NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 24th September 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 30th July 2015	Chair	Approval
4	Matters Arising	Chair	
5	Public Questions	Chair	
6	Chair's Update	Chair	Information
7	Accountable Officer's Update	Mary Hutton	Information
8	Locality Development Plans 2015-17	Helen Goodey	Information
9	An Approach to Planning 2015/16	Ellen Rule	Approval
10	Performance Report	Cath Leech	Information
11	Assurance Framework	Cath Leech	Information
12	Integrated Governance and Quality Committee Minutes	Julie Clatworthy	Information
13	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
14	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday **26th November 2015** at 2pm in Board Room at Sanger House			

MINDFUL EMPLOYER

NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Minutes of the Meeting held at 2.00pm on Thursday 30th July 2015 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Alan Elkin	AE	Vice Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Charles Buckley	CBu	GP Liaison Lead
Julie Clatworthy	JC	Registered Nurse
Colin Greaves	CG	Lay Member - Governance
Dr Malcolm Gerald	MGe	GP Liaison Lead
Ian Goodall	IG	Associate Director of Operational Planning and Programme Management
Helen Goodey	HG	Director of Locality Development and Primary Care
Dr Will Haynes	WH	GP Liaison Lead
Mary Hutton	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Tristan Lench	TL	GP Liaison Lead
Dr Hein Le Roux	HLR	GP Liaison Lead
Dr Andy Seymour	AS	Deputy Clinical Chair
Valerie Webb	VW	Lay Member - Business
Mark Walkingshaw	MW	Deputy Accountable Officer
Margaret Willcox	MWi	Director of Adult Social Care, GCC
In attendance:		
Helen Ford	HF	Senior Commissioning Manager, Children Young People and Maternity Commissioning
Becky Parish	BP	Associate Director, Engagement and Experience
Kay Haughton	KH	Senior Quality and Safety Manager
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 7 members of the public present.		

1 Apologies for Absence

1.1 Apologies were received from Dr Helen Miller, Ellen Rule, Dr Caroline Bennett, Dr Jeremy Welch, Dr Sadaf Haque and Sarah Scott.

2 Declarations of Interest

2.1 There were no declarations of interest received.

3 Minutes of the Meeting held on Thursday 28th May 2015

3.1 The minutes of the meeting held on Thursday 28th May 2015 were approved.

4 Matters Arising

4.1 28.05.15 AI 7.2 – External Audit - Assurances from Management and those charged with Governance – It was confirmed that CL was the named executive lead for counter fraud. **Complete**

4.2 28.05.15 AI 12.23 – Cirencester Hospital Development Plan – MH advised that she would circulate an overview of the implementation plan in the following week.

4.3 28.05.15 AI 18.2 – Report from West of England Academic Health Science Network (WEAHSN) – MH advised that Dr Helen Miller had offered to take part in the Partnership Board which would oversee the work of the Genomics Medical Centre. **Complete**

4.4 28.05.15 AI 18.5 – Report from West of England Academic Health Science Network – MH advised that a meeting was being organised with the Local Enterprise Partnerships (LEPs) and WEAHSN in September 2015 regarding the Industry Advisory Group. MH agreed that she would update members following this meeting.

5 Listening to Patients: The chance to improve the lives of future generations – Perinatal Mental Health presentation

5.1 HF and BP provided a presentation around Perinatal Mental Health. HF provided a brief context to the work on improving the lives of future generation. It was noted that the government had invested an additional £75m over the next five years to give the right care to more women who experience mental ill health during the perinatal or antenatal periods.

5.2 The presentation covered:

- national and regional picture;
- key messages;
- what we have done in Gloucestershire;
- service improvements in Gloucestershire;
- patient feedback; and
- priorities for improvement.

5.3 MGe felt that it would be useful for GPs to be formally involved in the antenatal process i.e. two sessions during the pregnancy period.

5.4 **RESOLUTION: The CCG Governing Body noted the presentation.**

6 Public Questions

6.1 There were no questions received from the public.

7 Sign Up to Safety Presentation

7.1 KH provided a presentation on Sign Up to Safety. The Committee were advised that this was a national campaign designed to harness the commitment of staff across the NHS in England to make care safer and that it was one of the national initiatives to help the NHS improve the safety of patient care.

7.2 MAE requested that the CCG made a public commitment to play their part in reducing avoidable harm in the NHS as part of the Sign up to Safety campaign which represented a system wide commitment to this work.

7.3 The presentation covered:

- a promise to learn – a commitment to act;
- background;
- the five pledges; and
- the CCG's action against the pledges

7.4 HLR advised that the approach to safety was not new but this initiative enhanced and shared the initiatives the CCG had developed to promote patient safety.

7.5 JC queried if staff would be appropriately upskilled in the light of the fact that the science of improvement methodology was being adopted and also queried how patients fitted into this process i.e. could they report incidents directly to the CCG? KH advised that the CCG were working closely with the providers and highlighted that GHFT were establishing a safety academy which the CCG were linking in with. This would include improvement methodology workshops which would be shared across organisations. KH also advised that patients already reported incidents directly via other mechanisms such as the Patients Advice and Liaison service (PALs).

7.6 MGe felt that it would be useful if there was a systematic process for the analysis of data relating to safety issues. MAE advised that a national reporting and learning system was available. This system had highlighted that primary care had a low level of reporting and that HLR was working to improve this.

7.7 CBu stated that the CCG was already in a good position to sign up to safety as the underpinning work had already been undertaken.

7.8 MAE informed members that KH was appointed as a 'Q fellow' by the Health Foundation. It was noted that this was another safety initiative.

7.9 <u>RESOLUTION:</u> The CCG Governing Body noted the report and fully committed the CCG to the 'Sign up to Safety' campaign

8 <u>Gloucestershire Clinical Commissioning Group (CCG) Clinical Chair's Report</u>

8.1 AS presented this report on behalf of the Clinical Chair. The report was taken as read, with a summary of key issues that arose during June and July 2015 being highlighted.

8.2 AS highlighted Section 2 of the report regarding the Learning Disability Service and advised that work to actively repatriate people back home who were placed out of county was continuing as is the follow-up to the Winterbourne Joint Improvement Programme. The reshaping of Hollybrook and Westridge had also provided opportunities to improve outcomes for people who may have been cared for long periods in hospital settings. These efforts have been supported by integrated team working called the Learning Disability Intensive Support Service.

8.3 AS highlighted that the Learning Disability Quality Assurance Team, with its partners was awarded a Municipal Journal Award last month in recognition of its achievement in protecting the safety and well-being of all people with a learning disability placed in supported living or residential care across the health and social care domains. It was also noted that a highly successful Health Check Day was held in May with well over a thousand people having attended.

8.4 AS updated members on the developments within the Clinical Programme team and advised that the MSK (Musculoskeletal) team were directing an extensive change programme and had been running a highly successful series of workshops to inform recommendations and service specifications. Recent workshops included a Pain Service event on the 9th June, Podiatry on the 25th June and Orthotics on the 16th July.

8.5 It was noted that the Cancer team had launched a new season of Macmillan GP Masterclasses, with over 70 GPs attending a Breast event on the 22nd June. Members were informed that new NICE Guidelines were published for Suspected Cancer and a new Joint Working Group has been established with the GHFT to co-ordinate the changes to referrals and diagnostic requirements.

8.6 AS highlighted Section 3.5 of the report regarding the Gloucestershire Clinical Pathways website 'G-Care' and advised that it went live in July 2015 providing a valuable new resource for all the GP members. The Governing Body members expressed gratitude to the team that was involved in developing the website.

8.7 AS highlighted Section 4 of the report and advised that the Engagement Team had undertaken focused work for the CPGs which included cancer, eye care, musculoskeletal and frail older people.

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

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

9.1 The Accountable Officer introduced this report, which was taken as read, and provided a summary of key issues arising during June and July 2015.

9.2 MH provided a brief update on the Any Qualified Provider (AQP) procurement process to replace the existing Care UK contract, which was due to expire at the end of October 2015. The procurement was being led by NHS South, Central and West Commissioning Support Unit (SCWCSU). It was noted that SCWCSU will award recommendations to commissioner's mid-August which would be out of synchrony with the Governing Body meeting dates. Therefore, it was proposed that the Governing Body delegated authority to certain members to formally approve the decision. It was proposed that authority was delegated to MH, CL, HM along with AE or CG and that any progress would be updated at the Development Sessions. It was noted that Gloucestershire CCG would have a separate contract from the other four CCGs, which will stand for one year, with the possibility to extend for a further year if required.

9.3 MH updated members regarding the elective day case activity. It was noted that Care UK had formally advised that they would not be offering elective day case activity at Cirencester Hospital following the completion of the current contract. Preliminary discussions had taken place between GHFT and GCS with reference to GHFT undertaking elective day case activity at Cirencester Hospital. MH highlighted that Care UK had indicated that they were keen to provide outpatient services under an AQP contract option from Cirencester Hospital.

9.4 MH presented a summary of progress with the Prime Ministers Challenge Fund (PMCF) initiative. This seeks to offer increased access to GP care between 8am and 8pm seven days a week with 100,000 appointments at a number of specific locations. It was noted that a key focus for 2015/16 would be developing the initiative 'Choice+' element of the plan. The summary of the progress of the PMCF was outlined in section 3.4 of the report. Members noted the good progress being made and expressed their thanks to the team involved.

9.5 MH highlighted Section 4 of the report relating to Urgent Care and advised that a review of the previous winter period had been undertaken and that work was progressing to plan for the next winter period during the next two months and to improve the system modelling. MH advised that an extended Development Session on the 17th September was being arranged to provide assurance on the plans for the winter.

