NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire Clinical Commissioning Group
Governing Body

Meeting to be held at 2pm on Thursday 26th March 2015 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 29th January 2015	Chair	Approval
4	Matters Arising	Chair	
5	Patient's Story	Becky Parish	Information
6	Public Questions	Chair	
7	Chair's Update	Chair	Information
8	Accountable Officer's Update	Mary Hutton	Information
9	Planning 2015/16 • Operational Plan 2015/16 • Budget Plan 2015/16	Ellen Rule Cath Leech	Information
10	Primary Care Offer Enhanced Service	Helen Goodey	Approval
11	Assurance Framework	Cath Leech	Information
12	Report from West of England Academic Health Science Network Board	Mary Hutton	Information
13	Performance Report	Cath Leech	Information
14	Integrated Governance and Quality Committee Minutes	Julie Clatworthy	Information
15	Audit Committee Minutes	Colin Greaves	Information

16	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 28th May 2015 at 2pm in Board Room at Sanger House			

A recording will be made of this meeting to assist with the preparation of the minutes. This recording will be made on an encrypted device owned by the CCG and will be held securely for a maximum of one week before being deleted.

NHS
Gloucestershire
Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group (CCG)
Governing Body

Minutes of the Meeting held on Thursday 29th January 2015
in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Dr Helen Miller	HM	Clinical Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Caroline Bennett	CBe	GP Liaison Lead
Dr Peter Brambleby	PB	Interim Director of Public Health
Dr Charles Buckley	CBu	GP Liaison Lead
Colin Greaves	CG	Lay Member - Governance
Julie Clatworthy	JC	Registered Nurse
Alan Elkin	AE	Lay Member – Patient & Public Engagement
Mary Hutton	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Hein Le Roux	HLR	GP Liaison Lead
Ellen Rule	ER	Director of Transformation & Service Redesign
Dr Andy Seymour	AS	Deputy Clinical Chair
Valerie Webb	VW	Lay Member - Business
Dr Jeremy Welch	JW	GP Liaison Lead
Mark Walkingshaw	MW	Deputy Accountable Officer
Margaret Willcox	MWi	Director of Adult Social Care, GCC
In attendance:		
Caitlin Lord	CLo	Patient Advice & Liaison Service (PALS) Advisor
Caroline Smith	CS	Senior Manager, Engagement and Inclusion
Helen Goodey	HG	Associate Director Locality Development & Engagement
Alan Potter	AP	Associate Director Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 4 members of the public present.		

1 Apologies for Absence

1.1 Apologies were received from Dr Will Haynes, Dr Malcolm Gerald and Dr Martin Gibbs.

2 Declarations of Interest

2.1 All GP members declared an interest in Agenda Item 10 – Co-Commissioning of Primary Care.

3 Minutes of the Meeting held on Thursday 27th November 2014

3.1 The minutes of the meeting held on Thursday 27th November 2014 were approved subject to the following amendments:

- Section 7.7 to be amended to read *'CBu pointed out that GP services were available 24 hours a day;'*
- The following sentence to be deleted at Section 10.4 *'SA confirmed that Public Health was involved throughout the whole pathway.'*

4 Matters Arising

4.1 27.11.14 AI 9.4 – Time to Heal Project Evaluation Report – A request had been made regarding the need for further discussions on the interface between the service organisations involved in the care for homeless people and it was noted that this had been initiated. **Complete**

4.2 27.11.14 AI 9.6 – Time to Heal Project Evaluation Report – MW advised that the business case was being worked up and it was scheduled to be sanctioned at the QIPP Assurance Group in February 2015. It was agreed that an update would be presented at the March Governing Body meeting. MW

5 Patient's Story

5.1 CLo presented two patient case studies which related to the patients' experiences of a hospital discharge.

5.2 The patient case studies presented related to:

- A middle aged lady who had elective surgery on Achilles Tendon; and
- An elderly lady who had a stroke.

5.3 CLo summarised the context to the stories and explained the discharge planning process concerning these cases and suggested that learning from these studies could be taken forward in order to inform the improvements of the discharge pathway to allow for a better service experience.

5.4 CLo referred to the new booklet that the Gloucestershire Hospitals NHS Foundation Trust (GHFT) had produced on 'Discharge from Gloucestershire Hospitals'. It was noted that this aimed to help improve patient experience and discharge planning.

5.5 Members were informed that a joint project was being established with Healthwatch Gloucestershire to review the patient's experience on discharge.

5.6 It was recognised that communication and education of hospital staff was imperative in order to empower patients to make their own decisions.

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 December 2014 and January 2015 being highlighted by HM.

7.2 HM updated members regarding the Extraordinary Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) meeting held on the 16th December 2014 to discuss issues relating to hospital discharges following the media communication released by GHFT. HCOSC members had requested all Chairs of the NHS provider organisations and the Chair of the GCC Health and Wellbeing Board to meet together and to provide a report on the outcomes of their discussion at the next HCOSC meeting in March 2015. HM advised that the Chairs had met at the end of December 2014 and agreed a Consensus Statement and Principles which was

outlined at section 2.5 of the report. HM informed members that this had been subsequently relayed to the HCOSC members who were satisfied with the agreed process but noted that a full report would be presented at the March 2015 meeting.

7.3 HM highlighted that the CCG was working closely with the homelessness service to ensure that vulnerable homeless people had good access to care.

7.4 HM drew attention to Section 4 of the report relating to the Gloucestershire Health Community Choose Well Campaign and the work being developed to inform individuals on self-care and the service options when accessing healthcare service.

7.5 HM drew attention to Section 6 of the report which highlighted the meetings she had attended and advised that the meeting on the 15th January 2015 (CCG Development Working Group, London) and 27th January 2015 (SW SCN Cardiovascular Steering Group, Taunton) was cancelled and requested that this was noted in the minutes.

7.6 HM highlighted that the CCG Executive Team were undertaking GP Practice visits and noted that this had been appreciated by the practice staff.

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

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

8.1 The Accountable Officer introduced this report, which was taken as read, and provided a summary of key issues arising during December 2014 and January 2015.

8.2 MH advised that the respiratory pilot for 7 day working across the acute and community sector was developing well. It was noted that this pilot would be evaluated in the next few months to understand the costs and benefits to the system.

8.3 MH reminded members that the contract with the Independent Sector Treatment Centre provider (Care UK) expired on the 31st

October 2015. Members were informed that work was ongoing to manage the process and details of this were outlined at section 4.2 of the report. MH highlighted that the impact upon the Cirencester Treatment Centre was being considered and that this was being reviewed with GCS and Care UK.

8.4 MH advised that work on the Better Care Fund was progressing and that the plans were also developing well. MH advised that the Better Care Forum was well attended and that there was a great commitment to work together. MH informed members that the Better Care Fund Plan had recently been submitted and was awaiting final approval.

8.5 MH advised that the CCG were introducing 24 hour single point of clinical access but recognised that further work to develop this was required. MH highlighted that the Rapid Response service was available in the Forest of Dean and Stroud & Berkeley Vale and anticipated that the service would be available in the South Cotswold Locality by the end of February 2015. It was noted that the date for the North Cotswold Locality service launch was currently being discussed and would be available once final agreement was reached. Members noted that the work on the proposed model of the integrated case management model was currently being tested in two ICT locality teams; Gloucester City South West and Bishops Cleeve and Winchcombe, which included 7 GP Practices.

8.6 MH highlighted the work of the Patient Safety Forum. It was noted that this was a well-attended multi-provider forum that builds on the work of the South West Patient Safety Collaborative. MH informed members that the Forum was applying for a Health Foundation bid to support the introduction and joining up of safety initiatives across acute and community services and into primary care.

8.7 AE identified a typo on page 5 of the report and requested the following highlighted item to be deleted 'This level of performance is slightly **below** target for same period (675 cases).'

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

9 Commissioning Intentions for 2015/16

9.1 ER introduced the Commissioning Intentions for 2015/16 documents which was taken as read. The Commissioning Intentions outlined the CCG priorities for 2015/16 doc, the key dates in this year's planning round and would form the basis of the CCG operational plan for 2015/16.

9.2 ER advised that the Commissioning Intentions build on local strategic and operational plan priorities and responds to national planning priorities set out in the 5 Year Forward View Into Action.

9.3 ER indicated that there were risks associated with the delivery of the objectives set out in the document and that these were reflected in the corporate and divisional risk registers. There was inherent risk in the planning round related to securing sufficient level of buy in from local providers and the agreement of contracts for delivery in 2015/16. ER advised that the contracting round was progressing well and was on track to complete by end of February 2015.

9.4 JC queried the priority of Genomics and was advised that this would be scoped further once the programme group priorities were developed.

9.5 JC highlighted the work of the rehabilitation review and felt that the work around system measures could be framed within this. MH agreed that the plans should be coherent to include any transformational programme changes and questioned if this should be reflected in the milestones within the contract.

9.6 CBu highlighted Annex 6 of the report which he felt was weak and sought further Public Health support. CBu considered that it would be useful in terms of the prioritisation activity and identifying the interventions gaps. MH acknowledged that the Public Health resources were tight and felt that this should be worked through collaboratively. PB felt it would be useful to acquire patient feedback following the development of the Clinical Programme Groups (CPG) and the next steps outlined. PB agreed for Public Health input to each of the CPGs. ER ER

advised that the programme briefs for each of the programme areas would be circulated the following week.

9.7 MH proposed that the NICE guidance and interventions were reviewed by the CPGs in order to prioritise what was included in the 2015/16 Plan and suggested that this workstream was completed by the end of March 2015.

9.8 JC highlighted page 46 of the report which provided an overview of the BCF Plan on a page. HM felt it would be useful to have a narrative which outlined the context.

9.9 <u>RESOLUTION:</u> The CCG Governing Body approved this report.

10 Co-commissioning of Primary Care

10.1 AS introduced this item which was previously raised at the Governing Body meetings in May 2014 and November 2014 following the invitation by NHS England giving CCGs the opportunity to express an interest in taking an increased role in the commissioning of primary care services.

10.2 HG advised that following an exercise of thorough due diligence and engagement with members and stakeholders, the Executive Team and the Audit Committee Chair submitted a proposal on the 9th January 2015 for delegated commissioning arrangements.

10.3 HG advised that the CCG had undertaken a process of due diligence, including an assessment of the risks and benefits, which was inclusive of engagement with member practices and identified stakeholders. HG referred to page 7 of the report which outlined the high level benefits.

10.4 AP informed members that the potential change to CCG commissioning responsibilities required amendments to both the Constitution and the Conflicts of Interest policy which was aligned with the recently published guidance received from NHS England.

10.5 AP provided an overview of the principle changes within the

constitution. These were:

- Introduction of Sections 5.3 – 5.5 relating to the new joint commissioning arrangements;
- Establishment of a Primary Care Commissioning Committee which would undertake procurement decisions relating to primary care contracts. The Terms of Reference were outlined in Appendix O.
- Maintaining a public register of procurement decisions as outlined in section 8.6.4; and
- The revision of the Conflicts of Interests policy.

10.6 HG informed members that the proposal submitted for delegated commission was subject to a positive membership vote. It was noted that the CCG would be undertaking a two week membership vote on the proposals which would be commencing on the 2nd February 2015, in partnership with the Local Medical Committee.

10.7 MH requested clarity on the next steps and an update on the financial position. AS advised that the completion of the membership vote process would coincide with the outcome of NHS England final decision on the submission and added that if delegated authority was approved, then delegated commissioning arrangement would commence on the 1st April 2015. It was noted that a weekly Primary Care Co-commissioning Transition Group meeting was being held jointly with NHS England to review the transitional arrangements.

10.8 CL updated members on the financial implications and advised that the current information to date indicated that the risk was manageable although conclusive information was still awaited.

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

- **Noted the CCG Executives and Audit Committee Chair's decision to apply for delegated commissioning responsibilities**
- **Agreed the revised documentation required for delegated commissioning:**
  - **CCG Constitution**
  - **Policy for Managing Conflicts of Interest**

11 Locality Development Action Plan Progress Report

11.1 HG introduced the report which provided a further update on the two-year development plans on the seven localities which had been previously shared with the Governing Body in July 2014. This paper outlined the continuing progress made to date of the priorities identified by each locality along with the newly identified priorities for 2014/15.

11.2 HG highlighted that localities have continued to develop their links with District and Borough Council colleagues during 2014/15 as well as building on and establishing working relationships with many of the voluntary and community sector organisations. This had resulted in collaborative working in all localities, specifically around the different social prescribing models. HG advised that six of the CCG localities were piloting social prescribing within their locality.

11.3 HG advised that the key elements of the Locality Development Work Programmes were highlighted on pages 5-6 of the report. HG also advised of the key challenges identified in the July 2014 report i.e. limited project resource; financial constraints and communication with localities. It was noted that these challenges had now been mitigated following the implementation of additional project support. It was also noted that Locality Chairs were receiving additional support to develop their roles further going forward.

11.4 HG advised that the CCG was working with Public Health and the Finance Team to revise these plans and ensure that any new priorities were captured.

11.5 AS commended on the good locality managers in place and the improved working relationships between the teams.

11.17 RESOLUTION:

The CCG Governing Body:

- **noted the progress made during 2014/15 to date within localities; and**
- **supported the progression of the action plans.**

12 Assurance Framework

12.1 CL presented the Assurance Framework for 2014/15 which was taken as read. The Assurance Framework identified gaps in assurances and controls regarding the organisational objectives, along with details of the principal risks that have been identified by lead managers.

12.2 CL highlighted that the key issue related to the 4 hour wait and the constitutional target.

12.3 CL reported that the original risk rating for Risk Nos Q13, Q14 and Q15 had decreased as the risks had mitigated due to actions plans being implemented.

12.4 AE highlighted Risk No Q14 relating to Radiography and queried if the latest position was stipulated within the report as it indicated that the action plan was still outstanding. MW advised that the latest position was reported within the performance report.

12.5 CBu queried if the risk rating for Risk No Q7 should decrease as the national targets for C.Difficile and MRSA was zero and that there were no obvious avoidable factors.

12.6 MAE drew attention to Risk No Q3 regarding services for children with mental health problem and informed members that a review was being undertaken on the provisions available for children and young people with mental health problems as concerns had been identified and requested that the risk rating was increased. AP

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

13 Promoting Equality in Commissioning: Meeting the Public Sector Equality Duty Annual Report

13.1 VW presented the Gloucestershire CCG second Public Sector Equality Duty Report. The report highlights the work the CCG had undertaken towards meeting its general Public Sector Equality Duty, gaps it has identified and action it was planning to

take to improve its performance on equalities.

13.2 VW informed members that the pie charts illustrated on Appendix 2 of the report would be omitted from the final published version. It was also noted that accessibility information would be included prior to the submission deadline of 31st January 2015.

13.3 VW advised that the focus for 2015/16 would be to ensure implementation and compliance with the equality system, addressing local needs and measuring outcomes.

13.4 RESOLUTION: The CCG Governing Body approved this report.

14 Performance Report

14.1 CL presented the Performance Report which provided an overview of the CCG's performance against the organisational objectives for the period to the end of December 2014.

14.2 The report was broken down into the five sections of the CCG Performance Framework as highlighted in Section 1. CL advised a Lead Director had been assigned to each area.

Clinical Excellence

14.3 MAE advised that the Cardiology correspondence delays had been raised as an issue and noted that this was showing improvements, although it remained under close scrutiny. A root cause analysis had been received from GHFT and the results of this would be discussed at a further meeting being held to seek assurance.

