we design, deliver and evaluate services and how we commission and procure from others. Below are examples of groups with whom we seek to engage, many of whom want to be heard, but also those who traditionally have been referred to as 'seldom heard', 'frequently ignored', 'unheard voices' or more recently 'under-served'.

Communities of interest

A community of interest is a community of people who share a common interest or passion. These communities exchange ideas and thoughts about the given passion, but may know (or care) little about each other outside of their area of interest. Participation in a community of interest can be compelling, entertaining and create a 'sticky' community where people return frequently and remain for extended periods. Frequently, they cannot be easily defined by a particular geographical area.

A community of interest is a gathering of people assembled around a topic of common interest. Its members take part in the community to exchange information, to obtain answers to personal questions or problems, to improve their understanding of a subject, to share common passions.

It is important that the CCG also aims to keep abreast of social movements and seeks opportunities to engage with them under their terms, seeking to establish constructive relationships

Communities of place

A community of place or place-based community is a community of people who are bound together because of where they reside, work, visit or otherwise spend a considerable portion of their time. Such a community can be a neighbourhood, town, workplace, gathering place, public space or any other geographically specific place that a number of people share, have in common or visit frequently.

Particular communities of place important to the CCG are the seven CCG Localities and communities on our 'borders' – Gloucestershire is located within the NHS England Area Team which covers, Bath, Gloucestershire, Swindon and Wiltshire. It is important we engage with people living in bordering counties when we are developing or considering changes to services locally, which due to proximity, are accessed by people from outside Gloucestershire, or vice versa by Gloucestershire residents who may access services out of county. We also border Herefordshire, Oxfordshire, Warwickshire and Worcestershire.

Welsh Border: The CCG Forest of Dean Locality also borders Wales, where NHS services are organised and commissioned under the direction of the Welsh Assembly. We recognise that it must pay particular attention to engaging with residents in this area as their experiences of care can be influenced by the differences in national policies and operational delivery of services between the English and Welsh NHS systems.

Individuals with one or more 'protected characteristics'

Our approach to inclusion of people from all parts of the Gloucestershire community and from all walks of life is to pay due regard to our duties in relation to equality, diversity and human rights. This ensures elimination of discrimination and harassment; advances equality of opportunity and fostering of good relationships with people with relevant protected characteristics.

Quiet and unheard voices

In Gloucestershire there are people and communities who struggle to have a voice, for example people whose first language is not English, those with communication impairments, migrants, travellers and refugees.

Public Health colleagues assist in identifying key populations for whom care could be improved. They can also assist in identifying the voices we are going to find it most difficult to hear.

Working with partners, including those strategic partners identified above, it is crucial we hear these voices. We regularly work with colleagues in Gloucestershire County Council, who already have workers in touch with many groups and also with third sector groups who have good, respectful, contacts across the county, to obtain feedback from individuals and communities.

Experience collected by providers

A challenge for a commissioning organisation is to obtain experience feedback collected by provider organisations. A focus for our discussions with providers through Clinical Quality Review Groups will be how to maximise the sharing of 'experience' data between organisations to influence the design of future services.

Who are our strategic partners?

(A-Z – this is not an exhaustive list and will be refreshed as necessary)

Clinical Senates

Clinical Senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent. They are comprised of a core Clinical Senate Council and a wider Clinical Senate Assembly or Forum. The Clinical Senate Assembly or Forum is a diverse multi-professional forum providing the Council with ready access to experts from a broad range of health and care professions. Membership of the Assembly or Forum will encompass the ‘birth to death’ spectrum of NHS care and will include patient representatives. The Clinical Senate Council is a small multi-professional steering group. This group co-ordinates and manages the Senate’s business. It will maintain a strategic overview across their region and be responsible for the formulation and provision of advice working with the broader Senate Assembly or Forum.

Clinical Senates will now perform the role previously undertaken by the National Clinical Assurance Team (NCAT).

From 1 September 2014 the 12 Clinical Senates across England will take on the role formerly delivered by the National Clinical Assurance Team (NCAT), which ceased to exist as of April 2014. This additional role for Clinical Senates will extend the role of Senate Assembly members, who will be asked both to sit on clinical review panels in the South West and in neighbouring regions where local clinicians cannot be used due to perceived conflicts of interest. Senate Council members will also be asked to sit on Clinical Review panels and the Senate Council will be required to oversee the Terms of Reference for each clinical review that takes place. A brief overview of the process outlined in NHS England Guidance notes at Appendix 4.

District/Borough Councils

The CCG works closely with District and Borough Councils through its seven Localities, seeking opportunities to identify and deliver shared priorities. Of particular relevance in relation to experience and engagement is social prescribing and asset based community design (ABCD⁶).

Gloucestershire County Council (GCC)

⁶ Asset-based community development is a methodology that seeks to uncover and use the strengths within communities as a means for sustainable development.

GCC is not only a strategic partner but also a joint commissioner of many services, such as services for people with learning disabilities and support for Carers.

Gloucestershire County Council hosts and chairs the Health and Wellbeing Board and is a co-signatory to 'Our Shared Vision' and is the recipient of £40m through the Better Care Fund⁷.

GCCG Member practices, Patient Participation Groups and registered populations

As previously stated, Clinical Commissioning Groups are membership organisations. All general practices in Gloucestershire, incorporating the seven Localities, are members of the CCG. Therefore, they are part of our organisation rather than partners. However, we must not forget to seek the engagement of our Member practices and remember that the practices themselves provide an essential route to practice populations through their Patient Participation or Patient Reference Groups.

Gloucestershire Health and Care Overview and Scrutiny Committee

Gloucestershire's Health and Social Care Overview and Scrutiny Committee (HCOSC) has responsibility for the scrutiny of services which look after the health and social care needs of people in Gloucestershire. This includes local NHS organisations, Public Health, Adult Social Care and Children's Social Care. The Committee has a key role to play in ensuring that health and social care providers are providing the most effective and efficient outcomes for the people of Gloucestershire.

Gloucestershire Health and Wellbeing Board

Gloucestershire's Health and Wellbeing Board has a duty to encourage integrated working to improve the health and wellbeing of the population. The CCG Clinical Chair, Dr Helen Miller, is the Vice Chair of the Gloucestershire Health and Wellbeing Board, collaborating alongside other key leaders in public representation – Healthwatch Gloucestershire Chair, public health – Director of Public Health and care systems – Directors of Adult and Children's and Young People's Social Care, to understand the needs of local people and agree priorities. Specifically this Board has responsibility for the oversight of the local Joint Strategic Needs Assessment⁸ and the development and delivery of a local Health and Wellbeing Strategy.

⁷ The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

⁸ Joint Strategic Needs Assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA will

Gloucestershire Voluntary and Community Sector (VCS) Alliance

The Alliance is an independent charitable organisation working to strengthen the voluntary and community sector (VCS) in Gloucestershire. Its aim is to collect and represent the views of the VCS to create a stronger and more proactive sector capable of influencing policy and decision making. The Alliance has been established to act as the independent voice of the VCS in Gloucestershire and to ensure the independent voice of the VCS is heard by commissioners, policy holders and service planners. We have established constructive links with the Alliance, with members involved in projects across CCG Localities; particularly in the emerging activities of social prescribing and asset based community design (ABCD) and capacity building.

Healthwatch England and Healthwatch Gloucestershire

Healthwatch England is the national consumer champion in health and care. It has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. Each local authority area with responsibility for delivering social care is required to have a local Healthwatch.

Healthwatch Gloucestershire is an independent third sector organisation, jointly funded by Gloucestershire County Council and the CCG (for the information and signposting function formally known as The GUIDE Information Service⁹). Local Healthwatch, like Healthwatch England are established in statute through the Health and Social Care Act 2012. The aim of Healthwatch Gloucestershire is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided in their area. The CCG works closely with Healthwatch Gloucestershire, recently signing a Memorandum of Understanding setting out how we will work together. Healthwatch Gloucestershire is a key engagement partner for us, with Healthwatch representatives frequently invited to join CCG led programmes, procurement activities and projects. The CCG sends representatives to attend Healthwatch Gloucestershire Board Meetings in public in order to respond to queries raised and to collect experience feedback.

MPs and other elected representatives

underpin the health and well-being strategies, a proposed new statutory requirement and commissioning plans. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. The NHS and upper-tier local authorities have had a statutory duty to produce an annual JSNA since 2007 in The Local Government and Public Involvement in Health Act.

⁹ The GUIDE Information Service became part of Healthwatch Gloucestershire in 2013/14. The four thousand plus up to date and pro-actively monitored records on the GUIDE database have been transferred to the new Healthwatch 'Find a Service' webpage. All other GUIDE services - telephone, e-mail or postal enquiries - are still available from the former GUIDE staff, who are now part of Healthwatch Gloucestershire

Elected representatives play a pivotal role in ensuring local views and priorities are heard both locally and nationally. We host regular meetings with elected representatives in Gloucestershire and opportunities are provided for their engagement in informing the priority setting and decision making of the CCG.

NHS England

In relation to engagement and experience, we link with NHS England at several levels. Good working relationships have been established with the local NHS England Area Team (NHSE AT), particularly in relation to the implementation of the Friends and Family Test (FFT), engagement regarding the national 'Call to Action', providing a localised primary care PALS for people registered with Gloucestershire GPs and supporting public involvement in local developments within primary care services. We also link with NHS England Specialised Commissioning in terms of involvement in potential changes to specialised services associated with the new specialised commissioning service specifications.

Parish and Town Councils

The CCG works closely with Parish and Town Councils through its seven Localities. All Parish and Town Clerks are included in the CCG's Stakeholder Database and representatives are frequently invited to attend events and contribute to engagement and consultation activities.

Provider organisations

Our relationship with providers of NHS funded services is constructive. Our contracts with providers set out our expectations with regards to patient experience and engagement. Co-designing care pathways and service developments with providers is crucial to ensuring clinical 'buy-in'. Together we maintain our focus on patient experience and good clinical outcomes as key drivers for change. Our Clinical Programme Approach supports this. The feedback providers receive from those who experience the services they provide is a valuable source of information to inform experience based design.

NHS Reference Group

The CCG hosts the NHS Reference Group, which provides a forum for informal and confidential discussions between the CCG, NHS provider organisations and representatives from HCOSC and Healthwatch Gloucestershire, about potential service developments. The NHS Reference Group is chaired by the CCG Clinical Chair and is attended by the Chair of Healthwatch Gloucestershire, both of whom are members of the Gloucestershire Health and Wellbeing Board. The Group supports the maintenance of a productive working relationship between Gloucestershire Health Community and stakeholders and supports the CCG aim to be '*accountable and transparent in our decision making*' – an approach referred to by the NHS Reference Group members as 'no surprises'.

Stakeholder database

The CCG maintains a database of contacts for local individuals and groups identified as having a potential interest in local health and care services. These include Practice/Patient Participation Groups, carers support groups, protected groups and local community and voluntary organisations. This database is used as a source of contacts for our experience and engagement activities. There are other resources within the county, which we frequently refer to in order to access details of groups. These include Healthwatch Gloucestershire's 'Findaservice', Gloucestershire Association for Voluntary and Community Actions' 'Find a Group' and the Gloucestershire Voluntary and Community Sector Alliance website, which provides a Search facility for local voluntary organisations, public organisations and businesses.

Which key resources have influenced our thinking?

(The following are referenced in the online resources to support the delivery of this Strategy)

<http://www.gloucestershireccg.nhs.uk/feedback/gccg-engagement-and-experience-strategy/>

The Francis Report

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC was published on Wednesday 6 February 2013 and made 290 recommendations. This Strategy acknowledges and responds to recommendation 135 of the Francis Report on public accountability and commissioners and their responsibilities for public engagement.

Patients First and Foremost 2013

Patients First and Foremost sets out an initial overarching response on behalf of the health and care system as a whole to the Mid Staffordshire NHS Public Inquiry and the 'Francis Report'. It details key actions to ensure patients are 'the first and foremost consideration of the system, and everyone who works in it and to return the NHS to its core humanitarian values.' It sets out a collective commitment and plan to eradicate harm and to promote excellence. The CCG has reviewed its process for handling complaints (4Cs compliments, comments, concerns and complaints) in response to the Francis recommendations.

Hard Truths: the journey to putting patients first 2014

Hard Truth's is the Government's further response to Robert Francis QC's report on the Mid Staffordshire NHS Foundation Trust public inquiry. 'Hard Truths' Volume 1 explains the changes that have been put in place since the initial response was published, and sets out how the whole health and care system will prioritise and build on this. Volume 2 outlines the responses to each of the 290 recommendations made by the public inquiry.

NICE¹⁰ Quality Standards for Patient Experience in Adult Services 2012

The NICE Quality Standards aim to deliver the best possible experience for people who use NHS services.

Excellence Framework for Patient Experience 2012

This Framework sets out several guiding principles, of particular relevance here are:

¹⁰ NICE: The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. <http://www.nice.org.uk/about>

- Respect for patient-centred values, preferences and expressed needs, including cultural issues, the dignity, privacy and independence of people who experience care; an awareness of quality of life issues; and shared decision making.
- Welcoming the involvement of family and friends, on whom individuals rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers.

The Operating Framework (annual contracting arrangements including CQuINs)¹¹

As part of the annual commissioning cycle, NHS Commissioners are expected to work with providers of NHS funded services to put in place mechanisms for systematically collecting and reacting to feedback from individuals' experience of care. The explicit details of methodologies to be used by providers changes from year-to-year (e.g. real time feedback, Friends and Family Test). CQuINs, both national and locally developed, are used as the mechanism within provider contracts for defining quality requirements.

Transforming Participation in Health and Care 2013

Transforming Participation in Health and Care has been developed by NHS England with a wide range of stakeholders and partners and its purpose is to support commissioners to improve individual and public participation and to understand and respond better to the needs of the communities they serve.

It highlights a range of ways in which NHS commissioners can fulfil their statutory responsibilities and seize the opportunity to deliver personalised and responsive care to all. It includes a wide range of tools, resources and case studies that we have found useful when developing our own responses. The document is in interactive pdf format and is a key component of our on-line resource.

The Engagement Cycle

The Engagement Cycle is another key component of the online resource.

¹¹ The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.



The Engagement Cycle:

- Serves as the foundation for an engagement culture – where working with people who experience care and the public becomes part of everyday behaviours, and effective relationships between professionals and patients is the norm.
- Provides the basis for developing sustainable systems and processes in order to turn engagement into everyday practice.
- Sets out what is required when engaging people, carers and the public at each stage of the commissioning process.
- Supports the development of effective engagement strategies and plans that embed engagement in decision-making – ensuring that ‘nothing about us without us’ is more than rhetoric.
- Outlines, who needs to do what at each stage of the commissioning cycle, to ensure meaningful engagement for maximum impact.

Statutory duty of candour for health and adult social care providers

From October 2014, subject to parliamentary approval, NHS providers will be required to comply with the duty of candour. This means providers must be open and transparent with service users about their care and treatment, including when it goes wrong. The duty is being introduced as part of the fundamental standard requirements for all providers. It will apply to all NHS trusts, foundation trusts and special health authorities from October and the government plans to implement the standards for all other providers by April 2015, subject to parliamentary approval. The CCG will consider processes to be put in place locally from 2015 with our providers during the annual contract discussions.

Excellence Framework for Patient Experience

The excellence framework is a resource for commissioners, trust managers, senior clinicians, providers, policy leads and other senior personnel with a common sense of purpose and a common language with which to discuss patient experience. The articles forming the framework have been written by thought leaders and experts in their fields.

<http://patientexperienceportal.org/>

Is there is a business case for engagement?

Yes. Investment in good engagement makes good sense. The reasons why are set out below:

- Safety – people who experience care are most likely to identify safety failings in services and systems and responding to these issues is essential. We, as commissioners, must expect providers to develop effective processes for identifying and responding to safety issues raised by individuals.
- Pathway redesign – engagement with individuals who experience care is crucial to understanding fully the best way to redesign care pathways to meet their needs. Listening to a wide range of voices will help to ensure a more effective outcome. Seeing their experiences from other people’s perspectives can transform redesign. Once redesign is implemented it’s important to check back with those involved, to make sure the changes have been effective and expected outcomes have been achieved. Closing the loop is important to the CCG and to those we have heard from. Explaining the impact people’s engagement has made respects their contribution and we hope, encourages their future partnership.
- Procurement – using experience and engagement feedback and involving lay representatives in the procurement of services (whether existing or new) ensures the voice of those who experience care informs and influences the design of new specifications, the evaluation of bids and supports our stated value and aim to be *‘accountable and transparent in our decision making’*. At Appendix 2b there is recommended wording to be included in the CCG Procurement Strategy in relation to engagement.
- Problem solving – lay representatives can be very helpful in working through tough ethical choices facing the CCG.
- Decommissioning – we will on occasion have difficult and contentious decisions around decommissioning services. By adopting an approach that involved people and communities from the outset, it is more likely to lead to an acceptable outcome, with the reasons for any decision both recognised and understood. It is important that we manage expectations. We know that we will not be able to please everyone all of the time but we will be open and honest in our decision making and we will explain that it is our responsibility not only to achieve the best outcomes for local people, but also to get the best value out of the pot of money, which in Gloucestershire in 2013/14 was £67.8m, allocated to us by the Department of Health nationally, this equates locally to £1,088 per local resident¹².

¹²Information taken from the CCG’s Annual Review 2013/14. http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2012/12/CCG_Annual-Review_document.pdf

What are the governance and accountability arrangements to ensure we achieve good engagement and experience?

Our Constitution

Throughout the CCG Constitution there is reference to communications and engagement. Future iterations of our Constitution, which can be updated twice a year with the approval of NHS England, will continue to reflect the CCG's developing approach to engagement and experience. At Appendix 2a there is recommended wording to be included in the next version of the CCG Constitution.

What are the lines of accountability for engagement and experience activity?

The CCG has identified a Governing Body Lay Member with responsibility for Engagement and Experience. The CCG Executive Nurse and Quality Lead is the Accountable Director for Engagement and Experience and Equality. The CCG Associate Director, Engagement and Experience takes day-to-day responsibility for the CCG Engagement and Experience functions. The Senior Engagement and Inclusion Manager takes day-to-day responsibility for promoting equality.

Reporting

Updates on experience, engagement and consultation activities, including outcome of engagement and consultation reports, are provided through regular Reports to the CCG Integrated Governance and Quality Committee and CCG Governing Body. These are published on the CCG website and through other public facing CCG communication channels. We will advise those individuals and groups who have provided feedback how their views have informed our decisions by sending information about how to access relevant reports and attend meetings for two-way updates.

CCG Equality Impact Analysis

What's it about?

What is the proposal? What outcomes/benefits are you hoping to achieve?

An open culture: a strategy for engagement and experience sets out a 'Framework for Delivery' underpinned by 'Principles,' , 'experience' and 'engagement' which will enable the CCG to establish, nurture and maintain two-way relationships with individuals, groups, 'anyone and everyone' - the public as citizens - and our strategic partners, ensuring those with the quietest voices are heard.

This Strategy promotes Equality and working in Partnership and the desire to enable 'Anyone and Everyone' to have a voice. It will enable the CCG to achieve its aim to: *achieve the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual's experience of care is a driver for quality and service improvement.* This aim is underpinned by a key operational objective: *to make 'Engagement' a crucial infrastructure function of the CCG's core business across all constituent parts.*

Who's it for?

The Strategy will enable the CCG to achieve its aim to effectively engage with the population and key stakeholders in Gloucestershire and ensure that the individual's experience of care is a driver for quality and service improvement. It will also underpin the work of the Engagement and Experience team, providing the framework to ensure that the CCG discharges its legal duty to involve patients and the public in commissioning decisions.

How will this proposal meet the equality duties?

The Strategy recognises the diversity of the county and the importance of ensuring that consideration of equality issues is made as part of any decision making process. It gives some examples of groups with whom the CCG seek to engage, many of whom want to be heard, but also those who traditionally have been referred to as 'seldom heard', 'frequently ignored' or 'unheard voices'.

The draft Strategy has been promoted to community partners (many of whom represent the communities of interest, communities of place, quiet or unheard voices, or individuals with one or more 'protected

characteristics' identified in the document) and is available on the CCG website, to give people an opportunity to help shape the Strategy, before it is presented for agreement to the CCG Board.

By working within the framework and principles set out in the Strategy we will ensure that we gather feedback from individuals and groups from all walks of life, proactively targeting our engagement where appropriate, to ensure equity of opportunity for patients and the public to influence the development of services and decision making of the CCG. Specific methodologies available to the CCG are signposted through the online resources that support this strategy.

What are the barriers to meeting this potential?

Ensuring that CCG staff access the Strategy and use the framework and principles within it to inform their engagement work. The CCG has dedicated resources to provide an Engagement and Experience team who will work with staff across the CCG to ensure robust engagement is undertaken and tools developed to capture and act on patient experience.

2 Who is using it?

Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?

This is an universal strategy, which has the potential to impact on all Gloucestershire residents, staff and GCCG members.

How can you involve your customers in developing the proposal?

This Strategy has already been informed by constructive feedback received regarding engagement activities undertaken in the first year of the CCG, in particular the Joining up your care – 5 year commissioning strategy engagement exercise, which ran from 2 January to 28 February 2014. The CCG also took part in a NHS England Ipsos MORI 360 degree feedback survey, which provided partners with the opportunity to comment on our first year of operation as a commissioning organisation. We also provide Evaluation Forms at our engagement events, which provide an opportunity for as close to 'real time' feedback as possible on activities undertaken.

The draft Strategy was promoted to all CCG staff and member practices in August 2014, with an invitation to submit feedback by 11 September 2014.

As detailed above, the draft Strategy has also been promoted to community partners (many of whom represent the communities of interest, communities of place, quiet or unheard voices, or individuals with one or more 'protected characteristics' identified in the document) and is available on the CCG website, to give people an opportunity to help shape the Strategy, before it is presented for agreement to the CCG Board.

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)

Given the target audience for this Strategy, we believe our processes are inclusive.

3 Impact

Refer to dimensions of equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation

and if appropriate: financial economic status, homelessness, political view, gypsies & travellers, sex workers, people who misuse drugs & alcohol

Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified?

This Strategy promotes Equality and working in Partnership and the desire to enable 'Anyone and Everyone' to have a voice. Implementation of the Strategy will ensure that there is no adverse impact for any group or individual.

What can be done to change this impact?

No adverse impact.

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for other groups?

Implementation of the Strategy will help to ensure that 'anyone and everyone' in the county has an opportunity to influence the development of services and decision making of the CCG. It will enable the CCG to achieve its aim to: *achieve the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual's experience of care is a driver for quality and service improvement.*

Does further consultation need to be done? How will assumptions made in this Analysis be tested?

Prior to the CCG Governing Body meeting on 25 September 2014, the Strategy will be finalised to incorporate and respond to feedback received from staff, key stakeholders and the wider communities across the county. No further engagement on the strategy is planned at this stage.

An action plan has been developed to support the delivery of this Strategy. The objectives and actions correspond to actions set out in Our Journey to Quality, Implementation Plan as well as CCG Engagement and Experience Team objectives.

The Action Plan has been developed based on a wide range of activity:

- Incorporation of actions from the Implementation Plan of 'Our Journey for Quality 2014 -19'.
- Review of the legacy activities relating to engagement and experience undertaken by the previous organisation NHS Gloucestershire Primary Care Trust.
- Discussions with the CCG's Governing Body.
- Meetings with partners to discuss the appropriate level and type of engagement and experience work required to suit particular situations.
- Review of other key strategic plans such as: Joining up your Care, Our Journey for Quality 2014-19,

Gloucestershire Health and Wellbeing Strategy.

- Reviewing the legal framework for CCGs, notably NHS Act 2006, amended 2010, the NHS Constitution and the Equalities Act 2010 and national guidance on engagement and involvement, in particular ‘Transforming Participation in Health and Care’.
- Listening to feedback from the public and partners.

This Strategy will be reviewed and refreshed on an annual basis and updated as required in response to local feedback and to meet any new legal requirements and duties and national and local guidance.

4 So what?

[Link to business planning process](#)

What changes have you made in the course of this EIA?

None. We have received positive feedback from Healthwatch Gloucestershire regarding the equality aspects of the Strategy.

What will you do now and what will be included in future planning?

Prior to the CCG Governing Body meeting on 25 September 2014, the Strategy will be finalised to incorporate and respond to feedback received from staff, key stakeholders and the wider communities from across the county. The Strategy will be promoted to staff via meetings and CCG Live/What’s New this Week.

When will this be reviewed?

An Equality Impact Assessment will be completed as part of the annual review process for this Strategy.

How will success be measured?

The Strategy sets out a number of outcome measures including:

- Support the CCG in delivering its statutory and good practice obligations under the Equalities Act 2010, endeavouring to work with as wide as possible a cross-section of the people who use or may use NHS funded services locally.

One of the measures of success will be demonstrated via Outcome of Engagement reports, where we would expect to see evidence of inclusive engagement activity for the specific project.

For the record	
Name of person leading this EIA Becky Parish	Date completed 12/09/14
Names of people involved in consideration of impact Becky Parish and Caroline Smith	
Name of director signing EIA Marion Andrews-Evans	Date signed 16/09/2014

Feedback summary

A four week consultation period, from 14 August to 11 September 2014, provided an opportunity for comment on the original draft of this Strategy and its Action Plan. This final version of the Strategy has benefitted greatly from the feedback received in terms of content, structure and length.

Feedback has been received from individuals (members of the public and staff), community representatives and strategic partners.

In total the CCG received 21 items of feedback. Responses have been received from: Healthwatch Gloucestershire, NHS England Area Team, NHS England Specialised Commissioning, Aneurin Bevan Health Board, Gloucestershire County Council, CCG Lay Champions, Parish Councils as well as from individuals.

Feedback received will not be published in full as received as it differs widely in format and length. Extracts from written are not be used as permission has not been sought. Instead themes have been identified under two heading 'general' and 'specific'.

The CCG is very grateful to all who took the time to read the draft Strategy and Action Plan and to visit the online resources. We appreciate your constructive comments which we believe have improved and enhanced this final draft.

The majority of the more general comments received about the content of the draft strategy have been positive; in particular the ambition to listen to the 'quiet voices', work with partners and the desire to be open has been well received. More specific comments identified where improvements could be made to the draft Strategy, particularly in relation to points of clarification, improved structure, reduction in duplication, greater assurance of compliance with requirements and, very importantly the overall length. This meant transferring much of the detail into supporting Appendices.