9.6 MH updated members on the Strategic Planning and Healthy Individuals programme and advised that a Gloucestershire Workforce Steering Group had been established. This Group would be responsible for developing the workforce strategy to underpin the work and delivery of the strategic objectives of the Gloucestershire Strategic Forum and our five year plan. Section 5.2 outlined the progress on the Healthy Individuals programme and it was noted that good progress had been made and that there was a key focus on prevention and self-care. MH informed members that the team were working on a number of key initiatives to support the CCG's ambitions to promote health and wellbeing. These included taking forward the Cultural Commissioning Programme and working with Public Health to agree a programme of work to address obesity across the county and on developing the annual Joint Strategic Needs Assessment (JSNA).

9.7 MH drew attention to Section 6 of the report outlining engagement activities and advised that an engagement activity plan was being developed and should be available for a future Governing Body meeting. MAE

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

- **noted the contents of this report;**
- **approved the delegated authority to MH, CL, HM along with AE or CG for the AQP contract award recommendation.**

10 Locality Development Planning 2015 -2017

10.1 HG introduced the paper which provided an update on the creation of the new two year Locality Development Plans for 2015 – 2017. HG provided a background context to the development of the locality plans since 2013.

10.2 HG advised that Gloucestershire's seven CCG localities and the supporting infrastructure had developed significantly over the previous two years.

10.3 HG introduced the locality plans for Forest of Dean, North Cotswold and Tewkesbury, Newent and Staunton and advised that the remaining four locality development plans, Cheltenham, Gloucester, South Cotswold and Stroud and Berkeley Vale would follow at the September 2015 meeting.

10.4 HG highlighted that the three locality plans required further refinement and final sign off by the wider locality membership.

10.5 HG updated members on the locality development planning process and highlighted that each of the seven localities met with representatives from Public Health and with their District and Borough Council. This resulted in a strong partnership working emerging across the county, both in terms of planning and shared priorities but also in the development of joint projects by working collaboratively.

10.6 The key emerging themes from the development planning process were outlined in Section 3.5 and the Governing Body were advised that the priority themes identified from this process had been triangulated with the CCG operational plan and QIPP schemes.

10.7 HG advised that as the Locality Development Plans are widely shared with the public, patient participation groups, local stakeholders and all GP practices, her team had been

working with the Graphics Team to develop a new, more aesthetically pleasing and engaging format.

10.8 JC felt that the link to the QIPP target was ambiguous in the report and queried if there was detailed tangible information on benefits realisation. HG advised that a QIPP target was not set and that the key focus was on addressing variation. TL added that savings and efficiency targets were actively discussed at the Forest of Dean Locality.

10.9 MWi highlighted a typographical error on page 9 of the Forest of Dean Locality Development Plan and requested that *'career'* was amended to *'carer'.*

10.10 MWi advised that at a recent meeting with the District Councils' Chief Executives she had identified that that there was not an awareness of the locality plans at senior management level within their organisations. MH acknowledged that further work was required to enhance the communication channel and that a formal programme of work with the District Councils was being established in order to ensure a more joined up approach.

10.11 HG emphasised of the importance of the Locality Managers working with the Locality Executive Groups and felt that this resource had driven the process further forward.

10.12 CG felt from his experience of attending locality meetings that there was a lack of awareness of the higher level saving requirements. However, he felt that the plans demonstrated that this was understood and noted that the localities were working closer with the Governing Body which was a positive development.

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

- **noted the key achievements for 2013 – 2015 for the three localities presented; and**
- **provided sign off of the Locality Development Plans 2015 – 2017 for the Forest of Dean, North Cotswold, and Tewkesbury, Newent & Staunton localities.**

11 Approach to Planning 2015/16

11.1 IG introduced this report and advised that the process described aimed to improve the CCG's current approach to planning and proposed the adoption of a planning cycle to develop a systematic approach to the CCG's operational planning.

11.2 IG advised that it was proposed that the CCG embed engagement with patients and the public into the planning cycle so that it becomes an integral part of the approach.

11.3 IG drew attention to the diagram on page 7 which formalised the planning cycle and to the table at pages 9 and 10 which laid out the approach and timeline for engagement.

11.4 IG highlighted that there were three main areas of change and these related to; ensuring that there was a systematic and scheduled approach to review and prioritisation of business cases, ensuring the engagement cycle was embedded throughout the process and that implementation was through a clear and coherent.

11.5 JC queried the timeline of Joint Strategic Needs Assessment (JSNA) and felt that this should be driving the commissioning plans and highlighted that the cycle stated that the Operational Plan would be published prior to the JSNA. MH responded that the development of the JSNA was an on-going and iterative process and that the operational plan would take into account the findings of the assessment.

11.6 CG welcomed this report and recommended that a rigorous and disciplined approach was undertaken to conform to the timescales. MW advised that providers and partners were briefed on key strategic plans as part of the contracting round this year and that this had been reflected in the timetable.

11.7 CBu felt that the CCG outcomes indicator set should be included into the planning cycle and should be reflected in the process. IG advised in response that progress was measured.

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

- **agreed the high level Planning Cycle for adoption**

by the CCG;

- **approved the Strategic Planning forward work programme; and**
- **noted the approach to greater integration of locality planning with the wider planning cycle.**

12 Assurance Framework

12.1 CL presented the Assurance Framework for 2015/16 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 issues related to Q3 regarding the transfer of specialist commissioning to NHSE and C6 regarding the maximum four hour wait in ED.

12.3 RESOLUTION: The CCG Governing Body noted the paper and the attached Assurance Framework.

13 Performance Report

13.1 CL presented the Performance Report which provided an overview of the CCG's performance against the organisational objectives and national performance measures for the period to the end of June 2015.

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

Clinical Excellence

13.3 MW updated members on the ambulance targets and advised that South West Ambulance Service NHS Foundation Trust (SWASFT) achieved the Red One performance target.

13.4 MW advised that there was a continued achievement of 31 day cancer target and improved performance against the 2 week wait standard.

13.5 MW reported that the four hour emergency department target was achieved in full during June 2015.

13.6 The Red Two ambulance performance target was not achieved. MW advised that a detailed recovery plan was in place with SWASFT which included the deployment of additional resources. MW advised that there was a clear improvement trajectory during Quarter 2 and assured members that improvements were underway.

13.7 The number of 52 week breaches continued to be of concern. It was noted that these breaches were not with local providers and related to specialist services. MW highlighted that there were 20 incomplete pathways reported at the North Bristol Trust (15 in Trauma and Orthopaedics, 2 in Neurosurgery and 3 in Neurology). Discussions had been held with North Bristol Trust and that an agreed plan was in place for the identification and active management of any other likely breaches for Gloucestershire patients. MW advised that the CCG had also commissioned an independent consultant review of each of the spinal patients and identified additional spinal capacity. The CCG were now looking to transfer these patients to an alternative provider during August.

13.8 MW highlighted that the proportion of patients waiting over 6 weeks for a diagnostic procedure had increased in 2015/16. Performance in June (3.9%) was adversely affected by delays for Endoscopic and Echocardiogram tests at GHFT. It was noted that a detailed action plan was in place including an improvement trajectory to improve performance.

13.9 MW updated members on the 62 day cancer performance target and advised that performance in the first two months of the year had been red rated and that 50% of the breaches occurred in Urology. It was noted that there were workforce issues and that GHFT were recruiting two new consultant urologists.

13.10 JC sought assurance that issues would be resolved long term and was advised that there was a recovery trajectory for each area which was being worked through robustly with the providers and that there was strong commitment to resolve

the identified issues.

Patient Experience

13.11 MAE reported that there were comprehensive experience and engagement activities supporting CCG work programme and identified some recent activities.

13.12 MAE advised that the Friends and Family Test (FFT) had been removed from the national and local CQUIN schedules and it would be a challenge to maintain response rates across local providers. MAE advised that there would be a focus on primary care FFT going forward.

13.13 MAE informed members that overall complaints had risen during 2014/15 although there had been a fall in complaints during the first quarter of 2015/16. However, it was emphasised that particular themes had not been identified.

13.14 MAE updated members on the staff survey for provider organisations and advised that the feedback from the CQC visit indicated that this did not reflect the views of the staff who were considered to have a positive attitude and were loyal to the organisation. It was noted that the full details on the CQC inspection would be reported to the IGQC in August 2015 and that the findings of the CQC visit of GCS would be available at the end of September 2015.

Partnerships

13.15 MW highlighted the work on the development of the system-wide Operational Resilience and Capacity Plan for the winter and noted the strong engagement from providers, local authorities and the voluntary sector in the planning process.

Staff

13.16 MW provided a brief update on the Staff Perspective and assured members that the appraisal process was being developed and that all staff should have a personal development plan.

Finance and Efficiency

13.17 CL provided a brief summary of the 2015/16 financial performance and reported that the CCG was forecasting to deliver a surplus of £7.3m and that there were risks identified

within this position. CL highlighted that the known risks and pressures had been fully assessed and included within the CCG's forecast position, with mitigating actions implemented where appropriate.

13.18 CL reported that the CCG had achieved the 95% target to pay all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice.

13.19 JC drew attention to page 34 of the report identifying the position with delayed transfers of care which were exceeding the planned trajectory and queried what actions were being undertaken to mitigate this. MW stated that the CCG benchmarked favourably on these metrics and advised that there was a significant focus on the medically stable patients in the acute and community settings and ensuring that discharges were not being delayed. It was also noted that there was a key focus on utilising the Integrated Discharge Team. MWi added that Gloucestershire's performance was good in comparison with other CCGs.

13.20 CL advised members that the format of the report was being reviewed and requested that any suggestions for improvements should be fedback to her or Alex Holland.