14.4 MW updated members on the ambulance targets and advised that performance for quarter two had been good with achievement of the key indicators, although it was noted that the system was under pressure particularly during December 2014 (8.8% higher than anticipated).

14.5 ER updated members on the year to date achievement of the 31 and 62 day cancer targets and advised that performance was good overall. It was noted that the radiology reporting delays

had improved although this continued to be monitored. However, a challenge remained in the follow-up Outpatients Pending List and that discussions were ongoing regarding the action plan and validation. ER informed members that the current information indicated that there were improvements in the Ophthalmology service.

14.6 HM commended the collaborative working between GHFT and SWAST particularly during the recent period where there was an increased pressure within the system.

Patient Experience

14.7 MW reported that the performance against the emergency department four hour waiting time target in December was 83.6% and assured members that the CCG and the wider health community continued to work together to address the system-wide pressure. MW emphasised the strong partnership in place across the wider health community. MW articulated that the CCG continued to implement a programme to increase urgent and emergency care system resilience to ensure that the system can cope with peaks in demand. These initiatives were outlined in the system resilience plans and focused upon self-care, signposting, admission avoidance, in-hospital care, hospital discharge and community services.

14.8 MW referred to the NHS 111 performance and advised that there were challenges identified during December as there was an increase in the volume of calls which peaked particularly during the weekend. MW advised that this issue was being addressed and that additional resilience were being embedded during the weekend. MW also reported that the performance of the warm transfer target (% of calls passed as a 'live transfer' to clinical advisor) had deteriorated and that additional resources were being implemented.

14.9 ER highlighted the input of the Patient Engagement and Experience Team into the Ophthalmology outpatient surveys which included patient representatives and advised that this would inform the pathway mapping work for the cataracts and community eye care service.

14.10 ER reported that the two week cancer targets had been

achieved although this had been challenging due to an increase in referrals. It was noted that the issue had been addressed following the provision of extra capacity and enhanced medical staffing although it was recognised that the area remained under pressure.

14.11 ER advised that the proportion of patients waiting over 6 weeks for a diagnostic procedure decreased in October although this had increased in November. It was noted that this was primarily related to echocardiogram capacity and pressures within the urgent care system.

14.12 ER highlighted the issue in relation to the Referral to Treat (RTT) pathway where 14 incomplete pathways in excess of 52 weeks had been reported. It was noted that 13 of these breaches were within North Bristol NHS Trust and 1 at GHFT. ER informed members that there were capacity issues within the North Bristol Trust particularly for complex spinal services across a number of providers and advised that alternative solutions were being sought.

14.13 MAE advised that GCS and 2gether were achieving the CQUIN milestones relating to the implementation of the Friends and Family Test. However, it was stated that achieving the target was challenging for GHFT. MAE reported on the latest information and advised that the current response rate indicated that GHFT trajectory had significantly deteriorated (circa 11%). MAE assured members that there would be an emphasis on this area going forward.

14.14 MAE highlighted that there had been significant improvements in mixed sex ward performance and that this had been sustained recognising the increased pressure within the urgent care pressure system.

Partnerships

14.15 MW highlighted that the report updated members against the progress of the Better Care Fund and Health and Wellbeing Plans and referred to the progress of the key indicators outlined within Pages 32-35 of the report.

Staff

14.16 MW reported that the staff performance was rated as green with all indicators on target for achievement. It was highlighted that the objective setting round and performance reviews would shortly be commencing during February. MW informed members that the organisational development plan was being progressed by the CCG.

14.17 JC enquired if the re-launch of Datix had been formally introduced and was advised by HLR that the 'Quality Alerts' system would initially be presented at a development session the following week prior to formal roll-out.

14.18 HM queried the mechanism in place to monitor primary care compliance of the Friends and Family Test. MAE advised that the feedback she had received from the Area Team indicated that there had been a positive sign up rate from all GP practices.

14.19 AE drew attention to the graphs illustrated on Pages 33-34 and highlighted that the graphs did not accurately reflect the figures specified within the report. MW advised that the scaling required correcting and recognising that the presentation of the data needed to be improved.

14.20 MWi provided an analogy relating to the reducing inappropriate admissions of older people (65+) in to residential care and the proportion of older people (65+) who were still at home after 91 days performance. It was noted that measures such as an increase use of telecare, effective collaboration within the reablement service and being lenient around the length of stay were being driven and also developing the domiciliary care market.

14.21 CG expressed concerns regarding the delay in planned care treatment in excess of 52 weeks and queried what measures were being undertaken to ensure that the issues were being addressed. The importance of this treatment was questioned, particularly due to the extensive period of waiting time and it was felt that further discussions with the patients was required in order to prompt further discussions on the best options for procedure.

Finance and Efficiency

14.22 CL outlined the financial position and reported that the CCG was forecasting to deliver a planned surplus of £8.473m, representing an increase of £1.6m on the surplus originally planned. CL explained that the reason for the increase related to the funding reimbursed to the CCG due to the predicted underspend on the national CHC risk pool. It was stated that NHS England had directed all CCGs to not commit against this unanticipated gain and to increase their surpluses by an equivalent amount.

14.23 CL advised that known risks and pressures, including over-performance on contracts, have been fully assessed and included within the CCG's forecast position, with mitigating actions where appropriate.

14.24 CL updated members on the CCGs estimate of prescribing pressures and the forecast position.

14.25 CL highlighted that there was an identified risk of slippage on QIPP schemes (i.e. Care Homes Enhanced Service and DVT Enhanced Service) within the current financial year and that this was being closely monitored.

14.26 CL updated members on the allocation that had been received in respect of the referral to treatment costs. It was noted that this was currently being audited nationally.

14.27 CL reported that the Better Payment Practice Code target had been achieved.

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

- **noted the financial position as at December 2014 and the inherent risks within the position; and**
- **noted the performance against local and national targets and the actions taken to ensure that performance.**

15 <u>Integrated Governance and Quality Committee Minutes</u>

15.1 The Governing Body received the minutes of the meeting of the

Integrated Governance and Quality Committee held on the 23rd October 2014.

15.2 **<u>RESOLUTION:</u> The CCG Governing Body noted these minutes**.

16 **<u>Audit Committee Minutes</u>**

16.1 The Governing Body received the minutes of the meeting of the Audit Committee held on the 16th September 2014.

17 **<u>Any Other Business</u>**

17.1 There were no items of any other business.

18 **The meeting closed at 15:45.**

19 **Date and Time of next meeting: Thursday 26th March 2015 at 2pm in the Board Room at Sanger House.**

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair):_____ Date:_____

Matters arising from previous Governing Body Meetings – March 2015

Item	Description	Response	Action with
27.11.14 Agenda Item 9.6	Time to Heal Project Evaluation Report	CG queried the governance arrangements for signing off the business case and was advised by MW that it was proposed for the Governing Body to support the work of the business case with a view that it was sanctioned through the QIPP Assurance Group and suggested that an update was presented at the January 2015 Governing Body meeting. 29.01.15 MW advised that the business case was being worked up and it was scheduled to be sanctioned at the QIPP Assurance Group in February 2015. It was agreed that an update would be presented at the March Governing Body meeting	**MW**
29.01.15 Agenda Item 9.6	Commissioning Intentions for 2015/16	PB felt it would be useful to acquire patient feedback following the development of the Clinical Programme Groups (CPG) and the next steps outlined. PB agreed for Public Health input to each of the CPGs. ER advised that the programme briefs for each of the programme areas would be circulated the following week.	**ER**
29.01.15 Agenda Item 12.6	Assurance Framework	MAE drew attention to Risk No Q3 regarding services for children with mental health problem and informed members that a review was being undertaken on the provisions available for children and young people with mental health problems as concerns had been identified and requested that the risk rating was increased.	**AP**

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 7

Governing Body

Governing Body Meeting Date	**Thursday 26 March 2015**
Title	**Gloucestershire Clinical Commissioning Group Chair's Report**
Executive Summary	This report provides a summary of key issues arising during February & March 2015
Key Issues	The key issues arising include: • Delegated Primary Care Commissioning • Respiratory Study Morning • Get Health Advice ASAP • Time to Heal Project • 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	Helen Miller
Designation	Gloucestershire CCG Chair
Sponsoring Director (if not author)	Not applicable

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire Clinical Commissioning (GCCG)
Clinical Chair's Report

1. Introduction

1.1 This report provides a summary of key issues arising during February and March 2015.

2. Delegated Primary Care Commissioning

2.1 We submitted an application for delegated commissioning arrangements on the 9 January 2015, subject to practice membership approval.

2.2 LMC undertook voting process for us during first 2 weeks of February, asking every practice to vote on whether they supported the CCG in taking delegated authority for commissioning of primary medical care services. 90% of practices (75/83) took the opportunity to vote, with every one of those practices voting in favour.

2.3 Furthermore, on 18 February, NHS England wrote to confirm Gloucestershire CCG's submission had been approved by the national team.

2.4 We have now commenced the planning process to transition the delegated functions from NHS England to the CCG from 1 April 2015, which will include a period of 'shadow' / 'dual' running where certain functions require a longer transition period.

2.5 In order to successfully achieve the smooth handover, a transition project group has been established with representation from across both our CCG and NHS England. We have a full project plan, by directorate, with senior representation from CCG and NHSE AT directorates to ensure the identified milestones are achieved. A Risk Register, Questions Log and Action Log provide the full suite of project documentation. We are now reporting weekly to the Core Team who are providing the assurance and oversight of the project team.

2.6 This transition project group will also oversee the set-up of the new Primary Care Commissioning Committee, specifically established to undertake procurement decisions relating to primary care contracts. This will be chaired by Alan Elkin.

2.7 National training dates for lay members have been announced by NHS England for handling conflicts of interest, and we are also investing in additional training for our lay members with regards to Primary Care.

3. Respiratory

3.1 Respiratory Study Morning

3.1.1 The Respiratory Clinical Programme Group recently hosted a morning of bite-size updates and top-tips on a range of topics including the latest in COPD, Asthma and Bronchiectasis management. In addition, the Gloucestershire Respiratory Team provided an overview of the range of support services offered to primary healthcare teams including Pulmonary Rehabilitation, Home Oxygen Assessment and Review Service and Telehealth. Speakers included the hospital respiratory physicians, Drs Helen Miller and Charles Buckley and representatives of the Gloucestershire Respiratory Team. The event, largely targeted at primary care GP and PN respiratory leads, was attended by everyone (70) who registered….surely a first?!

3.1.2 Feedback was extremely positive and it is the intention to replicate the format and share with other Clinical Programme Groups.

3.2 Case Note Review

3.2.1 Given the recent acute-based pressures arising from high levels of unplanned admissions, a more detailed analysis of recent hospital activity revealed that there were a significant number of those that were aged 80+ admitted with respiratory disease. It was therefore decided to undertake a rapid case note review and on Thursday 26th February, a review team of Helen Miller, Andrew White (Consultant Chest Physician) Duncan Thomas and Sarah Riordan-Jones bunkered down at GRH and reviewed notes from 40 such patients

with a view to looking to identify some of the underlying issues that contributed to this particular cohort tipping over into crisis where hospital admission became the only option at that point.

3.2.2 Analysis is underway and the team will also be looking at any input from primary and/or community respiratory teams. This will help to inform the sequence of events leading up to leading up to these patients crash-landing in ED and in particular, what alternative strategies, treatment and/or management options might have been considered.

3.2.3 The findings will initially be shared with the Respiratory Clinical Programme Group and the Urgent Care team and will inform consideration of future developments.

3.3 **Respiratory and the HSOSC**

Led by Dr Helen Miller, members of the Respiratory Clinical Programme Group met with HSOSC members at their request on 29th January at Shire Hall to provide an overview of our commissioned respiratory services with particular emphasis on how services are delivered and supported by partnership working. A further workshop is planned to accommodate more in-depth discussions around further opportunities in this particular area.

4. Get Health Advice ASAP

4.1 The NHS in Gloucestershire will launch its ASAP (Choose Well) public information campaign on 25 March.

4.2 The campaign targets adults and parents of young children with advice on what to do if they are ill or injured and are unsure where to turn.

4.3 The ASAP website and App will allow users to ‘Search by Service’ or ‘Search by Condition’ – providing a step by step guide through symptoms, self-care and signposting to the appropriate NHS service/s.

4.4 They can also find opening hours, service locations and waiting times where applicable.

4.5 Pharmacy is central to the campaign for treatment of minor ailments and signposting on to other NHS services when needed.

4.6 **ASAP** stands for **A**pp, **S**earch the website, **A**sk NHS 111, **P**harmacy.

4.7 The campaign will include targeted social media advertising, traditional media, distribution of promotional material in key public places, outdoor advertising and outreach work (e.g. schools, shopping centres).

5. Time to Heal Project

5.1 A business case for the Time to Heal project was approved by the QIPP Assurance committee in February 2015. With respect to the more technical outcomes of the service, we hope to see reduced acute readmissions, and reduced acute length of stay within GHFT, for persons of no fixed abode during 2015-16.

6. Meetings attended

- 29 January – HCOSC Respiratory Workshop, Gloucester
- 5 February – Mental Health Task and Finish Group, Gloucester
- 10 February – Respiratory Study Day, Gloucester
- 10 February – VCS Meeting, Gloucester
- 26 February – Respiratory Case Review
- 3 March – HCOSC, Gloucester
- 3 March – Gloucestershire SRG Escalation Meeting – Gloucester

7. Recommendation

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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 8

Governing Body

Governing Body Meeting Date	**Thursday 26th March 2015**
Title	**Gloucestershire Clinical Commissioning Group Accountable Officer's Report**
Executive Summary	This report provides a summary of key issues arising during February & March 2015
Key Issues	The key issues arising include: • Better Care Fund (BCF) • New Primary Care Out of Hours Service • Integrated Community Teams (ICTs) • Urgent Care • Experience and Engagement Update Q3 • Ophthalmology • Respiratory • Diabetes • 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)	Not applicable

Gloucestershire Clinical Commissioning (GCCG)
Accountable Officer's Report

1. Introduction

1.1 This report provides a summary of key issues arising during February and March 2015

2. Better Care Fund (BCF)

2.1 Gloucestershire's Better Care Fund (BCF) plan was resubmitted with supporting evidence in January. In early February a letter was received from Dame Barbara Hakin, National Director of Commissioning for NHS England, informing the CCG and Local Authority that the plan is considered to be strong and robust and the national team has every confidence that Gloucestershire will be able to deliver against it. The plan, therefore, is classified as 'fully approved' and Gloucestershire will be able to move forward as a health and social care community without additional oversight from the central BCF Task Force.

2.2 Through a process of detailed planning with Local Authority partner's agreement has been reached regarding how monies will be allocated and monitored within the 2015/16 pooled budget of £39.948m. The schemes and enablers supported by the budget will be monitored using agreed data collection processes and governed by existing joint forums (reporting in to the Joint Commissioning Partnership Executive, Joint Commissioning Partnership Board and the Health and Wellbeing Board).

2.3 The schemes underpinning the BCF plan include Integrated Care Teams, Integrated Discharge Teams, Risk Stratification, the Care Home Enhanced Service and Reablement service. All the schemes are focused on supporting more people to live at home for longer and are integral to the achievement of Gloucestershire's BCF and Joining Up Your Care aspirations. These will continue to be a high priority for commissioners and providers to ensure the culture of integrated working is fully embedded across the county to improve health and wellbeing outcomes.