General themes, with CCG response

Themes from comments/questions received	GCCG response (where possible)
Overall	
Strategy welcomed, provides insight into planned approach to engagement.	
Welcome the changes proposed.	
Using the 'Engagement Cycle' is positive.	
Start again. Significant redrafting required. Not clear what it is. The Action Plan is a list. The Action Plan and Strategy should be better aligned. The two documents are not engaging.	The final version of the Strategy has been changed in response to feedback. The Action Plan will be revised following presentation of the Strategy to the Governing Body in September.
Regarding the timing of the preparation and presentation of the new draft Strategy. Has engagement and experience been a low priority for the CCG up to now? Are the current arrangements for engagement and experience activity appropriate, have they met the CCG's legal responsibilities to date?	<p>The draft Strategy updates a 10 year Strategy prepared for the former NHS commissioning organisation, NHS Gloucestershire Primary Care Trust. The new Strategy has been informed by the first year of operation of the CCG, lessons learned from engagement and experience activities undertaken during that period and feedback we have received.</p> <p>We are not complacent. We are always looking to enhance and extend the ways in which we engage locally and gather the experiences of people who experience care through the services we commission.</p> <p>The County Council's Health and Care Overview and Scrutiny Committee (HCOSC) has the responsibility for scrutinising our activities in this area through their meetings in public. They are required to consider whether consultation on any proposal has been adequate in relation to content or time allowed. The CCG has not been required to repeat or extend any engagement or consultation activity at the request of Gloucestershire HCOSC since its establishment in April 2013.</p>
Who will do anything to improve care and experience?	The CCG's Mission Statement is: <i>to commission excellent and modern health services on behalf of the NHS for</i>

	<i>all people in Gloucestershire through effective clinical leadership with particular focus on patient safety and continuous improvements in patient experience.</i>
The commitment to the 'quiet voices' and 'commissioning on the ground' is well received.	
Identifying 'quiet voices': a creative way to describe how 'seldom heard' groups will be listened to.	
The Strategy is not rhetorical. The Strategy is diplomatic, sincere and reflective.	
It would be helpful to indicate how this document fits with the Strategic direction of the organisation.	A good suggestion, the final draft aligns the Strategy with other key strategies
There seems to be an underlying increasing reliance on the public volunteering their resources (time, knowledge, capacity)	'Joining up your care', our commissioning strategy, places a large emphasis on people and communities becoming partners in their own care.
Good to encourage greater involvement of individuals in their own health.	
Good that the public will be involved in all stages of planning services, procurement and evaluation.	
Is it a Strategy?	
Comprehensive	
Ambitious	
The Strategy has a positive attitude.	
Feedback about the Structure	
The draft is too long and repetitive. Material included, though interesting, does not need to be included in the Strategy. Core messages should be more prominent. Some of the structure and presentation works, elsewhere can be improved. Will there be a summary?	We agree. The revised draft is shorter and re-structured. Some material has been moved to appendices or the online resource. Materials will be produced which will summarise the Strategy and specific materials will be produced to explain how people can provide feedback and get involved.
The layout is clear	
Who is the author of the Strategy?	The author of the Strategy is Gloucestershire Clinical Commissioning Group.
Who is the Strategy for? Who is it addressing, consistency.	The Strategy is for internal and external audiences: Gloucestershire Clinical Commissioning Group staff and GP Members and our Partners and the people who live and work in Gloucestershire.

Long lists make it difficult to read as a narrative.	There are fewer lists in the final version.
Consider using a 'PEST' analysis structure to reorder the Strategy: Political, Economic, Social, Technological. Consider adding: Legal, Environment, Demographic and Regulatory.	The PEST analysis structure is a useful methodology to apply. It has not been possible to realign all elements of what we wanted to include in the final version of the Strategy. However, consideration has been given to Political, Economic, Social, Technological, Legal, Environmental, Demographic and Regulatory matters where possible.
Complex subject matter.	
The front cover could state what the document is more clearly. And add a date.	This is included in the final version.
The resources section is helpful.	
Why does it say it is a draft? How will the final version be updated?	The version distributed for comment was a 'draft'. The final version has been amended in response to feedback. The Strategy will be reviewed annually. The next review date is September 2015.
Feedback on the Strategy's Aims and Objectives	
Refine how the Strategy's aims and objectives are presented.	The final version of the Strategy has been changed in response to feedback.
Aims and Objectives very organisation focussed. Consider patient perspective. e.g. Aim = Ensure individuals experience of care is a driver for quality and service improvement. Objective = Achieve the essential conditions and culture within the organisation to make effective engagement a reality. Spell out what the essential conditions are and how these will be achieved.	The final version of the Strategy has been changed in response to feedback.
There is a clear statement of aims and intentions	
The Outcomes the Strategy are not explicit.	The final version of the Strategy has been changed in response to this feedback.
Say 'why' more than 'how'.	The final version of the Strategy has been changed in response to this feedback.
Say where the impact of engagement and experience is discussed within the organisation and how this will evolve and increase.	The final version of the Strategy has been changed in response to this feedback.
Feedback on the Strategy's approach to Equity	
Explicit reference should be made to young people's voices and experiences and the methods of engagement appropriate to this group.	The final version of the Strategy has been changed in response to this feedback.

Explain the criteria for selecting which methods are used to support engagement and experience activities.	The final version of the Strategy has been changed in response to this feedback.
Equality matters are well handled	
Feedback on the relationship with Strategic Partners	
Parish Councils should be included.	The final version of the Strategy has been changed in response to this feedback.
Parish Councils should consider having health champions.	We will continue to send information to Parish Council Clerks for onward distribution.
Does the Strategy meet the expectations of the Gloucestershire Health and Wellbeing Board in relation to public engagement.	<p>The CCG Clinical Chair, Dr Helen Miller, is the Vice Chair of the Gloucestershire Health and Wellbeing Board. Dr Miller will continue to work proactively with fellow members of the Health and Wellbeing Board to promote best practice in engagement with the public in Gloucestershire.</p> <p>The CCG's predecessor organisation, NHS Gloucestershire Primary Care Trust, co-managed with Gloucestershire County Council, the public consultation 'Fit for the Future' regarding the County's Health and Wellbeing Strategy. That consultation activity brought together 'Let's Talk Health' and 'Let's Talk Care, Support and Services'.</p>
Feedback about Partnership and Community working	
There could be greater recognition of the resources within communities which are available.	The final version of the Strategy has been changed in response to this feedback.
There is good recognition of value of partnership working.	
Local groups have local intelligence. Feeding in as well as feeding back is a collective responsibility.	
Feedback on the proposed review of the Strategy	
Good that the Strategy will be reviewed annually.	
Comments regarding the drafting of the Strategy	
Identification of typographical and grammatical errors or naming inconsistencies.	These have been addressed in the final draft.
Whether to use of the word patient or not. The Strategy states we will not use it, preferring not to label people, but does use it on more than 70 occasions. This needs rethinking as it is not natural	The final version of the Strategy has been changed in response to this feedback. We say 'you'.

language.	
Consider using the word 'Relationships' rather than 'Partnerships'.	The final version of the Strategy has been changed in response to this feedback.
Use plain English. http://www.plainenglish.co.uk	The final version of the Strategy has been changed in response to this feedback.
How will the final version of the Engagement and Experience Strategy be communicated?	The final version of the Strategy will be discussed at the meeting in public of the CCG Governing Body in September 2014. The Strategy will be made available on the CCG website in the 'Feedback' section. This section will also include the following online resources, which will be regularly updated: relevant legislation, practical resources, useful links and NHS complaints handling. Those who have provided comments on the draft will be advised that the final version is available.
Too much jargon and too many acronyms. Expectation that readers will be familiar with terminology used.	The final version of the Strategy has been changed in response to this feedback.
Inconsistency in naming e.g. the CCG, GCCG.	The final version of the Strategy has been changed in response to this feedback.

Feedback on specific contents in the original draft Strategy, with CCG response

Elements in the original draft Strategy	Comments	Response
Foreword		
Summary on a page	<p>This is not a summary of the Strategy, it is a list of the outcomes of delivering the Strategy.</p> <p>Reference to key strategic partners such as Healthwatch Gloucestershire in the summary page should be made.</p>	The final version of the Strategy has been changed in response to this feedback.

	Explain 'health literacy'.	
Who are we?	<p>This is background information.</p> <p>The desire not to 'label' people is welcomed.</p> <p>If you say you won't use the word 'patient', don't use it.</p>	This concept is better described in the final version of the Strategy.
How have we demonstrated an 'open culture' in our first year?	This background information.	
What are this Strategy's aims, objectives, expectations and methods?	<p>The Strategy should say what it is.</p> <p>Objectives: Explanation required of how engagement is an 'infrastructure function'.</p>	The final version of the Strategy has been changed in response to this feedback.
What is the Framework for delivering this Strategy?	<p>Anyone and Everyone: This section should say 'how' people can get involved.</p> <p>Reference to the Healthwatch Master Comments should be revised.</p> <p>Jury service is not a helpful example of engagement.</p>	<p>The final version of the Strategy has been changed in response to this feedback.</p> <p>An example of involvement using the Strategy's Framework in conjunction with the 'Engagement Cycle' is now included.</p>
Who are our strategic partners?	<p>This section should be an Appendix.</p> <p>Reference should be made to the statutory nature of the Healthwatch role.</p> <p>Further explanation of the role of the former role of the GUIDe Information Service required.</p> <p>The Libraries and Information Service of Gloucestershire County Council can be a key partner.</p>	<p>The final version of the Strategy has been changed in response to this feedback.</p> <p>The CCG is pleased to be working with the Library Service to support its 'Health Individuals' work. We recognise that libraries and mobile libraries have good networks across communities.</p>

<p>Which key resources have influenced our thinking?</p>	<p>This section should be an Appendix.</p> <p>Further explanation required regarding the implementation of the Duty of Candour.</p> <p>'Patients First and Foremost' is fundamental to the NHS.</p>	<p>The final version of the Strategy has been changed in response to this feedback.</p>
<p>How can we hear what the experience of care feels like?</p>	<p>This section should be an Appendix.</p> <p>Explain how the services provided by the GCCG Experience Team differ from Healthwatch.</p> <p>Provide information about the response times for PALS and Complaints enquiries.</p> <p>Further clarity required regarding the Lay Champion role and its difference to Healthwatch representation.</p> <p>Explain how 'communities of interest' will be defined and engaged with.</p> <p>The use of Stories allows a personal story to be heard and understood. There is scope to reflect more diversity through stories.</p> <p>It would be worth mentioned the cross border responsibilities between the Health Boards and the CCG, specifically referencing the cross-border protocol between England and Wales in this section.</p>	<p>The final version of the Strategy has been changed in response to this feedback.</p> <p>Communications materials produced to promote the strategy will address these issues.</p>
<p>Is there is a business case for</p>	<p>This section should be an Appendix.</p>	<p>The final version of the Strategy has been changed in response to this</p>

engagement?		feedback.
What are our legal responsibilities?	<p>This section should be an Appendix.</p> <p>The Strategy should say whether its application would mean the CCG is compliant with its legal responsibilities.</p> <p>Add reference to Border Protocol.</p> <p>Add reference to Healthwatch Statutory status.</p>	The final version of the Strategy has been changed in response to this feedback.
What are the governance and accountability arrangements to ensure we achieve good engagement and experience?	This section should be an Appendix.	The final version of the Strategy has been changed in response to this feedback.
How will we know if this Strategy is achieving its aims and objectives? What are the expected outcomes?	<p>This is a repeat of the Summary on page 7.</p> <p>Explain how success will be evaluated and how different objectives will be developed.</p> <p>Explain how 'member GP practice' involvement will be increased.</p>	<p>The 'summary on a page' has been re-written.</p> <p>The final version of the Strategy has been changed in response to this feedback.</p>
What are the next steps?		
Appendix 1a: Other GCCG Strategies, policies, guidance and procedure documents which should be read in conjunction with the Strategy (a-z)		
Appendix 1b: GCCG's Mission, Values and Aims as set out in our Constitution		

(revised version 2014)		
Appendix 2a: Recommended content to be included in the next version of the GCCG Constitution	<p>Does the current GCCG Constitution meet all relevant requirements?</p> <p>The Engagement Cycle Diagram is too small.</p>	<p>The GCCG Constitution has been approved by NHS England. CCGs are able to update their Constitutions twice each year.</p> <p>The diagram has been enlarged and an example of its application has been included.</p>
Appendix 2b: Recommended additional content to be included in the next version of the GCCG Procurement Strategy	<p>Does the current GCCG Procurement Strategy meet all relevant requirements?</p> <p>Building capacity for people to be involved in procurement activities is very important.</p>	<p>The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations April 2013, do not reference patient or public engagement. They do refer to Patient Choice: choice of alternative provider, but there is nothing in this statutory instrument about a requirement to engage. National guidance is awaited from NHS England which may provide greater clarity.</p>
Appendix 3: Our Shared Vision (2014)	<p>GP practices will need to be proactive to support patients to take greater responsibility.</p>	
Appendix 4: Legislation and Policy		
Appendix 5: Action Plan	<p>This is a list. A Gantt chart would be better.</p> <p>Include resources (including people required to deliver actions)</p> <p>Page numbers are missing.</p> <p>The Action Plan should be updated following sign of the Strategy.</p> <p>Dates need to be more specific in weeks (incl. duration)</p> <p>Objectives should have a product not only the completion of an action – add</p>	<p>The Action Plan will be updated following the presentation of the final version of the Strategy to the meeting in public of the CCG Governing Body in September 2014. The update Action Plan will be published on the CCG website and updated regularly and reported to the CCG Integrated Governance and Quality Committee.</p>

	<p>a column 'to be demonstrated by'.</p> <p>Objective 2: Many of the actions are only internal. The Objective will not be achieved by the Actions. Be more explicit regarding 'staff training' – what will this mean</p> <p>Objective 4: Involving Healthwatch is important.</p> <p>Objective 5: Signpost needs definition. Explain how reports will be made available publicly and how individuals' feedback will inform decision making.</p> <p>Objective 6: Alternatives for those not online should be considered.</p> <p>Objective 2 and 6 are similar</p> <p>Objective 12: explain who will submit articles and where to.</p> <p>Objective 13 – ensure actions recommended by the Equality Impact Analysis are implemented to ensure the Strategy meets Equality requirements</p> <p>Objective 14: how will opportunities to improve outcomes be identified?</p> <p>Objective 15: describe who the local teams are.</p> <p>Objectives under the heading Anyone and Everyone should be clear about staff and</p>	
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	<p>public facing actions.</p> <p>Objectives 20/21: State that meetings in public should be advertised widely.</p> <p>Objective 22: not everyone will know how to use new media. Use well established methods too.</p> <p>Objective 24: Patient Stories are a good idea. How will the stories be selected?</p> <p>Objectives 27/28: How will they be achieved?</p> <p>'Ensure' should replace 'enable'.</p> <p>How will people with no access to the internet be able to know how delivery of the Action Plan is progressing?</p>	
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Governing Body

Governing Body Meeting Date	Thursday 25th September 2014
Title	Procurement Strategy
Executive Summary	<p>The attached paper is a draft Procurement Strategy incorporating a Contestability Framework, Market Management and Dispute Resolution Policy which has been prepared by the Head of Procurement and endorsed by the Director of Commissioning Implementation for consideration by the NHS Gloucestershire Clinical Commissioning Group (GCCG) Governing Body.</p> <p>The objective of this policy is to provide a framework to ensure that all procurement activity is transparent; evidence based and delivers key business objectives. Clinical services procured should be innovative, affordable, viable, clinically safe and effective. The procurement strategy does not offer detailed advice for specific health care groups or activity but sets out guidance for the GCCG on how to decide on the appropriate activity to be undertaken whilst ensuring compliance with current European Union procurement regulation, UK Government legislation and Department of Health procurement best practice.</p> <p>This document builds on the previous NHS Gloucestershire procurement strategy document, incorporating revised Department of Health best procurement</p>

	practice, secondary procurement legislation introduced by the UK Government from 1 April 2013 and revised substantive procurement guidance issued by Monitor in December 2013.
Key Issues	The GCCG needs to ensure it implements robust procurement practices and principles in order to successfully deliver high quality commissioned health care services to the population of Gloucestershire.
Risk Issues: Original Risk Residual Risk	<p>Failure to identify and address shortfalls in the provider market leading to continuing poor or substandard performance.</p> <p>Impact Likelihood Risk 3 2 6</p> <p>Challenge from new or existing providers on the GCCG's procurement process and the awarding of new contracts.</p> <p>Impact Likelihood Risk 3 2 6</p>
Financial Impact	By implementing the strategy the GCCG will have a more structured approach to the procurement of commissioned services and this will enable the GCCG to deliver better value.
Legal Issues (including NHS Constitution)	The strategy sets out a structured approach to procurement which meets legal requirements. Separate legal advice may be needed for individual procurements.

Impact on Health Inequalities	The processes outlined within the strategy, especially relating to Public and Patient Engagement and the adoption of the regulations and principles of Monitor's Substantive Guidance, will support the delivery of reduced health inequalities.
Impact on Equality and Diversity	Yes Using Equality and Diversity Impact Assessments as the tool to identify areas of need, the GCCG will be able to use the procurement strategy to engage with a variety of providers who can offer services tailored to meet specific requirements within our diverse population.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report, however the GCCG will endeavour to minimise environmental impact through the adoption of robust sustainable procurement principles.
Patient and Public Involvement	No public involvement in the development of the strategy. However, any specification developed for new services will involve / engage key stakeholders and the public as part of the process.
Recommendation	The GCCG Governing Body is asked to endorse this procurement strategy for healthcare services.
Author	David Porter
Designation	Head of Procurement
Sponsoring Director (if not author)	Mark Walkingshaw Deputy Accountable Officer / Director of Commissioning Implementation



Procurement Strategy for the Purchase of Health Care Services

Incorporating:

**Contestability Framework, Market Management Policy &
Dispute Resolution Policy**

September 2014 to August 2015

Document Control:

Date of Issue:	5 September 2014
Version:	v2
Author:	David Porter, Head of Procurement
Next Review Date:	August 2015
Approved by:	NHS Gloucestershire Clinical Commissioning Group

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1. Introduction
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- Appendix 1 Decision Not to Tender Form
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Executive Summary:

This Procurement Strategy incorporating a Contestability Framework, Market Management and Dispute Resolution Policy has been prepared by the Head of Procurement and endorsed by the Director of Commissioning Implementation for consideration by the NHS Gloucestershire Clinical Commissioning Governing Body.

This document builds on the previous NHS Gloucestershire procurement strategy document, incorporating revised Department of Health best procurement practice, secondary procurement legislation introduced by the UK Government from 1 April 2013 and revised substantive procurement guidance issued by Monitor in December 2013

The document will require regular review / updates to take into account planned changes to the European Union procurement directives in 2014, case law emerging from the introduction of The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and any further guidance issued by NHS England.

Part A Procurement Strategy

1. Purpose / Introduction:

NHS Gloucestershire's Clinical Commissioning Group (GCCG) is responsible for the commissioning of high quality, value for money health care services to the patients of Gloucestershire. The GCCG procurement strategy sets out its approach to achieving its delivery objectives through the application of good procurement practice.

Selecting the correct (most appropriate) procurement process can produce considerable quality improvements and cost savings. In the current NHS economic climate, we shall be required to make savings and efficiencies and strategic procurement is a useful tool in achieving this. It will also open up the market to a wider range of providers. This in turn shall help to drive up service quality, innovation and patient choice.

The objective of this policy is to provide a framework to ensure that all procurement activity is transparent; evidence based and delivers key business objectives. Clinical services procured should be innovative, affordable, viable, clinically safe and effective. Clinical service specification documents should set stretched targets to improve health outcomes and the quality of patient experience.

This procurement strategy does not offer detailed advice for specific health care groups or activity but sets out guidance for the GCCG on how to decide on the appropriate activity to be undertaken whilst ensuring compliance with current European Union procurement regulation, UK Government legislation and Department of Health procurement best practice.

The July 2010 White Paper "Equity and Excellence: Liberating the NHS" made clear the need for the NHS to deliver efficiency savings, whilst setting out the proposed direction for the NHS. This included:

- Focussing on clinical outcomes (quality) rather than targets
- Empowering clinicians and other health care professionals to use their judgement and innovate
- Giving patients greater choice

To achieve these aims, the GCCG will:

- Continuously review current health care services provision arrangements from a broad clinical and contractual perspective.
- Obtain quality information data to inform transparent and fair decision making processes.
- Ascertain whether it is necessary, desirable or appropriate to invite competition in accordance / compliance with EU competition regulations and / or the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013.
- Actively manage the provider market, creating greater patient choice whilst maintaining quality outcomes
- Engage and work closely with the local community and a range of health care providers to deliver collaborative and integrated services
- Apply robust, fair and proportionate procurement processes that follow all mandated and 'good practice' requirements.
- Apply award criteria that takes account of whole life costs and overall service quality (Most Economically Advantageous Tender)
- Put in place robust contractual arrangements to ensure service delivery.

2. Procurement Policy:

In order to achieve its strategic objectives, and in accordance with Department of Health guidance, the GCCG will ensure that all procurement activity undertaken is:

- Transparent
- Proportionate
- Non-discriminatory
- Equal (equality of treatment)

GCCG procurement staff will work in accordance with national and European Union procurement guidelines which will include, but not be limited to, the following policy / guidance documents:

Body:	Publication:
Department of Health	Any Qualified Provider Operational Guidance (2011)
	Patient Choice (Nov 2011)
	Securing Best Value for NHS Patients (Aug 2012)
	The Operating Framework (Annual)
European Union	EU Public Procurement Regulations 2006 (and any subsequent amendments to legislation as enacted from time to time)
	EU Remedies Directive (20 Dec 2009)
Monitor	Substantive guidance on the Procurement, Patient Choice and Competition Regulations (December 2013)
NHS England	Managing Conflicts of Interest – Guidance for CCG's (28 March 2013)
NHS Gloucestershire Clinical Commissioning Group	Equality strategy
	Gloucestershire Joint Health and Wellbeing Strategy
	Integrated Annual Operating Plan
	Public and Patient Engagement Strategy
	Quality Strategy
	Prime Financial Policies
	Strategic Commissioning Intentions
	Gloucestershire Clinical Commissioning Group Constitution
UK Government	The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
	Social Value Act (2012)

The National Health Service (Procurement, Patient Choice and Competition Regulations) (No.2) 2013 came into force on 1 April 2013. Monitor, the sector regulator for health services in England, has the role of protecting and promoting the interests of patients and has been granted powers to set and enforce a framework of rules for providers and commissioners. In December 2013, Monitor published its Substantive Guidance on the Procurement, Patient Choice and Competition Regulations, designed to support CCG's and NHS England.

The guidance does not introduce any general policy requirement that all NHS services should be subject to competitive tendering. The policy is to create an NHS that is much more responsive to patients and achieves better quality outcomes. A step to achieving this is to increase the current offer of choice, giving patient's choice of Any Qualified Provider where relevant.

Monitor's Substantive Guidance makes it clear that it is for Commissioners to decide which health care services to procure and how best to secure them in the interest of patients. Competition will be employed only where it serves the interests of patients and is not an end in itself. The regulations do not impose competition on the NHS.

The Regulations apply to all Clinical Commissioning Groups (CCG's) and also to NHS England where it is responsible for procuring health care services.

The principles GCCG will follow include:

- To secure the needs of patients who use services and to improve the quality and efficiency of those services, including through providing them in an integrated way;
- To act transparently and proportionately, and to treat providers in a non-discriminatory way;
- To procure services from providers that are most capable of delivering the overall objective and that provide best value for money; and
- To consider ways of improving services (including through services being provided in a more integrated way, enabling providers to compete and allowing patients to choose their provider).

3. Overarching Principles of Procurement:

The GCCG will adhere to the principles of public procurement whilst undertaking all procurement activity as follows:

Principle:	GCCG Undertaking:
Transparency:	State Commissioning Strategies and Intentions:
	Publish short / medium procurement intentions on the GCCG web site
	State outcomes of service reviews and whether a competitive tender / AQP process is to be used.
	Pricing tariffs and other payment regimes will be fair and transparent.
	Advertise all procurement opportunities and contract awards via Contracts Finder, the Official Journal of the European Union and the GCCG website as applicable.
	Maintain an auditable tender documentation trail (and for decisions not to tender), providing clear accountability.
	Publish details of all contracts awarded on its website, including contractor names, addresses, contract type, value, duration and procurement process utilised.
Proportionality:	Commissioner resources must be proportionate to the value, complexity and risk of the service being procured.
	Contract duration to be proportionate to service type being commissioned.

	Whilst maintaining quality standards / patient safety, Additional award criteria (including financials) must be proportionate to the value, complexity and risk of the service being procured and will not discriminate against smaller organisations such as voluntary sector / social enterprises etc.
	The GCCG will seek to minimise bidder tender costs by avoiding timetable delays and significant changes to scope
Non-Discrimination:	The GCCG will ensure that the entire procurement process and associated documentation will not contain bias towards any particular bidder
	All evaluations criteria and associated weightings will be fully disclosed
	All relevant information will be disclosed equally and in good time to all prospective bidders
Equality of Treatment:	The GCCG will not favour a particular market sector i.e. public over private. Award decisions will always be taken based on a bidders ability to deliver the service rather than on the organisational type.
	Finance and quality assurance checks will be applied equally to all bidders

4. Commissioning Strategy / GCCG Procurement Intentions:

Procurement schemes undertaken are determined by the GCCG and are dependent on its annual Commissioning Intentions.

5. When to Procure (see Part B – Contestability Framework):

The GCCG as a Public Sector Contracting Authority is governed under the EU Procurement Directive and the following thresholds apply from 1 January 2014* (subject to on-going review):

	Supplies:	Services:	Works:
Entities listed in Schedule 1:	£111,676	£111,676	£4,322,012
Other Public Sector contracting authorities:	£172,514	£172,514**	£4,322,012

Thresholds shown above are net of VAT

*Rates show applicable from 1 January 2014

**Services threshold of £172,514 used for the provision of Health Care Services (EU Service Category: Part B)

6. Procurement Processes / Procedures (including Any Qualified Provider):

The procurement process starts from identification of need, the decision to tender through to the conclusion of a services contract and its on-going management. The development and management of provider markets to ensure capacity and capability is essential.

This Procurement Strategy has been developed to support consistent and transparent decision making within the GCCG when commissioning health care services.

The Procurement Strategy will identify the systems and procedures required for the GCCG to meet patient needs, demonstrate quality, governance and probity, good procurement practice and achieve value for money by delivering cost effective high quality services.

The GCCG's aim is to improve the quality and accessibility of services to patients through a process of service review, robust contracting, key performance indicators (KPIs) and provider development activity. The GCCG will work to develop provider markets as well as working with existing providers to improve service quality.

Once a decision has been made to procure, the main procurement routes available to the GCCG are detailed below. Advice should be sought from GCCG procurement staffs on the most appropriate route for each service tender.

Procedure/ Process:	Description:
Any Qualified Provider:	Allows Commissioners to increase choice to patients by qualifying / registering organisations to provide services via an assurance process that test providers fitness to offer the particular NHS-funded service. The Commissioner sets local pathways and referral protocols which providers must accept. Referring clinicians offer patients a choice of qualified provider for the service being referred to. Competition is based on quality not price; providers are paid a fixed price determined by a national or local tariff (in the absence of a national tariff).
Competitive Dialogue:	<p>Allows input into the tender process by participating bidders. There will be a 'Dialogue' phase where bidders are able to discuss all aspects of the contract with the commissioner. Dialogue generates solutions to the agreed requirements, and tenders are invited based on the bidder's solution.</p> <p>The Competitive Dialogue route should only be used where the GCCG is unable, due to the complexity of its requirements to define the technical means capable of satisfying the GCCG's needs or objectives, specify either the legal or financial makeup of the project, and where neither the open or restricted procedure would be appropriate for the award of the contract.</p>
Framework Agreements:	Although currently limited in scope for clinical services applications, the GCCG is permitted to access nationally negotiated framework agreements where appropriate. GCCG must conduct a mini-competition within the framework to select the most appropriate service provider where such framework rules apply.
Grants:	<p>Public bodies must follow public procurement policy at all times. In certain circumstances grants are payable to third sector organisations. However, there should be no preferential treatment for third sector organisations. Use of grants can be considered where:</p> <ul style="list-style-type: none"> • Funding is provided for development or strategic purposes. • The provider market is not well developed. • Innovative or experimental services. • Where funding is non-contestable (i.e. only one provider).