13.21 <u>RESOLUTION:</u> The CCG Governing Body noted the performance against local and national targets and the actions taken to ensure that performance is at a high standard.

14 <u>Refresh of the Information Management and Technology Strategy</u>

14.1 CL presented the refresh of the Information Management and Technology (IM&T) Strategy to enable delivery of the CCG's objectives.

14.2 CL advised that the Strategy had been split into four themes:

- commissioning enablement;
- records access and sharing;
- patient/citizen empowerment; and
- enabling infrastructure.

14.3 CL drew attention to Appendix E which outlined the initial assessment of programme priorities for 2015-2018.

14.4 Members noted that this document would be refreshed again during the next nine months.

14.5 CL informed members that the National Information Board published a paper in November 2014 outlining key dates for the NHS. These were:

- from March 2018 all individuals would be enabled to view their care records and to record their own comments and preferences on their record;
- all patient and care records will be digital, real-time and interoperable by 2020; and
- by 2018, clinicians in primary, urgent and emergency care and other key transitions of care contexts will be operating without needing to use paper records.

14.6 CL advised that the National Information Board was currently consulting on eight roadmaps and that consultation was due to end in September 2015. CL informed members that CCGs would need to publish their local roadmaps by April 2016.

14.7 CL felt that the refresh document was approved in its current form and proposed that an update was presented at the March 2016 Governing Body meeting as part of the Annual Operating Plan.

14.8 <u>RESOLUTION:</u> The CCG Governing Body approved the refreshed Strategy.

15 <u>Joining Up Your Information – Outline Business Case</u>

15.1 CL introduced the outline business case for record sharing between NHS organisations and the County Council.

15.2 CL explained that the business case covered the first part of sharing records and that it was aimed to run the project in several phases in order that it would be manageable.

15.3 CL reported that the focus of phase one was to support the

urgent care service delivery. This was aligned with the national priority outlined by the National Information Board.

15.4 CL informed members that the business case contained four options and that the recommendation was option 3. CL provided a summary of the four options. These were:

- Option one - do minimum;
- Option two – “quick-start” followed by a full solution procurement;
- Option three - full solution procurement with phased delivery (with its application in phase one outlined in detail); and
- Option four - partner with a similar project.

15.5 It was noted that the third and fourth options were under consideration in order to make the best use of the capital funding that had been provided for 2015/16. The information required in order to fully review Option 4 had been sought but was not currently available. Initial indications were that it may be subject to a procurement challenge if chosen. Option 3 was therefore being pursued but this does not preclude option 4 as this option may result from the procurement.

15.6 CL advised that the business case had been developed with input from a wide range of stakeholders and that it was important that the governance structure included all partners as well as patient involvement to ensure that each part of the project has the right input.

15.7 CL highlighted the key issues:

- ensuring that the right specification had been produced to go to procurement;
- ensuring that the consent model was agreed, understood and communicated clearly to patients, clinicians and other care professionals. A communication campaign was under development;
- ensuring that a common, clear information governance framework and underpinning agreements were agreed in time for implementation; and
- measurement of benefits and being able to attribute these to record sharing specifically would be difficult

when partners were also implementing new Patient Administration Systems.

15.8 CL explained that the key risks were outlined within the report and advised that one particular risk related to the cost of the project as it would not be known until the completion of the procurement and that the recurrent costs could exceed the agreed envelope.

15.9 JC queried the organisation that would be hosting the shared care record system and also queried the benefits realisation and how that would be monitored. CL advised that a meeting with the HSCIC was held to discuss benefits realisation and it was noted that funding through the Integrated Digital Care Fund (Tech Fund) of £1m had been received. It was advised that the Tech Fund team would be working with the CCG in order to ensure that benefits were captured. It was also noted that learning from the Hampshire Health Record, Bristol Connecting Care Records and Oxfordshire Care Summary was being captured as they were all live. CL advised that the host organisation was still under consideration but articulated that this was a Gloucestershire solution and was not owned by one individual organisation.

15.10 CBu queried if the system was a read only solution or would it also include data entry solution as he felt that data quality would be an area of concern. MGe responded that it would be 'read-only' although the data quality would be reviewed going forward.

15.11 <u>RESOLUTION:</u> The CCG Governing Body approved the outline business case.

16 <u>Cultural Commissioning Grant Programme</u>

16.1 IG presented the report which provided an update on the Cultural Commissioning Programme and a summary on how the forthcoming Grant Programme would be delivered over the next 16 months.

16.2 IG explained that the Cultural Commissioning Programme was a key enabling project within the Healthy Individuals Programme.

16.3 IG informed members that £150K had been allocated to commission a small number of pilot interventions through the voluntary and community sector where appropriate.

16.4 IG advised that the purpose of the Grant Programme will be to deliver approximately 10 to 15 small scale pilots between September 2015 and November 2016, in order to increase our knowledge and understanding on the role of non-traditional providers and the impact they have on the health and wellbeing of our communities. IG advised that grant applications would be reviewed through a formal prioritisation process.

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

17 <u>Primary Care Commissioning Committee Terms of Reference</u>

17.1 AP presented the Primary Care Committee Terms of Reference. It was highlighted that minor amendments to the Committee's Terms of Reference were required to ensure the continued efficient management of primary care commissioning.

17.2 AP advised that the changes proposed had been highlighted within the document and summarised the changes. It was noted that clarity around membership and quoracy had been improved as well as transferring some responsibilities to the Committee that previously sat with the Governing Body.

17.3 CBu highlighted paragraph 22.i, regarding contractual action such as issuing breach/remedial notices and removing a contract; where responsibilities were being transferred to the Primary Care Commissioning Committee. CBu expressed concerns and felt that the Committee did not have strong GP representation. AS advised that the Primary Care Operational Group (that reports to the PCCC) would undertake a review and consider any clinical issues prior to any recommendation to the PCCC. It was noted that the Primary Care Operational Group had clinical representations from the Local Medical Committee (LMC). CG articulated that

this action would only be exercised in extreme circumstances.

17.4 AS suggested that Lay Members also had designated deputies included within the membership to allow for any leave.

17.5 <u>RESOLUTION:</u> The CCG Governing Body approved the revised Terms of Reference for the Primary Care Commissioning Committee.

18 Report from West of England Academic Health Science Network Board

18.1 MH presented the report which was taken as read. This was the eighth quarterly report produced by the West of England Academic Health Science Network.

18.2 MH highlighted Section 4 regarding Improving Outcomes through Patient Flow and advised that Gloucestershire was advanced in this area and had chosen not to participate in this initiative although good practice would be picked up.

18.3 MH advised that Gloucestershire would be involved in the Mobile Health Diabetes Challenge and that an evaluation process was being held shortly. It was noted that Matt Pearce would be representing Gloucestershire CCG.

18.4 MH highlighted Section 8 regarding Academic Health Science Network 360° Stakeholder Survey and encouraged members to take part if they were invited.

18.5 <u>RESOLUTION:</u> The CCG Governing Body noted the report.

19 Integrated Governance and Quality Committee Minutes

19.1 The Governing Body received the minutes of the meeting of the Integrated Governance and Quality Committee held on the 14th May 2015.

19.2 The Governing Body noted the following key matters that were discussed at the meeting:

- Policies for Approval
- NHS England Peer Review
- New Serious Incident Framework
- GHFT Dr Foster Mortality data

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

20 Audit Committee Minutes

20.1 The Governing Body received the minutes of the meeting of the Audit Committee held on the 10th March 2015 and the extraordinary meetings held on the 12th and 26th May 2015.

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

21 Any Other Business

21.1 There were no items of any other business.

22 The meeting closed at 16:17.

23 Date and Time of next meeting: Thursday 24th September 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 – September 2015

Item	Description	Response	Action with
28.05.15 Agenda Item 12.23	Cirencester Hospital Development Plan	HM requested an overview of the implementation plan and it was agreed that a diagram would be produced in order to provide assurance to the Governing Body. *30.07.2015 MH advised that she would circulate an overview of the implementation plan in the following week*.	MH
28.05.15 Agenda Item 18.5	Report from West of England Academic Health Science Network Board (WEAHSN)	MH felt that further clarity was required regarding the Industry Advisory Group and what it meant for Gloucestershire. It was noted that a meeting was held in March 2015 and that the CCG were not advised of the meeting date. *30.07.2015 MH advised that a meeting was being organised with the Local Enterprise Partnerships (LEPs) and WEAHSN in September 2015 regarding the Industry Advisory Group. MH agreed that she would update members following this meeting*.	MH
30.07.2015 Agenda Item 9.7	Accountable Officer's Report	MH drew attention to Section 6 of the report outlining engagement activities and advised that an engagement activity plan was being developed and should be available for a future Governing Body meeting.	MAE

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 6

Governing Body

Governing Body Meeting Date	**Thursday 24th September 2015**
Title	**Gloucestershire Clinical Commissioning Group Chair's Report**
Executive Summary	This report provides a summary of key issues arising during August and September 2015
Key Issues	The key issues arising include: • Clinical Programmes • Devolution bid for Gloucestershire • Winter Planning • 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	Andy Seymour
Designation	Gloucestershire CCG Deputy Chair
Sponsoring Director (if not author)	