3. New Primary Care Out of Hours Service

The new SWASFT Primary Care (Out Of Hours) contract will commence on 1st April 2015. In addition to SWASFT's internal implementation governance structure, a weekly Mobilisation Board takes place where SWASFT update the CCG on progress against the implementation plan, risks and issues are escalated and mitigations agreed. Given the start date just ahead of the Easter weekend, plans are in place to make sure that the new service is prepared to cope with the anticipated demand expected over the bank holiday period.

4. Integrated Community Teams (ICTs)

4.1 As members know, in order to develop the capacity and capability of community services to help reduce the demand on secondary care services and keep people as independent for as long as possible, we are introducing 24 hour single point of clinical access (SPCA), rapid response (urgent visit within 1 hour) and high intensity (enhanced level of planned interventions over an agreed period of time) functionality in addition to the existing range of core ICT services provided by Gloucestershire Care Services . This is being carried out as part of a phased geographical roll out during 2014/ 2015. The following summary provides the key actions taken since the last report:

- Work is ongoing to embed the functionalities of Rapid Response and High Intensity functionalities (HIS) within ICT teams located in Gloucester City, Cheltenham and Tewkesbury (Tewkesbury town, Churchdown, Brockworth, Bishops Cleeve and Winchombe practices). This will be taken forward through the wider plans to implement integrated case management
- A Rapid Response service is now available in the Forest of Dean, Stroud & Berkeley Vale and South Cotswolds;
- The North Cotswold locality is due to go live on the 22nd March 2015;
- The CCG are currently in the process of finalising service and financial arrangement for Rapid Response so that transition and service management into business as usual arrangements can take place. This is due to be completed by June 2015;
- The proposed model of integrated ICT case management is still

being tested in two ICT locality teams; Gloucester City South West ICT team and Bishop Cleeve & Winchombe. This includes 7 GP Practices. Multi-disciplinary team sessions continue with collective management of higher risk patients, testing the high intensity functionality and front line staff at the forefront of how final model will work. The findings of this work will be set out in a report to be reviewed by the ICT Steering Group at the end of March 2015. It will be used to agree ongoing development and implementation across the County

- During the period 1st April 2014 – 1st March 2015, 1,189 cases have been managed and completed by the strengthened ICT functionalities. This level of performance is below the CCG revised trajectory target for the same period (1,450 cases). The programme team is working closely with the service provider to ensure that anticipated throughput is realised in line with requirements as part of the Rapid Response finalisation process;
- A patient case review process has been agreed by the Programme and the proposed model was due to be tested between the end of January and the end of March 2015. However, the implementation is delayed and both organisations confirm information governance arrangements;
- The development of an ICT Phase Two has agreed four key work streams (i) Give staff permission to get to know someone, (Ii) Positive risk taking (Iii) Team formation (iv) Coaching and mentoring and People power. In terms of timescales, it is anticipated that the current pilot in Stroud and Berkley Vale will be refined in the period from now until the end of March. This work has now commenced;
- The 2015/ 2016 programme and proposed governance is currently being finalised. This will be reviewed and agreed at the ICT Steering Group in March 2015.

5. Urgent Care

5.1 The Urgent Care system continues to experience pressure which is particularly impacting upon performance against the four hour maximum wait standard in Emergency Departments.

5.2 At the beginning of the month a Tripartite System Escalation Meeting took place between system leaders and NHS England, Monitor and the Trust Development Authority. This session provided the

opportunity for a system wide review of current performance and plans for system recovery.

5.3 Four key areas have been prioritised, with a focus on delivery of a number of schemes to help remedy current performance and address root causes:

- **Emergency Department capacity and staffing**: This includes extension of consultant cover and the recruitment of additional Emergency Nurse Practitioners. This is being further enhanced by a pilot involving a Primary Care clinician working within Gloucestershire Royal Hospital (5 days a week 10am to 10pm seeing patients who present with primary care needs).

- **Acute bed capacity and flow**: This work stream focusses upon delivery of admission avoidance schemes. This includes a renewed emphasis upon discharge planning and concentrated work on reducing the number of medically stable patients in inpatient beds.

- **Community capacity and flow:** Work is underway to streamline flow from the acute trust into community services, with a focus on ensuring sufficient capacity is in place (particularly around domiciliary care and reablement services). There is also a continued focus on ensuring patients do not need to stay in community beds longer than clinically necessary.

- **Weekend discharges:** A detailed review is underway to remove barriers to weekend discharge.

6. Experience and Engagement Update Q3

6.1 The Experience and Engagement Report, which was presented to the Integrated Governance and Quality Committee in February 2015, provides an overview of key experience and engagement activity undertaken by the CCG during Q3. The Engagement and Experience Team has supported work within most CCG Directorates and directly with three of the CCG Localities during Q3.

6.2 Complaints and comments received by GCCG PALS

6.2.1 During Q3, the ‘advice and information’ aspect of the PALS service has increased significantly, particularly in relation to primary care enquiries. The large increase from 47 contacts to 138 in Q3 is also due to improved recording and housekeeping, along with a genuine increase in contacts during the Q3. Over the last few months recording systems have been refreshed to remove outdated ‘coding’ and improve functionality. Of those 138 contacts 89 related to the team’s Primary Care PALS function.

6.2.2 The Experience Team seek to resolve individuals’ enquiries at first contact through provision of advice and information. Only when necessary, or when it is more appropriate to do so, do they pass enquiries on to others. During Q3 the Experience Team provided advice and information on a range of topics including:

- NHS complaints handling arrangements
- De-listing from a GP practice
- NHS England specialist commissioning issues
- Contacts for GHNHSFT
- Continuing Healthcare (CHC) Funding

6.3 Healthwatch Gloucestershire (HWG) Comments Summary Q3

6.3.1 HWG provides a Cumulative Master Comments Summary to the CCG each quarter. A total of 2302 views and experiences were collected by HWG in the period April to December 2014 (Quarters 1-3 2014/15). This is an increase of 80% over the same period last year.

6.3.2 Information from the Master Comments is regularly ‘mined’ by the CCG to provide experience data to inform CCG programmes and projects. The data from Q2 has been mined to support work in the following areas: MSK, mental health, ophthalmology and falls. Following discussion at IGQC, routine provision of HWG quarterly data will be reintroduced in the next quarter.

6.3.3 The HWG Master Comments full data set is available on request from the Engagement and Experience Team.

6.4 Engagement update

6.4.1 **Individual Project Work Q3**

6.4.2 CCG Engagement and Experience staff has been involved in a range of projects during Q3. Key amongst these are:

- Continence Review
- Social prescribing
- Choose Well 2015
- Community Hospitals Development Group
- Learning Disabilities Assessment and Treatment
- The Care Act implementation (Information)
- Carers Rights Day
- Patient survey questionnaire for Florence Project
- Gloucestershire Information Governance Working Group
- Gloucestershire Shared Care Records Project
- Glos Research Support Service
- Care Pathways Project
- CCG Locality work in Tewkesbury, Gloucester City and Cheltenham
- Procurement support for the Out of Hours Service

6.5 HWG representation on GCCG projects Q3

6.5.1 HWG are currently represented on over thirty CCG programmes and projects. These include Clinical Programme Groups, Locality Reference Groups and specific groups, such as the Community Hospitals Development Group

6.6 Proactive Engagement activities Q3

6.6.1 The Engagement Team has undertaken focussed work for five of the CPGs during Q3: Children and Young People, Cancer, Ophthalmology, Muskulo-Skeletal and Frail Older People.

6.6.2 In addition to the CCG Engagement Team's input, all CPGs have representation from a CCG Lay Champion and a HWG member. Lay Champions and HWG members have been directly involved in some of the engagement activities described below and in pathway 'walk-

throughs'. Their observations and insights have informed CPG discussions and planning.

6.7 Information Bus Activity October to December 2014

6.7.1 Quarters 2 and 3 are traditionally the busiest for Information Bus Activity, with Q4 the quietest period (weather constraints). The Information Bus has provided a mobile venue during Q3 for both GCCG activities and Partners, making 34 visits across the county and engaging with more than 2500 individuals.

Locality	**Number of visits**	**Number of people engaged with approx.)**
Cheltenham	3	45
Forest of Dean	6	392
Gloucester City	7	255
North Cotswold	7	1674
South Cotswold	3	95
Stroud and Berkley Vale	3	111
Tewkesbury, Newent and Staunton	5	95
Total	**34**	**2664**

6.8 Other activities

6.8.1 There are activities which the Engagement and Experience Team are involved in which are difficult to categorise. Highlights in Q3 include:

- The Senior Manager, Engagement and Inclusion gave evidence to the Welsh Affairs Select Committee to inform their investigation into Cross-border health arrangements between England and Wales.

- Two Engagement Case Studies were submitted by the CCG to the NHS Patient Voice South Case Study Competition. These were: Setting up a Cancer Patient Reference Group (living with and beyond cancer) and ED Reconfiguration, 12 months on. The competition winner was Hampshire Healthwatch, Young Carers

Project. However, the CCG's contributions were well received and have been published on the Patient Voice website. GCCG was the only organisation to prepare more than one entry to the competition.

- Preparation is underway for co-commissioning and the impact on CCG Engagement and Experience activity and capacity. National guidance is awaited regarding complaints and PALS governance arrangements. An update will be provided in the next report to IGQC

7. Ophthalmology

7.1 Ophthalmology has been identified as a priority area for the CCG given current and anticipated service pressures (rising demand and associated spend) and the corresponding service development opportunities. The Ophthalmology CPG, chaired by Dr Graham Mennie is leading that change programme which has been informed by a number of on-site hospital and community eye-service pathway walk-throughs; this has provided a unique patient perspective and helped to inform both the challenges and opportunities within eye-care services

7.2 A number of service areas/pathways have already been identified as offering up prospective development opportunities and facilitated workshops have already been undertaken to scope out existing and prospective pathways for cataracts, community eye services and glaucoma services. Attendance and engagement at these workshops has been excellent with a wide and varied group of stakeholders in attendance including patient representatives, voluntary sector organisations and primary, community and specialist providers. The very positive feedback attests to the collaborative nature of the engagement and the collective willingness to effect change that will ultimately deliver improved quality and clinically and cost-effective care.

7.3 A suite of recommendations arising from the workshops has already been shared with the Ophthalmology CPG and corresponding implementation plans are currently being developed.

7.4 The management of medical retinal disease and the associated high

drug costs associated with this treatment will be scoped out and addressed in the final workshop.

8. Diabetes

8.1 As part of the our strategy to improve the quality of diabetes care and deliver it closer to home, the Diabetes Clinical Programme Group has overseen the development of a Diabetes Community Enhanced Service. This innovative approach will result in:

- Increased training and resource to primary care healthcare teams which will enable them to provide all generalist/non-complex diabetes in their own practices with the support of the Community Diabetes Team
- An increase in the number of practices who are able to provide and initiate injectable therapies such as insulin
- The repatriation of stable Type 2 patients from long-term hospital follow-up care
- More timely referrals to education for those who are newly diagnosed
- An increase in the number of patients who receive the NICE recommended 9 care processes

8.2 We are pleased to report that 75 practices have so far signed up to the Diabetes Enhanced Service which is now in the process of being implemented.

9. Meetings attended

- 02-Feb Healthwatch Lay Reps, Gloucester
- 05-Feb Telehealth presentations, Gloucester
- 10-Feb South Cots PLT, Cirencester
- 18-Feb Meeting with Dr Furn Davies. Moreton in Marsh
- 19-Feb Quarterly Meeting SW Region NHSCC, Somerset
- 24-Feb South Cotswold Commissioning Locality Open Meeting, Cirencester
- 26-Feb GHWB Development and Provider Engagement,

Gloucester
- 02-Mar BCF Forum, Gloucester
- 03-Mar Health & Care Overview Scruity Committee (HCOSC), Gloucester
- 03-Mar Gloucestershire System Resilience Group - Escalation Meeting, Gloucester
- 11-Mar NHS England Health and Wellbeing Board in London
- 24-Mar GH&WB, Gloucester
- 25-Mar Gloucester Criminal Justice Board, Police HQ, Gloucester

10. Recommendation

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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Governing Body

Governing Body Meeting	**Thursday 26th March 2015**
Title	Primary Care Offer Enhanced Service – 2015/16
Executive Summary	In 2014/15, Gloucestershire CCG developed a Primary Care Offer Enhanced Service. The purpose of this new enhanced service was to focus on quality improvement in primary care by reducing variation, raising standards based on best practice and also to provide a framework to encourage productive and supportive engagement between our GP membership and the CCG. This first year proved very successful, with 100% sign-up of all practices to all four elements ('building blocks'), and early evaluation providing a strong indication as to the efficacy of the enhanced service. A full evaluation will follow during 2015/16. It is therefore our proposal to continue to offer the enhanced service in 2015/16, along with some additional new services included within the building blocks as a mechanism to continue to tackle health inequalities arising from primary care variation, and promote innovation to deliver new ways of working.
Key Issues	It is vital to have high quality, evidenced based local enhanced services that reflect the health needs of the county; to ensure that they offer good value for money and provide equity for patients based on health needs.
Risk Issues: **Original Risk** **Residual Risk**	Identified risk of inequitable service for patients if not all practices provided the services within the Primary Care Offer, resulting in exacerbated variability of provision. With 100% sign-up in 2014/15, and continued LMC and CCG GP engagement, we currently consider this to be of a low risk.

Financial Impact	Additional funding for 2015/16 agreed as part of Annual Operating Plan prioritisation process
Legal Issues (including NHS Constitution)	All enhanced services will need to be commissioned using NHS Standard Contracts CCGs must follow National and EU Procurement rules
Impact on Health Inequalities	A key driver for originally developing the Primary Care Offer in 2014/15 was to support reducing healthcare inequalities arising from variation within primary care across all 83 GP practices
Impact on Equality and Diversity	All enhanced services commissioned by the CCG reflect equity for patients based on health need.
Impact on Sustainable Development	Services provided closer to home for patients, avoiding the need to travel to secondary care settings.
Patient and Public Involvement	
Recommendation	Approval for the continued commissioning of the Primary Care Offer Enhanced Service, with additional elements included for 2015/16.
Author	Helen Goodey
Designation	Associate Director – Locality and Primary Care Development
Sponsoring Director (if not author)	Dr Andy Seymour Deputy Clinical Chair

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Governing Body

26th March 2015

Primary Care Offer Enhanced Service

1. Introduction and background

1.1 Until April 2013 all GP Local Enhanced Services (LES) were commissioned through the GP Contract (GMS, PMS, APMS) and were the responsibility of PCTs.

1.2 However from April 2013 with the restructure of the NHS commissioning landscape, the commissioning responsibility for the majority of local enhanced services was passed to Clinical Commissioning Groups (CCGs).

1.3 CCGs are able to commission a wide range of community-based services funded from their overall budgets, which must be commissioned through the NHS standard contract. CCGs must determine if these services could be delivered by one or more providers (including general practice), and whether to undertake competitive procurements to identify a single provider (or limited group of providers) or whether to allow patients to choose from a range of qualified providers by using Any Qualified Provider route.

1.4 It should be noted that Gloucestershire CCG has recently received approval to take on delegated responsibility for commissioning of all Primary Medical Services and therefore this will now include the commissioning of all enhanced services. This will be with the exception of those enhanced services commissioned by the Public Health Local Authority, who will remain responsible for taking the lead in improving the health of local communities.