	Grants should NOT be used to avoid competition where it is appropriate for a formal procurement to be undertaken.
Negotiated Procedure:	<p>This procedure allows the Commissioner to select one or more potential bidders with whom to negotiate the terms of the contract. There are two types of Negotiated procedure either with or without prior advert. Bidders need to be invited to negotiate the terms of the advertised contract.</p> <p>Under the procedure without prior advert, the GCCG could negotiate directly with its supplier of choice – this is usually due to the protection of exclusive rights where the contract can only be carried out by a particular bidder. The procedure should only be used in limited circumstances as detailed in the Regulations.</p>
Open:	No pre-qualification stage. All prospective bidders may respond to the advertisement by tendering for the contract, although only those meeting the selection criteria (if stated) will be entitled to have their tender assessed.
Restricted:	All interested parties may express an interest in tendering for the contract but only those meeting selection criteria, assessed by a pre-qualifying stage, will be invited to do so. An Accelerated Restricted Procedure can also be undertaken.
Single Tender Action:	<p>Single tender actions should usually be avoided as this is contrary to achieving value for money through open and fair competition. Exceptionally, single tender actions may be justified where:</p> <ul style="list-style-type: none"> ▪ The work constitutes follow up work, which is directly related to a recently completed contract, and the added value gained from the additional work being given to the same contractor outweighs any potential reduction in price that may be derived through competitive tendering. However the follow up work should not be of significant cost (i.e. not more than 50% of the original contract value); ▪ The expertise required is only available from one source. This may be due to ownership of exclusive design rights or patents but, nonetheless, the specification should be reviewed to ensure that no other product / service would meet user requirements.
Spot Purchasing:	There will remain a need to spot-purchase for particular individual needs i.e. urgent medical requirement to place a patient in specialist care facilities. Whilst this requirement is infrequent, a waiver of standing orders will be sought to comply with the GCCG's requirements for financial transparency and probity.

7. Market Analysis:

GCCG procurement and contracts staff will utilise service specification detail to benchmark comparable contracts to determine a range of fair and appropriate service costs. This activity will be conducted routinely for all high value health care services and prior to determining whether formal procurement is undertaken.

Market analysis is carried out to determine if commercial sources exist and to establish whether a preferred contract option will result in fair and reasonable service costs. The GCCG should seek to determine:

- Likely (whole service) costs
- The types of organisations in the market place capable of delivering the required services
- Whether existing or new organisations have sufficient capacity to deliver the services solutions sought
- The most appropriate / proportionate procurement route

Market analysis should allow the GCCG to recognise local SME's and voluntary sector organisations operating in the area and help the GCCG to develop a capacity building plan for these organisations where required. This is useful when making service commissioning and procurement decisions by identifying market trends, market stability and performance profile of key prospective bidders.

Capacity building is an opportunity to identify areas of strength in supplying organisations to the GCCG and setting out opportunities for their development. To achieve this, GCCG staffs should work with potential service providers, as requested, to offer support, advice, training appertaining to the competitive tender process. This should enable SME's to compete more fairly with larger organisations.

8. Provider Engagement:

Engagement with potential providers of health care services is an important element of effective commissioning. It is essential that both incumbent providers (where applicable) and prospective providers are included equally in the engagement process.

GCCG Commissioners may, and in accordance with Department of Health guidelines, use provider engagement to:

- Consider provider willingness / capability to deliver a service
- Establish / understand current provider landscape
- Lessons learnt from previous procurement schemes
- Assessing barriers to entry
- Development and testing of service specifications
- Determine most appropriate procurement routes
- Establish provider approaches to cost, risk, innovation, capacity, service locations and staffing requirements.

Resulting specifications will focus on service outcomes and not specific bidder technologies to ensure that any procurement process is without prejudice.

The GCCG may engender pre-procurement engagement through the following means:

- Placement of a Contracts Finder advertisement (and relevant specific journal advertisements where applicable)
- Prior Information Notice in the Official Journal of the European Union
- Public / Private Reference Groups
- Website notifications

9. Public and Patient Engagement:

In accordance with s14Z2 of the Health and Social Care Act 2012, Clinical Commissioning Groups are required to involve and consult patients and the public:

- In their planning of commissioning arrangements;
- In the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which services are delivered to the individuals or the range of health services available to them;
- In decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

GCCG's patient and public engagement will be conducted in accordance with its engagement strategy: An Open Culture: A Strategy for Engagement and Experience. The strategy will use The Engagement Cycle to inform its engagement activities.

GCCG will actively engage and support patients and other members of the public in procurement processes to ensure:

- Their views inform the development of service specifications
- Identification of service providers who better meet the needs of patients
- Innovative approaches to service development are considered
- Potential service providers are identified and able to bid for contract opportunities
- Active participation in decision making panels including clarity about patient representation on panels, their role, terms of reference, support and training.

The benefits of this approach include increasing public confidence and better relationships with providers of services. It also paves the way to improved monitoring and performance management, particularly if patients are also part of those monitoring processes.

In addition, GCCG will keep the wider public informed, hold briefing events so that the public find out what is going on and about proposals being developed.

10. Procurement of Goods and Generic Services:

Procurement for the supply of all goods and non-clinical services is the responsibility of the Central Southern Commissioning Support Unit (CSCSU). The GCCG Commissioning Implementation Directorate shall be responsible for monitoring the quality of the service provided by the CSCSU.

The service level agreement between GCCG and CSCSU will contain key performance indicators to assist with the monitoring of the services provided.

11. e-Tendering:

A semi-automated / electronic approach to competitive tendering is presently used by GCCG procurement staffs when conducting competitive tendering processes. In-line with European Union guidance (December 2011), the GCCG is required to conduct all procurement processes electronically no later than 2017. The GCCG will investigate the availability of suitable electronic e-tendering systems and ensure that a compliant system is in place no later than the aforementioned date.

12. Collaborative Procurement:

GCCG Procurement staffs will design procurement work plans in accordance with year-on-year GCCG Governing Body commissioning intentions and any ad hoc in-year requirements as may arise from time-to-time. While it is envisaged that most procurement will be conducted in-house, GCCG procurement staffs will actively engage with Central Southern Commissioning Support Unit (CSCSU) staff, other Clinical Commissioning Group procurement staffs or nationally designated procurement teams to deliver complex / cross-boundary procurements where required.

The CSCSU will provide transactional, mobile phone and generic services procurement to GCCG in-line with their service level agreement.

13. Contract Duration:

Whilst the 3-year NHS Standard Contract will be applied for the majority of health care services procurements, the GCCG will take account of the following factors before finally determining contract duration (and prior to procurement advertisement):

- Overall contract value
- Complexity of the procurement process (i.e. nature of health care service to be commissioned and its interaction with other services and service providers)
- Number of potential providers in the market place.

Contract durations in excess of 3-years may be advertised, procured and awarded subject to GCCG Governing Body approval.

14. Contract Management:

GCCG Contract Team staff will work with GCCG procurement staff from project inception (or a pre-determined key stage) to ensure that robust contracts are developed, implemented and monitored on an on-going basis.

The GCCG's Commissioning Implementation Manager will lead and actively participate in high value / complex procurement projects to ensure that smooth transition from procurement contract award to service delivery commencement is managed in a proactive and timely manner ensuring key deadlines are achieved.

15. Procurement Participation Guides:

To develop the framework provided by this strategy document, we will produce comprehensive written procurement guides for use by our staff engaged in procurement related activity.

The guides will provide clear but comprehensive guidance for all GCCG staff when undertaking or participating in procurement activity. Initially two separate guides will be developed for Competitive Tendering and Any Qualified Provider processes. .

16. Social Value Legislation:

Under Social Value legislation which came into force in January 2013, Public Sector organisations are required to consider how the services that they commission and procure might improve the economic, social and environmental well-being of the area that they serve.

Social Value is a broad term and can be interpreted in a number of ways but could mean; a local person for a local job, an NHS Trust commissioning local patient groups (at cost) to run consultation events or a public body contracting with a private firm who employs local / long-term unemployed to service its contract requirements. The GCCG will consider the Social Value implications of all prospective procurement processes and incorporate its responsibilities under the Act in key procurement documentation. GCCG will ensure that positive health, social and environmental outcomes are captured and assessed during the commissioning process at ITT stage and ensure that these added benefits are measured and linked to the performance of the contact.

17. Conflicts of Interest:

NHS England document (Gateway 0005 dated 28 March 2013) entitled: Managing Conflicts of Interest – Guidance for CCG's, outlines guidance for managing conflicts of interest where GP practices are potential providers of CCG-commissioned services.

The GCCG will fully adopt this guidance to ensure that potential conflicts of interest are managed appropriately and that the GCCG and GP practices are protected from any perceptions of wrong-doing.

18. Quality and Sustainability Impact Assessments:

It is essential that services delivered improve the quality of service that is delivered and enhance the patient experience. GCCG has developed a Quality and sustainability impact assessment which is used when there is any change to the way services are commissioned and delivered. The Impact Assessment includes:

- Duty of quality
- Patient experience
- Patient safety
- Clinical effectiveness
- Prevention
- Productivity and innovation

Sustainable healthcare commissioning is essential – prevention, self-care and low carbon health care must be delivered to ensure that resources (environmental, social and economic) are available to sustain health services into the future.

Part B Contestability Framework:

1. Introduction:

Contestability (or competition) can be an effective method of driving improvements to service quality, enabling change, managing overall service cost, and encouraging new providers and innovation into new, emerging or existing markets.

Traditionally, and in the majority of cases, elective care procedures have been provided by neighbouring NHS Trusts under existing standard Department of Health contractual terms. Whilst quality of care could be monitored / improved, patients were unable to select from a range of health care providers.

In July 2011, the Cooperation and Competition Panel (CCP) reported on the implementation of patient choice of Any Qualified Provider in elective services. Nine recommendations were proposed to increase patient choice and included the following requirement:

Commissioners to review their existing practices in relation to restrictions on patient choice and competition, and take steps to bring themselves into compliance with the Principles and Rules of Cooperation and Competition (July 2010).

Recently, and particularly since the introduction of the aforementioned Patient Choice and PRCC guidance, there has been a considerable increase in the number of voluntary (Third Sector) and private organisations entering the health care provision market. Patients are now actively encouraged to select the health care provider which provides the most timely and geographically convenient service.

There are, however, potentially risks in adopting a market based model of health care provision, not least in terms of the potential impact if a key local provider becomes financially or operationally unviable due to competitors taking on only certain elements of NHS provision. Many services also have important clinical, operational and financial linkages which may not as easily be maintained across different organisations.

Other risks in contesting the provision of services could include:

- Reduced service stability (i.e. existing service may for example struggle to recruit to key posts if its future is uncertain)
- Gaps in provision (where there is an insufficient market to provide all of the services being contested)
- Delays in effecting service change (given the length of time to complete a service specification, tendering and re-contracting process and the time for a new provider to implement a full service)

2. Obligations on Commissioners:

When procuring health care services, GCCG will act with a view to:

- a. Securing the needs of the people who use the services
- b. Improving the quality of services, and
- c. Improving efficiency in the provision of the services,

Including through the services being provided in an integrated way (including with other health care services, health-related services or social care services).

3. Triggers for Contesting a Service:

The GCCG will consider contesting services in the following circumstances:

- New Service Requirement - where there is a plan to place a new service contract (a service not previously provided)
- Contract Expiration - where an existing contract is coming to the end of its agreed term, or can reasonably be considered to be likely to come to an end for other reasons (for example a provider notifying commissioners that it is considering withdrawing provision)
- Failure to Achieve Quality Standards - where an existing provider is failing to achieve (or make sufficient progress on achieving) local or national quality standards or targets, or is not meeting the reasonable expectations of service users
- Value for Money - where an existing service offers poor value for money when compared to other relevant local or national benchmarking information
- Service Redesign - where a new type of service differs significantly from that currently in place (in terms of service model, volumes or types of activity, or financial value) such that a new range of service providers or partnerships might offer advantages in terms of patient care or cost compared to that currently in place

4. NHS Gloucestershire CCG Contestability Decision:

The GCCG In reaching a contestability decision will consider the anticipated benefit versus risk assessment which will cover, as a minimum, information in response to the following risk assessment checklist:

- a. Has the Commissioner clearly identified the reason(s) for contesting the service (see triggers for contesting a service above)?
- b. Is the Commissioner clear on the service specification and quality standards that are required in the contested service(s) (or is at least clear on the specific benefits that will be achieved by procuring a new service, if the detailed specification is to be developed at a later stage)?
- c. Has the Commissioner identified any linked services which are highly likely to become clinically, operationally or financially unviable for Gloucestershire residents if not contested in parallel with the main service(s) under consideration?
- d. Has the Commissioner considered the timescales and costs involved in contesting a service, such that they are able to fairly represent the benefits that could be achieved over and above an approach working with the existing provider(s)?
- e. Is there evidence of a sufficient market of providers, or potential providers, to minimise the risk of significant gaps in the service(s) concerned and to ensure that patient choice is maintained or expanded?
- f. Have current service costs been benchmarked, and an assessment of current and future demand and capacity been undertaken, such that the risk of increased costs is minimised and there is explicit information on affordability as part of the tendering decision?

- g. Has the proposer ensured that other key co-commissioners have been informed of the GCCG's proposals, and that explicit agreement is being secured where a service is jointly commissioned for Gloucestershire residents

Where a decision is taken by the GCCG to contest a service, consideration should also be given to the means by which the service might best be contested. There are two broad options:

- Opt 1. A traditional tendering process, resulting in the award of a time limited contract to a single provider, partnership of providers or consortia with lead bidder / subcontractor arrangements.

Procurement staff will follow one of a range of EU mandated procurement processes. This approach may be mandated for high value contracts or where there are significant non-clinical components of the service. The results of any tender process will be published on the Contracts Finder web portal, in the Official Journal of the European Union and the GCCG external web site.

- Opt 2. Use of the 'Any Qualified Provider' procurement process which allows for the contested service to be offered to, and provided by, a range of providers, as long as they can demonstrate they fulfil key requirements. These include:

- Fulfilling any obligatory registration requirement
- Ability to meet the GCCG's service specification in full
- Accepting the national or local tariff price (where applicable) as specified by the GCCG
- Accepting a standard DH contract with the GCCG, without any guarantees of volumes of activity or levels of funding.
- Ensuring potential conflicts of interest are acknowledged and minimised (for example where a referral is made into a service run or associated with the original referrer, and who may therefore gain financially from that referral)
- Ensuring adequate choice is provided on treatment options, and in any onward referral to another commissioned service
- Providing a service that is sufficiently flexible to respond to and meet individual needs

An AQP model may be more appropriate to higher volume services with less complex interfaces with other services.

All procurement processes (including AQP) will be advertised on the Contracts Finder web portal and the GCCG web site.

5. Decision Not to Tender:

- a. If, after a risk assessment and consideration of the principles contained within this framework, the GCCG determines that a competitive tender process is not required or is inappropriate, the reasons shall be recorded on the Decision Not to Tender Form (see appendix 1).
- b. The GCCG Governing Body must approve any decision not to tender for new or significantly re-designed services

Part C Market Management Strategy

1 Introduction:

This strategy sets out the way in which the NHS Gloucestershire Clinical Commissioning Group (GCCG) will work to develop a health care market which supports delivery of its strategic commissioning plan. The strategy will identify the principles by which the organisation will enable the development of an appropriate provider market to meet local needs and improve patient experience. This strategy should be read in conjunction with the GCCG's Procurement Strategy.

Our understanding of what constitutes an effective market management strategy in the NHS is still evolving. However, the dual functions of market analysis (understanding the current and potential market) and market development (supporting the development of innovation, quality and a diverse health care market) are central to developing a competitive provider environment and informed decision making about procurement routes.

This strategy will support the commissioning organisation to understand the steps to good market management that enables the delivery of the strategic commissioning plan and helps describe the market development needs at each stage in the commissioning cycle.

The GCCG is keen to ensure that the benefits of a competitive environment and new providers are harnessed. The ultimate aim in applying any system or market management techniques is to ensure that it results in an improvement in patient experience, outcomes and value for money.

2 Current Provider Landscape:

2.1 Monopoly Providers:

The current provider landscape is still largely dominated by monopoly providers. This presents challenges in offering patient choice and may influence the GCCG's ability to drive up quality, contract with providers able to respond to modernisation and local needs and develop new care pathways which rely on innovative models of service integration.

2.2 Developing the Third Sector:

Commitment to developing the third sector in a way that supports entry into the health care market must be conducted in a way that does not compromise the procurement principles of transparency, equity and value for money.

2.3 Information Technology:

The lack of a single patient record system poses constraints on the ease with which patient information and patient care can be transferred from one provider to another.

2.4 Transport:

The geography of the market can be defined by how far a patient is willing or able to travel to receive care. The inability or reluctance of patients to travel poses key constraints on the GCCG to increase the range of providers to increase patient choice.

3 Market Management in the NHS:

As leaders of the local health system the GCCG has a significant responsibility to lead and manage the NHS system. Market Management is a pivotal element of effective system management.

Ensuring Local Strategic Coherence	<ul style="list-style-type: none"> ▪ Engaging with the population around the strategy for the system (including formal consultation) ▪ Ensuring that all system tools and techniques including market management result in a cohesive local system
Building and Working the Market	<ul style="list-style-type: none"> ▪ Design of local incentives and local choice offer ▪ Market development ▪ Procurement ▪ Contracting
Maintaining Market Effectiveness	<ul style="list-style-type: none"> ▪ Information for, and communication to the Patients, Public and the Market ▪ Managing service change through the market ▪ Managing the market by: <ul style="list-style-type: none"> ▪ Managing service/ provider failure ▪ Managing disputes ▪ Driving quality in provision ▪ Managing local political interface on market decisions

Table 1: The Responsibilities of the GCCG Market Manager

The ultimate aim in applying any system or market management techniques is to ensure that it results in an improvement in patient experience, outcomes and value for money.

One of the best ways we can achieve this is to construct excellent provider relationships based on a common understanding of the service requirements through clear specifications for services based on good care pathways and models of care; effective contract performance monitoring and management systems, and to build up strong relationships with providers over time.

In some cases it is necessary and appropriate to have competition for services in order to secure improved outcomes, maintain complex service integration and patient experience. In other cases it is possible and desirable to maintain existing suppliers, whilst continuing to drive quality improvements.

4 NHS Gloucestershire CCG's Approach to Market Management:

The GCCG's approach to market management will focus on three clear activities; contract management; market analysis (including robust procurement processes) and market development. Market analysis and market development activities need to be undertaken in a planned and prioritised way in order to maximise the benefits to be derived through any procurements offered to the market.

The vision for the future provider landscape for the GCCG is to provide greater diversity where this is appropriate underpinned by two key principles:

- Increasing choice for users of services
- Provider development or contestability to drive up the quality of services and reduce costs

This will be achieved through a considered use of competition to improve quality.

It is not always possible or appropriate to increase the number of providers in the market; there are other levers which need to be utilised to improve and shape the market and drive up quality. These include using contract performance levers, patient user participation in service reviews and analysis of data in respect of quality of services.

4.1 Contract Management:

The first stage of Market Management will be to consider the appropriateness of contestability as a system lever. In some cases, as described in section 6, robust contract management and effective supplier management, i.e. working with our current providers of patient care will improve outcomes; patient experience; quality and reduce failings. There are some circumstances where it is immediately apparent that contesting the service is not feasible or beneficial to improving outcomes and value for money:

- The service is a specialised service where provider designation has already taken place at a national or regional level
- Where the service to be procured has such strong service alliances with an existing service that an extension to an existing agreement is appropriate (complex service integration).
- Where the cost of undertaking a contested approach cannot be justified in light of the contract value (proportionality)
- Where the GCCG wishes to encourage provision from within a sector that might otherwise not prevail through a contested approach
- Where failing to award a contract to a preferred provider would put other core services at risk i.e. recognising the need to safe guard against unintended consequences relating to service viability and tipping points.

The GCCG will also ensure it demonstrates how as many of the possible benefits associated with a contested approach are realised through strong commissioning and specification of services.

Where it is not absolutely apparent that competition would not be beneficial then the GCCG will use the Contestability Framework to support the making of a decision about contestability. The GCCG will ensure that when a decision not to contest a service is reached, this will formally be documented and made available to interested parties. Only after deciding that contestability is needed to improve outcomes will the GCCG progress to market analysis:

4.2 Market Analysis:

The GCCG will adopt an eight step approach to market analysis as follows.



Delivering outputs for each of these steps will require joint working across the GCCG. The GCCG's procurement team will support lead commissioners in understanding the tasks required to undertake market analysis.

The outputs for each step are defined below:

Agree Scope	<ul style="list-style-type: none"> ▪ Identify and clarify market segment area to be addressed: <ul style="list-style-type: none"> ▪ Geography ▪ Specific pathway ▪ Providers ▪ Competition and choice for patients ▪ Agree which part of the overall system for that market segment will be reviewed: <ul style="list-style-type: none"> ▪ Prevention ▪ Assessment ▪ Diagnostics ▪ Intervention ▪ Post acute
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Assess Market Needs & Demand	<ul style="list-style-type: none"> ▪ What services are required ▪ How can these be delivered ▪ Where are services required ▪ How will needs/demands change or grow
Assess Current Market Performance	<ul style="list-style-type: none"> ▪ Comparative analysis of existing providers ▪ Articulate performance issues
Provider Analysis	<ul style="list-style-type: none"> ▪ Map providers <ul style="list-style-type: none"> ▪ What capacity sits where ▪ What is the balance of spend/activity ▪ What access is there for the patient group ▪ Provider performance <ul style="list-style-type: none"> ▪ Do they meet GCCG requirements ▪ Do they meet patient needs ▪ Why over or under performing ▪ What plans to improve
Competitive Environment	<ul style="list-style-type: none"> ▪ Is there competition in the market ▪ What is the basis for competition ▪ Review barriers to entry or exit ▪ Who are the potential providers who could enter the market ▪ Are there examples of good practice elsewhere
Map out a Preferred Future Landscape	<ul style="list-style-type: none"> ▪ What provision does the GCCG want to see where ▪ What will the basis for performance measurement be ▪ Should it be contestable ▪ Should integration be encouraged at certain points of the system
Assessment of Market Intervention Levers	<ul style="list-style-type: none"> ▪ What can the GCCG do to change the provider landscape: <ul style="list-style-type: none"> ▪ Competitive tendering ▪ Contracting ▪ Talk to Providers ▪ Incentives ▪ Penalties
Implementation Plan	<ul style="list-style-type: none"> ▪ What levers should be used by when ▪ How does the GCCG want to monitor market performance ▪ What information does the GCCG need to do this better in the future

4.3 Market Development:

The aim of provider development activity is to encourage a range of providers, willing and capable of responding to GCCG contracting opportunities and hence facilitating the commissioning of services of a high quality and which demonstrate effective use of NHS resources.

As services are reviewed and potentially redesigned and as commissioners gain a greater understanding of the needs of their patients, the provider(s) best placed to deliver the needs of the patient may well be different from the current service provider(s), this will only be possible if there are effective and willing providers in the market capable of responding to GCCG contracting opportunities.

GCCG Procurement and Contracting staffs will undertake a number of activities to support the development of existing and potential providers.

- Develop and manage its relationship with existing and potential providers, including all sectors (NHS, Private / Commercial and Voluntary / Third Sector organisations)
- Advertise for new and potential providers using both traditional procurement processes and the “Any Qualified Provider” procurement routes
- Provide advice to potential providers on the qualification and assurance process required to become a local provider of NHS Services
- Proactively shape the market through dialogue and procurement
- Qualify providers who are interested in providing services to support the GCCG’s commissioning intentions. This will include an assessment of the providers capacity and capability to meet the minimum standards required to deliver NHS care
- Ensure that appropriate support is available to providers to facilitate their involvement in the procurement process.

5 Developing Provider Competence and Capability:

Where provider options are limited and the preferred procurement approach requires the development of providers to ensure that appropriate services can be secured; the GCCG will identify and support the development of providers to enable market entry. This support may take the form of advice, signposting to education, training and business development opportunities. Any offer of support in this way must be transparent, proportionate, non-discriminatory and adhere to NHS rules of competition and contestability.

6 Market Management Support to the Commissioning Cycle:

6.1 Assess Needs/Review of Provision:

- Produce an updated map of current service providers relevant to the commissioning programme
- Identify providers that could be involved in helping define the needs assessment
- Provide market intelligence on the current provider market and any future trends
- Identify provider market gaps and any failing providers
- Are the current services delivering key national and local targets
- Do current providers offer services that are consistent with best practice and local and national strategy
- Determine the impact on the current and future provider market (will the introduction of new providers have a detrimental impact on the provision of services to patients)
- Where required begin a search for alternative providers

6.2 Decide Priorities and Investment:

- Identify and qualify potential providers
- Gain decision if to invest in developing providers
- Engage potential providers in the commissioning process
- Is the effort of developing the supply market justified by the benefits for patients

6.3 Define the Service:

- Ensure clear service specifications are developed
- Identify the implications on the provider market of the proposed service
- Support providers in bidding for services

6.4 Shape Structure of Supply:

- Provide assurance on the selection process of providers
- Ensure provider requirement documents are robust
- Oversee the commissioner selection process

6.5 Formalise and Communicate :

- Clear awards process with feedback to unsuccessful providers which may help them develop for the future
- Clear implementation plan for delivery of new services

7 Contract and Performance Management Frameworks:

Market management is underpinned by effective contract, performance management (including quality) and procurement frameworks.

7.1 Contract Management:

- Regular discussions with all key providers. Formal Contract Boards and appropriate subgroups in place for all major contracts
- Clear issue resolution/escalation processes
- Consistent and rigorous negotiation processes
- Use of the standardised NHS Contract

7.2 Performance Management:

- Predictive modelling, analysis and performance management
- Clear Key Performance Indicators (KPIs) and defined performance improvement targets
- Regular and timely performance data analysed by efficiency, quality, outcomes, comparative benchmarks and patient experience
- Achievement of national targets and local KPIs.

7.3 Service Quality:

- Understanding the quality of services provided is a key element of market management. The following indicators will all be considered as part of a provider review.
 - Mortality rates
 - Readmission rates

- Length of stay
- First to follow up ratio's - outpatients
- Conversion rates
- DNA rates

8 NHS Gloucestershire CCG's Progress in Market Management:

Since NHS Gloucestershire CCG's inception, while we have been developing the skills needed to deliver the competencies for market management, we have taken a number of services and applied a variety of market intervention strategies.

Category:	Market Intervention Strategy:	Procurement Route:
Direct Access Diagnostics for: <ul style="list-style-type: none"> ▪ CT ▪ Endoscopy ▪ MRI ▪ Non-Obstetric Ultrasound 	Diversify provision Clear signalling to the market and market stimulation Choice and information	Any Qualified Provider
Community Vasectomy Services	Diversify provision Clear signalling to the market and market stimulation Choice and information	Any Qualified Provider
Elective Care Services	Diversify Provision Choice and Information Clear signalling to the market and market stimulation	Any Qualified Provider
Provision of Diabetic Eye Screening Services	Clear signalling to the market / market stimulation. Simplified care pathway Overall cost reduction	Competitive tender

Table 2: Categories already addressed:

9 Measurement of Success:

- Clear articulation of current and future provider market
- Robust contracts negotiated with clear outcome measures
- Robust contract/performance management processes in place
- Capability is improved within the organisation

10 Conclusion:

This strategy sets out the GCCG's approach to market management and, together with the GCCG procurement strategy, forms an integral part of the GCCG's approach to system

management. It explains the way in which the dual functions of market analysis and market development will support delivery of the GCCG's commissioning intentions.

Market management is an evolving concept for the NHS and this strategy will require an annual review to ensure that it is consistent with patient experience, national policy and local requirements.