Gloucestershire Clinical Commissioning (GCCG)
Clinical Chair's Report

1.	**Introduction**
1.1	This report provides a summary of key issues arising during August and September 2015
2.	**Clinical Programmes**
2.1	The clinical programmes team remained very active over the summer, leading on a range of collaborative service transformation work. Some examples of our latest works are as follows:
2.2	The Respiratory team held a very productive COPD Emergency Pathways Workshop on 21st August to agree the interface and referral criteria for pathways and services ahead of the winter period. This will ensure that the right choices are made for patients with COPD, particularly when considering alternatives to hospital admission. Key work is also being completed ready for winter on Community Acquired Pneumonia; a workshop is to be held on 9th September with key partners (ED, AEC, Rapid Response and Respiratory Physicians). We will soon be publishing a set of "Top Tips" for primary healthcare teams and care homes to support decisions around the treatment of CAP, referral options and timely discharge to community pathways and services.
2.3	The MSK team have directed an extensive redesign programme during 2015 and a new Integrated Service Model is gaining the endorsement of key partners and decision makers. The design workshops concluded with Orthotics on 16th July and Interface Services on 4th August, the team are now planning towards a summing up workshop on 15th September to review the overall new model. For Rheumatology new annual monitoring clinics have commenced and we are gaining feedback from patients to inform the clinical teams decisions on service improvement. A new high level plan for Falls and Bone Health has been developed and workshop for Fractured Neck of Femur is to be held on 15th October.
2.4	The Cancer team have completed the service specification, agreed

	job description and designed patient education programmes for the new community based services. Based on patient research the service is to be branded Gloucestershire Macmillan Next Steps. Concluding the financial and contractual negotiations with GCS is now a priority. The team are expecting an excellent turnout for the county wide Cancer Summit on 30th September with attendees from across the health community and national speakers. The CCG's large scale work on Cancer Diagnosis Significant Event Audits, embodied in the primary care offer, has been recognised by the RCGP as part of a national improvement programme. A video interview is now available on G-Care providing GPs with a briefing on Breast Cancer.
2.5	A significant achievement for the team over the summer has been the launch of G-Care. This on-line resource provides all Gloucestershire GPs with vital information about our local health services and support for patients. We have received very positive feedback from primary care and plans are in place for the ongoing development of the resources.
3.	**Devolution bid for Gloucestershire**
3.1	We submitted the full "We are Gloucestershire" bid to Whitehall on 4 September. This is an ambitious bid that sets out our proposals for the county and demonstrates our commitment to working with our partners to bring together experience, ambition and enthusiasm to achieve better outcomes and reduced costs.
3.2	The bid follows the same format as the Statement of Intent and outlines five sections: • Accelerating growth – infrastructure, planning, transport, business skills and employment. • Health and social care – single vision for health and social care, delivered collectively by partners, based on what local people really need. • Community safety – joined up public protection and safeguarding practice to improve outcomes for some of our most vulnerable people. • Finance and assets – getting the best out of the £3 billion public sector money spent in Gloucestershire by commissioning together and investing together to prevent demand in future. • Governance – establishing a single point of governance to remove

	barriers without merging organisations.
3.3	The government will now select and negotiate on bids in time for the Chancellor of the Exchequer to announce further devolution deals in his public spending review statement on 25 November.
3.4	If the bid is successful, the CCG will develop a business case to test how best to accelerate our progress on integration, retaining a strong focus on self-care and prevention in all our plans.
3.5	The full bid and proposals available to view online at: www.weareglos.com.
4	**Winter Planning**
4.1	Preparations for the winter have begun in earnest, with: • an assessment of bed modelling across the system; • a review of last winter; a desktop escalation exercise; • compilation of the Winter plans from across the SRG system; • development of system-wide escalation measures; • flu planning; • review of current QIPP schemes successes and areas for development; • Winter "local" and national communications plans • Development of the ASAP app; • High impact actions; • Bank Holiday assurance process • Delivery of the resilience schemes
5.	**Meetings attended** • 1 September: Gloucestershire Strategic Forum Five Year Forward View Workshop 2 – National Star College, Gloucestershire • 2 September – Leadership Gloucestershire, Shire Hall, Gloucester • 3 September - CCG Commissioning Event - Cheltenham Racecourse, Cheltenham • 15 September - Gloucestershire's PM Challenge Fund / GDoc, Wotton-Under-Edge

	• 17 September – South West Clinical Senate Council Meeting, Taunton
6.	**Recommendation**
6.1	This report is provided for information and the Governing Body is requested to note the contents

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 7

Governing Body

Governing Body Meeting Date	**Thursday 24th September 2015**
Title	**Gloucestershire Clinical Commissioning Group Accountable Officer's Report**
Executive Summary	This report provides a summary of key issues arising during August & September 2015
Key Issues	The key issues arising include: • **Strategy & Prevention** • **Future in mind pilot & Gloucestershire Dementia Strategy** • **Procurement of Commissioning Support Services (CSU)** • **Urgent Care Network** • **Meetings attended**
Risk Issues: **Original Risk** **Residual Risk**	None.
Financial Impact	None.
Legal Issues (including NHS Constitution)	None.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note this report which is provided for information.
Author	Mary Hutton
Designation	Gloucestershire CCG Accountable Officer
Sponsoring Director (if not author)	

Gloucestershire Clinical Commissioning (GCCG)
Accountable Officer's Report

1. Introduction

1.1 This report provides a summary of key issues arising during August and September 2015

2. Strategy and Prevention

2.1 Our work on prevention and self-care is progressing well. The healthy individuals Programme Group is continuing to develop a shared work plan that will outline the key actions needed to enable individuals to better self-care. The team are working on a number of key initiatives to support the CCG's ambitions to promote health and wellbeing. These include:

- Undertaking a series of engagement activities with patients who have a long term condition to understand how they can better self-manage. This is being supported by comprehensive a review of the evidence to inform our service model going forward.

- We have started work on an obesity health needs assessments across the life course. This work will inform a co-ordinated approach to tackle obesity across the county and ensure that sufficient weight management services are in place.

- A Cultural Commissioning Grant Programme has been launched inviting arts and culture organisations from the VCSE sector to develop innovative solutions to address the priorities of our clinical programme groups. The grant programme is being supported by Create Gloucestershire and VCS Alliance along with Tewkesbury Borough Council, Forest of Dean District Council and Gloucester City Council.

- Florence Phase 2 will be launched on the 3rd September to coincide with the CCG's AGM. The aim is to roll Florence out in primary care and look at opportunities to support other community initiatives such as weight management, telecare, specialist services and flu vaccinations.

- The CCG and GCC are working with other areas across the South West to jointly submit an expression of interest to become a first wave site to join the NHS Diabetes Prevention Programme. If successful, the initiative would involve working in partnership with NHS England, and their contracted service providers, to deliver behaviour change interventions to prevent Type 2 diabetes in Gloucestershire

- Working in partnership with GCC and Active Gloucestershire we have been put through to the next stage of our 'Healthy Habits, Healthy Communities bid' to the Big Lottery. If successful, the aim of the project will be to develop a

social investment model on supporting people to become more physically active through both individual and community change programmes and creating a self-sustaining environment of permanent change to healthy living/physical activity participation.

3. Future in mind pilot & Gloucestershire Dementia Strategy

3.1 Mental Health and Wellbeing Strategy

Following a consultation event earlier this year there has been a refresh of the Gloucestershire Mental Health and Wellbeing Strategy and the associated action plan. The decision has been taken to transfer many of the strategic priorities identified through the 6 strategy sub-groups into other existing strategic forums (e.g. Building Better Lives, Suicide Prevention). Once this work has been completed a paper will be presented to the partnership board on gaps/ recommendations.

3.2 Crisis Concordat

Gloucestershire was the first area of the country to go live with a concordat and associated action plan. There has been significant progress made against many of the actions within the plan but there is now a need to take stock and review the 80 plus actions across 18 different organisations. The highlights to date include:

- Remodelling of the Gloucestershire Crisis resolution and Home Treatment Team to provide faster response to a wider range of referrers (particularly police). It is intended in phase one that this service will have an expanded age range (16+ as opposed to current 18+) with the future intention to reduce the age further down to 12 pending the evaluation of pilots within ED mental health liaison.

- ED mental health liaison is now available on a 24/7 basis.

3.3 Following a series of stakeholder engagement and workshops the Gloucestershire Dementia Strategy is in a final version, needing some graphic input to be ready for wider circulation by the end of September. It is based on 5 principles and values, identifying the programmes of work supporting those themes and building on earlier National Dementia Strategy and Dementia Challenge progress, as well as aligning with Growing Older in Gloucestershire and Care Act drivers:

- Dementia is everyone's business
- People living with dementia are engaged, involved and informed
- Placing the person with dementia and their carers/families at the centre
- Recognising dementia as a LTC
- Ensuring that the county workforce has the knowledge and skills to provide high quality care for people living with dementia

3.4 The NHSE target for a national Dementia Diagnosis Rate (DDR) is 67% by March 2016; we are waiting NHSE confirmation at the end of September on the local DDR following changes to dementia prevalence methodology. Using the 14/15 tool, Gloucestershire achieved 60% by March 2015, with a tentative indication that the new calculation increased this to 64.5%. The DDR released shortly will reflect the position in August 15, so we are hopeful we will be closer to the NHSE target. Engagement with GPs has continued in order to support primary care diagnosis of dementia, for example the recent Commissioning Event and NHSE Clinical Lead Professor Burns speaking at South Cotswold dementia Protected Learning Time next week.

4. Procurement of Commissioning Support Services (CSU)

4.1 Introduction

The CCG is currently in the process of procuring commissioning support services under the NHS Lead Provider Framework jointly with BANES CCG, Swindon CCG and Wiltshire CCG.

4.2 Issues

A number of issues have arisen recently as the procurement process has been progressed, these have been raised with the NHS England (NHSE) policy lead for LPF; these are:

- VAT on services – NHSE have indicated that their VAT advisors believe that between 5% and 9% of the VAT on CSU services will not be recoverable; we have requested that this advice is shared, along with the specifications that were used to arrive at the assessment. The NHSE view is that efficiencies generated through the LPF framework will outweigh the additional cost. This has implications for the CCG's cost envelope

- TUPE information – TUPE information has not been provided to CCGs which has meant that the CCGs have been unable to test their financial envelope to date. This, along with the experience in another area where a procurement which progressed without this information has now had to be paused is seen as a potential block to enabling a successful procurement to take place.