2. Local Enhanced Service Review Group

2.1 To support the CCG with its role as commissioner of enhanced services, a project working group was established in 2014/15. This is a clinically led group where recommendations are made based on clinical evidence and best practice to ensure high quality enhanced service provision for patients of Gloucestershire

2.2 The Enhanced Service Review group developed a number of criteria that all enhanced services, both existing and newly developed, are assessed against. These are:-

- Equity for patients;
- Value for money;
- Commissioning decisions based on best evidence;
- No duplication with other service provider or existing contract payment i.e. QOF, DESs;
- Appropriate for NHS funding;
- Demonstrate measurable outcomes.

2.3 The group recognised the potential for conflicts of interest and these are recorded. To further support the management of conflict, the Associate Director for Locality and Primary Care Development undertakes the role of Chair of the group. The group meet monthly and from the 1st April 2015 will report to the new Primary Care Operational Group and the Primary Care Commissioning Committee as part of the new Primary Care Co-commissioning governance structure.

3 Primary Care Offer (PCO) 2014/15

3.1 In 2014/15 the CCG developed a new enhanced service called the Primary Care Offer. This was developed in conjunction with a number of local stakeholders, CCG commissioning leads and clinicians. The purpose of this new enhanced service was to focus on quality improvement in primary care by reducing variation, raising standards based on best practice and also to provide a framework to encourage productive and supportive engagement between our GP membership and the CCG.

3.2 Aims and objectives:

- Reducing unexplained variation in primary care
- Supporting quality improvement and innovation

- Focussing services at patients with complex health needs
- Support Gloucestershire CCG commissioning priorities
- Improve access to primary care/support urgent care agenda
- Support member practices to influence clinical commissioning agenda
- Clear outcomes but avoid unnecessary bureaucracy
- Support Innovation and Quality Improvement

3.3 **Structure of the Primary Care Offer**

3.3.1 There are four components (building blocks) to this enhanced service and there are a number of elements within each component which make up the full enhanced service.

Table A

Building Blocks	**Payment Level**
Building Block 1: **Improving Quality in Primary Care** *[Mandatory]*	20%
Building Block 2: **Enhanced Primary Care** *[Optional]*	40%
Building Block 3: **Supporting the Urgent Care Agenda** *[Optional]*	60%
Building Block 4: **Influencing Clinical Commissioning** *[Optional]*	100%

3.3.2 **Appendix A** attached provides the full detail of the enhanced service, including a brief description and the deliverables required.

3.3.3 GP practices have the opportunity to provide some but not all of the building blocks, however building block one is a mandatory requirement. Therefore GP practices could provide building block one and then choose to provide some or all of the remaining building blocks. It is important to note that all of the elements within each building block must be delivered to meet the requirements.

3.4 Early Evaluation for 14/15 Primary Care Offer

3.4.1 A full evaluation will be undertaken in 15/16 however we have some early learning from 14/15, in particular around Cancer education.

3.4.2 GP engagement with participation in the Cancer Management Programme has been hugely successful as part of the Primary Care Offer 2014/15.

3.4.3 To date we have held 9 Macmillan GP Cancer Master classes with over 500 GPs in attendance. The understanding stipulated in the PCO is that attending GPs share with their GP practice colleagues the Top Tips gained from their participation.

3.4.4 The Cancer Master classes have enabled good dialogue and education between primary and secondary care colleagues involved in the whole cancer patient pathway, with alerts of patient red flag symptoms not to miss, discussion of patient issues including need for symptom control. The anticipated outputs are earlier stage at diagnosis, improved quality of GP referrals with appropriate investigations arranged beforehand so as not to hinder cancer waiting times, improved patient experience and clinician collaboration.

3.4.5 GP feedback has been overwhelmingly positive regards the education value, innovative method of delivery (‘speed-dating’ rotating groups) and appreciation of a variation of daytime and evening events. Clinicians involved have valued the opportunity of face- to-face dialogue with their primary care colleagues, having a greater appreciation of the difficulties encountered in

clinical practice and managing uncertainties.

3.4.6 Detailed Cancer Significant Event Audits have gradually been submitted over the year. Preliminary analyses has revealed some excellent learning points around education of the practice teams within primary care, identification of system failures and need for improvement in public awareness of potentially worrying symptoms.

3.4.7 A further report will be presented to Governing Body once the full evaluation is complete.

4 Primary Care Offer 2015/16

4.1 The 14/15 Primary Care Offer enhanced service was reviewed by the enhanced services group and a number of recommended changes were put forward. This includes the introduction of a number of new elements; these are outlined below and are highlighted within **Appendix A.**

4.2 New additional elements for 15/16:

1. Local Quality Improvement Indicators
2. Practice Variation Reports
3. Introduction and use of Care Pathways website
4. Supporting Innovation

4.3 Finance

4.3.1 Total budget for 14/15 for the Primary Care Offer enhanced service was based on £1.14 per registered patient, with a projected outturn budget of £736,000.

4.3.2 Total budget for 15/16 for the Primary Care Offer enhanced service has been based on £3 per registered patient, with a total budget allocation of £1.9m.

4.3.3 This will be funded partly through 14/15 enhanced services budget, as well as further funding allocated through the Annual Operating Plan and utilisation of headroom. The uplift reflects the additional work required by GP practices to deliver the new elements introduced for the 15/16 Primary Care Offer. The new elements have been introduced to deliver improved quality

outcomes, reduce variation and achieve greater engagement from GP member practices on commissioning priorities.

The remuneration has been further informed by the recent benchmarking exercise undertaken by NHS England outlining enhanced services spend across other local CCGs.

4.3.4 The payment structure has been developed to try to encourage GP practices to provide all of the building blocks. **Table A** outlines the % payment level set against each Building Block. In 14/15 all 83 GP practices signed up to provide this enhanced service and agreed to provide all four building blocks. Therefore budget assumptions for 15/16 have been based on 100% sign up across all four building blocks.

5. Recommendations

The Governing Body is asked to:

- Approve the continued commissioning of the Primary Care Offer Enhanced Service, with additional elements included for 2015/16.

6. Appendices

Appendix 1 - Primary Care Offer Enhanced Service building blocks 2015-16

APPENDIX 1: PRIMARY CARE OFFER

BUILDING BLOCK 1: IMPROVING QUALITY IN PRIMARY CARE - Mandatory					
ACTIVITY	**DESCRIPTION 2015-16**	**DELIVERABLES 2015-16**	**TEMPLATES**	**READ CODES**	**COMMENTS**
1. Participate in Cancer Management Programme	**A.** GP practices to give significant event consideration to all cancer diagnoses in the practice during 2015/16. To select [one case per 2,000 head of population] for conducting an in-depth Significant Event Audit	In-depth Significant Event Audit completed for one case per 2,000 head of practice population. The completed SEA's should be sent to Sarah Riordan-Jones (sarah.riordan-jones1@nhs.net)	Primary Care Acute Oncology Audit Temp RCGP-Example-of-a-better-SEA.pdf RCGP-Example-of-poor-SEA.pdf	Not applicable	
	B. GP practices to participate in an education programme, consisting of Macmillan GP "Lunch/Supper & Learn" Master Classes and/or a full-day Cancer PLT. Practice discussion sheets will be provided and supporting information will be made available via the new Care Pathways web tool. Attendees will be expected to share key messages with practice colleagues. All events will be CPD accredited.	GP practices are expected to send a GP attendee to at least 2 Macmillan Masterclasses and 1 full-day Cancer PLT event OR 4 Macmillan master classes The full Macmillan Masterclass programme is to be published in April 2015. However for advanced notice the first event is:- Upper GI Cancer: 11th May 2015, 13.30 – 16.30 at Sandford Educational Centre The full-day Cancer Super PLT is scheduled for 30th September, at the Cheltenham Race Course. This conference event will enable GPs to learn about the CCG's new approach to cancer survivorship and the role of primary care. The programme will include leading national and local speakers. The day will also include feedback on the learning to date from the Significant Event Audits, and recaps on the collated Top Tips from the education programme.	Not applicable	Not applicable	

ACTIVITY	DESCRIPTION 2015-16	DELIVERABLES 2015-16	TEMPLATES	READ CODES	COMMENTS
	C. GP practices to actively support a successful 'in practice' Cancer Screening programme for the county, including follow-up letters to maximise attendance for screening appointments.	To support one 'in practice' cancer screening programme from the following – Breast, Bowel or Cervical Screening. GP practices to identify patients and contact by either phone or letter as a reminder to make an appointments	example letter cervical non-responde Example personal letter from GP to Bow Example letter for breast screening non Tips for all types of cancer screening to ir	**Version 2** 9Ok9 Cancer screening follow up **Version 3 (SystmOne only)** XaKJk Cancer screening follow up	
2. Advanced palliative care/EOL plan	**A.** GP practices to agree 'End of Life' plan with patient following the Gold Standard Framework and add to patient record using Read Code and GP practices to add via Adastra EOL template as free text	Agree End of Life plan with patient. Adastra template completed.	http://www.gloucestershireccg.nhs.uk/your-services/eolc/advanced-care-planning/ How Do I…a quick guide for using the Ec	Version 2 8CMW3 End of life care pathway Version 3 (SystmOne only) XaZe1 End of life care pathway Please also add "End of Life Care Plan Agreed" as free text Version 2 9e0 GP out of hours service notified Version 3 (SystmOne only) XaItp GP out of hours service notified Please also add "Via Adastra EoL template" as free text	
3. Practice based clinical audit	**A.** GP practices to continue quarterly clinical audit activity through GCCG PCCAG, including reviewing audit feedback and implementing suggestions highlighted within the audit results.	Quarterly clinical audit activity completed and agreed actions implemented.	MIQUEST queries provided by GCCG	Not applicable	
	B. GP practices to sign up to a clinical audit data sharing agreement to comply with Information Governance requirements.	Clinical audit data sharing agreement signed.	Clinical audit data sharing agreement to be provided by GCCG	Not applicable	
4. Local Quality Improvement Indicators NEW	**A.** The CCG has developed a set of quality indicators as set out below, GP practices to review the benchmarking data, understand the	**A.** Review the Benchmarked data at a Practice Level and agree a practice Action Plan to reduce any clinically unjustified variation.	CCG TO INSERT BENCHMARK DATA, GUIDANCE		

ACTIVITY	DESCRIPTION 2015-16	DELIVERABLES 2015-16	TEMPLATES	READ CODES	COMMENTS
	outliers and attempt to explain any unexplained variation. This will involve peer discussion at locality level. 1. Smoking – recording status and advice given 2. Antibiotics Prescribing - (Antimicrobial Stewardship) 3. Improving Atrial Fibrillation (AF) diagnosis rates and use of Anti-coagulants 4. Identifying patients at risk of Acute Kidney Injury (AKI)	Implement and maintain best practice (to be completed by September 2015). Relevant data and support materials will be provided by CCG **B.** To meet with practices in the Locality twice a year to share Benchmark data and Action Plans – as part of regular Locality meetings - so that good ideas and best practice can be disseminated. **C.** Produce a brief annual report using simple standard template highlighting any issues, concerns and progress on practice Action Plans	NOTES AND TEMPLATES		
5.Practice Variation Reports - NEW	CCG to provide a Practice Variation report. The report will provide activity and performance detail across urgent care, planned care and referrals, it will also include prescribing data and GP Access data. This report will include actual and taxonomy position. Each surgery would pick two areas out of the list supplied, where they are an outlier (e.g. T&O referrals) to review. The practice will have the learning from looking in detail at an area where they are an outlier Each practice will be provided with a refreshed Practice Variation Report at Quarter 3 2015.	**A.** The GP surgery would look at the chosen areas in detail and give feedback using the proforma provided **B.** The learning from this will be shared with the Locality Executive Groups to support further learning and planning	To be attached The CCG will provide a brief proforma to support GP practices in responding to this request		
6. Use Care Pathways Website as described - NEW	The CCG are developing a website which holds information on local clinical pathways, clinical guidance, community resources (voluntary sector organisations which might support patients), patient and carer information, referral forms and commissioning policies (previously IFR) and GP educational material. As services change or new services are established this will be the main reference site which holds all this information. Website will be launched at end of May 15 and web address will be made available – GPs will be informed in What's New this week.	**A.** Using care pathways website **B.** Provide feedback on functionality and content to support developing content **C.** Each practice to support the development of one new local pathway and guidance			• There will be an on-line survey which will need to be completed by each GP within the practice regarding the functionality and content of the site in August 15 • Provide a named individual from the practice to support the development of pathways, identifying if they have a particular area of interest

BUILDING BLOCK 2: ENHANCED PRIMARY CARE - Optional					
ACTIVITY	**DESCRIPTION 2015-16**	**DELIVERABLES 2015-16**	**TEMPLATES**	**READ CODES**	**COMMENTS**
1. 'Not yet approved' Amber drugs ***(activity c/f from Miscellaneous LES)***	GP practices to prescribe in-year Amber drugs. *New proposed Amber drugs may be added or removed in-year from the list by the Medicines Interface Group (MIG) without a change to the funding arrangements. This agreement will be renegotiated on an annual basis.*	GPs to prescribe agreed Amber medications for patients registered at their practice. Liaising with specialists, where appropriate.	Not applicable	Not applicable	
2. Post-operative wound care ***(activity c/f from Miscellaneous LES)***	**GP practices to provide post-operative wound care (including removal of sutures).**	**GP practices to provide post-operative wound care for patients registered at their practice.**	**Not applicable**	**Not applicable**	
3. Prostate cancer reviews ***(activity c/f from Prostate Cancer LES)***	**GP practices to follow a defined pathway (to be developed) for prostate cancer reviews, including blood tests/PSA checking and administration of LHRH analogue.** **Pathway expected to rolled out in quarter 2 of 15/16**	**Blood tests/PSA checking and administration of LHRH analogue.** **To those patients who are referred back to primary care for follow up as requested**	**Not applicable**	**<u>Version 2</u>** **8A90 Prostate-specific antigen monitoring** **<u>Version 3</u>** **(SystmOne only)** **Xalqh Prostate-specific antigen monitoring (Capital i)**	
4. Care for carers	**A.** GP practices to undertake and offer opportunistic health checks (including mental wellbeing check) to all carers who are registered.	Health checks should include as a minimum the following areas: **A.** Physical and mental health **B.** Prevention advice to avoid becoming a patient themselves **C.** Social care needs.	Not applicable	**<u>Version 2</u>** 69DC Carer annual health check 8IEP Carer annual health check declined (Capital i) **<u>Version 3</u>** **(SystmOne only)** XaX4N Carer annual health check XaZKp Carer annual health check declined Note; Although Read codes states "annual", health check can be done more than once	