Part D Dispute Resolution Policy:

1. Introduction:

NHS Gloucestershire first developed its Dispute Resolution Policy in September 2009 and is now updated to reflect the introduction of the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations which came into effect on 1 April 2013 and the advent of the NHS Gloucestershire Clinical Commissioning Group (GCCG), 1 April 2013.

The GCCG will work to reach resolution of any dispute arising from contracting and commissioning decisions. Disputes, not resolved by access to any contractual terms that may exist between them, may arise over decisions about contractual sanctions and termination, remuneration, practice area and 'opt-outs.'

Contractors have the right of appeal in some circumstances against contracting / commissioning decisions. The Procurement, Patient Choice and Competition Regulations apply alongside the existing Public Contracts Regulations 2006. The new regulations, however, are a bespoke set of rules for the health care sector and provide a mechanism for Monitor, as sector regulator, to investigate complaints and take enforcement action. The regulations are designed as an accessible and effective alternative to challenging decisions in the courts.

For the avoidance of doubt this Dispute Resolution Process is a non-contractual process and is intended for use in situations where the prospective parties have decided not to follow other resolution solutions that may be available to them including formal contract dispute resolution or action under statutory or legal provision available in UK law.

In the event that a provider or potential provider of services wishes to dispute the procurement / contracting / commissioning or related decision-making decisions by use of this Dispute Resolution Process, the following process will be followed:

- The GCCG will seek to resolve any disputes by local resolution. A conciliation process will be proposed in all cases.
- If the dispute is not successfully resolved at local level, the complainant or the GCCG can refer the dispute to NHS England.
- If the dispute is not successfully resolved by NHS England, it may be referred to the Monitor for investigation / review.

The appellant may withdraw the appeal at any time during the process. If for any reason an appeal is withdrawn, the GCCG will not accept a future appeal on the same grounds.

2. Objectives of the Dispute Resolution Process:

The GCCG's objectives of this process are as follows:

- To resolve competition disputes transparently, fairly and consistently and to mitigate risks and protect the reputation of the NHS.
- To be compliant with Monitor's acceptance criteria
- To prevent where possible legal challenge and external referral processes.

- To provide confidence to parties that the process is fair and transparent, enhancing willingness to participate in the market.

3. Acceptance Criteria:

The CGG will only accept appeals that meet the following criteria:

- The content of the dispute is covered by Monitor's complaints procedure and no legal proceedings have commenced.
- There is complete disclosure of all relevant and applicable information. Any individuals connected to the complaint are available to provide further evidence or testimony and the GCCG is not precluded from requesting more detailed information to make an informed decision.
- To provide confidence to parties that the process is fair and transparent, enhancing willingness to participate in the market.
- That the GCCG is the commissioner or lead commissioner for the service in question.
- The dispute is not trivial or vexatious
- The dispute is raised within 3 months of the disputed event occurring.

4. NHS Gloucestershire CCG Process:

Stage 1 - The Complaint:

The GCCG will acknowledge the appeal within two working (business) days of receipt.

The first stage is to gather information (see attached form – Appendix 2) and complete an initial assessment. A nominated officer will be appointed to carry out the assessment.

Following the initial assessment, the GCCG may instigate an informal investigation to add further detail. This stage is to be completed within 14 days. Following this assessment there will be an opportunity for conciliation between the parties. A timescale will be set and notified to each party.

If the criteria for dispute are met and conciliation has not resolved the issue, the nominated officer will complete a report for the GCCG Panel.

Stage 2 - GCCG Panel:

Membership – the Panel has three core members:

- Non-Executive Member (Chair)
- Executive Director
- Head of Procurement

The nominated officer will attend to present their investigation.

The Panel will formally meet and review the case. This stage is to be completed within 20 working days. Both parties will have had the opportunity to submit written material in advance of the hearing. Both parties may be offered the opportunity to attend the Panel.

Stage 3: The Decision:

The GCCG Panel has 4 potential outcomes:

- Complaint upheld
- Further investigation needed – to be completed within a maximum 20 working days
- Complaint rejected
- Complaint judged to be beyond the scope of the Panel so will be referred to NHSCB Regional Panel or to the National Co-Operation and Competition Panel.

The GCCG will write to the complainant(s) notifying them of its decision, explaining the rationale and any course of action required.

If the complainant does not believe the case has been satisfactorily resolved an appeal can be lodged with NHS England.

All results of the process will be presented to the GCCG Governing Body on an annual basis for information. Reports will include summaries of complaints and outcomes, as well as performance against target timescales.

Decision Not to Tender

Project Manager: <i>(Name)</i>	
Project Director: <i>(Name)</i>	
Date:	
Reference Number:	

<p>1. Project Title and Background: <i>(Include summary of proposed service and cross reference to annual operating plan)</i></p>
<p>2. Proposed Contract: <i>(Include proposed provider, contract duration and proposed commencement date)</i></p>
<p>3. Market Assessment: <i>(Summary of outcome of market assessment supporting the proposal)</i></p>
<p>4. Financial Assessment: <i>(Anticipated total aggregated contract value)</i></p>
<p>5. Reasons for Not Tendering:: <i>MUST ensure that reasons are permitted in accordance with the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. See Appendix 1 for summary of Regulations.</i></p>

6. Risk Assessment: <i>(Identify risks to patients if proposal is rejected / Identify risks to GCCG if proposal is accepted)</i>
7. Due Diligence: <i>(Basic financial and quality assurance checks must be undertaken in respect of proposed service provider. This will include: financial viability, economic standing, clinical capacity & capability, governance, affordability / value for money)</i>
8. Stakeholder Engagement: <i>(Is the proposal acceptable to patients? Include findings of any patient engagement)</i>
9. Procurement Comments: <i>(Confirmation that the narrative provided in 5 (above) complies with current legislative requirements as summarised in Appendix 1)</i>

Approved / Rejected by GCCG Governing Body / Core Executive Team in accordance with Prime Financial Policy: <i>(Signature)</i>	
Date:	
Comments:	

Summary of the National Health Service (Procurement, Patient Choice and Competition (No.2) Regulations 1 April 2013

Reg No.	Narrative:
<p>Two</p>	<p><u>Objective</u></p> <p>When procuring health care services for the purposes of the NHS, a relevant body must act with a view to:</p> <ul style="list-style-type: none"> (a) Securing the needs of the people who use the services, (b) Improving the quality of the services, and (c) Improving efficiency in the provision of the services, <p>Including through the services being provided in an integrated way including with other healthcare services, health-related services, or social care services.</p>
<p>Three</p>	<p><u>Procurement - General Requirements:</u></p> <p>When procuring health care services for the purposes of the NHS, a relevant body must comply with paragraphs 2 to 4:</p> <p>(2) The relevant body must:</p> <ul style="list-style-type: none"> (a) Act in a transparent and proportionate way, and (b) Treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership. <p>(3) The relevant body must procure the services from one or more providers that:</p> <ul style="list-style-type: none"> (a) Are most capable of delivering the objective referred to in regulation 2 in relation to the services, and (b) Provide best value for money in doing so. <p>(4) In acting with a view to improving quality and efficiency in the provision of the services the relevant body must consider appropriate means of making such improvements, including through:</p> <ul style="list-style-type: none"> (a) The services being provided in a more integrated way including with other health care services, health-related services, or social care services), (b) Enabling providers to compete to provide the services, and (c) Allowing patients a choice of provider of the services. <p>(5) A relevant body must, in relation to each contract awarded by it for the provision of healthcare services for the purposes of the NHS, maintain a record of:</p> <ul style="list-style-type: none"> (a) In the case of a contract awarded by the Board, details of how in awarding the contract it complies with its duties as to effectiveness, efficiency etc, improvement in quality of services and promoting integration; (b) In the case of a contract awarded by a CCG, details of how in awarding the contract it complies with its duties as to effectiveness, efficiency etc, improvement in quality of services and promoting integration.

Five	<p><u>Award of a new contract without a competition:</u></p> <p>A relevant body may award a new contract for the provision of health care services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider.</p> <p>For the purposes of paragraph 1, a relevant body is not to be treated as having awarded a new contract:</p> <p>(a) Where the rights and liabilities under a contract have been transferred to the relevant body from the Secretary of State, a Strategic Health Authority or a Primary Care Trust; or (b) Where there is a change in the terms and conditions of a contract as a result of:</p> <p>(i) A change in the terms and conditions drafted by the Board under regulation 17 of the 2012 Regulations (terms and conditions to be drafted by the Board for inclusion in commissioning contracts), or (ii) New terms and conditions drafted by the Board under that regulation.</p>
Six	<p><u>Conflicts of Interest in Purchasing Health Care Services and Supplying Such Services</u></p> <p>A relevant body must not award a contract for the provision of health care services for the purposes of the NHS where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract.</p> <p>In relation to each contract that it has entered into for the provision of healthcare services for the purposes of the NHS, a relevant body must maintain a record of how it managed any conflict that arose between the interests in commissioning the services and the interests involved in providing them.</p> <p>An interest referred to in paragraph 1 includes an interest of:</p> <p>(a) A member of the relevant body, (b) A member of its governing body, (c) A member of its committees or sub-committees or committees or sub-committees of its governing body, or (d) An employee.</p>
Ten	<p><u>Anti-Competitive Behaviour:</u></p> <p>When commissioning health care services for the purposes of the NHS, a relevant body must not engage in anti-competitive behaviour(a), unless to do so is in the interests of people who use health care services for the purposes of the NHS which may include:</p> <p>(a) By the services being provided in an integrated way (including with other health care services, health-related services, or social care services); or (b) By co-operation between the persons who provide the services in order to improve the quality of the services.</p> <p>(2) An arrangement for the provision of health care services for the purposes of the NHS must not include any term or condition restricting competition which is not necessary for the attainment of:</p> <p>(a) Intended outcomes which are beneficial for people who use such services; or (b) The objective referred to in regulation 2.</p>

Dispute Resolution Form

1. Complainant Contact Details:

Name:	
Address:	
Telephone Number:	
Email Address:	
Date:	
Name and title of the person(s) authorised to represent the complainant:	

2. Acceptance Criteria:

Evidence that each of the acceptance criteria has been met:
<p><u>Acceptance Criteria 1:</u></p> <p><i>The content of the dispute is covered Monitor and that no legal proceedings have commenced.</i></p> <p><u>Evidence 1:</u></p>
<p><u>Acceptance Criteria 2:</u></p> <p><i>There is complete disclosure of all relevant and applicable information. Any individuals connected to the complaint are available to provide further evidence or testimony and the GCCG is not precluded from requesting more detailed information to make an informed decision.</i></p> <p><u>Evidence 2:</u></p>
<p><u>Acceptance Criteria 3:</u></p> <p><i>To provide confidence to parties that the process is fair and transparent, enhancing willingness to participate in the market.</i></p> <p><u>Evidence 3:</u></p>

Acceptance Criteria 4:

The GCCG is the commissioner or lead commissioner for the service in question.

Evidence 4:

Acceptance Criteria 5:

The dispute is not trivial or vexatious

Evidence 5:

Acceptance Criteria 6:

The dispute is raised within 3 months of the disputed event occurring.

Evidence 6:

3. Basis of Complaint:

Details of the basis of the dispute and which principles are breached:

4. Evidence:

Any supporting evidence available:

5. Summary Statement:

A statement as to the desired outcome or resolution:

This form should be completed and forwarded by email or post to:

David Porter
Head of Procurement
NHS Gloucestershire Clinical Commissioning Group
Sanger House

NHS Gloucestershire Clinical Commissioning Group
Procurement Service

5220 Valiant Court
Delta Way
Gloucester Business Park
Brockworth
Gloucester
GL3 4FE

Email: david.porter6@nhs.net

**Gloucestershire Clinical Commissioning Group
Board**

Governing Body Meeting Date	Thursday 25 th September 2014
Title	Performance report
Executive Summary	This performance framework report provides an overview of Gloucestershire CCG performance against organisational objectives and national performance measures including finance for the period to the end of August 2014.
Key Issues	These are set out in the executive summary within the report.
Risk Issues: Original Risk Residual Risk	All risks are identified within the relevant sections of this report.
Financial Impact	The CCG is planning a surplus of £6.8m and the current forecast is that this surplus will be achieved.
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	These are set out in the main body of the

Involvement	report.
Recommendation	The Board is asked to: <ul style="list-style-type: none">• Note the financial position as at August 2014 and the inherent risks within the position• 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

1.0 Executive summary

1.1 Introduction

The performance report is broken down into the five sections of the GCCG performance framework:

- Clinical Excellence
- Finance and Efficiency
- Patient Experience
- Partnerships
- Staff

A full summary of performance against all national and local standards is included within the relevant scorecard for that section of the report. An overarching GCCG performance dashboard is included as a supporting appendix; providing an overview of all key national and local targets. Further supporting appendices provide a full analysis of the CCG's Finance position and progress against individual QIPP programmes

1.2 Balanced scorecard 2014/15 – up to 31st August 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 – Green**, due to Amber rating of 1 success criteria.

Clinical excellence - Perspective highlights:

- The CCG is developing a stronger focus on patient safety with the topic a regular item on the agenda of the clinical quality review group meetings with providers.
- CCG is fully involved as an active member of the south west patient safety collaborative.
- Quality impact assessments (QIA) are now used to provide assurance that new service changes and developments do not negatively impact on quality, safety or patient experience.
- Operational resilience capacity planning (ORCP) funds of £3.6 million have been received by Gloucestershire CCG from NHS England to support winter planning and ensuring high quality care during peaks in demand. Following a rigorous process of bidding from organisations across Gloucestershire including the voluntary sector, these funds were prioritised and allocated to those proposals that will most impact performance.

Good performance

- Ambulance targets are monitored at a SWAST wide aggregate level. Performance in quarter one has been good with achievement of key timeliness indicators.
- On-going achievement of all cancer 31 day targets for diagnosis to treatment and subsequent treatment.
- Significant improvement in compliance with the 62 day cancer target. Quarterly performance was above the 85% target for the first time since quarter 4 of 2012/13.

Challenging performance:

- Number of Health care acquired infections. During quarter 1, 4 MRSA cases have been reported against a target of 0.
- Reduction in the proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit.

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

Finance and Efficiency - Perspective highlights:

- The overall assessment for the finance and efficiency perspective is amber.
- Known risks and pressures have been fully assessed and included within the CCG's forecast position, with mitigating actions where appropriate.

Good performance

- The CCG is forecasting to deliver a planned surplus of £6.862m.
- The better payment practice code performance for the year to date (for non-NHS invoices by volume) is 95.7% which is in line with the targeted figure.

Challenging performance:

- There continues to be a high risk of slippage on QIPP schemes within the current financial year. Slippage for the year to date is £3.048m
- Continuing health care cases are increasing significantly

Patient experience – Amber, due to amber rating of 3 success criteria.

Patient Experience - Perspective highlights:

- The Friends and Family test results continue to demonstrate improved performance.
- Overall A&E response rates are above the required rate; however, the CCG is reviewing the disparity between performance at each A&E department.
- Inpatient response rate is above the level achieved in 2013/14.
- Staff FFT implemented with all providers
- In addition to the ORCP funds highlighted in clinical excellence; Gloucestershire CCG has also been successful in provisionally securing an addition £2.1 million from central funds to support RTT activity at GHNHSFT.

Good performance

- 6 week wait performance for diagnostic tests has improved and was green rated in July. The issues identified with echocardiograms have been resolved.
- There have been significant improvements in mixed sex ward performance. During the first 4 months of 14/15 there were 0 cases reported.
- IAPT & CPA approach indicators have both been achieved in Quarter 1; continuing the improvements seen throughout 2013/14.

Challenging performance:

- Emergency department 4 hour waiting times for the year to date are below the 95% target. August performance was 96.3%; the GCCG continue to co-ordinate a range of wider system actions.
- RTT pathways in excess of 52 weeks, increases seen during the first 4 months at out of county providers, this is being investigated
- Number of patients seen within 2 weeks of urgent referral for breast symptoms is significantly below the target level. The issues identified in quarter one have started to be resolved with the provision of extra capacity and enhanced medical staffing.

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

Partnerships - Perspective highlights:

- Further progress made on the Better Care Fund (BCF) submission.
- Full sign up to collaborative commissioning agreement and contract performance of all health and social care services in the community provided by Gloucestershire Care Services.
- Development of system wide Operational Resilience and Capacity Plan (ORCP)

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

Staff - Perspective highlights:

- Monthly turnover has decreased from 1.78% to 1.6% per month
- The number of CCG vacancies has reduced from 3 to 6
- Staff sickness levels have decreased from 2.81% to 2.2%

1.3 GCCG Performance Framework Overview

The sections below provide an overview of each domain. Each of the sections is broken down into success criteria which when combined provide an overall rating for the domain. The development of the partnerships section is ongoing as this is an area of development for the CCG.

All indicators are RAG rated, based on the 2014/15 NHS Everyone Counts Planning for Patients thresholds. Key national and local indicators are given an overall rating by weighting their importance to the organisation. Indicators which feature in the NHS constitution, Quality Premium and CCG assurance framework receive the highest weighting with local targets being given a lesser value. The overall rating is then derived from the combined score of those targets rated Amber and Red.

Areas of performance assessed as being at risk of failure at year end, or other issues that engender concerns throughout the year, for which the 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.

Performance framework

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

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

Internal Perspective	Organisational Objective
Clinical Excellence	(1) Develop strong, high quality, clinically effective and innovative services. We will deliver this through a multi professional focus, with a particular emphasis on clinical programme approach and developing our member localities.
Finance and Efficiency	(3) Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation. (4) Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.
Patient Experience	(2) Work with patients, carers and the public; to inform decision making.
Partnerships	(5) Work together with our partners to develop and deliver ill health prevention and care strategies designed to improve the lives of patients, their families and carers.
Staff	(6) Develop strong leadership as commissioners at all levels of the organisation, including localities.

2.1 Perspective 1. Clinical Excellence

2.1.1 Clinical Excellence – Period up to 31st August 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: Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.		A
Key performance indicators		
Outcomes measures for patient safety have been developed based on the CCG Outcome framework and sign up for safety initiative.		A
Quality Impact Assessments are undertaken for all new proposed initiatives and service developments. This is considered by the QIPP assurance board before decisions are made to support new initiatives. Mitigation is planned where necessary to ensure patient safety.		G
Success criteria: 2. Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.		G
Key performance indicators		
A robust process to timely monitor compliance with NICE, which provides assurance that all NICE publications are considered and Technology Appraisals are implemented within the required time frame.		G
Clinical Quality Review Groups meet quarterly and provide assurance to the Governing Body through the production of a bi-monthly provider quality report. Ad-hoc meetings take place with providers on specific concerns.		G

Success criteria: 3. <i>The Organisation has a culture where clinical effectiveness underpins decision-making, through considering up to date evidence and horizon scanning.</i>	A
Key performance indicators	
CPGs have a portfolio of clinical evidence which informs and supports their decision-making.	A

2.1.2 Success criteria 1: Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.

The CCG is developing a stronger focus on patient safety with it being a regular item on the agenda of the clinical quality review group meetings with providers. In addition the CCG is fully involved as an active member of the south west patient safety collaborative. It is the intention of the CCG Quality Team to establish a Gloucestershire patient safety forum to enable shared learning between our main providers and primary care. The aim is to improve the level of harm free care to our patients.

Quality impact assessments (QIA) are now used to provide assurance that new service changes and developments do not negatively impact on quality, safety or patient experience.

QIA will be used to provide assurance to the CCG regarding the implementation plans for the new out of hours service following the awarding of the tender.

2.1.3 Success criteria 2: Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.

Clinical commissioning groups have 90 days after the publication date of a NICE Technology Appraisals (TAs) to make the treatment available to patients who are covered by the criteria published within the specified TA.

The table below provides details of the cumulative number of NICE TAs that have been published since 1st April 2013. The number issued refers to the actual number of TAs published, and the second box below refers to the number relevant to NHS Gloucestershire CCG i.e. some TAs will be the responsibility of specialised commissioning or the cancer drugs fund to implement.

NICE TAs	Q1 (Apr - Jun14 -	Q2 (Jul - Sept 14)			
Number issued	5	4			
Number relevant to GCCG	1	2			

The quality team have established quarterly Clinical Quality Review Groups (CQRG) chaired by the Executive Nurse and quality lead. These are held for Gloucestershire’s main providers, namely Gloucestershire Hospitals NHSFT, 2gether NHSFT, Gloucestershire Care Services Trust and a further CQRG for Care Homes. These meetings report directly to the relevant NHS Gloucestershire CCG/Provider contract boards, and provide a focused opportunity for quality to be discussed between provider and commissioner.

CQRG’s have the ability to escalate any issues to the full contract board, and where necessary to the regular wider Quality Surveillance meetings.

2.1.4 Success criteria: 3. The Organisation has a culture where clinical effectiveness underpins decision-making, through considering up to date evidence and horizon scanning.

Clinical effectiveness support to CPGs is being provided for a 6 month trial period by a part-time secondee from the University of the West of England (UWE). This has enabled access for CPGs to systematic evidence-based reviews and outcome data to support their work.

A small contract has been agreed with the CSU to provide the CCG

with access to their clinical effectiveness updates and NICE implementation impact assessments on a monthly basis. This information will be shared with clinical leads and CPGs.

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:

- Number of Health care acquired infections
- Reduction in the proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit

Areas of good performance include:

- SWAST wide Ambulance timeliness indicators
- On-going achievement of all cancer 31 day targets
- Achievement of all three cancer 62 day targets during quarter 1.

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					Amber 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%	June	99.1%	99.0%	
Cancer - subsequent treatment for cancer within 31 days - surgery	94%	June	95.0%	97.3%	
Cancer - subsequent treatment for cancer within 31 days - Drug Regime	98%	June	100.0%	100.0%	
Cancer - subsequent treatment for cancer within 31 days - Radiotherapy	94	June	98.8%	99.5%	
Cancer - first definitive treatment within 62 days GP referral	85%	June	89.9%	88.1%	
Cancer - first definitive treatment within 62 days screening service	90%	June	87.0%	93.0%	
Cancer - first definitive treatment within 62 days upgrade	90%	June	100.0%	92.9%	
Patients Access to unscheduled care					
Cat A RED 1 Ambulance incidents	75%	July	73.7%	75.4%	
Cat A RED 2 Ambulance incidents	75%	July	74.1%	75.0%	
Cat A 19 min response Ambulance	95%	July	94.6%	95.1%	
Over 30 minute ambulance handover delays (GHNHSFT)	<2013/14	July	90	283	
Over 1 hour ambulance handover delays (GHNHSFT)	<2013/14	July	8	38	
Crew clear up delays of over 30 minutes	<2013/14	July	16	39	
Crew clear up delays of over 1 hour	<2013/14	July	1	3	
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%	July	62.5%	79.2%	
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	60%	July	67.0%	67.0%	
Treating and caring for people in a safe environment & protecting them from avoidable harm					
Number of MRSA infections (Health Community)	0	July	0	4	
Number of MRSA infections (GHNHSFT)	0	July	0	0	
Number of C.diff infections (Health Community)	162	July	15	50	
Number of C.diff infections (GHNHSFT)	52	July	3	13	
Number of Never Events	0	July	0	0	

2.3 **SWAST Ambulance indicators**

Ambulance targets are monitored at a South Western Ambulance Trust wide aggregate level. Performance in July reduced across the range of timeliness indicators, with Red 1, 2 and A19 targets all amber rated for July.

Overall performance across the year remains very good, with all targets green rated during quarter 1.

Performance in Gloucestershire remains below the required standards and is similar to that achieved throughout 2013/14:

Red 1 – 67.2%

Red 2 – 70.2%

A19 – 93.5%

GCCG are in discussion with SWAST regarding improvements in local performance and specific actions to achieve improved performance. The CCG invested in the SWAST contract in 2014/15 to enable more targeted local interventions.

Activity levels in Gloucestershire increased by 5.3% in 2013/14 and have continued to rise in 2014/15.

SWAST have confirmed that additional crews and vehicles will be deployed within the Gloucestershire area.

Stroke specific targets – enhancing quality of life for people with long-term conditions

80% of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit.

Performance in April and May was green rated. Performance in June & July has been below the 80% standard and is amber rated.

In July 25 of the 40 confirmed stroke patients discharged from GHNHSFT spent more than 90% of their time on the stroke unit.

Capacity issues have been highlighted by GHNHSFT during June and July which has adversely affected performance. Root cause analysis has shown that the number of discharges for the unit has decreased impacting on length of stay. Key actions include:

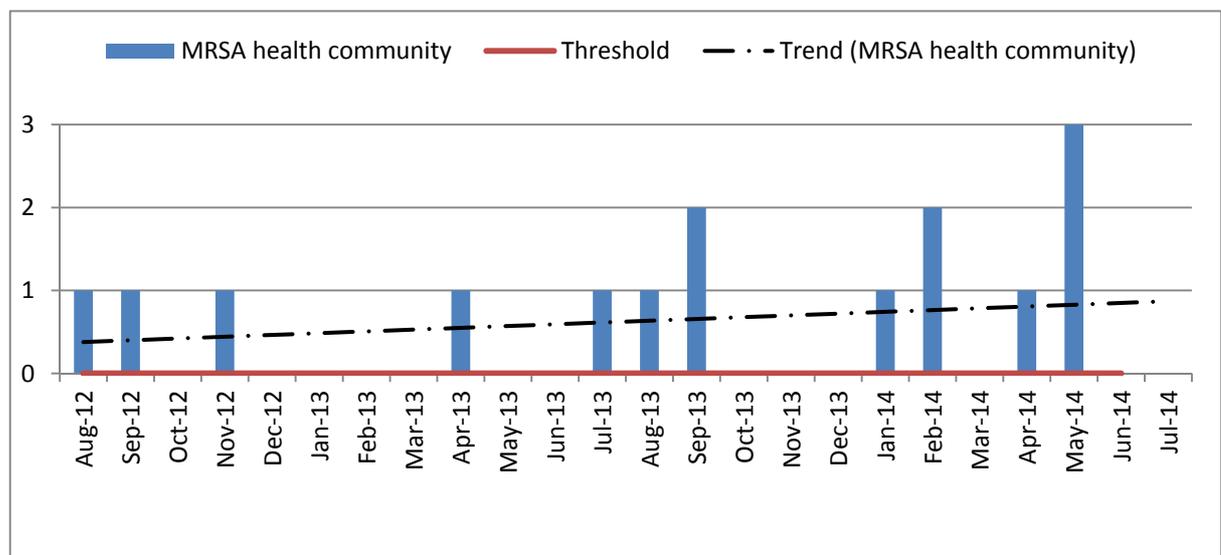
- Length of stay review in the service line
- Review of therapy services to the stroke unit

It is anticipated that the above actions will ensure that the 80% target will be achieved from August onwards.

Number of MRSA infections (Health Community)

Year to date performance is Red rated with 4 reported cases against a target of zero. All of the cases in Gloucestershire have been classified as pre 48 hour and have not been attributed to provider.

GCCG are investigating the cases reported in Q1; for CCG actions please see GCCG Quality report to the Integrated Governance Quality committee (IGQC).



Number of total C. diff infections (Health Community)

The threshold for 2014/15 has increased from 162 to 201 cases in line with NHS England guidance.

Current performance is green rated with 50 cases against a year to date target of 71.

3.1 Perspective 2. Finance and Efficiency

3.1.1 Finance and efficiency – Period to 31st August 2014

Summary:

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%	0.50%	
Surplus - full year variance to planned performance (%age)	0.10%	0.50%	
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%	75%	

- The CCG is forecasting to deliver a planned surplus of £6.862m.
- Known risks and pressures have been fully assessed and included within the CCG's forecast position, with mitigating actions where appropriate.
- There has been slippage on a number of QIPP schemes in this financial year.
- Financial risks are monitored through a continuous review of budgets and proposed investments and the use of the CCG's contingency and activity reserves.
- The better payment practice code performance for the year to date (for non-NHS invoices by volume) is 95.7% which is in line with the targeted figure.