- Asset information – CCGs do not currently have asset information relating to the CSU relevant to their contract. Asset information has now been requested by NHSE from CSUs. NHSE will undertake their own validation exercise on the information provided and CCGs have requested that they have access to the information too.

The four CCGs are currently working with NHS England to resolve these issues, however, this will take some time and the procurement has therefore been paused whilst this takes place.

4.3 Next Steps

Given the delays in the process the initial procurement timetable cannot now be met and that the procurement will not complete before 31st March 2016; this is the date when the contract with the current CSU ends. There is a consensus amongst the four CCGs that there is a need to extend the contract with the current CSU whilst these issues are being resolved.

4.4 Recommendations

The Governing Body is asked to:

- Agree an extension to the CSU contract beyond 31st March 2016, subject to negotiation and terms.

5. Urgent Care Network

5.1 Gloucestershire CCG have volunteered and been accepted as the co-chair of this Network alongside Proff. Jonthan Benger for a 1 year term.

The Network, named the Severn Network, covers 8 CCG's.

The objective of the Network is to operate strategically tackling issues that are difficult for the SRG's to progress on their own. We are currently developing the work programme for the Severn Network, which will take account of the NHS E objectives to:

- Create and agree a long term plan for the Urgent and Emergency Care Review
- Designate urgent care facilities
- Ensure the building of trust and collaboration.

6. Meetings attended

12-Aug	Quarter 1 Partners Meeting, Healthwatch Gloucestershire
13-Aug	AEC Walk Through, Cheltenham General Hospital
27-Aug	Devolution Project Team Mtg, Shire Hall, Gloucester
1-Sep	Gloucestershire Strategic Forum (GSF) – Forward Planning
2-Sep	CCG/Public Health Meeting, Shire Hall, Gloucester
3-Sep	CCG Commissioning Event, Cheltenham Racecourse
7-Sep	Secondary Care Doctor Interviews

14-Sep	Gloucestershire Quarter 1 Assurance Meeting
14-Sep	South Central Leadership Forum, Swindon
15-Sep	Gloucestershire PM Challenge Fund/Gdoc – Strategic Aim & Evaluation, Gloucester
17-Sep	NHSCC Quarterly Meeting SW Region, Somerset
21-Sep	Better Care Forum (BCF), Shire Hall, Gloucester
22-Sep	Gloucestershire Health & Well Being meeting, Shire Hall, Gloucester
24-Sep	Director of Public Health – Advisory Interview Panel, Shire Hall, 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

Gloucestershire Clinical Commissioning Group
Governing Body

Meeting Date	**Thursday 24th September 2015**
Title	**Locality Development Planning 2015 -2017**
Executive Summary	In July 2015, the new two-year Locality Development Plans covering 2015 – 2017, were presented to the Governing Body for Forest of Dean, North Cotswolds, and Tewkesbury, Newent & Staunton localities. This second paper provides the remaining four locality plans for Gloucester City, Cheltenham, South Cotswold and Stroud and Berkeley Vale localities. As per the original paper, this briefing provides some specific updates on key achievements from the last two years, and the common themes emerging from the four locality plans and where they align with CCG programmes.
Key Issues	The key challenges to delivery experienced in 2013 – 2015 plans were: • Management money constraints • Project delivery resource These issues have since been addressed and localities are now well placed to deliver against the work plans for 2015 – 2017.
Risk Issues: **Original Risk** **Residual Risk**	Communication between CCG programme areas and localities has been identified as a potential risk due to the potential for duplication of effort or misaligned approaches.

	This will be tackled through dissemination of plans widely, triangulation of locality plans with CCG programmes, and regular communication between the Primary Care and Locality Development team and the key programme areas.
Financial Impact	The Locality Operating Framework for 2015/16 sets out a consistent approach to management money funds, how those can be spent, and how they should be recorded. Within locality plans, all localities have identified locality and / or practice variation as an area they are committed to work on. Clinical project work-streams will be exploring approaches which aim to improve the quality and cost of services – aligning to QIPP where possible and supporting the delivery of countywide challenges.
Legal Issues (including NHS Constitution)	Localities are an important component of how the CCG responds to delivery of the NHS Constitution. Amongst others, localities particularly support the fifth of the seven key principles in the NHS constitution regarding working in partnership and across organisational boundaries in the interests of patients, local communities and the wider population. In addition, the right for patients to expect assessment of health requirements locally and to commission services accordingly is addressed directly by Locality Development Plans.
Impact on Health Inequalities	Localities are taking varying approaches to tackling health inequalities within their plans, including: • Child and Adult Obesity (Age) • Cultural Diversity (Ethnicity)

	• Men's Health (Gender) • Tackling variation – linked to locality demographics Gloucestershire's Public Health team has contributed to the development of all seven Locality Development Plans.
Impact on Equality and Diversity	Localities have assessed local demographics and deprivation with the aim to improve access to healthcare services as well as bringing care closer to home.
Impact on Sustainable Development	Services being provided closer to home for patients, avoiding the need to travel to secondary care settings.
Patient and Public Involvement	Locality Development Plans have taken into consideration 'on the ground' feedback from patients, either directly through patient representatives or indirectly from practice staff. Plans will be hosted on the Gloucestershire CCG website and shared with Patient Participation Groups and a variety of local stakeholders.
Recommendation	The Governing Body are asked to: • Note the key achievements for 2013 – 2015 for the three localities presented; and • Provide sign off of the Locality Development Plans 2015 – 2017 for the Gloucester City, Cheltenham, South Cotswold and Stroud and Berkeley Vale localities.
Author	Zaheera Nanabawa / Stephen Rudd
Designation	Locality Development Manager / Head of Locality and Primary Care Development
Sponsoring Director (if not author)	Helen Goodey Director Locality Development and Primary Care

Agenda Item 8

Governing Body

24th September 2015

Locality Development Planning 2015 – 2017

1 Introduction and Background

1.1 In July 2015, the new two-year Locality Development Plans covering 2015 – 2017, were presented to the Governing Body for Forest of Dean, North Cotswold, and Tewkesbury, Newent & Staunton localities.

1.2 This second paper provides the remaining four locality plans for Gloucester City, Cheltenham, South Cotswold and Stroud and Berkeley Vale localities.

2 Key achievements to date

2.1 Gloucester City Locality

2.1.1 **Choice+** – A pilot for local urgent care centres began on the 1st of October 2014, with 300 appointments per week available to nine Gloucester City practices that initially opted to take part. Additional appointments at the urgent care centres in Gloucester Health Access Centre (GHAC) and Matson Lane, frees up on average six hours of time in each practice every week to spend time with patients with long term conditions and continuity of care needs.

2.1.2 **Social Prescribing** – In partnership with Gloucester City Council the locality executive has supported the implementation of Social Prescribing for all GP practices across the City. GP's and healthcare professionals based in practices are able to offer a 'social prescription'.

Patients are referred into the Social Prescribing hub based at Herbert Warehouse. A hub coordinator then meets with patients to offer signposting to a range of local, non-clinical services which can support patients social, emotional or practical needs.

2.1.3 **Pharmacy First** – Promoting a new minor ailments scheme to GP practices, healthcare professionals and patients in Gloucester City to reduce GP appointments by providing medication for common ailments through local pharmacies. The scheme has been particularly successful for use by parents of younger patients, and the pilot will continued until the end of the financial year 2015/16.

2.2 Cheltenham Locality

2.2.1 **Care Home Zoning** – All practices have continued to support care/nursing home zoning whereby each GP practice has been aligned to a number of care/nursing home(s). This has improved the continuity of care and clinical outcomes for those patients in a care/nursing home, and enabled the practices to develop a relationship with care/nursing home staff. Due to the number of care/nursing home(s) premises within the Cheltenham locality, this has ensured practices visits are more manageable for GP staff.

2.2.2 **Electronic Prescribing** – The roll-out of electronic prescribing across all practices working with local pharmacies. The deployment has gone well from the outset as practices have been pragmatic about understanding the inherent challenges posed by a change in systems and process and will now take forward Phase II of the project during 2015/16.

2.2.3 **Greater Awareness of Suicide** – An education event for GP Practice Leads focused on suicide, following advice from Public Health that this was an area the locality needed to provide some focus to. Subsequently, the Locality Executive identified which Voluntary & Community Sector organisations are able to provide extra support so that practices have the confidence to refer/signpost their patients to those organisations.

2.2.4 **Patient Participation Groups (PPGs)** – PPGs routinely hear about patients' experiences: perspectives of existing services and about what developments the local community feel would be useful. In the light of this, the Locality Executive sought PPG's thoughts on the priorities in the Locality Development Plan (LDP) for 2013-15, along with any issues they would like to highlight, and feedback from patients who may have benefitted from these schemes. This feedback has then informed the development of plans for 2015-2017.

2.3 Stroud and Berkeley Vale Locality

2.3.1 **Cycling on prescription scheme** – This scheme was initially commissioned for the patients of 8 locality practices and has subsequently been rolled out to all 19 practices. This is a confidence building programme where individuals are supported by the Road Safety Partnership to return to cycling. The scheme is particularly for people who already own a bike but may not have used it for a while. In addition to confidence building sessions, the individual also receives a free bike maintenance check. People are then linked to local cycling clubs.