BUILDING BLOCK 3: SUPPORTING THE URGENT CARE AGENDA - Optional					
ACTIVITY	**DESCRIPTION 2015-16**	**DELIVERABLES 2015-16**	**TEMPLATES**	**READ CODES**	**COMMENTS**
1. Act on feedback from ambulance service ref Adastra Notes/TPP	GP practices to act on feedback from SWAST on when (i) Adastra Note/TPP had been requested but not provided and (ii) the quality of information provided had been poor.	Up-to-date and relevant Adasta notes and acting upon feedback from SWAST	Not applicable	Not applicable	
2. Peer review of emergency admissions	GP practices to undertake retrospective peer review of GP emergency admissions which had not subsequently been admitted by A&E, as a learning exercise. [Review of one quarter's activity]	Review one quarter's information supplied from A&E providers/consultants. Only patients referred by in hours practice GPs Audit results to be written up and shared with GCCG and Locality Executive	Template for audit purposes to be provided by GCCG and sent GLCCG.localityteam@nhs.net	Not applicable	
3. Feed-up of escalation indicators so hospitals can build up capacity	**A.** GP practices to use a set of specific Read Codes provided by GCCG to identify escalation indicators such as flu-like illnesses and gastroenteritis.	Use the Read Codes recommended to identify illnesses.	Not applicable	**Version 2** H27z Flu like illness J43 Gastroenteritis **Version 3** **(SystmOne only)** XM0rz Flu-like illness X30BN Gastroenteritis	
	B. GP practices to report daily using agreed Alamac template during the winter pressure period, looking at demand and staffing levels. To enable the CCG to understand the risks and help plan and mitigate any potential issues.	Complete Alamac template on a daily basis and send to the CCG	glosurgentcare@nhs.net – need to be updated	Not applicable	

BUILDING BLOCK 4: INFLUENCING CLINICAL COMMISSIONING - Optional					
ACTIVITY	**DESCRIPTION 2015-16**	**DELIVERABLES 2015-16**	**TEMPLATES**	**READ CODES**	**COMMENTS**
1. Participate in annual practice visit by CCG	GP practices to engage with GCCG at annual practice visits, to feedback areas of concern/opportunity for GCCG to take forward. To support meaningful discussion this will require the GP partners/Practice Manager to attend.	At least one GP plus Practice Manager to attend annual GCCG practice visit.	Not applicable	Not applicable	
2. Attend locality and countywide commissioning meetings/events	GP practice representative (either GP and/or Practice Manager) to attend locality and countywide meetings.	Regular practice representation at Locality and countywide meetings.	Not applicable	Not applicable	
3. Contribute to annual planning process	GP practices to contribute to the development of locality and countywide commissioning priorities to support the annual planning process – this would be achieved through discussion at Locality Executive Group meetings.	Regular practice representation at Locality Executive Group meetings.	Not applicable	Not applicable	
4. Engage with CCG Live to support sharing of issues and best practice	*GCCG has developed an interactive web based tool which will enable clinical discussion through Engage.* GP practices to (i) register on CCGLive and access the links and information to best effect and (ii) inform and feedback to GCCG any issues around IT connectivity in relation to CCGLive.	GP practice sign-up and use of CCGLive. Regular feedback from GP practices on experience of using CCGLive and recommend to GCCG any areas for improvement.	Not applicable	Not applicable	
5. Supporting Innovation - NEW	The CCG recognised that we need to listen and learn from our member GP practices in order to help inform the overall planning process Understanding what works well and what doesn't should feed-in to our overall planning process, however it is challenging for GP practices and the CCG to get the communication flows working effectively. It is therefore proposed that the CCG pose four questions and/or challenges that are affecting the performance of the CCG and send these to all GP practices. We would like GP practices to select two to review.	We ask that GP practices hold a practice meeting and discuss the two identified commissioning challenges Provide feedback and innovative ideas which could help the CCG in improving the position and improve patient care The results of the feedback will be used to inform the agenda for the newly formed Innovation Group by end of Qtr 1 2015/16	To be attached The CCG will provide a brief proforma to support GP practices in responding to this request		

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Gloucestershire Clinical Commissioning Group
Governing Body

Governing Body Meeting Date	**Thursday 26th March 2015**
Title	**Assurance Framework**
Executive Summary	The attached Assurance Framework for 2014/15 provides details of the assurances provided to the Governing Body regarding the achievement of the CCG's Objectives. The Assurance Framework identifies gaps in assurances and controls regarding the objectives along with details of the principal risks that have been identified by lead managers.
Key Issues	A number of risks have been identified which could adversely affect achievement of the objectives. Action plans have, however, been devised and are being implemented to mitigate these risks.
Risk Issues: **Original Risk** **Residual Risk**	The absence of a fit for purpose Assurance Framework could result in gaps in control or assurances not being identified and addressed. 8 (2x4) 4 (1x4)
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health	None

Inequalities	
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note this paper which is provided for information.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Governing Body

Thursday 26th March 2015

Assurance Framework

1. Introduction

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

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

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

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

2. The Assurance Framework

2.1 The Assurance Framework is based upon the summary objectives detailed in the Two Year Plan for 2014/16.

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

2.3 The Assurance Framework was last presented to the meeting of the Governing Body held on the 29th January 2015. The attached

document incorporates further updates received from the lead managers responsible for each area of activity.

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

3. Recommendation

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

4. Appendix

- Assurance Framework

Appendix

Gloucestershire Clinical Commissioning Group Assurance Framework 2014/15

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
Objective 1: Develop strong, high quality, clinically effective and innovative services.								
L1	Insufficient clinical engagement from primary care.	Helen Goodey	12 (3x4)	8 (2x4)	Website and e-GP newsletter, clinical programme approach, locality structure and meetings, contracts with providers, development and implementation of Engagement Plan.	Commissioning for Quality Report, Clinical Priorities Forum and Clinical Programme Groups.		Quarterly Locality Executive meetings. Supporting Local Protected Learning Time Events. (Ongoing)
L2	GP Practices running at maximum capacity and certain practices not being financially viable. Potential risk that the quality of primary care could be compromised as a result.	Helen Goodey	12 (3x4)	12 (3x4)	Practice visits by Executive Team and CCG Lead GPs. Senior Locality Manager attendance at Locality Executive Meetings. Implementation of Countywide Practice Manager Representative Group. Working closely with Area Team around joint responsibilities to ensure clarity, responsiveness and support.	Governing Body Reports		Ongoing monitoring. Investment to support unplanned admissions DES to practices. New ways of working pilot in Cirencester. Skype pilot in South Cotswolds. Funding identified in ORCP plan to support primary care initiatives for system resilience. (March 2015)
Q1	Insufficient clinical engagement from secondary care clinicians.	Marion Andrews-Evans	12 (3x4)	8 (2x4)	Website and e-GP newsletter, clinical programme approach, locality structure and meetings, contracts with providers will be regularly monitored to assure they remain as effective engagement methods.	Commissioning for Quality Report, Clinical Priorities Forum and Clinical Programme Groups.		Monitor clinician participation with Clinical Programme Groups and effectiveness of CCG Live. (March 2015)
Q3	Specialised Commissioning transferring to NHS England leading to fragmentation of pathways. Specific risk around the specialised services for children and young people with mental health problems.	Helen Chrystal/Simon Bilous	12 (3x4)	16 (4x4)	Monitoring service provision with local providers and feedback to the Area Team.	Assurance from Area Team		Raise the concerns with the Area Team and get feedback to ensure the lead commissioner is involved in this specific area. Work ongoing to review local services and identify opportunities and gaps for service improvement, including crisis support and hospital liaison services for young people. (March 2015)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
Objective 2: Work with patients, carers and the public to inform decision making.								
Q4	Failure to capture and ensure outcomes from patient, carer and public feedback and quality governance systems to inform commissioning and contracting arrangements resulting in failure to maintain and improve the quality of services.	Marion Andrews-Evans, Mark Walkingshaw, Becky Parish	12 (3x4)	6 (2x3)	Communications and Engagement Strategy, 4Cs Policy and Procedure, Provider Clinical Quality Review Groups, HCOSC, Health Watch Gloucestershire (HWG) comments.	Commissioning for Quality Report, Outcome of Engagement/Consultation Reports.		Maintain mechanism for 'feeding back' impact of patient, carer public experience data. The Patient Experience Strategy for Experience and Engagement was approved by Governing body at September 2014 meeting
Q11	Failure to implement Deprivation of Liberty Safeguards (DoLS) as per recent judicial review.	Mary Morgan	12 (4x3)	6 (2x3)	Adult Safeguarding Board and provider Clinical Quality Review Groups (CQRGs) in place to monitor.	Adult Safeguarding Board and CQRGs .		General awareness to be raised across the whole organisation with emphasis on Continuing Health Care (CHC) and mental health services. (Oct 2014)
Objective 3: Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation.								
C5	(Discharge) Risk that the number of medically stable patients exceeds agreed target.	Maria Metherall	12 (3x4)	12 (3x4)	GSRG, Urgent Care Delivery Group, 7 day services countywide group, ORCP schemes mitigated by fortnightly delivery calls and clear KPIs and milestones.	Performance Reports and dashboards, critical milestones reviewed, regular programme stocktake.		1. Integrated Discharge Teams - further development of approved models for the delivery of the IDTs who are responsible for diverting patients from the emergency department and support discharge planning. 2. Domiciliary Care/Reablement - improving access and timelines of domiciliary care and reablement service provision. 3. Community Hospital Bed Availability - review of Community Hospital inpatients services which will ensure appropriate utilisation and timely access to services. 4. Care Home selection - enhanced support to carers and patients in selecting care home. 5. Voluntary Sector Support - to make use of expertise in voluntary sector to prevent admissions, improve self care and support discharge. 6. Discharge Lounge - increase hours of discharge lounge to evenings and weekends to increase flow and reduce ED breaches. 7. Medically stable list - to reduce the medically fit list to have fewer than 35 patients over 1+ day 8. Integrated Community Discharge (Arriva) - to improve discharge transport flow from GHNHSFT to Community Hospitals.

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
C6	(Acute Care) Non-delivery of the Constitution standard for maximum wait of 4 hours within the Emergency Department.	Maria Metherall	12 (3x4)	12 (3x4)	GSRG, Weekly GHT, ECB, 7 day services project board, and steering group. ORCP schemes mitigated by fortnightly delivery calls and clear KPIs and milestones.	Performance Reports, weekly situation report, project status updates.		1. Directory of Services - develop long term strategy for the ongoing roll out of development of the DOS in order to support the right place, right care agenda. 2. Communications/Marketing campaign - to undertake an intensive marketing campaign to influence key groups behaviour to avoid ED attendances. 3. NHS 111 / 999 - enhanced NHS 111 service to reduce inappropriate attendances/ utilisation of urgent care services (including Red 1 999). 4. Access to expert advice within the ambulance service Clinical Desk - scheme which is providing enhanced clinical decision making within the ambulance service clinical desk. (This includes access to paediatric advice) (March 2015)
C15	Failure to comply with national and local access targets, including 18-week RTT, 62 day cancer target, diagnostic 6-week target, planned follow-ups could result in inadequate and/or delayed care.	Mark Walkingshaw/Ellen Rule	12 (3x4)	12 (3x4)	Acute provider contracts, including AQP.	Performance Reports and dashboard, fortnightly performance calls. Planned Care Board.		Performance calls in place to monitor action plans and trajectories with focus on services under pressure. Additional 18 week activity commissioned (June 2015)
F11 - F16	Failure to deliver financial targets.	Cath Leech	12 (3x4)	12 (3x4)	Robust financial plan aligned to commissioning strategy. Robust contract management and activity monitoring and validation (particularly at GHFT) Financial procedures being refreshed.	Budgets approved by the Governing Body. Monthly reporting to CCG Governing Body. Monthly performance dashboard for larger contracts with robust out of county contract monitoring reflected within performance reports. Internal audit plan in place and internal audit reports and recommendations to be reported to Audit Committee.		On-going work with specialist commissioning and other commissioning organisations to work through the detail of impact of changes to commissioning organisations. Review of existing budgets has been undertaken and has informed the 2015/16 planning process Performance dashboards being extended to other large provider contracts (actioned Sept 2014) Financial procedure refresh and training. (Sept/Oct 2014)

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
L3	The CCG's application for delegated co-commissioning arrangements may not be supported by NHS England, resulting in an inability to progress with our Primary Care Strategy and our CCG ambitions for the movement of out of hospital care through commissioning of whole pathways.	Helen Goodey	12 (3x4)	8 (2x4)	Robust application for delegated commissioning in accordance with national guidance.	Regular progress reports to Governing Body.		Work with Core Executive, Governing Body and the Audit Committee Chair to develop the submission; and engage NHS England Area Team. (March 2015)
Objective 4: Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.								
F8	Insufficient capacity and/or capability within the CSU as a result of the proposed merger could adversely affect the organisation's ability to adequately support the CCG during the transitional period.	Cath Leech	12 (3x4)	8 (2x4)	Contract/service level agreement signed between the CCG and CSU specifying the services to be delivered.	Monthly meetings between the CCG and the CSU to review service delivery. CCG service leads meet with their counterparts in the CSU to review more detailed aspects of delivery.		Monitoring meetings schedule set up. (Ongoing)
F3	Information required to support service transformation is limited or not available due to changes in legislation and uncertainty over access arrangements.	Sarah Hammond	12 (3x4)	8 (2x4)		IGQC report.		CCG application to become accredited safe haven has been approved following new guidance received. (March 2015)
L4	Delegated co-commissioning arrangements will mean additional functions transferring to the CCG without a transfer of resource from NHS England. This could result in insufficient capacity to deliver the functions of the CCG.	Helen Goodey	12 (4x3)	9 (3x3)	Transition Group in place.	Regular progress reports to Governing Body.		Directorates across the CCG consulted upon delegated commissioning arrangements to assess impact and determine requirements for consideration by Executive Team prior to submission. Transition Group formed in January to run through until 1st April to ensure all functions are smoothly integrated into CCG Directorates. (March 2015)
L5	Delegated commissioning arrangements create a cost pressure on the CCG through overspent primary care budgets, resulting in the CCG being unable to deliver against its statutory financial requirements.	Helen Goodey	12 (4x3)	9 (3x3)	Transition Group in place.	Regular progress reports to Governing Body.		Due diligence undertaken through November, December and January prior to submission and then continue through until March 2015.
Objective 5: Work together with our partners to develop and deliver ill health prevention and care strategies designed to improve the lives of patients, their families and carers.								

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
A1	Failure to build positive relationships with the local health community and other commissioners could impact on joined-up service delivery and transformation.	Mary Hutton, Helen Miller	12 (3x4)	8 (2x4)	Joint Commissioning posts, Joint Commissioning Boards and Executives in place between the CCG and the Local Authority. System vision agreed and Joining Up Your Care implementation with key members of the healthcare community established. GSF programme of work established to deliver on system vision.	Performance reports.	Risk to partner engagement due to austerity measures	Continued engagement with all partners.
A2	Failure to build positive relationships with key local stakeholders (HCOSC, HWG) could impact on implementation of service delivery and transformation.	Mary Hutton, Helen Miller, Becky Parish, Anthony Dallimore	12 (3x4)	8 (2x4)	Attend HCOSC meetings. NHS Reference Group 'No surprises' discussions. Attend HWG Meetings. Timely written briefing of stakeholders. Joint Health and Well Being Strategy agreed. Membership of Health and Well Being Board.	C4Q Reports, Outcome of Engagement/Consultation Reports, Written stakeholder briefings as part of integrated communication plans	Communications and Engagement Strategy requires revision.	Development of BCF to act as a catalyst for transformation. (Ongoing)
A3	Failure to build positive relationships with local media could impact on the ability of the CCG to promote its work effectively and promote engagement opportunities .	Anthony Dallimore, Helen Miller, Mary Hutton	12 (3x4)	8 (2x4)	CCG Communication and Engagement Strategy, Quarterly meeting with editors, 'no surprises' briefing on key announcements .	Sponsorship/partnership agreements, briefings arrangements within individual communication plans.	Communications and Engagement Strategy requires revision.	Implementation of GCCG Communications and Engagement Strategy (Ongoing)
Q7	Lack of compliance with national targets for *C.difficile* and MRSA could result in a lower quality of care for some patients.	Teresa Middleton, Karyn Probert	12 (4x3)	12 (4x3)	Countywide HCAI action plan. Monthly monitoring of incidents of C.difficile and MRSA. Countywide HCAI Committee oversees action plan implementation and monitors progress.	Performance reports.		Bi-monthly Strategic Countywide Healthcare Acquired Infections (HCAIs) Group. Ribotyping all *C.difficile* cases. Annual review of Countywide Antibiotic Formulary. Bimonthly CCG *C.difficile* Working Group. Regular communications with all Prescribers. Involvement in sharing good practise with Area Team Workshop. Explore faecal transplantation as a method to reduce relapse of C.Diff in patients as per NICE intervential procedures guidance (IPG). (March 2015)
Q13	Risk of delayed diagnosis due to lack of timely response in Histology.	Kay Haughton	16 (4x4)	4 (1x4)	GHNHSFT CQRG in place to review diagnostics, GPs reporting on DATIX, Serious Incident reporting and CQC reviews in place.	Performance reports. CQRG monitoring and incident reports.		High level review of histology awaited from GHT.