- Key risks:
 - Provider contracts over perform in excess of those levels within the year end forecast
 - Increased slippage on QIPP schemes (noting that the current RAG ratings are embedded within current financial forecasts)

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

3.2 Resources

The CCG's current anticipated resource limit (see Appendix 2) is £689.82m. During the month, net additional resource of £2,089k was received which primarily related to Referral to Treat (RTT) (£2,193k) funding, New-born Screening (£67k – with commissioning responsibilities returning from NHS England) and various other small deductions.

3.3 Expenditure

The financial summary as at 31st August 2014 shows a year to date surplus of £2.859m in line with the plan and further detail is shown at Appendix 3. Key budget areas with either a financial risk or forecast outturn variance are highlighted below:

<u>Key</u>	Trend	Forecast Over/ (Under) Spend £'000
Indicates a favourable movement in the month Indicates an adverse movement in the month		
Gloucestershire Hospitals NHS FT		
The contract performance highlights a continuing trend of over-performance in non-elective/emergency spells, particularly in paediatric, medical specialties and trauma and orthopaedics. ED attendances are above plan by 6.9% and the CCG has undertaken work to identify the cohort of		£0

<p>patients influencing this rise. The more significant increase in patient attendances at A&E relates to adults of working age and older adults with key areas of increase being in minor injuries/minor sprains. The year to date overall financial position on the contract benefits from performance below plan on elective activity in urology, colorectal and trauma and orthopaedics. However, there has also been a deterioration in waiting list performance with the size of the waiting list increasing overall, although referral to treat times are being maintained by the Trust. As in previous months, outpatient attendances and procedures are below plan by 2.1% and 4% respectively. The breakeven forecast reflects that the contract is broadly in line with the overall plan.</p>		
<p>Wye Valley NHS Trust</p>		
<p>Activity in Podiatric day surgery is significantly above those levels initially planned and subsequent analysis has highlighted practices with increased referral levels. Further work is in progress to review podiatric surgery performance across all contracts.</p>		<p>£317.0</p>
<p>Winfield Hospital</p>		
<p>Although the forecast under-performance has decreased during the month, the position on T & O activity highlights increases below those planned growth levels included within the initial 2014/15 SLA.</p>		<p>(£84.3)</p>
<p>Nuffield Hospital</p>		
<p>This position has improved from last month as activity seems to have levelled off. The over spend is still due to elective activity in Trauma and Orthopaedics.</p>		<p>£69.6</p>

Royal National Hospital for Rheumatic Diseases NHS FT		
Currently reporting an overspend and includes significant spend for one patient relating to minor knee procedures. A query has been raised with the provider.	↓	£41.1
University Hospitals Bristol NHS FT		
This anticipated overspend is being investigated further regarding, in particular, the commissioning responsibilities of activity of a, potentially, specialist nature.	↓	£200.0
Tetbury Hospital Trust		
There are small underspends in most areas but the significant being within Trauma & Orthopaedics.	↑	(£40.8)
Any Qualified Provider (AQP)		
The position has improved again this month due to Oxford Fertility and GP care (an AQP provider for diagnostic services). GP care are reviewing their capacity and are anticipating reaching their maximum but later than previously assumed; thereby improving the position.	↑	£76.3
Non Contractual Activity (NCA)		
There is no movement in the reported position. This area is reviewed on a monthly basis following receipt of further activity information which continually assists in forecasting.	↔	£200.0
Continuing Healthcare		
Activity has increased again in August relating to Funded Nursing Care and Domiciliary care. This is a significant shift in activity in a short period of time and analysis is taking place within the CCG and with colleagues in GCC to understand both the shift in expenditure and the trend in patient numbers to	↓	£1,961

establish whether an element relates to previous periods and also the ongoing trend.		
Mental Health		
Learning Difficulties placements jointly managed with Gloucestershire County Council are continuing to significantly overspend, this relates to slippage on planned savings through renegotiation on packages of care and also to 8 new known patients this year.	↓	£630.0
Home Oxygen		
This service continues to underspend due to benefits from pricing and the QIPP scheme that has been implemented. This saving is anticipated to progress throughout the year. The impact on patient numbers is being closely monitored.	↔	(£184.6)
Running costs		
The CCG has planned to underspend against this allocation on a recurrent basis to mitigate pressures in 2015/16 resulting from a 10% national allocation reduction. Although the forecast pay underspend recognises the impact of unfilled vacancies, these posts are now being filled and, therefore, the position in this area is not anticipated to improve any further. Property Services recharges continue to be a risk and discussions are underway with NHS Property Services understand the position and clarify questions around some of the charges.	↑	(£981.5)

3.4 QIPP

Forecasts for QIPP programmes have been based on information available at the end of August, Appendix 4 reports the extent of QIPP performance 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 2015/16. This shows slippage in

the CCG's overall programme of £3.048m; this forecast has been included in the CCG's overall financial position. Additional programmes are currently being reviewed to bring forward where it is believed that there is opportunity to deliver in year savings.

3.5 **Cash (Appendix 6)**

The CCG has now been given an initial indication by NHSE of its 2014/15 Maximum Cash Drawdown figure, which is broadly in line with expectations. By the end of August, the CCG has drawn down 3.9% more cash than it would have done under a straight line profile due to funds being paid over to Gloucestershire County Council at the beginning of the financial year. This is consistent with the position in the last financial year. The cash balance at the end of August was £5,936k.

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 current year to date position in the value of invoices paid is 98.86% and 95.65% by volume, which are both in line with the 95% target.

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

The position shown includes the audited opening balances from the 2013/14 Annual Accounts as a reference point.

3.8 **Financial Risk**

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

- Contract Performance
A large number of the CCG's contracts are variable and there is a risk of over performance against the contracted value.
- QIPP slippage
Due to the nature and scale of system changes within the QIPP programme along with the number of live schemes for the organisation there is a high risk of ongoing slippage to the programme.
- Properties
Under the charging regime for NHS Property Services the CCG will

be charged for any void space in properties owned or managed by NHS Property Service. The CCG will shortly be meeting with Prop Co to discuss ways to reduce this risk and to resolve a number of outstanding queries.

- LD Joint Funded Placements
Such packages have been reviewed regarding the extent of health and social need identified and it is anticipated that the NHS's share of costs will reduce in 2014/15. However, the trajectory to realise this decrease is under review.
- Continuing Health Care & Funded Nursing Care costs
The CCG has been made aware of a significant number of cases relating to a single provider where recharges have not been made for costs incurred by Gloucestershire County Council in previous financial years. Work is currently underway to quantify this issue and to assess its implications. Continuing Health Care cases are increasing significantly.
- Financial Ledger
The CCG has to use the national finance system and the associated Integrated Single Financial Environment reporting structure. This has led to very limited flexibility in reporting the position and the CCG is working with other organisations to enable greater flexibility in the reporting structure to enable effective local reporting.

Recommendations

The Governing Body is asked to

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

4.1 Perspective 3. Patient experience

4.1.1 Patient Experience – Period to 31st August 2014

PERSPECTIVE 3	Patient Experience	Amber
Success criteria 1: Reporting: <i>Improve reporting of patient experience and the use of feedback to influence commissioning intentions</i>		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: <i>Improve staff reporting if three domains of quality: safety, effectiveness and experience</i>		A
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		A
Success criteria 3: Effecting change based on patient experience feedback : <i>Staff recognise the value of patient experience in their commissioning role</i>		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	R
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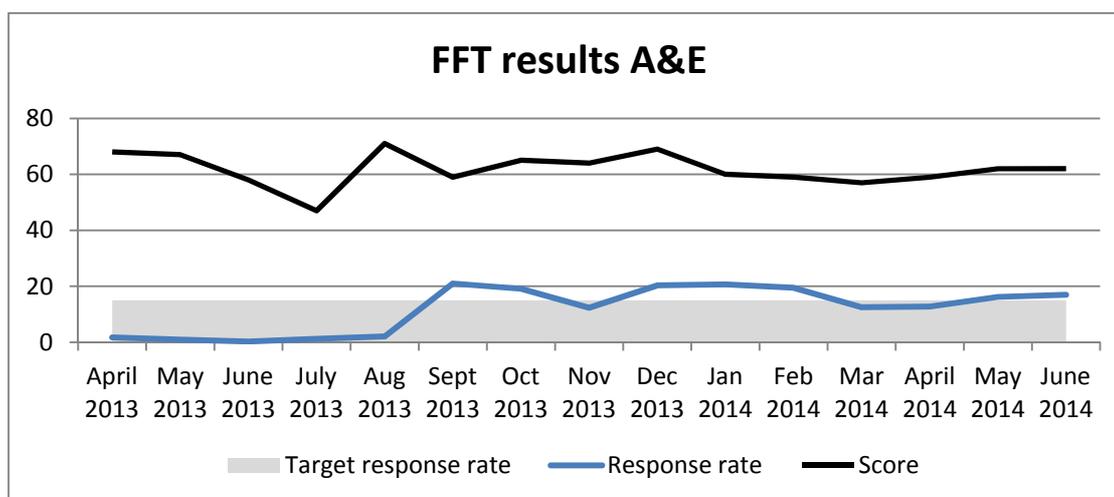
Key performance indicators	
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Achievement of key local and National standards relating to Patient Experience – see section 4.2.1	R
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4.1.2 Success Criteria 1: Reporting – Improve reporting of patient experience and the use of feedback to influence commissioning intentions (Amber).

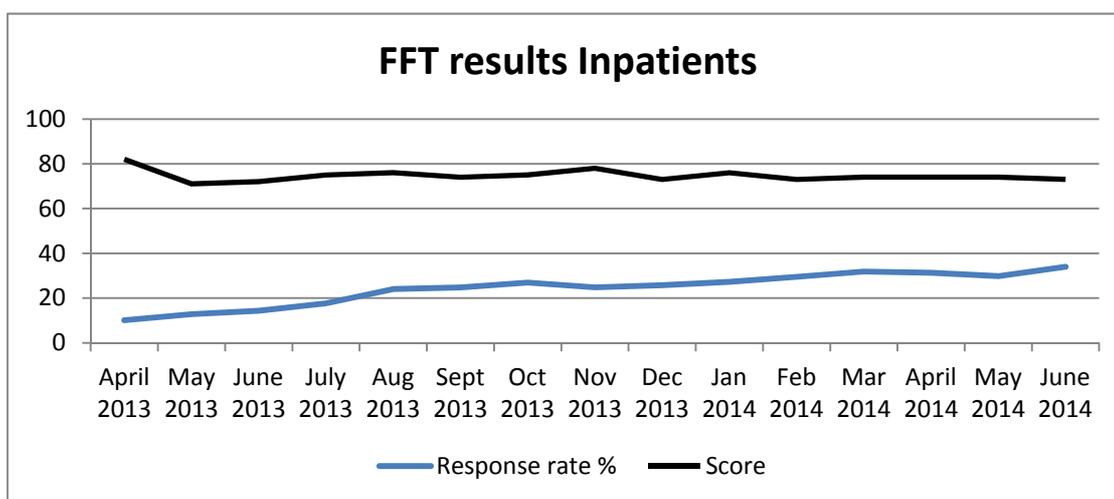
Currently reporting overall recorded as ‘Amber’ for this element.

Whilst an overall response rate for A&E is above the 15% required for validity, and this has been maintained above the 15% target over the past three months, there is a substantial difference between the response rate for Gloucestershire Royal Hospital (11.4%) and Cheltenham General Hospital (26.2%).

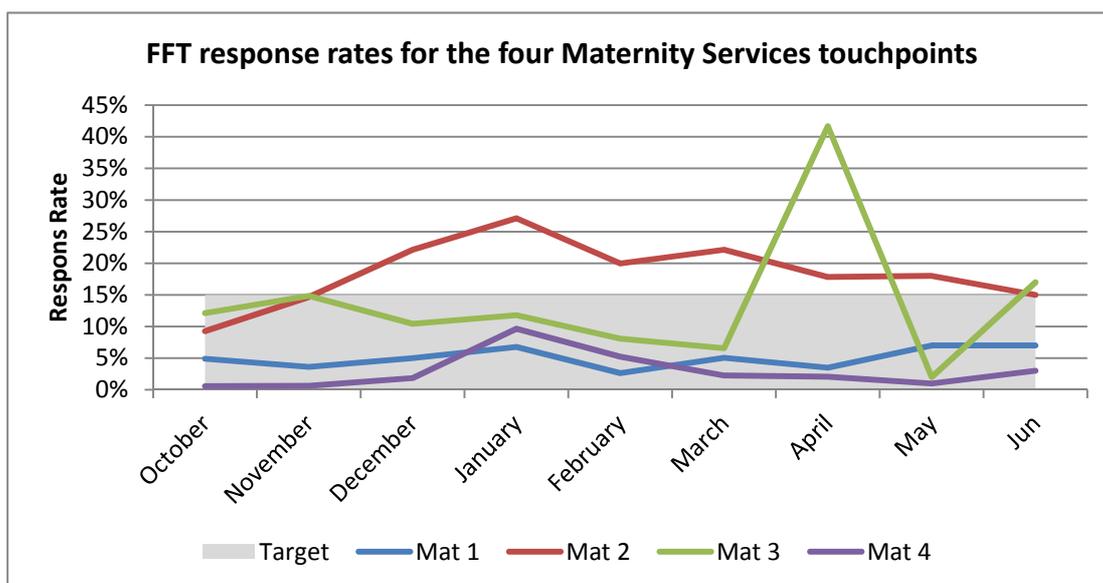


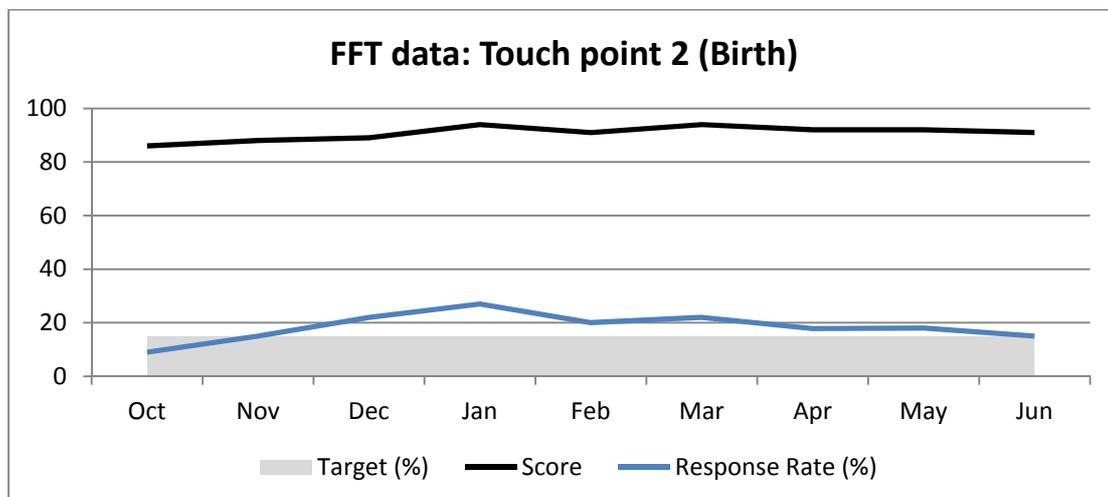
The overall response rate for inpatient services continues to be

above the agreed CQUIN target of 30%. The response rate for Gloucestershire Royal Hospital inpatients is 30.75% and for Cheltenham General Hospital it is 37.1%. The CCG's focus is also on the qualitative aspects of the FFT, which is reported by GHNHSFT to regular Clinical Quality Review Group meetings as part of CQUIN monitoring reporting.



For maternity services, only the response rate for Question 2 (Labour) consistently meets validity criterion of 15%.





Response rates for touch point 1 (Antenatal) vary widely between the sites (44% for Cheltenham, 2% for Gloucester and 33% for Stroud, reflecting the different nature of the service at each location. Obtaining responses for touch point 4 (Post-natal following discharge home) continues to prove challenging.

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

Within provider organisations Gloucestershire Care Services (GCS), 2gether NHS Foundation Trust (2GNHSFT) and Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) have each implemented a staff FFT and outcomes are reported through CQUIN reports, these are also monitored at quarterly CQRG meetings.

2GNHSFT reported some initial staff FFT results within the CQUIN report for quarter 1 of 2014-15. It does not include any reference to the response rate and clarification is being sought on this; further reporting of the qualitative data for the first staff FFT is also to follow. 2GNHSFT is running a further staff FFT survey throughout the month of August.

The results of GHNHSFT’s staff FFT was reported in the CQUIN report for quarter 1 of 2014-15. The response rate was 5.8%

(compared to a 63% response rate for their staff survey). The feedback is currently being analysed in order to maximise the themes and learning from the qualitative data which was returned as part of the staff FFT exercise.

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).

Following consultation with affected staff, the new structure for the patient engagement and experience function within GCCG commenced for a one month trial period on 1 September 2014. The new structure provides increased capacity to ensure patient experience feedback is collected, collated and used to inform Clinical Programme Groups and other GCCG led projects.

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
- RTT pathways in excess of 52 weeks
- Number of patients seen within 2 weeks of urgent referral for breast symptoms.
- Planned diagnostics – 6+ week wait
- Cancelled operations

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
- Achievement of Q1 mental health performance indicators

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					Red rated
Patients Access to planned care services	Threshold	Month	Performance	YTD performance	Trend
% of admitted pathways treated within 18 Weeks	90%	July	90.1%	90.9%	
% of non - admitted pathways treated within 18 Weeks	95%	July	95.3%	95.4%	
% of incomplete Pathways that have waited less than 18 Weeks	92%	July	91.7%	91.9%	
Zero RTT pathways greater than 52 weeks	0	July	9	37	
% of patients seen within 2 weeks of GP referral for suspected cancer	93%	June	95.0%	88.2%	
% of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected	93%	June	88.9%	58.4%	
% of patients waiting more than 6 weeks diagnostic test	1%	July	0.6%	1.00%	
% of patients waiting more than 6 weeks for a Planned/ Surveillance diagnostic test from their to be seen date – Endoscopy procedures only	1%	July	27.3%	27.3%	
Patients access to community care					
% referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	95%	July	95.0%	98.0%	
% referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	95%	July	99.0%	97.0%	
% referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	95%	July	100.0%	99.0%	
% referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	95%	July	96.0%	97.0%	
% referred to the Podiatry Service who are treated within 8 Weeks	95%	July	82.0%	91.0%	
% referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	95%	July	96.0%	97.0%	
% referred to the Adult Physiotherapy Service who are treated within 8 Weeks	95%	July	96.0%	96.7%	
% referred to the Parkinson Nursing Service who are treated within 8 Weeks	95%	July	100.0%	100.0%	
% referred to the Diabetic Nursing Service who are treated within 8 Weeks	95%	July	97.0%	99.0%	

Patients Access to unscheduled care	Threshold	Month	Performance	YTD performance	Trend
4-hour A&E target GHNHSFT	95%	July	96.3%	93.5%	
4-hour A&E target GCS MIU	95%	July	100.0%	99.9%	
12 hour trolley waits	0	July	0	0	
Positive patient experience of secondary care					
Mixed-sexed accommodation breaches	0	July	0	0	
Cancelled operations - 28 day breaches	0	July	3	12	
Urgent operations cancelled for a second	0	July	0	0	
Positive patient experience of mental health services					
Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	95%	Q1 14/15	97.3%	97.3%	
The proportion of people who have depression and or anxiety disorders who receive psychological therapies	3.5%	Q1 14/15	4.1%	4.1%	
The proportion of people who complete therapy who are moving towards recovery	50%	Q1 14/15	50.5%	50.5%	

4.3 4-hour A&E target - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge.

Threshold – at least 95% of patients should be transferred, admitted or discharged within 4 hours.

Performance in August was 96.3% (95.9% at Gloucestershire Royal & 97.0% at Cheltenham General)

Improvements to performance in August have increased year to date performance to 93.5%.

A number of key areas of performance challenge have been identified within the GHNHSFT action plan. The three main themes are as follows:

- The timely treatment of minor injuries within the ED department (non-admitted patients who are able to be discharge following treatment in the A&E department)
- Hospital flow - bed capacity

- Medical staffing - nurse and doctor vacancies

GCCG have invested in the following to improve flow through the unscheduled care system:

- Purchase of additional clinic appointment slots at Gloucestershire Health Access Centre (GHAC)
- Increase in the provision of Rapid Response, which is now operational in Gloucester City and Cheltenham localities.
- Expansion of the integrated discharge team.

A trajectory has been agreed with GHNHSFT and performance is monitored via fortnightly performance calls.

Current year to date performance is below the level required to meet the trajectory at 93.0%. The number of people attending A&E departments in 2014/15 has been above expected level and this has impacted upon performance. Increases have been seen in adults of working age and also older adults.

Operational resilience capacity planning (ORCP) funds of £3.6 million have been received by Gloucestershire CCG from NHS England to support winter planning and ensuring high quality care during peaks in demand. Following a process of bidding from organisations across Gloucestershire including the voluntary sector, these funds were prioritised and allocated to those proposals that will most impact performance.

Gloucestershire CCG has also been successful in provisionally securing an addition £2.1 million from central funds to support RTT activity at GHNHSFT.

Number RTT pathways greater than 52 weeks

Breaches continue to be high with 9 incomplete pathways of 52+ weeks reported at the end of July. During Q1 there were a further 28 incomplete

pathways of 52+ weeks reported to the CCG.

The majority (32) of the breaches have 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 contracts 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.

Performance in June improved to 88.9%; however quarter one performance was significantly below the 93% threshold at 58.4%.

Capacity issues within the breast surgery and breast screening teams have been compounded by an increase in referral. GCCG are reviewing the increase in referrals to identify key trends.

An action plan is in place with performance improving in June. The key actions have included:

- Recruitment of an additional Breast surgeon
- Provision of additional capacity to limit backlogs and reduce waiting times
- Pathway reviews and improved tracking of patient pathways

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

The proportion of patients waiting over 6 weeks for a planned procedure has increase over recent months.

Discussions with providers are on-going. The key actions have included:

- The provision of additional endoscopy capacity at GHNHSFT
- Review of elective capacity across a number of specialties
- Recruitment of additional senior Radiology clinicians

This issue is being reviewed via the fortnightly performance calls; actions are also being taken to increase capacity for diagnostic imaging and endoscopy.

The number of patients waiting has increased following the backlog clearance exercise during 2013/14, as a significant proportion of the patients seen in 2013/14 are on annual surveillance.

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 current year-to-date position shows that so far in 2014/15 12 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.

Of the 3 cases cancelled in July, 2 were in General Surgery and the 3rd was in Cardiology.

The year to date position compares favourably to the 32 cancellations (who weren't offered another date within 28 days), during the same period in 2013/14.

5.1 Perspective 4. Partnerships

5.1.1 Partnerships – Period to 31st August 2014:

1

PERSPECTIVE 4	Partnerships	Green
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Success criteria 1: Building effective partnership working	Amber
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<i>by putting in place a joint planning and governance framework to improve outcome for the Gloucestershire population</i>	
<i>Key performance indicators</i>	
Better care fund (BCF) plan	A
Develop a 5 year commissioning plan agreed with key providers	G
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	Green
<i>Key performance indicators</i>	
Increase the range and volume of services commissioned jointly with both GCC and District Councils.	G
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.	G
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	G
Partnership working group established to review dashboard and set targets.	G
Develop and agree an Operational Resilience and Capacity Plan (ORCP)	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 (Amber)

In April of this year Gloucestershire submitted a successful Better Care Fund (BCF) proposal which was underpinned by a shared programme of work. It is timely to remember that the shared programme of work associated with the BCF reflected our system wide commitment to the precepts underpinned Joining Up Your care. The six metrics associated with the BCF each had an emerging plan of service re-design and development.

As a system we had implemented new engagement methodologies in order to move forward, such as the BCF Providers Forum. Wherein we could engage and co-design system change with our provider partners. However, over the past few months there has been much national discussion on the subject of the Better Care Fund with revised guidance issued at end of July. In essence there are now additional requirements to need to be included in the plan;

- Previously: Reducing avoidable emergency admissions & local target. Now: reducing all emergency admissions by 3.5%
- Performance element now only linked to emergency admission reduction metric
- Other metrics – changes to baseline year
- The case for change: additional analysis and evidence
- Plan of action: tighter description of detailed plans to deliver reduction in admissions
- Governance: more detail on risk sharing arrangements, contingency plan, accountability

5.1.3

- Alignment of plans: clearer articulation
- Impact on providers: ensuring the impact is understood and providers fully engaged

Success criteria 2: Delivery of the Health & Well Being plan (Green)

There is currently a comprehensive assurance methodology being applied to all Local Authorities and Clinical Commissioning Groups and H&W Boards are required to re-sign off on the plans with a view to a submission date of the 19th of September for updated return.

The CCG has a long established history of collaborative and joint commissioning with the local authority both on a county and district level, a key example of how we work in partnership would be the Joint Commissioning Partnership. The Joint Commissioning Partnership between Gloucestershire County Council (GCC) and Gloucestershire Clinical Commissioning Group is a key element of the Governance arrangements that support joint commissioning. The scope and role of the JCP is includes:

- Assessing policy impact - mapping and interpretation leading to directing development of new commissioning strategies
- Scoping, testing and prior approval of joint commissioning strategies
- Implementation of joint commissioning strategies including performance oversight
- Oversight of joint funding arrangements - approval and assurance

The JCP consists of an Executive made up of Chief Officers/Senior officers from both organisations and a Board (JCPB), drawn from GCC Cabinet and CCG Board. The role of the JCPB is to set policy direction, and to assure themselves that joint commissioning is carried out with due regard to each organisation's statutory roles and responsibilities, including service quality, performance and outcomes. The role of the Executive is to develop and implement joint commissioning strategies, policies and plans, to draw to the attention of the Board any issues arising from current joint commissioning that require resolution, and to keep the Board informed of likely future developments.

In support of joint commissioning, the CCG and GCC jointly fund a small number of Joint (or Lead) Commissioner posts:

5.1.4

- Mental Health

- Children and Young People
- Older People / Long Term Conditions
- Learning Disabilities
- Physical Disabilities

Success criteria 3: Partnership working group established to review dashboard and set targets (Green).

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.

In addition to the above, commissioners working within the CCG have achieved full sign up to a collaborative commissioning agreement with regards to jointly commissioning and contract performance of all health and social care services in the community provided by Gloucestershire Care Services. This joint work programme is underpinned by an agreed shared governance methodology.

In line with new national requirement we have developed a Gloucestershire Operational Resilience and Capacity Plan (ORCP) and prioritised additional non-recurrent system resilience resources.