2.3.2 **Social Prescribing** – our social prescribing pilot initially ran in 6 GP practices. The most common reason for referral was social isolation, followed by mental health and

wellbeing. The scheme was jointly sponsored by Stroud District Council and the CCG. Following an evaluation, an in practice model has been adopted and will roll out during the coming months.

2.3.3 **Facts4Life** – The locality commissioned the development of this programme which aims to change the attitude of children in Key Stage 1 to their health and wellbeing. The aim is to promote an understanding of illness as part of normality, helping children to understand how to keep as well as possible and how to manage ill-health effectively. The project helps children to put information in context when making decisions about their health. The pilot demonstrated positive results and the CCG has now funded the project to enable roll out to 153 schools across the county.

2.4 South Cotswold Locality

2.4.1 **Social Prescribing** – The locality developed and successfully implemented a Social Prescribing scheme with four GP practices in the locality; in partnership with Cotswold District Council and other local voluntary and community organisations. The Hub Coordinator has worked closely with GP practices at St Peters Road, Rendcomb, Lechlade and The Park surgeries. Through the hub, patients are signposted to relevant organisations to assist with social issues a patient is facing. Over 110 patients have been seen through the Social Prescribing hub since April 2014. A majority of individuals have needs around social isolation and caring responsibilities. The scheme will be rolled out into all practices in the locality by the end of 2015.

2.4.2 **Cirencester Hospital** has been established as an innovation test bed for community hospital service development within the county. Working together with CCG colleagues, Gloucestershire NHS Hospitals

Foundation Trust and Gloucestershire Care Services, a Cirencester Hospital working group has been formed. A range of options for the hospital are being considered with partners including: the best model of medical cover for local patients, increasing outpatient provision, supporting county-wide work on day surgery and diagnostics, and working with Wiltshire and Avon CCG's to assess appropriate services after the Care UK contract comes to an end on 31st October 2015.

2.4.3 **Dementia** was a priority identified by the JSNA data for 2013-2015 in the South Cotswold locality, as the prevalence levels were lower than expected for our population. An education event for all South Cotswold GP's has increased awareness to support dementia diagnosis. This has led to an increase in the recording of dementia cases in the locality and enabled the implementation of formal memory testing. A follow-up education event in September 2015 with Professor Burns seeks to ensure we continue to build on our good work in this area, for the benefit of our ageing population.

2.4.4 **Identifying financial variation in practices** – Building on an approach developed by Yorkshire and Humber Public Health Observatory (now Public Health England), the South Cotswold Locality Chair took the lead in developing an approach which allows comparison to 'similar' practices within taxonomy groups, enabling a comparison not only to locality practices but also to 'practice peers.' Based on the relative position of each practice's registered list against five themes (% of older patients, deprivation, employment, health conditions and carers, lifespan and disease mortality) seven taxonomy groups were created. This approach will continue to be developed through 2015-17 as part of the newly established variation programme where the key focus will be based on what actions should take place when variance that is real, material and

influential has been identified.

2.4.5 **<u>Complex lower limb service</u>** – With an increasing ageing population, the locality has identified long term condition planning as imperative to the sustainability of the locality in forthcoming years. The locality has worked towards the implementation of a holistic community based complex lower limb wound service – modelled on appropriate community based care, closer to home for patients. The developed service is aligned to a social model of care and will enable efficient use of district nurse time. This scheme will begin in the South Cotswold locality and will then be rolled out across countywide locations.

3 Key emerging themes and alignment with CCG programme areas

3.1 The priority themes identified from this process have been triangulated with the CCG operational plan and QIPP schemes. The table below maps the emerging themes from the four localities against their correlation with existing CCG Programmes.

3.2

Locality	Emerging themes mapped to CCG Programme Areas
Gloucester City	**Dermatology** – addressing variation **Mental Health** – Improving communication between health professionals and identifying gaps in provision **Healthy Individuals** – Place based approach to tackle health inequalities
Cheltenham	**Healthy Individuals** – Establishing a Junior Park Run **/** Rollout of countywide Social Prescribing model / Establish a health education programme in schools **Prescribing** – review of polypharmacy in patients over 85 years **Urgent Care** – addressing variation
Stroud and Berkeley Vale	**Healthy Individuals** – Reducing obesity and related conditions (e.g. diabetes) / Reducing smoking and related conditions (e.g. CVD) **Integrated Community Teams (ICT)** – Rollout in the locality of ICT Phase 2 **Cancer –** Earlier diagnosis of Colorectal Cancer
South Cotswold	**Prescribing –** addressing variation **Planned Care –** addressing variation in cardiology first outpatient appointments **Community –** scoping a community geriatrician service

Mental Health – Improving communication between health professionals and identifying gaps in provision

4 Recommendations

The Governing Body are asked to:

- Note the key achievements for 2013 – 2015 for the four localities presented; and
- Provide sign off of the Locality Development Plans 2015 – 2017 for the Gloucester City, Cheltenham, South Cotswold and Stroud and Berkeley Vale localities.

5 Appendices

- Appendix 1– Locality Development Plan for Gloucester City
- Appendix 2 – Locality Development Plan for Cheltenham
- Appendix 3 – Locality Development Plan for Stroud and Berkeley Vale
- Appendix 4 Locality Development Plan for South Cotswold

NHS
Gloucestershire
Clinical Commissioning Group

Gloucester Locality Development Plan 2015-17

Foreword

The aim of this Locality Development Plan for Gloucester City is to identify the challenges that health and social care services face today, how these challenges will evolve with time and how the services of today can evolve to become the services of tomorrow. The plan takes into account the 'demographics' of the population, how we expect this population to change with time and the key Public Health 'themes' that are more relevant to Gloucester than other parts of the county.

There are approximately 168,000 patients registered to GP practices that constitute the CCG Gloucester Locality. As a locality we expect this population to grow in the next 20 years, and that this growth will predominantly occur in the elderly and young populations, potentially bringing additional pressure on the resources for services looking after these two population groups. Gloucester is also more culturally diverse than other parts of Gloucestershire, has more socio-economic deprivation, unmet mental health needs and more people dying prematurely due to chronic disease that could possibly be prevented. These are very real challenges, but even in an era of diminished resources, we are optimistic that we can make real and measurably positive change through the way in which services are organized, integrated and delivers.

In the two years since Gloucestershire Clinical Commissioning Group came into being we have made real progress in some key areas identified through the 2013-15 priority setting process, including the development of the Care Homes Enhanced Service; which has brought care closer to patients and reduced emergency admissions.

We are aware that primary care and general practice across the UK is facing significant pressures including preserving the workforce of dedicated doctors and healthcare professionals. We strongly believe that supporting the local workforce in primary care leads to supporting the patients we serve; therefore we are committed to working with key stakeholders on this important area.

As a locality executive team of GPs and managers we have a strong pipeline of ideas and projects that we are working on, and these are described in detail in this document. We believe that our role as an executive committee is to help services evolve to deliver the right care, in the right place, at the right time. Every time.

Gloucester Locality GP Executives – Drs Bob Hodges, Will Haynes, Rachael Bunnett, Joan Nash and Irene Mawby.

1 Purpose

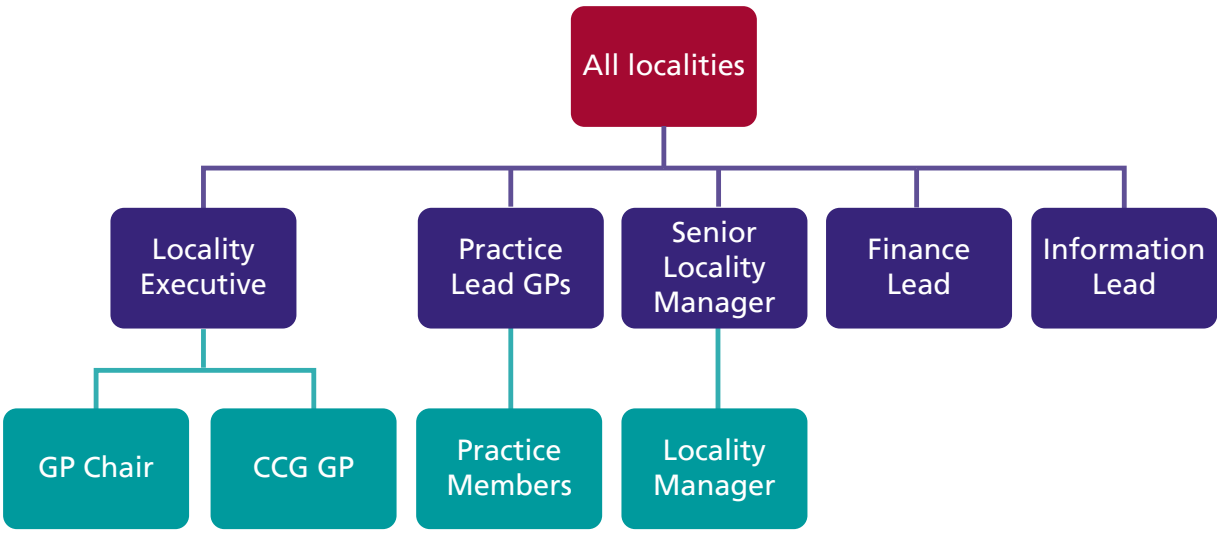
1.1

This Locality Development Plan has been produced to describe the specific health needs for the population of the Gloucester City Locality and sets out how the Locality Executive Group will lead work to address these needs over the next two years.

2 Background

2.1 The county of Gloucestershire covers a diverse range of populations, from the very deprived to the very affluent, from people living in very rural areas to people living in one of two large urban areas where there are a significant number of immigrant populations. This leads to a countywide population with very different health and social care needs, spread over a large geographic area.