Risk No	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action Plan and Target Date
Q15	Delay in GHNHSFT issuing Cardiology letters which could result in appropriate treatment being delayed.	Kay Haughton	16 (4x4)	8 (2x4)	CQRG in place. Contract team weekly conference call with GHT. Datix reporting by GP's	Performance reports. CQRG monitoring and incident reports. First copy of HLR received.		Reporting rates currently 2-3 weeks rather than 5 day target. Monitoring of progress will be maintained until target achieved
C32	**2015/16 Impact of Care Act 2014:** 1) Significantly reduced social care capacity within ICTs associated with early assessment and review for national eligibility criteria. 2) Predicted increased demand on services (information, advice & advocacy), focus on early intervention and prevention and promotion of independent advocacy. 3) GCC new duties for managing provider failure and other service interruptions. CQC new duties for managing 'hard to replace' provider failure. New arrangements with prisons, approved premises and bail accommodation. 4) Equal rights for carers - assessments and duty to meet assessed needs.	Donna Miles	12 (3x4)	12 (3x4)	Maintain regular monitoring of performance/progress at quality groups. Active participation from joint commissioners into new contractual arrangements, input into market management (via Commissioning Intentions / safeguarding / compliance).	Reports to Governing Body		NHS engaging fully with GCC implementation plan. (March 2015)
C33	**Impact of Children & Families Act 2014:** GCCG new duties associated with assessment, planning and provision of services for children and young people up to age 25 who have special educational needs and disabilities, and their families. New provisions for these duties to be challenged and potentially taken to tribunal / tested by case law.	Simon Billous	12 (3x4)	8 (2x4)	Maintain regular monitoring of performance/progress at quality groups. Active participation from joint commissioners into new contractual arrangements, input into market management (via Commissioning Intentions / safeguarding / compliance).	Reports to Governing Body		NHS engaging fully with GCC implementation plan. Interim champion arrangements. QIPP to formalise contracted capacity to ensure NHS Trusts are enabled to discharge their duties. (March 2015)
Objective 6: Develop strong leadership as commissioners at all levels of the organisation, including localities.								
F9	Lack of staff engagement and staff development could limit the achievement of financial balance.	All directors	6 (2x3)	6 (2x3)	Organisational development plan in place.	Organisational Development Plan progress reports.	Organisational Development Plan update needed to reflect new information. Appraisal process needs to be developed to fit the organisation's needs.	Refresh of the Organisational Development Plan. Senior Manager's Group developing an appraisal process (March 2015)

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Agenda Item 12

Governing Body

Governing Body Meeting Date	**Thursday 26th March 2015**
Title	**West of England Academic Health Science Network Report**
Executive Summary	The attached document is the sixth quarterly report produced by the West of England Academic Health Science Network.
Key Issues	The following key issues are referred to in the report: • Business Plan 2015/16 • Patient Safety • Evidence into Practice • Connecting Data of Care • Enterprise and Translation • Engagement and Events
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	Deborah Evans
Designation	WEAHSN Managing Director
Sponsoring Director (if not author)	Mary Hutton, Accountable Officer

Report from West of England Academic Health Science Network Board, 3 December 2014

1. Purpose

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

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

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

2. Business Plan 2015/16

The Academic Health Science Network is in the process of engaging with all of its member organisations on the content of the Business Plan for next year. The draft Business Plan was considered by the Board who noted that most of the Business Plan items from 2014/15 will roll over into 2015/16.

In the Evidence into Practice workstream, the project to use Magnesium Sulphate to prevent Cerebral Palsy in pre-term babies will have concluded, as will the cemented hip replacement work.

Comments are invited on the Academic Health Science Network's Business Plan from member organisations and individual conversations will take place over the next three months, prior to the Board approving the final Business Plan for 2015/16, which will be accompanied by a resource and delivery plan.

3. Patient Safety Update

The Patient Safety Collaborative has approved in principle its work programme for 2015/16 and all organisations have actively contributed to this process. The draft plan is attached to this report.

Over the past three months, we have run south west-wide themed patient safety workshops on Getting Medicines Right, Falls and Peri-operative care. These continue to be well attended.

The Academic Health Science Network has contributed to a piece of work with the Health Foundation is leading about the national initiative to create up to 5000 "Patient Safety Fellows" which is expected to have an initial cohort of 200 people in 2015/16.

4. Evidence into Practice

a. Pre-Term Births Project

All five obstetric units in the west of England are implementing the project to use Magnesium Sulphate to prevent Cerebral Palsy in pre-term babies. Project midwives are training their colleagues in support of the clinical guideline which has been developed and so far, 240 staff have been trained.

b. Don't Wait to Anti-Coagulate

This project on optimising anti-coagulation use in Primary Care to reduce Atrial Fibrillation-related strokes is being piloted with 11 GP practices who are testing four different models for delivery. This will inform the wider rollout of the project during 2015/16.

c. Evidence Informed Commissioning

- Six GP Clinical Evidence Fellows have been recruited and had a two day induction in October. Their role is to help support their Clinical Commissioning Groups in using evidence in commissioning.
- A mapping exercise has been undertaken to identify the resources available to each Clinical Commissioning Group to support their use of evidence and evaluation in decision making. The report highlights that Clinical Commissioning Groups have significant variation in the extent to which they have support available to them for evidence and evaluation. A web-based evaluation toolkit is being developed as a collaboration between the West of England Academic Health Science Network and the Avon Primary Care Research Collaborative. It is currently being tested across the West of England.

5. Connecting Data of Care

- Feasibility studies are underway in Gloucestershire, Bath and North East Somerset, Swindon and Wiltshire.
- A collaboration agreement has been signed with the "Connecting Care" programme in Bristol, North Somerset and South Gloucestershire, which will allow the other health communities to use key documents to support their feasibility studies and save time.

6. Enterprise and Translation

- The second outreach event, which was held jointly with the West of England Local Economic Partnership on Modelling in Healthcare, took place on 13 November and was over-subscribed and very well evaluated.
- Our latest Small Business Research Initiative competition is on Child and Adolescent Mental Health and has received 49 applications from companies.
- We have worked with four companies who were successful in gaining £100,000 each at Phase One of SBRI and were applying for Phase Two funding of £1m each in a national competition. Each of these companies has been successful and we will continue to work with them to develop their innovations further. In each case, these are ideas which our clinicians believe could be of direct benefit in their work.
- Deborah Evans, Managing Director of the Academic Health Science Network, spoke at a national conference on 10 December to showcase the role of

Academic Health Science Networks in supporting the Small Business Research Initiative for health.

- The next outreach event will be held jointly with Gloucestershire Local Economic Partnership and is on the subject of Nutrition and Exercise [12 March 2015, Campden BRI, Chipping Campden, Gloucestershire].

7. Engagement and Events

- For further details on our Nutrition and Exercise event that is taking place on 12 March, as mentioned in point 6 above, please click here
- Primary & Community Care Sub Group Workshop, 4 February 2015, University of the West of England
- Early Warning Score workshop, 5 March 2015, Holiday Inn, Filton, Bristol
- Our latest Patient Safety newsletter is available here

SAVE THE DATE

All Chairs, Chief Executives and Accountable Officers are invited to attend our Patient Safety Collaborative Launch and Quality Improvement Conference on Thursday 16 April 2015, which is taking place at the De Vere Hotel, Swindon.

Further details will be released early in January 2015.

Deborah Evans
December 2014

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 14

Governing Body

Governing Body Meeting Date	**Thursday 26th March 2015**
Title	**Integrated Governance and Quality Committee (IGQC) minutes**
Executive Summary	The attached minutes provide a record of the IGQC meeting held on the 18th December 2014.
Key Issues	The following principal issues were discussed: • Patient's Story • Quality Report • Children in Care Annual Report • Risk Register • Internal Audit Report – Quality Monitoring • Information Governance • Role of Clinical Senates • Sign-up to Safety from Providers • Quality Watch Annual Report • Revalidation for Nurses – Implications
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 of 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 18th December 2014, Board Room, Sanger House

Present:		
Julie Clatworthy	JC	Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Andrew Beard	AB	Deputy Chief Finance Officer
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
Colin Greaves	CG	Lay Member – Governance
Mary Hutton	MH	Accountable Officer

In Attendance:		
Teresa Middleton	TM	Head of Medicines Management
Cate White	CW	Project and Business Manager – Quality Team
Alan Potter	AP	Associate Director Corporate Governance
Fazila Tagari	FT	Board Administrator

1. Apologies for Absence

1.1 Apologies were received from Dr Helen Miller, Valerie Webb, Mark Walkingshaw, Dr Martin Gibbs and Cath Leech.

2. Declarations of Interest

2.1 There were no declarations of interest received.

3. Minutes of the meeting held on 23rd October 2014

3.1 The minutes of the meeting were accepted as a true and correct record, subject to the following amendments:

- Section 7.6 of the minutes to read *'MAE reported that a feedback session was being held in January 2015 following a serious case review into the sexual and financial abuse of residents in a learning disabilities supported living residential home by the manager and his wife.'*
- Section 7.13 of the minutes to read *'.....Gloucestershire were well below the national average.'*
- Section 7.16 of the minutes to read *'MAE alerted members that the Gloucestershire Health Protection Assurance Group were planning an intensive deep-dive…….'*
- Section 9.3 of the minutes to read '*MW outlined that a strengthened triage process had been introduced which was intended to reduce the number of cases proceeding to the IFR panel.'*
- Section 16.2 of the minutes to read *'CBu advised that a patients reference group was established which was working on developing the improvement strategy and action plan.'*

3.2 JC highlighted section 4.1 of the minutes and requested an update on the progress of the Datix system re-launch. MAE advised that the process was being streamlined for practice staff and that the system was being amended in order to prevent patient identifiable information being held by the CCG. The CCG were now focusing on themes and trends from the information provided. MAE advised that the re-launch was delayed due to testing the system with practices prior to formal launch and anticipated that this would be by the end of January 2015. CBu articulated that the system re-launch should be marketed effectively.

3.3 CBu highlighted section 5.2 of the minutes and requested that the GHFT discharge leaflet was re-circulated to him. CBe highlighted that the leaflet required further clarification on the options that were available. It was agreed that this required a review to ensure accuracy of the information published. FT/MW

3.4 JC asked for further information on the GCS quality review and outcomes (Section 14.2). MAE advised that following the review, GCS had improved its Committee arrangements. MAE advised that this had been developed jointly with GCS following a review of the structure and the meeting papers process.

4. Matters Arising

4.1 **IGQC71 Risk Register**

Regarding Risk Q1 CBu advised that he had been made aware that GPs were experiencing difficulties accessing the CCG Live website. Committee members concurred and stated that they also had issues with access.

23/10/14 AP confirmed that improvements to CCG Live had been made following feedback from the survey and it was noted that a password was no longer needed to access the site. CBu expressed concerns on access for the wider health community and it was agreed that BP would feedback to Anthony Dallimore.

18/12/14 CBu advised that letters were circulated to all GP locums and the wider health community. **Item Closed.**

4.2 **IGQC72 Minutes of the meeting held on 19th June 2014**

VW drew attention to section 8.1 of the minutes and highlighted that there was a delay in the turnaround time following requests for amendments by the Policies Working Group. AP to feedback to the CSU HR Lead.

23/10/14 AP advised that a further Policy Working Group meeting would be convened.

18/12/14 AP advised that the policies which required amendments were due to be published on the website that week. **Item Closed.**

4.3 **IGQC79 Any Other Business**

MAE informed members that an internal review of the quality assurance system was being undertaken by Internal Audit. It was indicated that a verbal feedback would be received tomorrow and this would be

communicated to JC although it was noted that the formal report would initially be reviewed by an external nurse in Birmingham. JC requested an update.
23/10/14 Feedback was still awaited from Internal Audit. AB to chase.
18/12/14 This was covered under Agenda Item 9. **Item Closed.**

4.4 **IGQC81 Patient's Story - The Experience of Hospital Discharge: 5 Patients' Stories**
CLo explained the background relating to each story and referred to the new booklet that GHT had produced on 'Discharge from Gloucestershire Hospitals'. It was noted that this would help improve patient experience and discharge planning. It was agreed that this booklet would be emailed to members for information.
18/12/14 Booklet was circulated on 28/11/14. **Item Closed.**

4.5 **IGQC82 Quality Report**
CBu felt that the report should incorporate an update on the activities being undertaken within the Clinical Programme Groups and was informed that an update was presented at the August Committee. It was recognised that a written update would be useful in terms of seeking assurance that improvements were being implemented. TM to discuss with Ruth Hallett in order to progress this forward.
18/12/14 Clinical Programme Group update report was included in the Quality Report (agenda item 6) and was being discussed at the development session later that day. It was noted that this report would be updated each month.

4.6 **IGQC83 Quality Strategy Action Plan Update**
CBu queried the progress of the sign-up to safety from providers and was advised that all providers had signed up to this campaign. MAE agreed to produce a briefing for the next Committee meeting.
18/12/14 This was covered under Agenda Item 12. **Item Closed.**

5. Patient's Story

5.1 MAE introduced a video titled 'Barbara's Story' which was produced by Guys and St Thomas NHS Foundation Trust to raise awareness of dementia amongst staff. MAE advised that this video was open for discussion and how this could be shared with staff.

5.2 JC suggested that the CCG should produce something to illustrate what the CCG commissioned and draw on the role of the Mental Health Liaison Nurse or the Rapid Response Service. JC felt that the CCG should promote further its functions as commissioners to the wider public.

5.3 MH stated that it was important to consider how the culture was developed within the hospitals in Gloucestershire. It was recognised that staff required training to embed a dementia friendly approach within the culture. It was suggested that this could be picked through the quality programme pathway within GHFT.

5.4 MAE suggested that this video was uploaded on the CCG website and agreed to liaise with Anthony Dallimore. MAE

5.5 MH indicated that a discussion with GHFT was required in relation to its commitment for a dementia friendly hospital, Enhancing the Healing Environment (EHE) programme and quality programme. MH understood that this would fit under the Gloucestershire Strategic Forum programme.