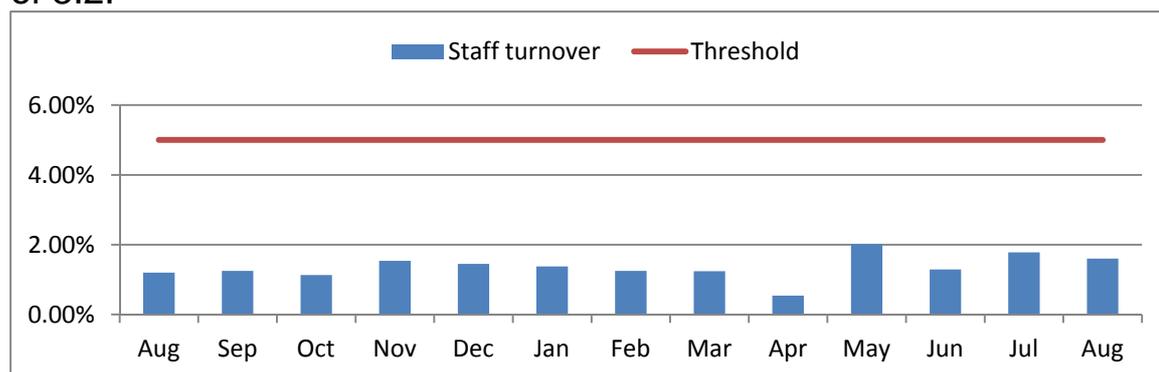
6.1 Perspective 5. Staff

6.1.1 Staff – Period to 31st August 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		1.6%
Number of current Vacancies in structure		6
Success criteria 2: Personal development processes that are linked to the strategic plan		Baseline to be established during 2014/15
<i>Key performance indicators</i>		
All staff should have a personal development plan		Baseline to be established during 2014/15
Proportion of staff with appraisal meeting within the last 6 months		Baseline to be established during 2014/15
Success criteria 3: Staff are Happy and Motivated		G
<i>Key performance indicators</i>		
Staff sickness levels		2.2%
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 1.78% to 1.6% per month. The number of leavers in since the 1st April is 16, giving a monthly average of 3.2.



There is one job live on NHS Jobs and a further 5 roles are in the recruitment process.

6.1.3 Personal development processes (PDP) that are linked to the strategic plan

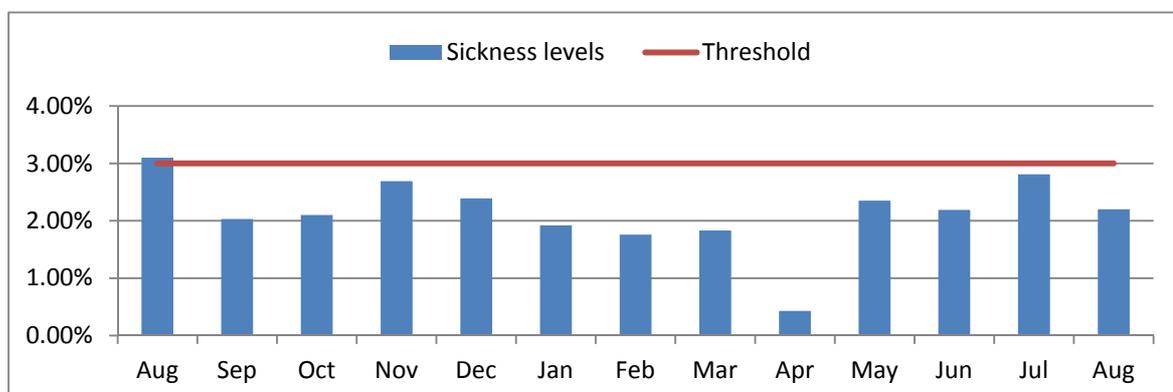
The CCG has commenced the roll-out of their PDP process to ensure that objective setting is in place.

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 August have equated to 2.2% which is below the GCCG target of less than 3%. Sickness levels have decreased from the figure reported in July 2014 and are below the level reported in August 2013.

2.2% equates to 782.9 full time equivalent (FTE) working days or 3.9 days per employee since the 1st April 2014. 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 2014/15
2	Resource Limits
3	Summary Financial Position
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Gloucestershire CCG 2014/15 Integrated Performance Scorecard

Target	Principal Delivery Targets	2013-14 Outturn	Apr-14	May-14	Jun 2014/ Q1	Jul 2014	Aug 2014	Sept 2014/ Q2	Oct 2014	Nov 2014	Dec 2014/ Q4	Jan 2015	Feb-15	Mar 2015/ Q5	Year / Quarter to date	Year end forecast	Perf. Measured		
Unscheduled Care																			
Accident & Emergency																			
CB_B5	4-hour A&E target - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative		
		GRH	93.0%	91.6%	91.4%	90.0%	89.4%	95.9%											
		CGH	95.4%	97.5%	96.9%	97.1%	95.9%	97.0%											
		GHNHSFT total	93.9%	93.7%	93.4%	92.6%	91.8%	96.3%											
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	0	Cumulative		
		GRH	0	0	0	0	0	0											
		CGH	0	0	0	0	0	0											
		GHNHSFT total	0	0	0	0	0	0											
CB_B16	Cat A 19 min response - The percentage of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative		
		SWASFT		95.4%	95.2%	95.0%	94.6%												
		Glos only	94.4%	94.2%	92.4%	92.9%	93.5%												
		Actual	1,151	75	126	82	90												
CB_S7	Ambulance handover delays - 30 to 60 mins (GHNHSFT)	Actual	1,151	75	126	82	90												
CB_S7	Ambulance handover delays - over 60 mins (GHNHSFT)	Actual	207	3	5	15	16												
CB_S8	Clear up delays of over 30 minutes	Actual	201	3	5	15	16												
CB_S8	Clear up delays of over 1 hour	Actual	43	3	9	9	0												
Delayed Transfers of Care (DTOC)																			
Local	Average number of Delayed Transfers of Care for acute patients in the month	GHNHSFT target	14	14	14	14	14	14	14	14	14	14	14	14	14	14	Cumulative		
		GHNHSFT actual	10.8	7.5	7.4	10.0	6.2												
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	GHNHSFT	0	0	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	10	10	M		
		GCS actual	5.3	3.0	0.8	1.3	2.6												
Harmoni 111																			
Local	Calls answered within 60 seconds	Target	N/A	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	M		
		Actual	94.7	91.1%	92.2%	92.7%	90.7%												
Local	Calls abandoned after 30 seconds	Target	N/A	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	M		
		Actual	1.2	1.6%	1.8%	1.6%	1.9%												
Local	Calls triaged	Target	N/A	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	M		
		Actual	78.0%	77.1%	77.4%	76.1%	76.7%												
Local	Calls warm transferred	Target	N/A	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	M		
		Actual	67.2%	66.8%	63.6%	59.9%	56.4%												
Local	Longest wait for an answer	Target	N/A	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	M		
		Actual		00:17:43	00:10:15	00:14:17	00:15:09												
Local	Longest wait for a call back	Target	N/A	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	M		
		Actual		00:16:39	00:12:48	00:10:19	00:09:00												
Planned Care																			
Acute Care Referral to Treatment																			
CB_B1	Percentage of admitted pathways treated with in 18 Weeks	Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	Cumulative		
		Actual		91.2%	92.1%	90.4%	90.1%												
CB_S6	Number of completed admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative		
		Actual		2	1	2	6												
Local	Number of specialties where admitted standard was not delivered	Actual		5	7	9	8												
CB_B2	Percentage of non - admitted pathways treated within 18 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative		
		Actual		95.2%	95.6%	95.3%	95.6%												
CB_S6	Number of completed non-admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative		
		Actual		0	0	1	1												
Local	Number of specialties where non-admitted standard was not delivered	Actual		7	5	5	6												
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%	Cumulative		
		Actual		92.0%	91.9%	91.9%	91.7%												

Gloucestershire CCG 2014/15 Integrated Performance Scorecard

Target	Principal Delivery Targets	2013-14 Outturn	Apr-14	May-14	Jun 2014/ Q1	Jul 2014	Aug 2014	Sept 2014/ Q2	Oct 2014	Nov 2014	Dec 2014/ Q4	Jan 2015	Feb-15	Mar 2015/ Q5	Year / Quarter to date	Year end forecast	Perf. Measured	
CB_S6	Number of incomplete pathways greater than 52 weeks	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative	
		Actual	8	11	9	9										37		37
Local	Number of specialties where incomplete standard was not delivered	Actual	7	9	9	9												
Cancelled Operations																		
CB_B18	Cancelled operations - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative	
		Actual	0	2	7	3												
CB_S10	Urgent operations cancelled for a second time - number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative	
		Actual	0	0	0	0												
Diagnostics																		
CB4	Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests	Target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	Cumulative	
		Actual breaches	640	112	105	55	44									316		316
		Actual Perf	0.75%	1.4%	1.4%	0.7%	0.6%									1.0%		1.0%
Local	Percentage of patients who have waited 6 weeks longer than their due date for a planned diagnostic surveillance test (GHNHSFT only)	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		17.8%	13.8%	27.1%	27.3%										27.3%	27.3%		
Cancer Waits																		
CB_B6	Percentage of patients seen within 2 weeks of an urgent GP or GDP referral for suspected cancer	Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	Cumulative	
		Actual breaches	134	156	65											290		
		Actual Perf	89.0%	87.4%	95.0%											88.2%		
CB_B7	Percentage of patients seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	Cumulative	
		Actual breaches	107	75	19											182		
		Actual Perf	52.7%	64.6%	88.9%											58.4%		
CB_B8	Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis	Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	Cumulative	
		Actual breaches	0	5	2											5		
		Actual Perf	100.0%	98.1%	99.1%											99.0%		
CB_B9	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	Cumulative	
		Actual breaches	0	1	2											1		
		Actual Perf	100.0%	96.9%	95.0%											98.6%		
CB_B10	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regime	Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	Cumulative	
		Actual breaches	0	0	0											0		
		Actual Perf	100.0%	100.0%	100.0%											100.0%		
CB_B11	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	Cumulative	
		Actual breaches	0	0	1											0		
		Actual Perf	100.0%	100.0%	98.8%											100.0%		
CB_B12	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	Cumulative	
		Actual breaches	9	25	11											34		
		Actual Perf	92.4%	83.4%	89.9%											87.4%		
CB_B13	Percentage of patients receiving first definitive treatment for cancer within 62 days from an NHS Cancer screening service	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	Cumulative	
		Actual breaches	0	1	3											1		
		Actual Perf	100.0%	94.1%	87.0%											97.1%		
CB_B14	Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	Cumulative	
		Actual breaches	1	0	0											1		
		Actual Perf	75.0%	100.0%	100.0%											85.7%		
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%	80.0%	Cumulative	
		Glos	87.0%	90.0%	74.0%	62.5%												
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%	60.0%	Cumulative	
		Glos	73.0%	71.0%	57.0%													
CB_A9	Dementia diagnosis rate (Annual)	Target														56%	Cumulative	
Glos																		
Community Care Referral to Treatment (GLOUCESTERSHIRE only)																		
Paediatric																		
Local	Percentage of patients referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative	
Actual		97.0%	100.0%	99.0%	95.0%										98.0%	98.0%		
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%	Cumulative	
Actual		97.0%	100.0%	100.0%	99.0%										97.0%	97.0%		
Local	Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative	
Actual		99.0%	95.0%	96.0%	100.0%										99.0%	99.0%		
Adult																		
Local	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative	
Actual		98.0%	98.0%	96.0%	96.0%										97.0%	97.0%		
Local	Percentage of patients referred to the Podiatry Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative	
Actual		100.0%	90.0%	91.0%	82.0%										91.0%	91.0%		

Gloucestershire CCG 2014/15 Integrated Performance Scorecard

Target	Principal Delivery Targets	2013-14 Outturn	Apr-14	May-14	Jun 2014/ Q1	Jul 2014	Aug 2014	Sept 2014/ Q2	Oct 2014	Nov 2014	Dec 2014/ Q4	Jan 2015	Feb-15	Mar 2015/ Q5	Year / Quarter to date	Year end forecast	Perf. Measured	
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%	95.0%	Cumulative
		Actual	100.0%	100.0%	99.0%	100.0%										97.0%	97.0%	
Local	Percentage of patients referred to the Adult Physiotherapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual	99.0%	96.0%	95.0%	96.0%										96.5%	96.5%	
Specialist Nurses																		
Local	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	Cumulative
		Actual	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%	95.0%	Cumulative
		Actual	97.0%	100.0%	100.0%	97.0%										99.0%	99.0%	
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%		95.0%			95.0%			95.0%			95.0%	95.0%	95.0%		Cumulative
		Glos	98.9%		97.3%													
Improving Access to Psychological Therapies (IAPT)																		
CB_S5	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Glos target			2.9%			5.9%			9.3%			13.0%				Cumulative
		Glos actual	13.7%		4.1%											4.1%	4.1%	
CB_S5	The proportion of people who complete therapy who are moving towards recovery	Glos target			50.0%			50.0%			50.0%			50.0%				Cumulative
		Glos actual	51.0%		50.5%											50.5%	50.5%	
Quality																		
Quality Indicators																		
CB_B17	Eliminate mixed-sexed accommodation breaches at all providers sites	GHT		0	0	0	0											Cumulative
		GCS		0	0	0	0											
		2gether		0	0	0	0											
	Number of Never Events	GHT		0	0	0	0											Cumulative
		Care Services Actual		0	0	0	0											
		2gether		0	0	0	0											
		SWAST		0	0	0	0											
		Ramsay Healthcare		0	0	0	0											
Cleanliness and HCAs																		
Methicillin Resistant Staphylococcus Aureus (MRSA)																		
CB_A15	Number of MRSA infections (Health Community)	Glos HC target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative
		Glos HC actual	8	1	3	0	0										4	
	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Cumulative
		GHNHSFT actual	4	0	0	0	0										0	
Clostridium Difficile (C.Diff)																		
CB_A16	Number of total C Diff infections (Health Community)	Glos HC target	162	19	16	16	20	20	10	15	12	12	21	21	19	71	201	Cumulative
		Glos HC actual	210	8	17	10	15									50	50	
	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target	52	6	5	4	5	6	2	4	4	4	4	4	5	15	52	Cumulative
		GHNHSFT actual	60	2	5	3	3									13	13	

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position as at 31st August (Month 5)

	2014/15		<u>Cash</u>	
	<u>R</u>	<u>NR</u>	<u>TOTAL</u>	<u>Limit</u>
AS AT Month 5 2014/15	£000	£000	£000	£000
2014/15 baseline excl growth	668,591		668,591	668,591
Growth	13,986		13,986	13,986
B/f surplus		6,762	6,762	6,762
Additional Baseline Transfer	(3,189)		(3,189)	(3,189)
Primary Care IT		1,581	1,581	1,581
Last month total	679,388	8,343	687,731	687,731
Adjustments in month				
1415 RTT Funding		2,193	2,193	2,193
M5 spec comm adjustment NR		18	18	18
Other Adjs	(119)		(119)	(119)
2G Court Liaison (Jul 14 to Mar 15); fye £105k	(70)		(70)	(70)
Newborn Screening	67		67	67
Maximum Cash Drawdown exercise				(8,027)
Adjustments actioned in month	(122)	2,211	2,089	(5,938)
TOTAL NATIONALLY REPORTED LIMIT	679,266	10,554	689,820	681,793

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Summary Financial Position

Overall financial position as at 31st August 2014 (Month 5)

	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)	136,595	133,917	(2,678)	327,787	328,464	677
Acute contracts - Other providers	4,286	6,835	2,549	10,286	10,280	(6)
Acute - NCAs	1,955	2,038	83	6,091	6,291	200
Pass-through payments						
Sub-total Acute services	142,836	142,790	(46)	344,164	345,035	871
Mental Health Services						
MH contracts - NHS	30,897	30,935	38	74,153	74,153	
MH contracts - Other providers	975	919	(56)	2,424	3,054	630
Sub-total MH services	31,872	31,854	(18)	76,577	77,207	630
Community Health Services						
CH Contracts - NHS	34,248	34,248		82,335	82,335	
CH Contracts - Other providers	(1,885)	(1,871)	14	(4,361)	(4,365)	(4)
CH - Other						
Sub-total Community services	32,363	32,377	14	77,974	77,970	(4)
Continuing Care Services						
Continuing Care Services (All Care Groups)	6,962	7,809	847	16,861	18,612	1,751
Local Authority / Joint Services	2,119	1,677	(442)	5,086	4,442	(644)
Free Nursing Care	3,644	4,000	356	8,746	9,599	853
Sub-total Continuing Care services	12,725	13,486	761	30,693	32,653	1,960
Primary Care services						
Prescribing	37,627	37,401	(226)	90,305	89,882	(423)
Enhanced services	1,804	1,804		4,341	4,341	
Other	2,723	2,626	(97)	6,535	6,351	(184)
Sub-total Primary Care services	42,154	41,831	(323)	101,181	100,574	(607)
Other Programme services						
Re-ablement funding	859	860	1	2,062	2,087	25
Other	2,988	3,111	123	7,155	7,247	92
Sub-total Other Programme services	3,847	3,971	124	9,217	9,334	117
Total - Commissioned services	265,797	266,309	512	639,806	642,773	2,967
Specific Commissioning Reserves (Inc headroom and Contingency)	12,498	12,454	(44)	28,099	26,113	(1,986)
Total - Programme Costs (excl Surplus)	278,295	278,763	468	667,905	668,886	981
Running Costs (incl reserves)	6,271	5,803	(468)	15,053	14,072	(981)
Total - Programme Costs (excl Surplus)	6,271	5,803	(468)	15,053	14,072	(981)
Surplus	2,859		(2,859)	6,862		(6,862)
Total Application of Funds	287,425	284,566	(2,859)	689,820	682,958	(6,862)

Appendix 4

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP QIPP Programme 2014/15

Theme	Planned Gross Savings 2014/15 £'000	Forecast £'000	Variance £'000
Unscheduled Care / Integration	4,985	3,678	(1,307)
Planned Care	1,536	1,273	(263)
Clinical Programme Groups	3,939	3,359	(580)
Community Care	1,461	1,036	(425)
Prescribing	2,710	2,810	100
Mental Health	330	75	(255)
Learning Difficulties	800	150	(650)
Continuing Health Care	500	300	(200)
Transactional QIPP	900	1,000	100
Unidentified	654	654	0
Grand Total	17,815	14,335	(3,480)
Additional Schemes			0
Additional QIPP / Slippage / Contingent resources / Application of QIPP rule		3,480	3,480
Grand Total	17,815	17,815	0

Theme RAG	Savings RAG	Recurrent / Trend RAG
A	A	A
A	A	A
A	A	A
A	A	A
G	G	A
A	R	A
G	R	G
A	A	A
A	G	A

n/a	n/a	n/a
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NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

QIPP Programme 2014/15 - Programme Overview

Theme	Component Projects	Scheme Overview	Progress
Community Care	Community Hospitals Programme, including Rehab Pathway	Develop a network of community services, embracing modern methods making appropriate use of NHS facilities. The initial focus in 2014/15 is on the service model for the use of community beds, including admission and discharge criteria and the medical cover to support the requirements.	Community Hospitals Programme Board established and working through priority initiatives.
	Use of MIUs	MIU and pathway development, to ensure MIU's are utilised in line with our agreed specification across the community - linking identified initiatives within our QIPP Programme i.e. NHS 111 Enhanced Clinical Service which aims to reduce Emergency Department attendances, moving appropriate patients into Minor Injury Units (MIUs).	Work ongoing with GCS to ensure consistent application of the service specification, and increase appropriate diverts from NHS 111 to an MIU as opposed to the Emergency Departments.
	Care Home Programme	Roll-forward of Community Enhanced Service (CES) for GP practices to provide enhanced care to care home patients (ES runs until Mar 2015), & Care Home services contract review (i.e. care home support team etc.)	80% of practices in Gloucestershire continue to deliver the enhanced service, covering 86% of care homes. Further work is being undertaken on evidencing commissioning outcomes and conducting episode reviews with clinicians. 100% of participating practices have completed the safeguarding training required as part of the enhanced service.
	Physiotherapy & Podiatry	Review of the services provided in Gloucestershire to: <ul style="list-style-type: none"> provide a baseline assessment and compare to best practice and comparative populations to inform future commissioning agree appropriate waiting times identify interdependencies with the wider change programme 	Outline brief for Physiotherapy is in final development; the next stages will look at a detailed scope to be developed and agreed with all key stakeholders by September 2014.
	Assessment Beds (interim)	Monitoring the use of assessment beds, following the agreement to end interim placements from April 2014. The scheme aims to deliver a reduction in the number of interim beds used, length of stay, permanent placements and length of stay within residential and nursing home settings.	The use of assessment beds continues to be monitored by the local health community as part of the hospital system discharge process. A Discharge Menu has been collaboratively developed and distributed across GHFT wards to assist staff. 6 month review of assessment bed process anticipated in September 2014.
Continuing Healthcare	Continuing Healthcare	The priorities are: <ul style="list-style-type: none"> to ensure the CCG is compliant with the National Framework for NHS Continuing Healthcare and Funded Nursing Care through implementation of robust assessment and appeal processes to ensure the commissioned services provide a high quality service to recipients and best value for money to the NHS 	Although a forecast overspend of the CHC budget it currently reported, full delivery of the QIPP target is anticipated based on planned impact of initiatives.
CPGs - Diabetes	Diabetes Service Re-Design	Continuation of 13/14 scheme, while moving to a more significant service redesign during 14/15 to repatriate patients from secondary to primary and community care settings	Draft enhanced service currently out for engagement with clinicians and phased roll out will lead to countywide implementation from October 2014. A 6 month impact is therefore anticipated.
CPGs - FOP	Older People's Assessment Liaison (OPAL)	Alignment of Emergency Physicians, Geriatricians, GPs & Social Care with multi-disciplinary teams in hospital and community to provide clinical risk assessment & management for older people attending Emergency Department and developing systems to reduce need for attendance in future.	Noted progress made regarding implementation of full model but still existing pressures regarding permanent recruitment of clinicians. Service is currently only available at Gloucestershire Royal Hospital. 2014/15 delivery being updated based on alternative staffing model due to locum cover and implementation in one site.

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

QIPP Programme 2014/15 - Programme Overview

Theme	Component Projects	Scheme Overview	Progress
CPGs - GI	Redesign of Irritable Bowel Syndrome (IBS) pathway	Opportunity to re-design the pathway for primary care management of Irritable Bowel Syndrome by use of an alternative diagnostic test (measuring raised FC levels) as a marker of IBS; will result in a reduction of acute-led interventions e.g. colonoscopies.	GHFT developing IBS Pathway Business Case; anticipated August 2014.
CPGs - MSK	MSK: Interface Service (Current)	Full implementation of MSK (transitional) Interface Service and associated monitoring, review and evaluation to support development of longer term solution, including testing triage model.	Revised MSCKAT service went live on Choose & Book in April 2014, including extended provision in the North Cotswolds. Foot and Ankle element of the service went live in July 2014. Orthotics review to be undertaken. Programme of engagement underway with Primary Care
	MSK: Clinical Thresholds including pathways and increased compliance with spinal pathways	The scheme aims to build on the successful clinical engagement on pathway development in 2013/14 in order to develop clear, clinically agreed thresholds for MSK related procedures and ensure that these are built into contractual arrangements with providers.	Secondary Care thresholds and revised IFR policies developed and signed off by MSK Clinical Programme Group, which are currently being implemented as part of the formal contract process with GHFT. Further work to be undertaken on MSKCAT thresholds not addresses as part of Phase 1 review.
	MSK Outpatient Follow-ups	Redesign of follow ups against benchmarked levels. Partial year potential effect and requires redesign and not just shifting work with no defined end point i.e.. Multidisciplinary team approach.	
CPGs - Ophthalmology	GROUPED SCHEME: Ophthalmology	Based on benchmarking potential the Clinical Programme Group has worked with Gloucestershire Hospitals NHS Foundation Trust colleagues to deal with the implementation of NICE TAs, plus Cataract and Wet Age related Macular Degeneration (AMD) re-patriation for outpatient activity to Community Optometrists.	5 key projects identified as part of the Ophthalmology Programme to deliver £683k QIPP saving. Benchmarking analysis has been undertaken to understand potential from optimising Anti-VEGF treatment interventions, alongside cataract pathways based on adherence to NICE and uniformity of pathways across sites. Alternative pathways scheme will also commence with Glaucoma.
CPGs - Paediatrics	Paediatric medicine urgent care pathway review (Two phased)	The review will: <ul style="list-style-type: none"> • Develop an accurate map of current pathways and evaluate existing referral criteria • Assess the potential for alternative pathways that treat children more efficiently, safely, closer to home and/or in a more patient focused way • Identify scope for improvements in clinical/referral protocols, operational systems or treatment regimes in any part of the children's urgent care system • Identify any gaps in primary, community, MIU or GP OOH services • Understand and evaluate the impact of current services 	Distribution of 'Big 6' (high volume pathways) across Primary Care and MIUs to be completed by August 2014. ED front door scheme currently under development, which includes a pilot of a Registered Nurse Practitioner (RNP) be based in Gloucestershire Royal Hospital (GRH) Emergency Department (ED) between the hours of 14:00 and 22:30, 7 days a week to support ED staff particularly in the assessment, management and treatment of paediatric patients.
	Establishing a sustainable GP urgent telephone advice service	Telephone access direct to a consultant paediatrician for GPs who consider there may be a need to urgently admit a child to the Paediatric Admissions Unit. The outcome of the calls is: <ul style="list-style-type: none"> • Advice only • Referral to the next day paediatric 'hot clinic' • Admission 	Based on initial evaluation of pilot extension of service provision amended to 9am-9pm with advice overnight from other doctors as per existing model. Full evaluation anticipated October 2014.

QIPP Programme 2014/15 - Programme Overview

Theme	Component Projects
CPGs - Respiratory	Respiratory emergency pathways - COPD admissions
	Pneumonia
	Respiratory outpatient first and follow-up
Integration	Integrated Community Teams and Rapid Response
Learning Disabilities	Learning Disabilities Intensive Support Service
	Joint Funding
Mental Health	Liaison Services (Acute & Community) - including RAID model and Alcohol / substance mis-use
	Art on Prescription
CPGs - Healthy Individuals	Telehealth Contract Negotiation

Scheme Overview
Reduction in COPD non-elective admissions achieved through a number of rolled-over and new schemes including: • Continued development of Gloucestershire Respiratory Team (rolled-over) • Respiratory Hot Clinics • Integrated Community Teams/Rapid Response
Joint audit with Gloucestershire Hospitals NHS Foundation Trust in order to review the current pneumonia pathway.
The plan (the detail of which is to be worked up with GHFT) is to move GCCG outpatient first/follow-up to peer group average releasing efficiency savings from the system.
Development of Integrated Community Team Model that focuses on case management of high risk patients, inclusive of a high intensity service and rapid response.
This scheme involves a remodelling of existing services to people with learning disabilities who present with challenging behaviours to ensure they are delivered in line with the recommendations of the Mansell Report (2007) and Department of Health Winterbourne View Final Report (2012)
Develop an agreed Joint Funding Policy and Process for health and social care.
Enhancement of current model that enables rapid access and turnaround of patients presenting at A&E and on the wards of acute hospitals with a potential mental health problem. Patients to be assessed and triaged by the Mental Health Liaison Team and immediate decisions actioned regarding their treatment plan
Evaluation of current provision of Art On Prescription within Primary Care, that looks to improve mental well-being in those at risk of poor mental health.
GCCG are working with Gloucestershire Care Service and Clinical Leads to address the limitations of the current care model and specify future service requirements such as integration within ICTs; this could include a procurement exercise for future provision.