2.2 In recognition of the need to understand and represent these differences, the CCG has formed seven localities; one of these is for the Gloucester City area. In each locality, lead GPs work alongside key partners to help determine how best to meet the needs of its population, informing the wider work of the CCG; this is known as the Locality Executive Group. The structure of localities is shown below:



2.3 For our locality, these roles are:

- Locality GP Chair: Dr Bob Hodges
- Locality CCG GP: Dr Will Haynes
- Locality Executive GP's: Dr Rachael Bunnett, Dr Irene Mawby and Dr Joan Nash
- Senior Locality Manager: Andrew Hughes
- Locality Development Manager: Zaheera Nanabawa
- Finance Lead: Jeremy Gough
- Information Lead: Chris Roche/Simon Curtis

2.4 The key functions of a locality are:

Planning	Service change delivery	Engagement and relationships
Reviewing health needs, patient insight	Locality specific projects	Utilising/ shaping practice level patient participation groups
Shaping CCG Plans	Local implementation of CCG wide initiatives	Developing links with key community groups
Local delivery plan	Joint initiatives with local partners	Key stakeholders/ partners

Participation	Quality, utilisation and performance	Locality organisational development
Operation of committees, groups and protected learning time	Review locality performance information and take necessary action	Supporting the development of local membership model – e.g. what does greater federation feel and look like
Encouraging wide membership engagement	Understanding variations	Development between localities and the Governing Body
Practice visits and individual membership opportunities	Improving quality and performance	Developing the locality executive

2.5 This document will seek to describe the local health needs for the Gloucester City Locality. The Public Health team within the Local Authority and other key stakeholders have supported this work and will continue to support us in identifying the best way of meeting the needs at both a strategic and operational level.

2.6 In accordance with national requirements and working with partners and stakeholders (including patients, carers and the public), the CCG has formulated a five year strategic plan for Gloucestershire – Joining Up Your Care, which aligns with the Gloucestershire health community Health and Wellbeing Strategy ('Fit for the Future') that sets out the priorities for improving health and outcomes for the people of Gloucestershire from 2012-2032.

Joining Up Your Care –
Our Shared Vision for the next 5 years:

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

Our Ambitions:

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

2.4 This Locality Development Plan must be seen in the context of these important strategic documents; projects and initiatives in the Plan will be complementary to this strategic context and the CCGs operating plan.

This Locality Development Plan therefore fits within this wider context as follows:

2.8 To identify the health needs of the population of the Gloucester City Locality, three main sources of information have been identified:

- Public Health Intelligence
- Activity, performance and financial data on the use of services, highlighting those areas where the Locality is significantly over or below 'expected' levels. This analysis has included consideration of benchmarking data and information on variation between usage of health care at a GP Practice population level
- 'On the ground' intelligence – i.e. conversations with local colleagues who are working directly with patients to understand their views about need

2.9 The Locality Executive Group will work closely with key stakeholders to identify the health and social care needs of the local population, prioritise actions, and provide ideas for how these needs could be addressed. These stakeholders include:

- Local GP Practices and their staff
- Patients and their representatives
- Gloucestershire Care Services
- Gloucestershire Hospitals NHS Foundation Trust
- [2]gether NHS Foundation Trust
- Gloucestershire County Council including Public Health
- Gloucester City Council
- Tewkesbury Borough Council
- Local voluntary organisations
- CCG colleagues

2.10 Whilst assessing the evidence gathered around local health needs, the Locality Executive Group has also taken into consideration the variety of existing work streams within the CCG's countywide Clinical Programme Groups (CPGs) and countywide clinical and service improvement projects to ensure locality initiatives are complementary or where the locality can support or influence countywide schemes. This will allow for a continuous feedback loop where successful learning from the locality projects can be embedded into the CPGs, and also from the CPGs into the locality.

3 Key Achievements during 2013 - 2015

3.1 Key achievements of the Gloucester City Locality from the previous 2013-2015 plan are detailed below:

3.1.1 **Choice +** – A pilot for local urgent care centres began on the 1st of October 2014, with 300 appointments per week available to nine Gloucester city practices that initially opted to take part. Additional appointments at the urgent care centres in Gloucester Health Access Centre (GHAC) and Matson Lane, freed up on average six hours of time in each practice every week to spend time with patients with long term conditions and continuity of care needs.

Initially the pilot had a total patient population of around 100,000, which rose in January 2015 to 122,025 when three additional practices joined into phase two of the pilot. The scheme has been very successful and proved valuable for both patients and GP's. It has allowed increased choice and convenience for patients in Gloucester city, and fostered a collaborative approach between GP practices.

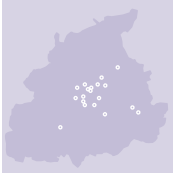
The accessibility of urgent care centres contributes to reduced pressure on emergency admissions to hospital and prevents A&E attendances. A successful submission to the Prime Minister's Challenge fund has enabled the replication of this effective model for other locality areas across the County.

3.1.2 **Social prescribing** – In partnership with Gloucester City Council the locality executive have supported the implementation of Social prescribing for all GP practices across the City. GP's and healthcare professionals based in practices are able to offer a 'social prescription'. Patients are referred into the Social prescribing hub based at Herbert Warehouse, then a hub coordinator meets with patients to offer signposting to a range of local, non-clinical services which can support patients social, emotional or practical needs.

The social prescribing hub has developed strong links with local organisations who can provide support including the Community Health Trainers, Aspire Sports and Cultural Trust, GreenSquare Housing, Carers Gloucestershire, Fairshares Timebank, Civica, and GL communities. Having run successfully since the launch in December 2014, the pilot project will continue for a further period across all practices in the city. Prime Ministers Challenge and CCG funding will contribute to the growth of the hub, including the additional recruitment of extra hub coordinators who will develop the service, linking in to local GP practices across the locality.

3.1.3 **Pharmacy First** – Promoting a new minor ailments scheme to GP practices, healthcare professionals and patients in Gloucester city to reduce GP appointments by providing medication for common ailments through local pharmacies. The scheme has been particularly successful for use by parents of younger patients, and the pilot will continued until the end of the financial year 2015/16.

3.1.4 **Care Homes Enhanced Service** – The 2013-15 locality development plan for Gloucester identified care homes for the elderly as a priority. This lead to the CCG investing in and establishing a GP 'Enhanced Service' for care homes across the whole of Gloucestershire, and this has resulted in significantly improved care support for elderly care home residents and a significant reduction in the number of elderly people living in care homes need to be transferred to acute hospitals as emergencies.



3.1.5 **Workforce Survey and planning** – We have coordinated a primary care workforce survey to understand the potential future demographic of GP's in the city of Gloucester. The survey is the first step in understanding and planning for future need in the city, and we will work closely with the CCG to enable Gloucester City to be an attractive place for GP's to be employed. The survey also identified the need to assess the staffing situation for other staff in primary care, including practice nurses. This approach was replicated across locality areas across the county.

We are committed to working with the CCG and other stakeholders to develop innovative initiatives to consider an appropriate and relevant skills mix in primary care to ensure the best possible outcomes for patients.

3.1.6 In addition, the Locality Executive Group has also achieved:

- Membership engagement – successfully established regular visits and contact with GP practices across the city to identify key issues and concerns, and to inform and share best practice
- Patient and Stakeholder reference panel – a quarterly meeting for patient participation groups and other relevant locality stakeholders to gather views 'on the ground' and to inform attendees around locality progress on projects
- Continued work on assessing the requirements of a culturally diverse population – including the review of a local enhanced service
- Activity audits on A&E attendances contributing to the development of General Practice representation in the Front door of A&E service in collaboration with the Urgent Care team at the CCG
- A GP 'informed client' approach to identifying and tackling financial variation at both practice and locality levels
- Initiated development of a Park Run in Kingsway with local volunteers linked to running and athletics clubs in Gloucester City
- Continued successful Protected Learning Time (PLT) and education opportunities for GP's and healthcare professionals across the city including topics such as 'Child Safeguarding', 'Adult Safeguarding', 'Cancer', 'ENT', 'Eyes' and 'Elderly Care'
- Working with local stakeholders to ensure appropriate discharge and GP cover for local intermediate care home Great Western Court
- Linking with practice managers across the city to support their development including a peer mentoring scheme
- Supporting the introduction of integrated community and rapid response teams – including clinical oversight and advice around countywide implementation
- Ongoing engagement with local NHS service providers;

  a) [2]gether NHS foundation Trust – to open the dialogue around mental health services provision in the locality including access into services for GPs into Let's Talk and CYPS – Children and Young People's services.

  b) Gloucestershire Care Services – to communicate local needs, concerns and opportunities around a variety of services including Single Point of Clinical Access, District Nursing, School Nursing and Health Visitors, Homeless Care and MSKCAT (Musculoskeletal Clinical Assessment & Treatment Service).