5.6 MH suggested that this video should be presented at the staff briefing meeting later that afternoon.

5.7 MAE advised that the previous patient story relating to hospital discharge would be presented at the January 2015 Governing Body meeting. MH requested that the final version was sent to her for review prior to the presentation. MAE agreed that she would ask Caitlin Lord. MAE

5.8 RECOMMENDATION: The Committee noted the patient story.

6. Quality Report

6.1 MAE 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.

6.2 MAE informed members that a presentation from the Gloucestershire Research Support Service was presented at the Clinical Effectiveness Clinical Effectiveness Group meeting which was highlighted at Appendix one of the report. TM advised that the Various Leg Ulcer Compression Treatment was considered at the meeting. It was agreed that two layer component compression bandaging was equally effective as four layer bandaging. Other key topics discussed at this meeting related to focusing on the Clinical Outcomes. It was felt that the CCG required an organised and systematic approach to embedding clinical effectiveness within its operations.

6.3 CBu referred to the NICE 'Do Not Do' recommendation list and highlighted that the CCG possibly commissioned treatments that were on this list. MH suggested that this was reviewed and recommended that this was assigned to the CPGs for analysis. MAE

6.4 MH informed members that the NICE director of Public Health had offered to visit Gloucestershire in January 2015 to review the operational plan and to help prepare an action plan. PB agreed that this would be useful.

6.5 MAE drew attention to section 3.2.4 of the report relating to the Serious Care Review into the sexual and financial abuse of residents in a learning disabilities supported living residential home by the manager and his wife.

6.6 The schedule of the engagement activity was MAE/BP

discussed. JC requested illustrations of improvements that were implemented following any engagement activity. AE articulated his concerns relating to the engagement report and felt that this required further information. MAE advised that the regular standalone report could not be produced due to other commitments and would be available for the next Committee meeting. MAE advised that she had called an additional Clinical Quality Review Group meeting in December with GHT to ensure a greater focus on patient experience. MAE agreed that she would instruct Becky Parish to circulate a briefing on engagement activities in between meetings.

6.7 MAE advised that there was one Never Event reported which related to an incident at the Winfield Hospital.

6.8 MAE advised that she was a member of the Health Protection Group and highlighted that Norovirus was a significant issue during the winter months. It was recognised that there were implications for patients as well as staff. JC highlighted the issue of quality improvement year on year. TM advised that Norovirus incidences continued to be monitored on a weekly basis. MAE advised that the CCG was closely working with the infection control nurses at GHT to evaluate the causes of the outbreaks. JC queried what steps were being taken to reduce these incidents and was advised that staff awareness levels were being raised. MAE also advised that a review was required into the support provided in the care homes and ensuring that the Rapid Response service was utilised to ensure patients were supported to remain within the care homes when presenting with the Norovirus symptoms to reduce admissions.

6.9 JC enquired of the plans to monitor the compliance against NICE clinical guidance and quality standards. TM advised that provider organisations were actively encouraged to comply with the NICE guidance. TM informed members that individual guidelines were considered as an agenda item at the Clinical Programme Group meetings. MAE advised that a

database was being established with providers to provide updates as necessary.

6.10 JC requested an update in relation to the issues within radiology and it was agreed that an update would be provided at the next Committee meeting. MAE

6.11 JC enquired on the outcome from the CCG Quality Summits and MAE agreed that she would circulate the notes from the Summits held to JC. It was advised that the schedule of the issues raised were reported to Ellen Rule in order to influence the Commissioning Intentions going forward. MAE

6.12 JC queried if there were any local health staff who had recently returned from any of the Ebola affected countries and was advised that a nurse from GHFT had recently travelled to West Africa. It was agreed that this would be monitored and an update on the quarantine arrangements would be provided when the member of staff returned from their travels. PB felt that it was vital that there were robust measures within pharmacies to ensure that the symptoms were fully understood and clarifications on what to do next. It was advised that the Area Team were managing this piece of work. MAE

6.13 MH informed members that the CCG was joining with other commissioners to write a letter to the Secretary of State, NICE and the GMC to allow the use of Avastin. It was noted that Gloucestershire CCG was producing these letters as templates in order to be used nationally by other commissioners.

6.14 It was noted that Clinical Quality Review Group (CQRG) was not fedback through the IGQC or minutes provided for information. It was agreed that CQRG information would be included in future quality reports. MAE

6.15 The minutes of the Clinical Effectiveness Group meeting of 13th November 2014 were noted. JC raised the question of the CCG's ability to carry out evaluations/research through local research MAE

arrangement. It was agreed that an update would be provided at the next IGQC and an overview of which local providers are research active.

6.16 RECOMMENDATION: The Committee noted the contents of this report.

7. Children in Care Annual Report

7.1 MAE presented the Annual Report which was provided for information and members were invited to provide feedback.

7.2 AE expressed concerns on the health performance assessment outlined at Appendix 5 of the report in terms of the falling rate for the annual health assessment and dental checks.

7.3 JC queried the provisions being made for recruiting the Adoption Medical Advisor which was currently vacant. MAE advised that the contracts was managed by the Hadwen practice and was being resolved.

7.4 The Committee discussed the high Out of County placements and requested further details and felt that this needed monitoring.

7.5 PB suggested that there should be an additional narrative on the emotional wellbeing of the Children in Care. CBu requested that a headline report from the Task and Finish Group should be made available for information. MAE

7.6 MH questioned if a family incentives programme could be developed to prevent children going into foster care. MAE advised that schools received additional funding for providing support to the children and considered that a coordinated approach was required. MH asked whether an initiative could be developed in terms of prevention.

7.7 RECOMMENDATION: The Committee noted the progress and service delivery of health services for

Children in Care in Gloucestershire

8. Risk Register

8.1 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 organisational objectives.

8.2 AP confirmed that details of all risks for consideration to be removed from the Risk Register had been provided at Appendix 2.

8.3 JC requested that Risk No C1 was clarified to indicate that it related to Cheltenham Emergency services. AP

8.4 It was noted that no legal challenge had been received in relation to Risk No C30 and that the time for any challenges had elapsed.

8.5 RECOMMENDATION: The Committee:

- **Noted this paper and the attached Risk Register.**
- **Approved the closure of risks as detailed in Appendix 2.**

9. Internal Audit Report: Quality Monitoring Review

9.1 MAE presented the Audit Report which was presented for information. MAE advised that there were three findings from the review.

9.2 The first finding related to the timely submission of papers for the IGQC meetings and it was understood that this was a wider issue with all the main CCG Committees. CBu recognised the requirement for the release of the latest information and queried if a system could be developed to incorporate these updates. AP explained the current review process for papers and stated that this was a perennial issue.

9.3 JC drew attention to the second finding which related

to the lengthy IGQC meetings and sought feedback from members. JC suggested that a quality assurance dashboard was established to ensure a high level tracking was implemented.

9.4 The Committee recognised the additional responsibility if the CCG took an increased role in Co-Commissioning Primary Care in relation to the significant increase in data and it was articulated that the Committee structure and Terms of Reference would need re-evaluating to reflect this.

9.5 CBu felt that it would be challenging to secure attendance from clinicians if it was returned to separate Governance and Quality meetings and suggested that the meetings were streamlined. JC suggested that questions could be submitted in advance of the meetings being held.

9.6 The Committee were informed that the Governing Body papers would be converting to electronic format going forward and was currently being piloted prior to roll out.

9.7 CBu suggested that the minutes from the Clinical Quality Review Group meetings were available to the IGQC meeting as it was felt that common quality themes were discussed at those meetings and tracked.

9.8 CG recommended that the process was streamlined prior to the 1st April 2015 to prepare for the co-commissioning going forward.

9.9 MAE clarified that the third finding related to the notes from the internal senior managers meetings and advised that the recommendations was being taken forward.

9.10 RECOMMENDATION: The Committee noted the report.

10. Information Governance Update

10.1 MAE presented the paper providing an update on the

organisation's information governance arrangements. The paper was taken as read.

10.2 MAE advised that policies and procedures were currently being reviewed and ensuring that they were up to date with any recent changes.

10.3 MAE highlighted that there were issues with queries being dealt with in a timely manner from the CSU and informed members that an information governance service desk was being launched.

10.4 MAE reported that the CCG application for Accredited Safe Havens status had now been approved. This meant that the CCG was now able to validate invoices where patient identifiable information was required for validation. It was noted that training for the CCG was currently being developed and was being rolled out. MH requested that the training for the Governing Body members was arranged by AP. AP

10.5 The Committee were informed that a records management audit was being commissioned to review the arrangements for the electronic and paper records. MAE highlighted that the current server had reached maximum capacity and required a systematic approach to the filing structure and advised that a new server was being ordered.

10.6 The Committee received the minutes of the Information Governance Group meeting on 18th December 2014.

10.7 RECOMMENDATION: The Committee:

- **Noted the minutes from the Information Governance Group meeting**
- **Noted the contents of this report.**

11. Briefing on the Role of Clinical Senates

11.1 MAE presented the briefing report which was provided for information. The report was taken as read.

11.2 MAE highlighted that Gloucestershire had four representatives that were members of the Senate Council.

11.3 MAE explained the work of the South West Clinical Senate Council and advised that the previous meeting held covered the topic of emergency surgical care.

11.4 MAE advised that the Citizens' Assembly had been established to provide a strong patient and public voice to support the work of the Senate.

11.5 The issue with emergency laparotomy rates was discussed and it was agreed that a small working group would be established to consider the recommendations and how these could be taken forward locally.

11.6 JC asked if Gloucestershire CCG had posed any questions to the Senate and was advised that questions would be considered collectively if posed by a number of CCGs but not individually.

11.7 CG questioned the statutory role of the Senates. PB reminded members that the Clinical Senates were established under the Health and Social Care Act 2012 and that the role of the Clinical Senate was to work with commissioners and brings together medical professionals to offer advice on particular patients groups and conditions.

11.8 RECOMMENDATION: The Committee noted the contents of this report.

12. Sign-Up to Safety from Providers Progress Update

12.1 The briefing paper was presented to the Committee for information. The paper was taken as read.

12.2 JC enquired whether practices had signed up to this and was advised that Dr Hein Le Roux was the lead for patient safety and was also working with the Academic Health Science Network for one day a week supporting

the patient safety collaboratives and considered that this would be part of his role to promote and improve patient safety in Primary Care.

12.3 MAE advised that a local Patient Safety Forum was being organised in Gloucestershire in January 2015. The session would focus on joining up Acute Kidney Injury and safety initiatives across the county. JC requested feedback from this Forum to be presented at the February 2015 Committee. MAE

12.4 RECOMMENDATION: The Committee noted the contents of this report.

13. Quality Watch Annual Report

13.1 TM presented this paper which was provided for information. The paper was taken as read. TM explained that the Quality Watch was an independent research programme established between the Nuffield Trust and the Health Foundation.

13.2 TM drew attention to Appendix one of the report which highlighted concerns with the quality of care. The key findings identified in the report related to concerns with the mental health service and unscheduled care.

13.3 RECOMMENDATION: The Committee noted the contents of this report.

14. Revalidation for Nurses - Implications

14.1 MAE presented this paper which was provided for information. The paper was taken as read.

14.2 MAE reported that the General Medical Council (GMC) have decided that a system of revalidation for Registered Nurses would be introduced from January 2016 and was currently being tested at pilot sites. It was noted as there were 680,000 Registered Nurses in the UK, it would not be possible to have the same method of revalidation as the doctors currently had. It was indicated that the revalidation process will be

linked with the Nurses annual appraisal and would require sign off by another registered nurse.

14.3 The Committee recognised the significant work this would create in the preparation for implementing the revalidation process in terms of setting new systems up. MAE questioned how the process for the care homes nurses would be managed.

14.4 CG enquired as to the number of nurses that the CCG was responsible for and was advised that it was circa 30. MAE advised that the CCG supported these individuals to help maintain their registrations. CG also queried whether this would change if primary care commissioning was co-commissioned and suggested that this should be brought to the Governing Body attention.

14.5 RECOMMENDATION: The Committee noted the contents of this report.

15. Quality Review Groups

15.1 This item was covered under Agenda Item 6.

16. Any Other Business

16.1 PB advised that the Public Health team at GCC has been upgraded from C to B (satisfactory) in terms of training placements for F1, F2 Public Health Doctors by the Severn Deanery. It was anticipated that this should assist in the future recruitment and retention of staff.

16.2 TM updated members in relation to the figures for the Minor Ailment Scheme since its launch in November 2014 in Gloucester City and advised that there were 229 interventions of which 2 would have resulted in an A&E visit. TM informed members that this scheme was also being extended to Tewkesbury in the new year.

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17. The meeting closed at 12.05pm.

Date and time of next meeting: Thursday 26th February 2015 in the Board Room at 9am.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 15

Governing Body

Governing Body Meeting Date	**Thursday 26th March 2015**
Title	**Audit Committee minutes**
Executive Summary	The attached minutes provide a record of the Audit Committee meeting held on the 9th December 2014.
Key Issues	The following principal issues were discussed: • Internal Audit • External Audit • Counter Fraud • QIPP • Procurement decisions • Waivers of Standing Orders • Aged Debtor Report • Final Accounts timetable • Annual Governance Statement
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 of Corporate Governance
Sponsoring Director (if not author)	Colin Greaves Audit Committee Chair and Lay Member

NHS
Gloucestershire
Clinical Commissioning Group

NHS GLOUCESTERSHIRE CCG
AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Tuesday 9th December 2014 Board Room, Sanger House

Present:		
Colin Greaves	CG	Chair
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Dr Hein Le Roux	HLR	GP Liaison Lead
Dr Andy Seymour	AS	Deputy Clinical Chair

In Attendance:		
Andrew Beard	AB	Deputy Chief Finance Officer
Rubert Boex	RB	Financial Accountant
Liz Cave (part meeting)	LC	Grant Thornton
Paul Dalton	PD	Price Waterhouse Coopers
Rayna Kibble	RK	Local Counter Fraud Specialist
Cath Leech	CL	Chief Finance Officer
Lynn Pamment	LP	Price Waterhouse Coopers
Alan Potter	AP	Associate Director Corporate Governance
Peter Smith	PS	Grant Thornton
Fazila Tagari	FT	Board Administrator

1. Apologies

1.1 Valerie Webb

2. Declarations of Interest

2.1 There were no declarations of interest received.

3. Minutes From Previous Meeting held on 16th September 2014

3.1 The minutes of the previous meeting held on 16th September 2014 were approved as an accurate record.

3.2 AE highlighted section 11.2 of the minutes relating to the debt outstanding from GHFT (community equipment pool) and was advised that the debt had now been settled.

3.3 CG drew attention to section 8.4 of the minutes in relation to the QIPP programmes in localities and was advised that a process was being reviewed to develop locality reporting to ensure that pertinent data was being recorded.

3.4 CG updated members in relation to the letter being sent from the South West Audit Chairs Group to NHS England, detailed within section 16.2 of the minutes, and advised that this had slipped and anticipated an update in due course.

4. Matters Arising

4.1 **11.03.14 Item 5.4 – Counter Fraud Update**
It was agreed a further one hour bribery and corruption session would be organised for a future date.
9.12.14 It was agreed that this session would be re-scheduled in January 2015.

4.2 **11.03.14 Item 10.4 – Procurement Decisions**
CL agreed to feedback to Helen Goodey and David Porter to request a process for review and future recommendation. It was agreed that this issue would be raised at a future Governing Body meeting.
9.12.14 CL advised that the process was being reviewed going forward incorporating the recently published guidance.