Progress
Hot Clinics pilot commenced in May 2014 in Gloucester City allowing GPs to directly access a Respiratory Consultant for telephone advice and refer patients to Hot Clinic slots within 24hours. Continued development of the Rapid Response element of Integrated Community Teams based on agreed COPD pathway.
Given to the significant over performance in benchmarked pneumonia activity, it was decided to commence the Pneumonia Workstream in 2014/15. Joint audit commenced with GHFT in July 2014.
Bronchiectasis pathway out for review with stakeholders and patients and will be finalised in August 2014.
Gloucester City rolled out in January 2014, Cheltenham in May 2014 and is planned in Tewkesbury in September 2014. Phase 2 commenced in Stroud and Berkeley Vale in July 2014. A model of integrated case management now agreed and is being tested and shared within GCS for refinement and implementation planning.
Service fully operational and GCCG working with 2gether NHS Foundation Trust regarding all age caseloads.
Awaiting update from Gloucestershire County Council regarding delivery of support plans.
Review of contract requirements with GHFT to be taken forward by CCG; complexities to be worked through based on GHFT commissioning Liaison services from 2G.
Extension of interim funding for Art Lift for two further terms (6 months) to undertake full service evaluation.
Approval from GCCG Governing Body received in July 2014; procurement to commence in August 2014. During this period GCCG and GCS will develop a programme of engagement across the health community with particular regard to Primary and Community Care. This will include the development of pathways across primary care and ICTs to ensure a joined up end to end pathway that facilitates step up and step down with a seamless transition.

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

QIPP Programme 2014/15 - Programme Overview

Theme	Component Projects	Scheme Overview	Progress
Planned Care	Follow Up Care	Outpatient follow up reduction plan led by GHFT. The aim in 2014/15 is to have a clear plan to deliver recurring follow-up reductions associated with specific clinical pathways.	Implementation Plan requested from GHFT (GHFT hold 100% risk share.) CCG undertaking supporting data analysis to explore opportunity and links to benchmarking work within CPGs.
	Elective Referral Initiative : first 6m of 14/15 for Referral Peer Review	An interim solution for 14/15 to roll-forward Peer Review but re-launched with more reporting and just 5 specialties; a six month proposition while long-term strategy developed	63 practices taking part in 2014/15 Peer Review Scheme. The Peer Review database is operational and data is being collated from participating practices. Reports currently being developed to support the long term strategy development.
	Elective Referral Initiative, long-term strategy	The development of a long-term strategy for Elective Demand Management	Options Appraisal developed and discussed in CCG Development Session. Business Case under development based on indication of preferred option, to be discussed within September Governing Body.
	Individual Funding Requests (IFR): more stringent application of policy, increase inclusions	Development of a mechanism for identifying all procedures undertaken by any provider that appear on the CCGs Effective Clinical Commissioning Policies. Clear mapping of all internal processes that deal with funding requests to ensure that clear procedures and processes are in place.	IFR policy has been updated to clarify provider responsibilities and have been embedded within provider contracts. Initial test audit undertaken at GHT in Ophthalmology and Orthopaedics to test approach.
	Advice and Guidance Roll out	Subject to evaluation, further develop A&G services, which may include: <ul style="list-style-type: none"> • Review of payment mechanism to better reflect the workload in each speciality. • Roll out to additional secondary care specialties to support demand management. • Consideration of additional areas where feedback has suggested that A&G provides further benefit to Primary Care clinicians, such as psychiatry. 	Contract signed with GHFT to include existing specialties and roll out to Urology (by September 2014.) Evaluation undertaken in July 2014 to inform long term roll out.
	Dermatology: Intermediate Tier	Review of current service provision with a focus on the Dermatology Intermediate Tier.	Agreed with QIPP Assurance Group that this scheme is unlikely to deliver savings in 2014/15 (target £65k) based on inability to agree an intermediate tier tariff. Focus will now be to look at full review of existing services against the standards set out in the service specification developed by local Dermatology clinicians. This will include an action plan to ensure all quality and performance standards are met within agreed timescales.
Care UK Utilisation (UKSH)	Scheme aims to deliver increased utilisation by: <ul style="list-style-type: none"> • Developing relationships between providers (ICTS and local acute hospital) to encourage waiting list transfers to the ISTC. • ISTC to develop the marketing plan to ensure maximum return on investment from marketing activities • Increasing utilisation of local satellite clinic (GHAC) and associated elective procedures 	Review of GHAC utilisation continues. GHFT participating in planned Waiting List Transfer Initiatives; currently focusing on Urology and Hernia procedures.	

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

QIPP Programme 2014/15 - Programme Overview

Theme	Component Projects	Scheme Overview	Progress
Prescribing	Primary Care Prescribing Plan	More efficient use of prescribed medication, while improving patient outcomes, concentrating on Respiratory, Pain Management, Diabetes, Urology & Gynaecology, Specials, and improved prescribing practices.	Prescribing improvement plan (PIP) review meetings currently taking place within clusters to discuss outcomes and future plans for 2014-15.
	Reducing Waste	Prescribing waste initiative - concentrating on dressings, Ostomy, Incontinence and Sip Feeds.	Initiative rolled forward from 13/14 with a focus on continence 14/15, with an aim to implement changes by September 2014.
	Oxygen Assessment	FYE of 13/14 scheme - reviewing of current and appropriate prescribing for patients receiving Home Oxygen.	Roll forward of 2013/14 initiative, service in place and early indications of impact shown.
	Secondary Care Partnership	Joint prescribing initiatives with GHFT including: Homecare, GHFT Specials and formulary adherence.	Scheme under development to ensure partnership working with GHNSFT to achieve joined up pathway development, providing a holistic patient centred approach. Key deliverables will include cost effective generic prescribing according to NICE/MHRA recommendations, monitoring compliance with Joint Formulary, and reduction in cost of unlicensed and commonly prescribed special treatments.
Unscheduled Care	Integrated Discharge Team (IDT)	Bringing of existing discharge teams into a single integrated team within GHFT. The scheme ensures there are clear, demarcated roles at the front door (admission prevention) and back door (supporting complex discharge). Enables joint and truly integrated working across organisations, enables the benefit of the skills and experience of staff from different organisations and backgrounds, sees failure to discharge a patient within 1 day of being medically stable as a failure for the whole system and that its role is to ensure this never happens and resolve it quickly when it does.	IDT embedded within GHFT, but recruitment of some posts ongoing. Expect to be fully embedded by the end of August 2014.
	Ambulatory Day Unit/ Ambulatory Emergency Care	Building on the Ambulatory Care model currently being delivered, develop the service further to be medically led, pulling patients via the Single Point of Clinical Access and through Emergency Departments in Gloucester and Cheltenham.	Gloucester and Cheltenham AEC live. Block contract agreed for 2014/15 to enable an in year funding and tariff review with GHFT. Establishment and Development workshops undertaken to discuss AEC pathways.
	Hot Clinics and Access to Specialist Services	Develop specialty based Hot clinics for single point of clinical access/ clinical teams, while developing dedicated access to specialist medical advice. Initial focus will be on Cardiology.	Business Case awaited from GHFT for Cardiology Hot Clinic pilot. GCCG working with GHFT managers and clinicians to escalate timescales of implementation.
	NHS 111 enhanced clinical advice service	To reduce Emergency Department attendances and increase referrals to the Gloucestershire MIU services with the introduction of an enhanced clinical advisory pathway within NHS111.	Operational issues with regard to staffing impacting on ability to roll forward the scheme. Alternative schemes being considered.
	Deep Vein Thrombosis (DVT) pathway in primary care	To commission a sustainable, clinically effective and evidence based Primary Care Service in Gloucestershire for adult patients (= or >18years) with suspected DVT where the GP retains control of the patient pathway.	74 practices have signed up to the enhanced service and Q1 returns are awaited to understand utilisation in Primary Care. Referrals to secondary care are being monitored; early indications suggest a reduction for acute attendances for DVT with the ability to manage locally.

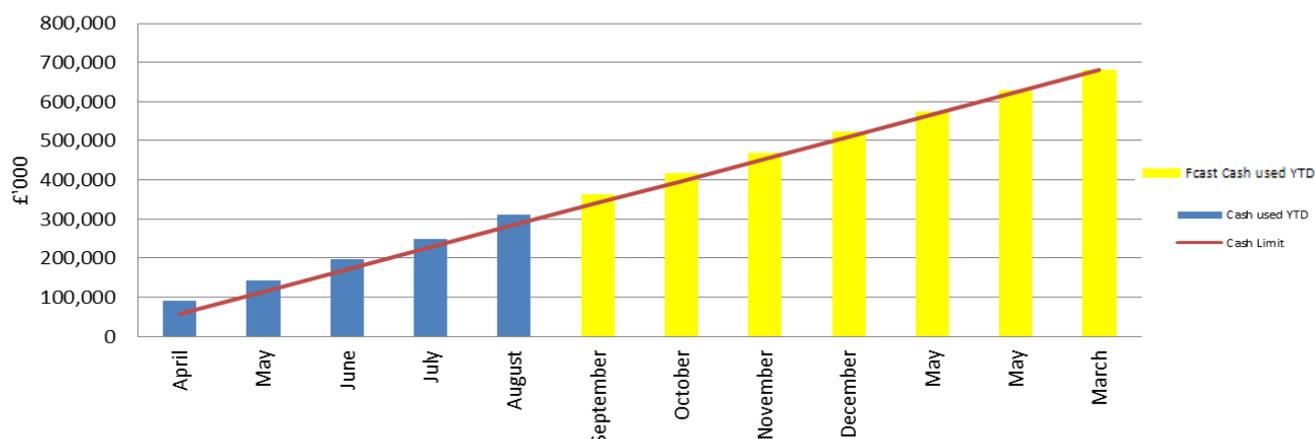
NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 31st August 2014 (Month 5)

Month	Status	Actual/Forecast Charges in Month					YTD	CASH	Mth end	Cash Limit	Ratio of
		Drawn £000	Prescribing £000	Home Oxygen £000	Advance Drugs Payments £000	TOTAL £000	TOTAL £000	LIMIT £000	Balance £000	Drawn %	Bal/Cash Limit %
April	Act	85,000	6,047	99	(33)	91,113	91,113	56,816	6,339	13.36%	0.93%
May	Act	46,000	6,484	95	23	52,602	143,715	113,632	6,117	21.08%	0.90%
June	Act	46,000	6,362	93	136	52,591	196,306	170,448	478	28.79%	0.07%
July	F'cast	45,000	6,611	93	(163)	51,541	247,847	227,264	1,645	36.35%	0.24%
August	F'cast	56,000	6,447	96	44	62,587	310,434	284,080	5,936	45.53%	0.87%
September	F'cast	46,565	6,390	96		53,051	363,485	340,897		53.31%	0.00%
October	F'cast	46,565	6,390	96		53,051	416,536	397,713		61.09%	0.00%
November	F'cast	46,565	6,390	96		53,051	469,587	454,529		68.88%	0.00%
December	F'cast	46,565	6,390	96		53,051	522,638	511,345		76.66%	0.00%
May	F'cast	46,565	6,390	96		53,051	575,689	568,161		84.44%	0.00%
May	F'cast	46,565	6,390	96		53,051	628,740	624,977		92.22%	0.00%
March	F'cast	46,567	6,390	96		53,053	681,793	681,793		100.00%	0.00%

**Proportion of Cash Limit Utilised
Actual and Forecast**



Overview of current position

The CCG currently has a nationally distributed maximum cash drawdown of just under £682m.

At the end of August £310m had been drawn down (46%) of the anticipated cash limit against 42% on a straight line basis for August.

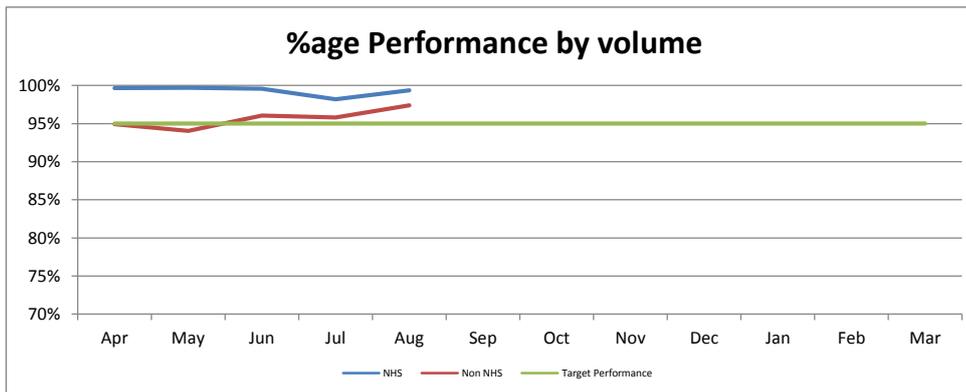
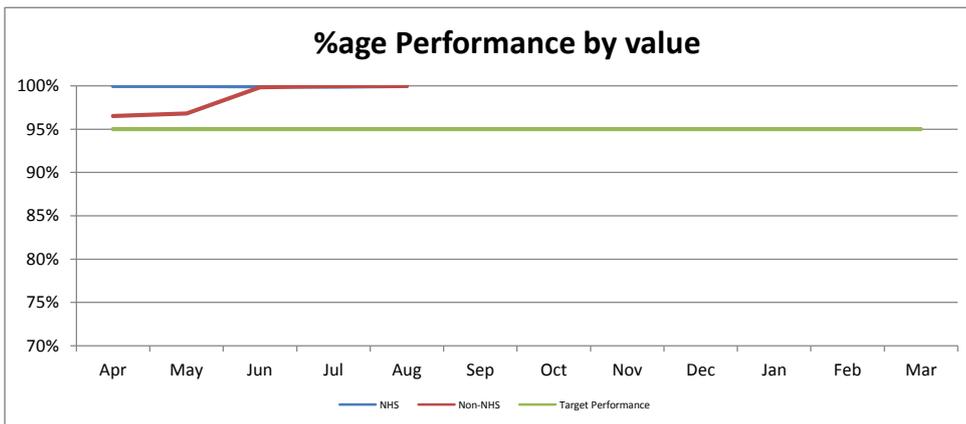
NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Performance against better payment practice code

As at 31st August 2014 (Month 5)

	In Month		Year to Date	
	NHS	Non NHS	NHS	Non NHS
By volume				
Total number of invoices	314	423	1,439	2,505
Number paid within target	312	412	1,427	2,396
Performance	99.36%	97.40%	99.17%	95.65%
By value				
Total value of invoices (£'M)	44.23	4.06	162.74	21.05
Value paid within target (£'M)	44.23	4.06	162.69	20.81
Performance	100.00%	100.00%	99.97%	98.86%

The target performance level is 95%



NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Statement of Financial PositionAs at 31st August 2014 (Month 5)

	Opening Position as at 31 March 2014	Current Month end Position £000	Forecast Position as at 31 March 2015 £000
Non-current assets:			
Premises, Plant, Fixtures & Fittings	61	52	41
IM&T		0	0
Other		0	0
Long Term Receivables		0	0
Total non-current assets	61	52	41
Current assets:			
Inventories		0	0
Trade and other receivables	8,350	32,356	8,350
Cash and cash equivalents	30	5,936	1
Total current assets	8,380	38,292	8,351
Total assets	8,441	38,344	8,392
Current liabilities			
Payables	(42,949)	(47,035)	(40,000)
Provisions	(870)	(819)	(500)
Borrowings		0	0
Total current liabilities	(43,819)	(47,854)	(40,500)
Non-current assets plus/less net current assets/liabilities	(35,378)	(9,510)	(32,108)
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)	(9,510)	(32,108)
Financed by taxpayers' equity:			
General fund	(35,378)	(9,510)	(32,108)
Revaluation reserve			
Other reserves			
Total taxpayers' equity:	(35,378)	(9,510)	(32,108)

Governing Body

Governing Body Meeting Date	Thursday 25th September 2014
Title	Integrated Governance and Quality Committee (IGQC) minutes
Executive Summary	The attached minutes provide a record of the IGQC meeting held on the 19 th June 2014.
Key Issues	The following issues were discussed: <ul style="list-style-type: none"> • Patient's Story • Patient Experience and Patient and Public Engagement Report • Quality Report • Quality Accounts • Policies for Approval • Risk Register • Assurance Framework • Equality Working Group Terms of Reference • Information Governance • Briefing Reports
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 IGQC Chair and Registered Nurse

NHS GLOUCESTERSHIRE CCG

Integrated Governance and Quality Committee (IGQC)

**Minutes of the meeting held on
Thursday 19th June 2014, Board Room, Sanger House**

Present:		
Julie Clatworthy	JC	Chair
Dr Caroline Bennett	CBe	GP - North Cotswolds Locality
Dr Peter Brambleby	PB	Interim Director of Public Health
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
Mark Walkingshaw	MW	Deputy Accountable Officer

In Attendance:		
Teresa Middleton	TM	Head of Medicines Management
Becky Parish	BP	Associate Director Patient and Public Engagement
Caitlin Lord (Item 5)	CLo	PALS Advisor
Craig Robinson (Item 5)	CR	Clinical Programmes Manager
Sarah Hammond (Item 14)	SH	Head of Information and Performance
Gill Bridgland (Item 18)	GB	Commissioning Implementation Manager
Alan Potter	AP	Associate Director Corporate Governance
Fazila Tagari	FT	Board Administrator

1. Apologies for Absence

- 1.1 Apologies were received from Marion Andrews-Evans, Dr Helen Miller, Mary Hutton, Cath Leech and Valerie Webb.

2. Declarations of Interest

- 2.1 There were no declarations of interest received.

3. Minutes of the meeting held on 24th April 2014

3.1 The minutes of the meeting were accepted as a true and correct record, subject to the following amendments:

- Section 10.3 – CG requested that a post meeting note was added to the effect that further guidance was issued by NHS England after this meeting which indicated that CCGs were not required to comply with the UK Corporate Governance Code. As a result, the following text had been included in the Annual Governance Statement:

“We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.”

3.2 CBU highlighted Section 6.8 and felt it would be beneficial to see the report on the review of district nursing which had been undertaken. JC advised that there was huge emphasis on this nationally and expressed concerns that information had not been received at a local level in particular relating to the performance against national targets. JC agreed that she would circulate the report as she was a member of the Royal College of Nursing. JC

3.3 JC drew attention to Section 9.2 and highlighted that the reference document regarding the Quality Strategy had still not been received. TM advised that further guidance had been issued from NHS England and informed members that the focus would be on refreshing the Quality Strategy. However, members agreed that it would be helpful that a draft reference document was made available for the next Committee meeting. TM

4. Matters Arising

- 4.1 **IGQC4 Incident Report Analysis** – AP reported that a draft report had been received following the external review of the incident reporting process. The final report to be presented at the next Committee.
- 4.2 **IGQC7 Any Other Business** – JC advised that the development session regarding governance processes was to be held in September 2014.
- 4.3 **IGQC11 Quality Report** – Helen Chrystal was finalising safeguarding report and would circulate when available.
- 4.4 **IGQC45 Quality Report** – The PAS access action point could not be progressed any further. **Item Closed.**
- 4.5 **IGQC48 Quality Report** – C.Difficile information covered under Agenda Item 7. **Item Closed.**
- 4.6 **IGQC58 Quality Report** – PALs service covered on Agenda Item 6. **Item Closed.**
- 4.7 **IGQC60 Corporate Governance Code** – Action has been completed. **Item Closed.**
- 4.8 **IGQC61 Risk Register** - Action has been completed. **Item Closed.**

5. Patient's Story

- 5.1 CLo presented a patient case study to the Committee which related to a couple's experience of being managed and cared for at home in the two year period following a severe stroke.
- 5.2 CR updated members on the current position in terms of service development and advised that an early supported discharge service for stroke patients had been developed which could also be accessed by long term condition patients. CR felt that the key issue was

the information being issued at the right time and this involved ensuring key access to the stroke coordinator role.

- 5.3 AE considered that there was a key issue between the health and social care relationship and felt that the issues highlighted could have been addressed by making alterations to the property using the disabled facilities grant offered through Local Authorities which was a statutory obligation. AE felt that the link between Local Authority was significant to this issue.
- 5.4 CBe commented that there was an expectation that individual services would be developed but understood that there were wider services available that were adapted to deal with this specific issue. CR agreed and indicated that the Integrated Community Teams were a good model where services were more generic which provided a more joined up approach to core delivery.
- 5.5 CG enquired if Village Agents were involved with this particular case as their role would be a key point of contact for providing information and access to services. It was noted that they were not mentioned in the story. CG also stated that this was a good story overall and suggested that the presentation was refined to progress it further.
- 5.6 MW advised that the key messages on integration could be clearer and felt that the feedback on the quality of care could be stronger within the presentation. BP responded that self-management and self-care was the key element being conveyed but recognised that this element needed to be strengthened.
- 5.7 CBu suggested that a handbook could be produced in order to clarify what services were available, who would be involved, defining their role with details of any turning points.
- 5.8 RECOMMENDATION: The Committee noted the story.**

6. Patient Experience and Patient and Public Engagement Report

- 6.1 BP presented the report which was taken as read. It was noted that this would now be presented as a stand alone report as previously updates had been provided within the Quality Report.
- 6.2 BP updated members on the key staff changes within her team. BP advised that North West London CSU had finalised the TUPE arrangements for a CCG member of staff into the substantive role to support primary care complaints for NHS England. BP also informed members that NHS England had confirmed agreement to fund the provision of a PALS service for Primary Care for Gloucestershire. It was noted that this was a unique service nationally which would inform national thinking regarding the future of PALS role in Primary Care going forward. The Committee welcomed this development.
- 6.3 BP advised that the draft report had been received following the external review undertaken on the Incident Reporting processes. The review concluded that the processes operated by the CCG should be streamlined.
- 6.4 BP advised members of the proposed structuring arrangements but emphasised that this was subject to the outcomes from HR and the staff consultation process.
- 6.5 CBu enquired if there was a process to capture feedback for a whole range of services and suggested whether this could be incorporated as part of the service redesign going forward. BP outlined the range of approaches used to capture patient feedback and how it was used in commissioning services.
- 6.6 CBe stated that the use of statistics were increasing and suggested that the new roles could be used to address this gap. BP advised that it was anticipated for

the new structure to be more systematic.

- 6.7 JC asked whether a web based feedback system could be developed by enhancing the current system in order to capture feedback from members of public.
- 6.8 BP drew attention to the healthwatch concerns detailed within the report and advised that those relating to the podiatry services were being investigated as it was inconclusive. BP highlighted that following investigation, it was learnt that there were three complaints received relating to the acute/stroke services.
- 6.9 BP advised that one of the features of the net promoter score was that an increase in response rate was likely to result in a reduction in the Friends and Family Test score. It was noted that this concern had been highlighted at a national level.
- 6.10 The Committee reviewed and approved the Gloucestershire CCG PALS Annual Report 2013-14.
- 6.11 RECOMMENDATION: The Committee welcomed and noted this report.**

7. Quality Report

- 7.1 TM presented the Quality Report which provided assurance to the Committee that quality and patient safety issues were given the appropriate priority and that there were clear actions to address them. The report was taken as read and TM invited questions from members.
- 7.2 JC enquired about the context of the process for research and development which was approved by the Core Group and highlighted that anything further would require approval by IGQC. TM explained that the process was to support additional costs for treatments and the processes in place for research proposals and to establish whether the CCG covered the funding for these treatments.

- 7.3 CBU suggested that the Research and Development Team was approached to request that the Annual Report and any updates to be reported to the CCG systematically.
- 7.4 JC requested future reports to include the progress of implementation of all the NICE TAs, and Quality Standards.
- 7.5 The report on the outcomes of the unannounced review of safeguarding and looked after children's services (March 2014) had not been presented at this meeting and it was agreed that feedback would be presented at the August IGQC meeting. The tragic child protection case was discussed and noted. Helen Chrystal
- 7.6 JC raised a concern relating to the increase in pressure ulcers. TM advised that GHFT had recognised the increase in Grade 3 and 4 pressure ulcers and were working with the Quality Team to mitigate these. GHFT had developed a Root Cause Analysis tool to monitor all Grade 3 and 4 pressure ulcers and it was noted that meetings with GHFT and the Quality Team were held each week, and that the outcomes would also be reported at a future CQRG for review. TM also advised that MAE had held discussions with Maggie Arnold (Director of Nursing) in order to escalate concerns regarding pressure ulcers and that GHFT were focusing heavily on this issue.
- 7.7 JC queried whether GCS were undertaking a similar process and was advised that it was understood that they were although this would need to be investigated and confirmed. CBe had learnt that community hospital patients were being transferred to secondary care prior to developing Grade 3 and 4 pressure ulcers. TM agreed that this would be monitored and an update would be included in the August Quality Report. TM
- 7.8 CBU informed members that it was proposed that there would be a systematic reporting mechanism for the Clinical Programme Groups (CPGs) which may also

report to the IGQC.

- 7.9 JC expressed serious concerns on the incident reported at Appendix 7 relating to the Grade 4 pressure ulcer acquired under the care of GCS. AP was asked to establish whether a claim for clinical negligence had been received by GCS regarding this case. AP
- 7.10 The in depth work with providers to reduce hospital acquired infections was discussed and noted.
- 7.11 The Committee received an update on Clinical Programmes from the Clinical Effectiveness Group.
- 7.12 The Committee received the 10th April 2014 minutes of the Effective Clinical Commissioning Policies Working Group.
- 7.13 RECOMMENDATION: The Committee noted the work to date and contents of this report.**

8. Quality Accounts

- 8.1 The Quality Accounts responses were presented to the Committee and taken as read. A Quality Account was a report provided by NHS healthcare provider Trusts and a Quality Report was a report provided by NHS healthcare provider Foundation Trusts, which satisfied both Monitor's and the Department of Health's requirements.
- 8.2 The Committee were asked to receive the CCG's response to the main providers Quality Reports and Accounts only, and not on the said reports themselves. CBu stated that the Quality Accounts had improved and felt that they were more consumer and patient friendly. The following comments were made:
- 8.3 **2gether Trust**
- JC queried the third paragraph – 'limited resources available', when 'limited' was not defined or explained.

- JC stated that there was no reference to the outcome of the review of Crisis Services.
- There was no reference to suicides in the CCG response and was an area of concern.

8.4 **GCS**

- Pressure sores were not identified in the CCG response.
- CG highlighted an administration error in the countersign-off process.

8.5 **GHFT**

- The Committee noted the good progress and recognised the huge investment made by GHFT to improve quality and safety.

8.6 CG queried if there was a standard template for the responses to Quality Accounts and was advised there wasn't although it was recommended that there should be a systematic process in place to ensure that information was not overlooked.

8.7 PB queried the top three reasons for mortality rates within GHFT. CBe stated that she would probe this further with GHFT.

8.8 RECOMMENDATION: The Committee noted the contents of this report.

10. Policies for Approval

10.1 The Committee was presented with the following policies. It was noted that these had been reviewed by the Policy Working Group on the 25th March 2014.

10.2 JC expressed concerns regarding the poor format and presentation of the HR policies which did not have the CCG logo or reference to them being a policy for a CCG. It was felt that the policies was generic and had not been personalised for each individual CCG for example referring to shift work e.g. night duty and that a standard format should be used. AP advised that

MW

when he had queried the format, he was told that this was not possible as these were used across all areas. MW to feedback to CSU HR Lead.

10.3 **HR Policies**

10.3.1 **Recruitment and Selection Policy**

- Approved

10.3.2 **Temporary Promotion Policy**

- Approved

10.3.3 **Training and Development Policy**

Approved subject to the following minor changes:

- Section on staff maintaining professional registration was required.
- Statement for developing management roles and commissioning skills required.

10.3.4 **Working Time Directive Policy**

Approved subject to the following minor change:

- Section 1.4 relating to night workers to be removed.

10.3.5 **Flexible Working Policy**

Approved subject to the following minor changes:

- The first sentence on Section 1.1 to be removed.
- MW advised that supporting guidance had been requested and was awaited.

10.3.6 **Further Education Policy**

Approved subject to the following minor changes:

- JC highlighted Section 4.5 relating to repaying fees and felt that a pro-forma should be attached to the policy to ensure a uniformed approach.

10.3.7 **Professional Registration Policy**

Approved subject to the following minor change:

- JC felt that this was a provider focused policy and requested that the terminology was amended to ensure relevance to the CCG.

10.3.8 **Recruiting Ex-Offenders Policy**

Approved subject to the following minor change:

- It was noted that clinical professionals had to comply with separate regulations and that a register had to be held of doctors and any identified issues. JC requested that this was reflected in the policy.
- The Organisation's Lead Counter signatory highlighted at Section 4.9 to be specified.

10.4 **Individual Funding Request Policy**

10.4.1 MW presented this policy and advised that this had been updated following the issue of new national guidance and that the ethical framework had also been added.

10.4.2 JC queried the governance arrangements and questioned whether this policy should be adopted by the Governing Body. AP advised that the Constitution defined that Group policies should be approved by the Governing Body and felt that as this was a high level policy it should be referred to the Governing Body for approval.

10.4.3 JC felt that Section 5.10.4.5 should be more coherent to ensure a clear understanding. In particular, it was felt that the term 'refractory' referred in the report, should be either replaced or explained.

10.4.4 It was also agreed that reference to the 'Chief Executive' stated at Section 5.13.5 should be amended to read 'Accountable Officer'.

10.4.5 The reference document 'The National Institute for Health and Clinical Excellence' listed at Section 10.1 to be amended to read 'The National Institute for Health and Care Excellence'.

10.4.6 PB queried how treatments were prioritised. CBU MW suggested that this should link with the prioritisation procedures. The Committee agreed that the

Prioritisation Framework should be included in this policy as an appendix.

10.4.7 BP suggested that section 6.1 should be amended to read 'users of the policy' to ensure greater clarity.

10.4.8 CBe suggested that a communication exercise was undertaken to inform localities and providers that the policy had been updated.

10.4.9 The Integrated Governance and Quality Committee recommended approval to the Governing Body subject to the minor amendments.

10.5 **Telephone and Mobile Policy**

Approved subject to the following minor changes:

- JC requested Section 2.3 to be explicit to ensure that the policy related to the equipment supplied by the CCG.
- JC highlighted typos in Section 3.1 and 3.2 of the report.
- JC suggested that Section 10.7 needed an additional clarification to indicate that replacement equipment would be provided if the original was faulty or had been lost or stolen.

10.6 **Policy Format and Approval Process**

Approved subject to the following minor changes:

- JC acknowledged that the policies presented that day were not in a standard format which needed to be addressed going forward and welcomes this Policy to agree standard for the organisation.
- Section 3.1.1 to be amended to reflect that the finance policies were ratified by the Audit Committee.
- CG felt that the Constitution wasn't clear regarding the sanction level of specific policies. It was agreed that the Terms of Reference would be reviewed at the next Committee meeting.
- BP suggested that Section 8.1.1 was further clarified to understand the membership of the expert groups and other stakeholders.

- AP confirmed that a central policy database, issue and review system would be in place.
- The Associate Director of Governance would act as the policy co-ordinator.

10.7 RECOMMENDATION: The Committee approved these policies, subject to the amendments suggested with the exception of the Individual Funding Request Policy which would be recommended to the Governing Body for approval.

11. Risk Register

- 11.1 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 Operating Plan, and the Assurance Framework.
- 11.2 AP confirmed that details of all risks for consideration to be removed from the Risk Register had been provided at Appendix 2.
- 11.3 JC highlighted Risk No Q13 and enquired where the issues had been identified. TM advised that the issues were within histology identified from Datix reports received from GPs and that high level reviews were being undertaken. CBe stated that the key issue relating to recruitment had progressed although further improvements were still needed. It was noted that this had been communicated to GPs to inform them of this issue and to expedite any critical cases if required. It was felt that a further comprehensive review of the risks were required. MW advised that the CCG were seeking further assurance that delivery against the action plans was being addressed and it was recognised that there were similar issues with capacity in similar regional areas. It was agreed for a report to be presented at the next committee meeting. MW/ MAE
- 11.4 Regarding Risk Q1 CBU advised that he had been made aware that GPs were experiencing difficulties AP/ Anthony

accessing the CCG Live website. Committee members Dallimore concurred and stated that they also had issues with access. It was agreed for an update to be presented for the next committee meeting.

11.5 RECOMMENDATION: The Committee

- **Noted this paper and the attached Risk Register; and**
- **Approved the closure of risks as detailed in Appendix 2.**

12. Assurance Framework

12.1 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.

12.2 CG expressed concerns regarding the achievement of the QIPP targets and questioned the risk rating level and was advised that the current rating was appropriate.

12.3 RECOMMENDATION: The Committee noted this report and the attached Assurance Framework.

13. Equality Working Group Terms of Reference

13.1 JC highlighted Section 1.1 and advised that the Governing Body was accountable for promoting equality and reducing avoidable health inequalities in every aspect of Gloucestershire CCG's business and that the IGQC monitor the progress as part of the assurance process.

13.2 It was agreed that Section 3.1 to be amended to read 'The purpose of the Equality and Health Inequalities Working Group is to assure the Governing Body that it is meeting its strategic objectives regarding avoidable health inequalities, diversity, human rights, and the establishment of a single equalities scheme.' JC advised that other relevant national legislation should

also be indicated.

13.3 JC felt that the links to improving public health and closing the inequalities gaps in Gloucestershire needed to be clearly outlined and recommended the following additions:

- Better health outcomes
- Reduced avoidable health inequalities
- Patient access and experience
- Staff health and well being
- Working with local partners

13.4 JC suggested that a regional Equality and Diversity organisation and a union representative could be included within the group's membership.

13.5 BP felt that the wider lay representatives should be considered or suggested that a reference group was developed who could inform the work of that committee.

13.6 JC confirmed that the group had no executive powers but was a standing committee of the IGQC. JC highlighted Section 6.1 and advised that an annual report should be produced for the Governing Body.

13.7 CG suggested that this was approved by the Governing Body and the IGQC agreed to recommended approval subject to the minor changes.

13.8 RECOMMENDATION: The Committee recommended approval to the Governing Body subject to the above amendments.

14. Information Governance Update

14.1 SH presented the paper providing an update on the organisation's information governance arrangements.

14.2 SH reported that the CCG submitted an action plan to the Health & Social Care Information Centre (HSCIC)

at the end of May 2014 to bring it to a level 2 status in the IG Toolkit. SH advised that the action plan had been assessed as satisfactory and actions within the plan are being taken forward and reported into the IG Working Group each month. It was noted that this would also provide access to apply for the Accredited Safe Haven status which was currently progressing.

- 14.3 SH advised that the Freedom of Information (FOI) requests were managed by the CSU and that the CSU had reviewed their processes and staffing issues. SH drew attention to the FOI Analysis at Appendix 3 which highlighted that there was an improvement in performance in meeting the 20 day deadline with only one breach in Quarter 4 which related to a complex enquiry. Members noted that the information from the analysis would be used to help inform the CCG's publication library.
- 14.4 CG enquired what the timescales were to achieve the Level 2 IG Toolkit status and was advised that this was driven through the HSCIC where timescales were not specified.
- 14.5 JC highlighted the IG Working Group Terms of Reference outlined at Appendix 1 and made the following comments:
- Amend IGC to read as 'Integrated Governance and Quality Committee'.
 - Queried whether a patient representative should be included as part of the membership.
- 14.6 The Committee received the minutes of the Information Governance Group meeting on the 22nd May 2014.
- 14.7 **RECOMMENDATION: The Committee:**
- **Approved the IG Working Group Terms of reference subject to the comments made;**
 - **Noted the minutes from the Information Steering Group;**
 - **Noted the contents of this report.**

15. 'Hard Truths' Briefing Report – Safe Nurse Staffing

- 15.1 TM presented the briefing report which was taken as read. JC explained the context of the acuity tool to members and queried whether the CCG provider organisations had safe staffing levels.
- 15.2 TM advised that the CCG had funded 40 additional trained nursing posts in the community hospitals run by Gloucestershire Care Services Trust. GHFT had invested £1.75m in extra nursing time and 2gether Foundation Trust had invested in a new consultant nursing post.
- 15.3 TM advised that the CCG providers will be publishing their staffing data on the NHS Choices website and that these would be monitored from the 24th June 2014 with a caveat that information may be inaccurate at first. TM informed members that measures were in place to gain that assurance on safe staffing levels.
- 15.4 JC requested that any emerging staffing issues were highlighted under 'Hot Topics' at the weekly Governing Body development sessions and then in more detail to the next IGQC to ensure members were updated promptly.
- 15.5 It was reported that GCS were looking at recruiting nurses wishing to return to practice after a career break.
- 15.6 RECOMMENDATION: The Committee noted the report.**

16. 6Cs Briefing Report – Compassion in Practice

- 16.1 The purpose of this paper was to provide an update on the progress made by NHS providers in Gloucestershire to embed the Compassion in Practice (6Cs) Strategy and deliver the CCG's Nursing Strategy.

16.2 RECOMMENDATION: The Committee noted the report.

17. High Level Reviews

17.1 This report was taken as read.

17.2 RECOMMENDATION: The Committee noted the report.

18. Any Other Business

18.1 Update on Non-Emergency Patient Transport

18.1.1 MW presented the report which provided an update on the performance provided by Arriva Transport Solutions Ltd. This followed issues raised by the PALs service and GHFT. GHFT expressed concern on the impact of Arriva's service delivery and the potential for reputational impact. It was articulated that this was a key focus for Healthwatch and a full report was being presented at the Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) on the 9th July 2014.

18.1.2 MW stated that page 3 of the report outlined the performance against the key performance indicators (KPI's). It was noted that the indicators highlighted in red were a key area of concern. MW articulated that the main concerns related to the impact on the quality of service specifically due to patients experiencing long waits for transport.

18.1.3 MW explained the actions that were to be undertaken by Arriva were highlighted at Section 4.2 and that GHFT also had joint actions to be undertaken with Arriva.

18.1.4 The Committee were advised that the key actions for Arriva were:

- To change staff rotas to ensure that capacity was in line with demand.

- Improvements in planning and scheduling of journeys to ensure that delays were escalated appropriately.
- Additional resources being utilised when required.
- Additional training for call handlers to improve the escalation process
- Improve communication with the acute hospitals.

18.1.5 Key actions for GHFT

- Improve the process for booking transport and planning in advance to match capacity requirements.
- Improve the use of the online system to ensure that the call handling time was effectively managed.

18.1.6 GB advised that she had been in contact with the GHFT Locality Manager (James Burns) who had a more focused role in monitoring the screens and ensuring patients were reaching the end of their KPI windows. It was recognised that GHFT and Arriva were committed to make the necessary improvements although further information was awaited from GHFT relating to the disparity in activity around the Cheltenham General Hospital site in order to assist Arriva to model capacity requirements.

18.1.7 CG understood that this was an underlying issue and enquired whether GHFT had accepted their responsibility for ensuring service delivery by means of maintaining their training. GB advised that fortnightly conference calls were being held with GHFT and Arriva to review issues and that reports were issued to steer them on the areas where specific focus was required.

18.1.8 CG understood that there had been previous issues relating to the system overheating and queried if this had resolved and was advised by GB that the overall activity level was balanced which was in line with the specification. However, there were challenges in relation to mobility and additional resources were

required which was not aligned with the original specification. Further discussions were being held in order to resolve this going forward.

18.1.9 It was noted that the Healthwatch feedback would be reported at the HCOSC meeting on the 9th July 2014.

19. The meeting closed at 12.35pm.

Date and time of next meeting: Thursday 21st August 2014 in the Board Room at 9am.

Governing Body

Governing Body Meeting Date	Thursday 25th September 2014
Title	Audit Committee minutes
Executive Summary	The attached minutes provide a record of the Audit Committee meetings held on the 3 rd June 2014.
Key Issues	<p>The following principal issues were discussed:</p> <ul style="list-style-type: none"> • Annual Report and Annual Accounts • External Audit • Internal Audit • Audit Committee Chair’s Risk Assessment • Counter Fraud • QIPP • Procurement decisions • Waivers of Standing Orders • Aged Debtor Report • Losses and Special Payments
Risk Issues: Original Risk Residual Risk	Not applicable.
Financial Impact	Not applicable.
Legal Issues (including NHS Constitution)	Not applicable.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note these minutes which are provided for information.

Author	Alan Potter
Designation	Associate Director Corporate Governance
Sponsoring Director (if not author)	Colin Greaves Audit Committee Chair and Lay Member

**NHS GLOUCESTERSHIRE CCG
AUDIT COMMITTEE**

**Minutes of the Audit Committee meeting held on
Tuesday 3rd June 2014
Board Room, Sanger House**

Present:		
Colin Greaves	CG	Chair
Dr Hein Le Roux	HLR	GP Liaison Lead
Valerie Webb	VW	Lay Member - Business

In Attendance:		
Andrew Beard	AB	Deputy Chief Finance Officer
Rupert Boex	RP	Financial Accountant
Liz Cave (part meeting)	LC	Grant Thornton
Sallie Cheung	SC	Counter Fraud Manager
Paul Dalton	PD	Price Waterhouse Coopers
Cath Leech	CL	Chief Finance Officer
Alan Potter	AP	Associate Director Corporate Governance
Peter Smith (part meeting)	PS	Grant Thornton
Fazila Tagari	FT	Board Administrator

1. Apologies

1.1 Dr Andy Seymour, Alan Elkin and Lynn Pamment.

2. Declarations of Interest

2.1 There were no declarations of interest received.

3. Minutes From Previous Meeting held on 11th March 2014 and 20th May 2014

3.1 The minutes of the previous meeting held on 11th March 2014 were approved as an accurate record with the following amendment:

- Section 6.9 to read '*LP informed the Committee that*

currently there were 3 areas where reviews were still ongoing and that this table would be updated subject to these reviews.'

- Section 7.1.5 to read '*CG raised concerns..... felt that there was potential for....*'
- Section 16.3 to read '*provide any comparative information as yet.*'

3.2 The minutes of the previous meeting held on 20th May 2014 were approved as an accurate record with the following amendment:

- Section 2.21 to read '*This was particularly impressive given the lack of definitive guidance from NHS England.*'

4. Matters Arising

4.1 10.12.13 Item 5.6 – Action had been completed. **Complete**

4.2 11.03.14 Item 8.2 – It was noted that no further specific details had been issued from the CSU and that this was a national issue where it was felt that no further actions could be pursued. **Complete**

4.3 11.03.14 Item 8.3 – Covered above. **Complete**

4.4 11.03.14 Item 8.5 – Resolved. **Complete**

4.5 11.03.14 Item 13.4 – Invoice paid. **Complete**

4.6 11.03.14 Item 17.2 – Meeting had been held. **Complete**

4.7 11.03.14 Item 17.3 – Checklist completed. **Complete**

4.8 20.05.14 Item 2.18 – CL advised that she was satisfied with the information and advised that this was also audited. **Complete**

4.9 20.05.14 Item 3.4 – Statement was correct. **Complete**

5. Annual Report and Annual Accounts

- 5.1 The Audit Committee considered and reviewed the draft statutory accounts in May 2014. CL presented the Audited 2013/14 Annual Accounts to the Committee and advised members of the key changes following the May Audit Committee meeting. These related to:
- Operating Expenses
 - Gross and Net income
 - Accounting Policies – Disclosure included within the financial statement in Section 1.4 relating to legacy balances requested by NHS England.
 - Provisions – Disclosure added within the accounts on page 31 relating to CHC claims.
- 5.2 CL advised that the external auditors had been made aware that further updated guidance could be issued from NHS England and that if so, information should be available on the 3rd June 2014 at noon.
- 5.3 CG highlighted typos in Sections 2.3 and 2.5 of the report and requested that the 'Trust' was amended to read 'CCG'.
- 5.4 VW expressed concerns relating to the method used to round numbers within the accounts and was advised that a standard NHS England template was used which was not adjusted but assured that the underlying figures remained correct. CG suggested that a letter should be sent to NHS England expressing concerns and to ensure that there was a solution going forward.
- 5.5 CL presented the draft Annual Report for 2013/14 and advised that the report had been produced in two parts. Part One included the annual review containing county and locality news and Part Two included the strategic review containing all statutory reports.
- 5.6 CL informed the Committee that page 41 detailed the Pensions Report and that the figures had been supplied by the NHS Pensions Agency. It was believed that the

figures supplied related to the CCG employment only and that a note would be added to the Annual Report to indicate this.

5.7 CG referred to the previous discussion where it was agreed that a statement would be added to explain the staff sickness figures and was advised that the rationale supporting the figures was still being investigated.

5.8 LC updated members regarding the pensions' disclosure issue. LC advised that there had been variations on what should be included within the disclosure statement. LC explained that the annual reporting guidance, which had to be followed by CCGs in order to comply with national guidance, had been repeatedly updated. The initial guidance received included a clause that all GPs' pensions had to be disclosed. It was noted that the CCG had only included the GPs' pensions accrued through CCG employment. LC indicated that this was satisfactory subject to the disclosure being added. However, LC had been advised to wait for the guidance that was expected to be published that day and explained that until this guidance was received, it was uncertain if an unqualified audit opinion could be given. It was noted that if the guidance changes, that section could be qualified.

5.9 The Audit Committee thanked Anthony Dallimore and his team for producing the Annual Report.

5.10 PS raised an issue relating to the endorsement of specific reports and advised that the Accountable Officer was required to sign the members report and strategic overview. Members noted this request.

5.11 **RECOMMENDATION:**

The Audit Committee:

- **Noted the contents of this report.**
- **Recommended approval of the CCG's 2013/14 Annual Accounts to the Governing Body.**
- **Noted the Annual Report 2013/14.**

6. External Audit

- 6.1 LC presented the Audit Findings Report and advised that the accounts production and audit process went smoothly which reflected that there was a strong team and management in place. LC explained that most of the errors and changes identified from the audit were due to differing processes or late or unclear guidance from NHS England.
- 6.2 It was noted that the significant issues were national issues. These related to hospital spells, provision for continuing health care claims and the GP pensions disclosure.
- 6.3 LC informed members that the audit was substantially complete although information was awaited on the following areas:
- Pooled Budgets
 - Obtaining and reviewing the management letter of representation
 - Updating the post balance sheet events review
- 6.4 LC reported that the audit identified no adjustments affecting the CCG's comprehensive net expenditure position. It was noted that the one adjusted error was an incorrect grossing-up of both income and expenditure. LC advised that there was only one identified error which was not adjusted relating to CHC provisions. It was noted previously that there were two reported and this had reduced following national advice being received. It was noted that an updated report would be circulated to members. LC/PS
- 6.5 LC reported that it was anticipated that an unqualified audit opinion would be issued although this was subject to the GP pensions' disclosure issue. LC explained that they were also required to give a regularity opinion on whether the expenditure had been incurred as intended by Parliament and advised that an unqualified regularity opinion would be given. LC reported that an unqualified

opinion would also be issued for the Value for Money conclusion.

6.6 PS explained that the Audit Commission had mandated Grant Thornton to undertake a different approach this year with regards to the Value for Money conclusion which had to be reported on five key criteria. It was noted that next year would be two key criteria. The five areas were:

- leadership
- commissioning
- financial planning and management
- data quality
- external relationships

PS advised that one additional area was identified for review which related to the Better Care Fund. PS reported that the review identified no significant issues.

6.7 LC emphasised the importance of delivering the QIPP schemes recurrently and advised that a recommendation was not made as they were aware that this was one of the CCG key aims. CL gave assurance that this was a key area of focus for this year. The Committee noted and shared this concern.

6.8 LC queried the letter of representation and asked if any changes had been made to the standard letter and was advised by CL that statement (vi) was revised relating to the misstatement. It was noted that this letter would be signed by the Governing Body.

6.9 CG requested a meeting with Grant Thornton in order to discuss issues and instructed FT to schedule this meeting. FT

6.10 It was noted that the Annual Governance Statement was up to date and that there were no changes since the previous draft was approved. CG felt that the statement should be reviewed on a continuous basis going forward.

6.11 **RECOMMENDATION: The Audit Committee noted the**

content of the report.

7. Internal Audit

7.1 **Core Financial Systems Review** – PD advised that the review was assessed as medium risk. The principle findings related to authorisation of journals and detailed financial procedures.

7.2 VW queried if different levels of authority were set for users and was advised that for invoices, controls can be set for a specific amount that users can approve up to. However, for journals there may be cases where users have the ability to create and authorise journals although it was recognised that there should be a process to ensure this was managed systematically.

7.3 **Information Governance Toolkit Self-Assessment** – PD advised that the review was assessed as medium risk. It was noted that three medium risk findings were identified which related to overall progress against the requirements of the Toolkit, plan and timetable for the IG Toolkit and Departmental responses. CL advised that the toolkit had been submitted and the CCG achieved level two in the majority of areas. Six of the areas were identified as level one and there was an action plan in place to achieve level two in all areas.

7.4 **CHC Review** – The review was assessed as medium risk. PD advised that the medium risk rated findings related to ratification of CHC decisions made without a multi-disciplinary team meeting and CHC/FNC funding review procedures not being followed.

7.5 SCh advised members that she was visiting the District Nursing Team at GCS that afternoon and suggested that she could reinforce the implications of their actions as part of her discussion. CL suggested that discussions were held with Mary Morgan as she managed the CHC team. CG requested that controls should be in place which were appropriate and at an appropriate level.

7.6 **Internal Audit Annual Report 2013/14** – PD advised

that this report outlined the work carried out during the year and included the Head of Internal Audit's annual opinion. PD drew attention to the opinion on page 2 of the report and informed members of the level of opinions that could be granted and advised that GCCG had achieved a second tier opinion and outlined the factors which had contributed to this opinion.

7.7 CG referred to the first paragraph stated within the Scope Section and expressed concern that the format was presented as a corporate statement. CG proposed that if this should be a personal statement, the template would need to be amended.

7.8 CG commented that the Charter of Internal Audit indicated that an assessment of assurance would be provided. However, it had been advised that under the new public sector guidance, that the internal audit standards would be focused on a risk based plan. PD agreed to feedback this comment. PD

7.9 **Risk Assessment and Internal Audit Plan 2014/15** – PD presented the Plan and advised of the minor changes made.

7.10 **CCGs One Year On** – PD presented the report which was provided for information. PD advised that this report was based on a survey that was sent to 93 CCGs in order to receive views, what the key issues were going forward and how they had reflected a year on.

7.11 **RECOMMENDATION:**
The Audit Committee noted the contents of the reports.

8. Audit Committee Chair's Risk Assessment

8.1 PS explained that in order to seek assurances as part of the audit work, this assessment assisted in forming a view of the control environment in place which helped underpin the issuing of the clear audit opinion. PS advised that the responses received were satisfactory.

8.2 CG requested that a minor amendment was made to the second part of the following question:
*'How does the Audit Committee encourage staff to report their concerns about fraud?'
'Have any significant issues been reported?'*
CG requested that the following statement was included:
'I am not aware of any significant issues being reported'

8.3 RECOMMENDATION: The Audit Committee noted the contents of the assessment.

9. Counter Fraud Update

9.1 SC provided a verbal update on the Counter Fraud activity and advised that she had produced a draft action plan and annual report and would be discussing these with CL.

9.2 SC highlighted that the fraud awareness month had progressed well. SC also referred to the district nurses meeting, previously mentioned, and emphasised the benefit of using one counter fraud provision across the whole of the Gloucestershire health community where good practices and concerns were shared.

9.3 SC informed members that the Counter Fraud Star Award was awarded to Nicola Sanders for the exceptional work done to reinforce procedures following the Glebe investigation.

9.4 SC raised concerns which related to the lack of cooperation from NHS England in relation to specialist medications and it was agreed that this needed to be escalated with NHS England by way of a formal letter. SC

9.5 SC advised that NHS England still had no specific templates for action plans or annual reports for the CCGs and that an adapted provider template was being used. It was noted that NHS Protect had submitted a draft template to NHS England in November 2013 and that information was still awaited. It was agreed that a formal letter should be sent including the above issue and agreed for SC to liaise with CL. SC/CL

9.6 RECOMMENDATION: The Audit Committee noted the verbal update.

10. QIPP Report

10.1 CL presented the report which provided an overview of the 2013/14 QIPP Programme delivery at Month 12 and provided an overview of the 2014/15 QIPP Programme.

10.2 CL reported that there was a shortfall in the total value of schemes currently identified against the £17.8m QIPP target for 2014/15; with plans at £17.1m. This shortfall will be addressed through challenging the current schemes including delivery in year from the priority work programmes.

10.3 CL advised that GCS and GHFT had agreed the risk share agreement and it was noted that additional project management posts were being resourced to support the delivery of the schemes.

10.4 The Committee emphasised the importance of delivering on the QIPP programmes, as previously discussed. CL responded that project leads would be identified within the provider organisations and they would liaise with the CCG project managers to ensure the sustainability of the programme and drive it forward. It was noted that a huge amount of work had been done to ensure that QIPP was embedded within the organisations.

10.5 RECOMMENDATION: The Audit Committee:

- **Noted the 2013/14 QIPP programme performance at Month 12 including the individual project updates provided.**
- **Noted the 2014/15 QIPP programme plan and current position.**

11. Summaries of Procurement Decisions

11.1 CL presented the document which outlined all CCG decisions relating to the procurement of health care

services between the 11th March 2014 and 3rd June 2014.

11.2 CL advised that there would be a joint procurement process in conjunction with GCS and GHFT in relation to the provision of enteral feeds.

11.3 CL informed members that the provision of Assistive Technology (Telehealth) Services was going to procurement and would be progressed closely with GCS in terms of reviewing the overlap between primary care and the Integrated Community Teams.

11.4 **RECOMMENDATION:**
The Audit Committee noted the report.

12. Procurement Waiver of Standing Orders

12.1 CL presented the report which outlined all approved/rejected applications for waiver of Standing Orders between the 11th March 2014 and 3rd June 2014.

12.2 **RECOMMENDATION:**
The Audit Committee noted the report.

13. Aged Debtor Report

13.1 AB presented the report which provided a summary of the aged debt raised up to 19th May 2014. Members noted that the outstanding debt, as per the Sales Ledger, was £4.7m.

13.2 CL reported that the major NHS debt was the £398k outstanding from GHFT which was not felt to be a significant risk. It was noted that no formal dispute had been raised and payment was being followed up. CL also advised that no issues had been raised relating to the debt for the CSU and payment was imminent.

13.3 CL updated members in relation to the Non-NHS debt and advised that there were no significant issues to report. It was noted that the debt relating to Francis & Co was the only risk identified and that this was being followed up by debt recovery agents. Members noted that

the CCG had received its first payment relating to this debt.

13.4 CG expressed concerns relating to the debt outstanding for Gloucestershire County Council. However, it was noted that no issues had been raised and it was understood to be the result of a delay in the system.

13.5 RECOMMENDATION:

The Audit Committee noted the current level of invoices on the Sales Ledger of NHS Gloucestershire CCG, and the actions being taken to recover the outstanding debts.

14. Debts Proposed for Write-Off

14.1 The Audit Committee noted that there were no debts to be cancelled.

14.2 RECOMMENDATION: The Audit Committee noted the verbal update.

15. Losses and Special Payments Register

15.1 CL advised that following a review of the financial year, CL the CCG had made one payment of £1.5K for a small claims court issue which related to the IVF treatment policy. Members requested that procedures were robust going forward and CL responded that information would be circulated to all staff to ensure that they were aware of procedures.

15.2 RECOMMENDATION:

The Audit Committee noted the payments and acknowledged the report.

16. Any Other Business

16.1 CG suggested that the self-assessment and the objectives were reviewed at the September 2014 Audit Committee. It was also stated that the Terms of Reference would need to be reviewed in the September Audit Committee as a systematic process going forward.

17. The meeting closed at 11.05pm.

Date and time of next meeting:

Tuesday 16th September 2014 in the Video Conferencing Room at 9am.