4.3 **16.09.14 Item 3.2 – Minutes from previous meeting held on 3rd June 2014**
CG highlighted section 5.7 of the minutes which related to the disparity of the staff sickness figures provided by NHS England. CG requested that this issue was investigated with NHS England.
9.12.14 The Committee noted the disparity of the figures and agreed that no further action could be pursued. **Complete**

4.4 **16.09.14 Item 3.3 – Minutes from previous meeting held on 3rd June 2014**

CG highlighted section 9.1 of the minutes and queried if the Counter Fraud annual report was issued. It was agreed that this would be added to the agenda of the next meeting. SC agreed to circulate the final version of the annual report to members.

9.12.14 Annual report included in the Counter Fraud Report (Agenda Item 7). **Complete**

4.5 **16.09.14 Item 5.3 – Internal Audit**

LP felt that if the September Committee had been held late September, there would have been more reports presented. LP advised that the reports could be circulated outside of the meeting when finalised. The Chair indicated that he was amenable to a further meeting if it was required. It was agreed for AP to consider this issue when scheduling the timing of future meetings.

9.12.14 Schedule for 2015/16 had been agreed. **Complete**

4.6 **16.09.14 Item 6.6 – External Audit**

CG referred to the demise of the Audit Commission and advised that this would affect the appointment of external auditors. It was important and that this should be covered within the Audit Committee Terms of Reference. CG indicated that the Audit Committee would propose a recommendation to the Governing Body for approval.

9.12.14 Awaiting statutory guidance.

4.7 **16.09.14 Item 6.7 – External Audit**

It was advised that the auditors would inform the Committee of any regulatory issues. CG recommended that this should be made clearer in the Terms of Reference.

9.12.14 Item covered in the above matters arising action point. **Complete**

4.8 **16.09.14 Item 7.5 – Counter Fraud Update**

VW highlighted section 2.1 of the action plan and queried whether staff awareness levels had been assessed

following the presentations and if so, what outcomes were encapsulated from the staff satisfaction reviews. SC advised that a survey had not been undertaken. CL suggested that this could be considered as part of a series of potential questions for the 2014/15 internal staff survey when conducted.
9.12.14 CL advised that the staff survey hadn't been conducted as yet but the questions had been put forward for consideration.

4.9 **16.09.14 Item 8.3 – QIPP Report**
CG expressed concern that actual performance continued to deviate from the target line. CL recommended that a robust review was required at an earlier point in the year in order to be more proactive.
9.12.14 Item covered by agenda item 8. **Complete**

4.10 **16.09.14 Item 16.1 – Annual Governance Statement**
CG felt that the Annual Governance Statement should be reviewed systematically going forward following the previous year's process and requested that this remained as a standing item on the agenda.
9.12.14 Item covered by agenda item 15. **Complete**

4.11 **16.09.14 Item 16.2 – Annual Governance Statement**
CG also raised concerns regarding access to the guidance as this was via SharePoint. CL acknowledged the issue and as everyone had web access she proposed that her team download the updates regularly in order to inform the Committee of any changes.
9.12.14 CL confirmed that her team had assimilated the download process as part of its procedure. **Complete**

5. Internal Audit

5.1 **Progress Report** - LP presented the progress report which outlined the progress against the 2014/15 plan. LP drew attention to the table on page 2 of the report which summarised the progress of the work to date against the internal audit plan. LP clarified that the reference to December 2015 against the QIPP review should read as December 2014.

5.2 LP reported that four areas were considered as low risk and one area as medium risk. It was noted that there were four further reviews to be undertaken to complete the 2014/15 audit plan. It was anticipated that these reports would be available along with the Annual Report and the 2015/16 proposed outline plan for the March 2015 Audit Committee meeting.

5.3 The Committee discussed the Key Performance Indicators and agreed that further improvements were required.

5.4 **Risk Management and Governance Review** - LP advised that the review identified one low risk rated finding and an advisory finding.

5.5 The low risk rated finding related to due dates detailed on the Risk Register which had been exceeded. LP advised that areas of good practice were noted during the review and that these were indicated on page 1 of the report.

5.6 AE expressed concerns that the Risk Register was not regularly updated and that it was vital for the organisation to receive up to date information in order to inform effective decisions. CL highlighted that a new process had been implemented where the Risk Register was presented for review at the Core Team meetings bi-monthly. AP explained that the issue was that the proposed action dates had exceeded the agreed deadlines and articulated that the register was reviewed systematically and regularly.

5.7 CG highlighted an error on page 1 of the report and requested that 'Integrated Governance Committee' was amended to read as 'Integrated Governance and Quality Committee (IGQC)'

5.8 CG sought clarification on the governance process for reviewing the Assurance Framework as it was stated on page 2 of the report that this will be reviewed by the Governing Body rather than the IGQC.

5.9 **Human Resources Review** – LP advised that the review

was assessed as low risk overall and identified four findings, one medium risk rated, one low risk rated, and two advisory findings.

5.10 The medium risk related to access to the payroll system and ensuring that the standing data entered by the payroll administrators were periodically checked and authorised in order to confirm the accurate maintenance of payroll records.

5.11 The low risk finding related to the HR policies and procedures which were scheduled for review after a three year period. It was recommended that this was reviewed annually to ensure that they were consistent with the needs of the organisation.

5.12 LP summarised the advisory findings to members which related to the communication process and acquiring staff feedback on the HR service.

5.13 LP advised that this review provided a baseline assurance on key controls which would subsequently underpin any further reviews going forward.

5.14 **QIPP Review** – PD advised that the review was assessed as medium risk overall and stated that the prior year report was classified as low risk.

5.15 The review identified three medium risk findings, three low risk findings, and two advisory points.

5.16 The three medium risk findings related to:

- Updating the Health Perform system
- Reporting of Key Performance Indicators (KPI)
- Incomplete QIPP project business cases

5.17 The three low risk findings related:

- Content of the 2014/15 QIPP programme plan document
- Reporting of savings
- Minutes of Urgent Care theme meetings

5.17 The two advisory findings were explained to members. These were reporting on quality outcomes and grouping of QIPP projects.

5.18 AE questioned how an incomplete business case was permitted. CL referred to the Integrated Community Team (ICT) business case which was presented at the July 2013 Governing Body meeting. It was noted that the KPI and assumptions were subsequently updated with a greater emphasis on the subsidiary activities. AE articulated his concerns particularly around the project evaluation process. It was also acknowledged that a formal process for specifying the next stage of rollout was required.

5.19 It was also noted that there had been a resource issue within the PMO team which affected minuting the Urgent Care themed meetings and which had since been addressed.

5.20 CG suggested that an evaluation of the ICT project was undertaken in order to review the progress to date It was agreed that Andrew Hughes would lead a presentation on this at a future development session. Andrew Hughes / CL

5.21 CG drew attention to the transfer of Kelly Matthews to a separate organisation and expressed concern that this may have an adverse effect on the QIPP process and queried the recruitment process. Members were advised that the recruitment of a replacement had commenced.

5.22 **Quality Monitoring –** PD advised that this review was assessed as low risk and the report identified three low risk findings.

5.23 These findings related to:

- Timely submission of papers for the IGQC meetings
- The length of the IGQC agenda and meetings
- Actions from quality team meetings

5.24 CG highlighted that this report would be reviewed at the IGQC meeting in December 2014.

5.25 <u>RECOMMENDATION:</u> The Audit Committee noted the contents of the reports.

6. External Audit

6.1 PS presented the progress report for 2014/15 year. PS drew attention to page 5 of the report relating to the allocation of staffing for the interim visit and informed members that these were being agreed that week. It was noted that a meeting with the CCG would be held to discuss the audit further.

6.2 PS explained that the value for money review would focus on two criteria specified by the Audit Commission. These were financial resilience and economy, efficiency and effectiveness. PS proposed that the summary of approach was circulated to CL.

6.3 PS explained the emerging issues and developments to members. These were:

- NHS Audit Committee Handbook
- NHS England - 360 degree Survey Report
- Consultation: Draft Code of Audit Practice for the audit of local public bodies
- Funding healthcare: Making allocations to local areas
- NHS England Five Year Forward View
- Pulling together the Better Care Fund

6.4 LC advised that Grant Thornton was hosting a cross-sector seminar on the Better Care Fund for CCGs and Local Authorities. It was noted that these were being held in Taunton and Bristol and that Kim Forey would be joining the panel at one of these events. It was agreed that LC would issue invitations to members. LC

6.5 CG stated that he had not seen any information on the Lead Provider Framework and queried when this would be shared. CL advised that the implications were currently being reviewed by the Finance team and that a briefing would be available for the March Governing Body

meeting.

6.6 The Committee noted that further guidance was awaited on the draft Code of Audit Practice. It was anticipated that this would be available early 2015. It was agreed that Grant Thornton would verify the latest position and report the findings at the next Committee meeting. LC/PS

6.7 LC suggested that the Better Care Fund report was circulated to members and it was agreed that this would be emailed to FT to distribute. LC

6.8 <u>RECOMMENDATION:</u> The Audit Committee noted the content of the report.

7. Counter Fraud Update

7.1 RK explained the activities undertaken within 2013/14 which was detailed within the Annual Report.

7.2 RK advised that NHS Protect had advised that the Commissioner Action Plan templates were likely to be issued in the New Year.

7.3 Regarding the 2014/15 programme, it was noted that 24 of the 40 scheduled days had been provided and there were currently no concerns over the allocated provision.

7.4 The National Fraud Initiative for 2014 was uploaded successfully.

7.5 RK highlighted that the Counter Fraud awareness presentations were progressing well.

7.6 Proactive work was underway regarding Personal Health Budgets, Healthcare Travel Costs Scheme and in conjunction with Care Services, Oxygen Therapy Services.

7.7 RK advised that there had been no allegations of fraud received in the period since the last Audit Committee although a small number of patient-related incidents with a potential impact on the prescribing budget had been

dealt with informally.

7.8 <u>RECOMMENDATION:</u> The Audit Committee noted:

- **the progress against the action plan; and**
- **agreed the Annual Report 2013-14.**

8. QIPP Report

8.1 CL presented the report which provided an overview of the 2014/15 QIPP Programme delivery at Month 7.

8.2 CL reported that there was currently a shortfall in the total forecast delivery of £3.5m against the £17.8m QIPP target (based on month 7).

8.3 CL advised that the slippages were in the following key schemes:

- ICTs
- AEC and OPAL
- Planned Care (Ophthalmology)
- Learning Difficulties
- Joint Placements

8.4 AE highlighted page 4 of the report and queried if the contractual risk share was assumed in full or part position and was advised that this was part position. CL referred to the GHFT AEC assessment process on the reported avoided admission and noted that a coding review was being undertaken to evaluate the accuracy of the reported avoided admissions. The Committee recognised that further work was yet to be undertaken.

8.5 CG highlighted section 4.2.4 in relation to OPAL and AEC reporting avoided admissions and was advised by CL that the issues were being discussed with GHFT and it was anticipated that a resolution would be reached that week.

8.5 <u>RECOMMENDATION:</u>
The Audit Committee:

- **noted the 2014/15 QIPP programme position at Month 7 including the savings delivery forecast**

position.

9. Summaries of Procurement Decisions

9.1 CL reported there were no Procurement Decisions for the period 16th September 2014 to 21st November 2014.

9.2 CG highlighted that the procurement register would require a review going forward in terms of documenting the procurement decisions.

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

10. Procurement Waiver of Standing Orders

10.1 CL presented the report which was taken as read. The report outlined all approved and rejected applications for waiver of Standing Orders for the period 17th September 2014 to 21st November 2014.

10.2 It was noted that four waivers of Standing Orders had been requested and subsequently approved by GCCG Executive Managers. These were outlined at Appendix 1 of the report.

10.3 CG requested that all waiver forms must be signed and dated.

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

11 Aged Debtor Report

11.1 RB presented the report which provided a summary of the aged debt raised up to 24th November 2014. Members noted that the outstanding debt, as per the Sales Ledger, was £1.5m and that the majority of outstanding debt was with Non-NHS organisations.

11.2 The Committee noted that the reduction in the debt since the previous Committee meeting. The Committee acknowledged that GHFT had paid the outstanding debt

of £398k.

11.3 CG highlighted that the Swindon CCG debt remained unchanged and queried if there were any issues. RB advised that payment should be received shortly.

11.4 RB advised that the major Non-NHS debt related to Gloucestershire County Council and that this related to public health recharges in respect of GP enhanced services. It was noted that this had been escalated formally and payment was expected shortly.

11.5 The CCG was engaging with the debt recovery agents in relation to the debt outstanding from Francis and Co. The Committee noted that payments were now being received.

11.6 CG queried the debt relating to Boehringer Ingelheim Ltd and was advised that this related to a regular recharge for a drugs rebate scheme and that payment should be received shortly. It was highlighted that the extended payment process was an on-going issue. CG queried if any additional levers could be exercised in order to resolve this and it was agreed that CL would investigate. CL

11.7 The Committee discussed the Better Payment Practice Code and queried if GCC conformed to this standard. It was understood that there was a wider issue within GCC which was currently being reviewed.

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

12. Debts Proposed for Write-Off

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

12.2 <u>RECOMMENDATION:</u> The Audit Committee noted the verbal update.

13. Losses and Special Payments Register

13.1 The Committee was advised that there had been no losses or special payments since 1st April 2014.

13.2 <u>RECOMMENDATION:</u> The Audit Committee noted the verbal update.

14. Final Accounts Timetable

14.1 RB presented the report which provided an overview of the timetable and plan which was in place to produce the final accounts for 2014/15.

14.2 RB outlined the key national dates and the current internal timetable adopted to enable the completion of the 2014/15 Annual Accounts.

14.3 The Department of Health had issued the following deadlines for the submission of the 2014/15 accounts:

- 23 April 2015 (noon) for the submission of the unaudited accounts to the Department of Health and External Auditors.
- 29th May 2015 (noon) as the final date for the accounts to be audited and sent to NHS England.
- 5th June 2015 (9am) as the final date for NHS England to submit audited accounts to Department of Health

14.4 The proposed dates of the Audit Committees were discussed and it was recommended that an Audit Committee was held on Tuesday 12th May and 26th May 2015 and that the Governing Body would formally approve the Annual Accounts on the 28th May 2015 prior to submission on the 29th May 2015.

14.5 CL requested feedback from external audit regarding the logistics around the proposed dates. PS confirmed that the 28th May 2015 was acceptable.

14.6 <u>RECOMMENDATION:</u>
The Audit Committee noted the plans in place and the timescales to which the CCG was working to

prepare and complete the final accounts for 2014/15.

15. Annual Governance Statement

15.1 AP provided a verbal update relating to the above statement and advised that further guidance was still awaited.

15.2 AP proposed that a draft statement was prepared for review for the next committee meeting. CG suggested that AP commenced populating the statement highlighting the events already held in preparation of the March Audit Committee. AP

15.3 CG requested sight of the guidance as soon as it was published. AP

15.4 <u>RECOMMENDATION</u>: The Audit Committee noted the verbal update.

16. Any Other Business

16.1 The schedule for the 2015/16 Audit Committee was discussed. AP proposed the following dates. These were:

- Extraordinary 12th May 2015 – review draft accounts
- Extraordinary 26th May 2015 – approve draft accounts
- 30th June 2015
- 29th September 2015
- 8th December 2015
- 8th March 2016

16.2 Members agreed the above dates and considered the 30th June 2015 meeting and it was agreed that this meeting should be deferred until the 7th July 2015 due to availabilities of members. AP to confirm VW availability. AP

17. The meeting closed at 10.35pm.

Date and time of next meeting:
Tuesday 10th March 2015 in the Board Room at 9am.