3.2 **Prime Minister's Challenge Fund**

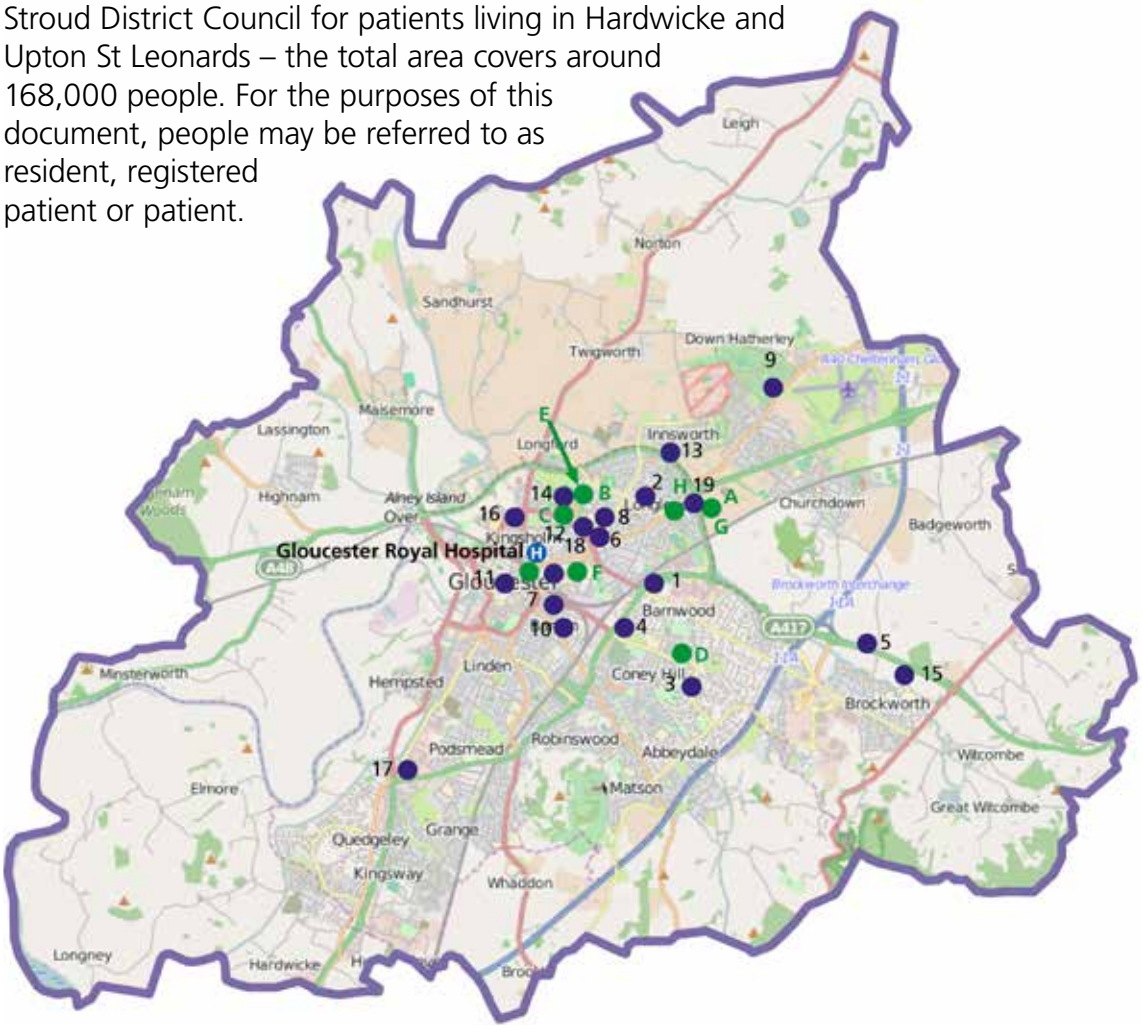
3.2.1 GPs from all localities have been key contributors to a successful application for the Prime Ministers Challenge Fund (PMCF) relating to improving access to general practice, thanks to joint working between the GP provider organisation, Gloucestershire Doctors (G-DOC) and the CCG.

3.2.2 In securing this £4million of additional national funding, localities will be supporting the delivery of providing local people with improved access to GP services in Gloucestershire, This includes the creation of 100,000 appointments a year across all localities to free up time in surgeries to be used on more planned and complex work with patients who have a long term condition. The bid also included greater use of technology, additional specialist nursing, case management and social prescribing.

3.2.3 A Delivery Board has been established to make key decisions and will include representation from each of the seven Gloucestershire localities.

4 Local Service Provision

4.1 The Gloucester Locality is comprised of patients who are registered in Gloucester City (approximately 128,000 people) and around a further 40,000 people who live outside the Gloucester City Council boundary area – largely Tewkesbury Borough Council for patients living in Brockworth, Coopers Edge and Churchdown, and Stroud District Council for patients living in Hardwicke and Upton St Leonards – the total area covers around 168,000 people. For the purposes of this document, people may be referred to as resident, registered patient or patient.



	Practice Name	Postcode	Patient list size
1	Bartongate Surgery	GL1 4HR	8,964
2	Cheltenham Road Surgery	GL2 0LS	8,372
3	Hadwen Medical Practice	GL4 4BL	17,561
		GL1 1HX	
		GL4 5ET	
4	Saintbridge Surgery	GL4 4SH	8,259
5	Hucclecote Surgery	GL3 3HB	8,993
6	Heathville Road Surgery	GL1 3PX	10,087
7	Partners in Health	GL1 5JJ	13,701
		GL2 4WD	
8	London Medical Practice	GL1 3PX	5,106
9	Churchdown Surgery	GL3 2DB	13,585
10	Rosebank Health	GL1 5JQ	23,463
		GL2 4WD.	
11	Gloucester City Health Centre	GL1 1XR	7,884
12	Barnwood Medical Practice	GL1 3PX	5,888
13	Longlevens Surgery	GL2 0AJ	7,148

14	Kingsholm Surgery	GL1 3EN	5,105
15	Brockworth Surgery	GL3 4PE	8,955
16	College Yard Surgery and Highnam Surgery	GL1 2RE GL2 8DH	4,612
17	Quedgeley Medical Centre	GL2 4NF	4,893
18	Gloucester Health Access Centre and Matson Lane	GL1 1PX GL4 6DX	4,971
		Total	**167,457**

Correct as at 1st April 2015 – Source: HSCIC – Health and Social Care Information Centre

[2]gether	A	Wotton Lawn Hospital
	B	GRIP team (Glos Recovery in Psychosis)
	C	Glos recovery and assertive outreach teams 1
	D	Glos community MHT OPS
	E	Denmark Road Team
	F	better 2 Work team
	G	CYPS and Crisis Team
	H	Learning Disabilities.
		Main Hospital GRH site

4.3 Health care facilities in the Locality

In addition to the main acute hospitals in Gloucester and Cheltenham and the GP Practice sites, local NHS health services are also delivered from:

- [2]gether locations including Wotton Lawn Hospital, Acorn House, Fieldview, Denmark Road, Eastgate Street and Ambrose House
- Gloucestershire Care Services locations including Hope House, Sexual assault referral Centre, Stop Smoking service – Southgate Street, Edward Jenner Court, Rikenel and others
- The Winfield Hospital
- Any Qualified Provider (AQP) organisations contracted via the CCG to provide health care – e.g. Care UK – providing services at Emerson Green NHS Treatment Centre;

4.4 Partnership Working

For patients living in any part of Gloucestershire their health issues are often closely linked to other 'social' factors, such as employment, education, and housing. We are committed to working in partnership with the Local Authority and third sector partners to both find and implement solutions.

The CCG also commissions a range of services from the local Voluntary and Community Sector.

Note: Any qualified provider – this is an approach to commissioning under which any provider who is able to provide a specific service and meets the required minimum standards can be listed as a possible provider. Patients choose which provider on the AQP list they wish to see. No provider is guaranteed any volume or exclusivity.

5 What are the Issues we face?

5.1 Over the last few months' colleagues from across Public Health, Local Councils and the CCGs Finance and Information team have held planning meetings to work together to identify which potential priorities the locality might want to consider based on relevant data and intelligence.

5.2 Public Health Information

The Local Authority in Gloucestershire produces a Joint Strategic Needs Assessment (JSNA) – this highlights the medical conditions that particularly affect the population of the county and its Localities. It also highlights population changes over the coming 20 years.

Current available data is based on the last JSNA completed in 2010; Public Health at the Local Authority (Gloucestershire County Council) will be working on the development of the next JSNA in late 2015.

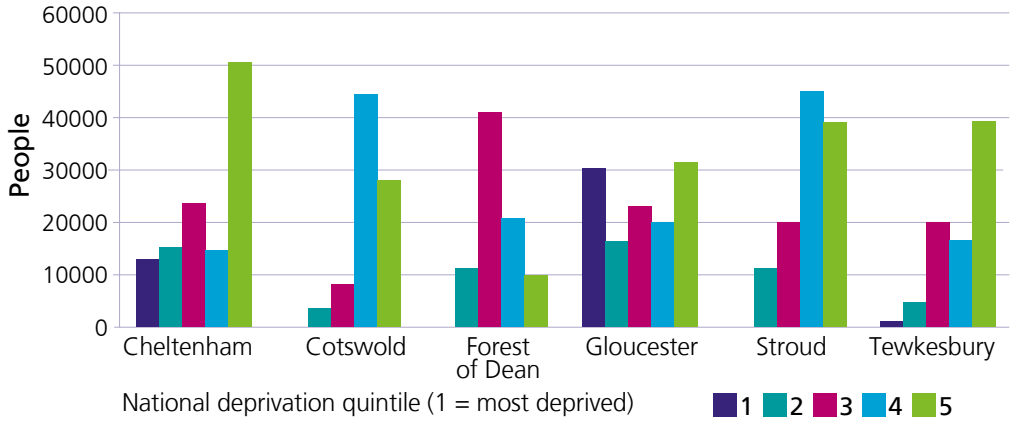
5.2.1 Deprivation

The Indices of Deprivation (2010) are national measures based on 37 indicators, which highlight characteristics of deprivation such as unemployment, low income, crime and poor access to education and health services. The revised indices offer an in-depth approach to pinpointing small pockets of deprivation. They are based on data from 2008. The indices are a key measure used by Central Government to help target policies and funding to improve the quality of life in disadvantaged communities. The headline measure is the Index of Multiple Deprivation. This can be analysed in more depth by looking the seven component domains of:

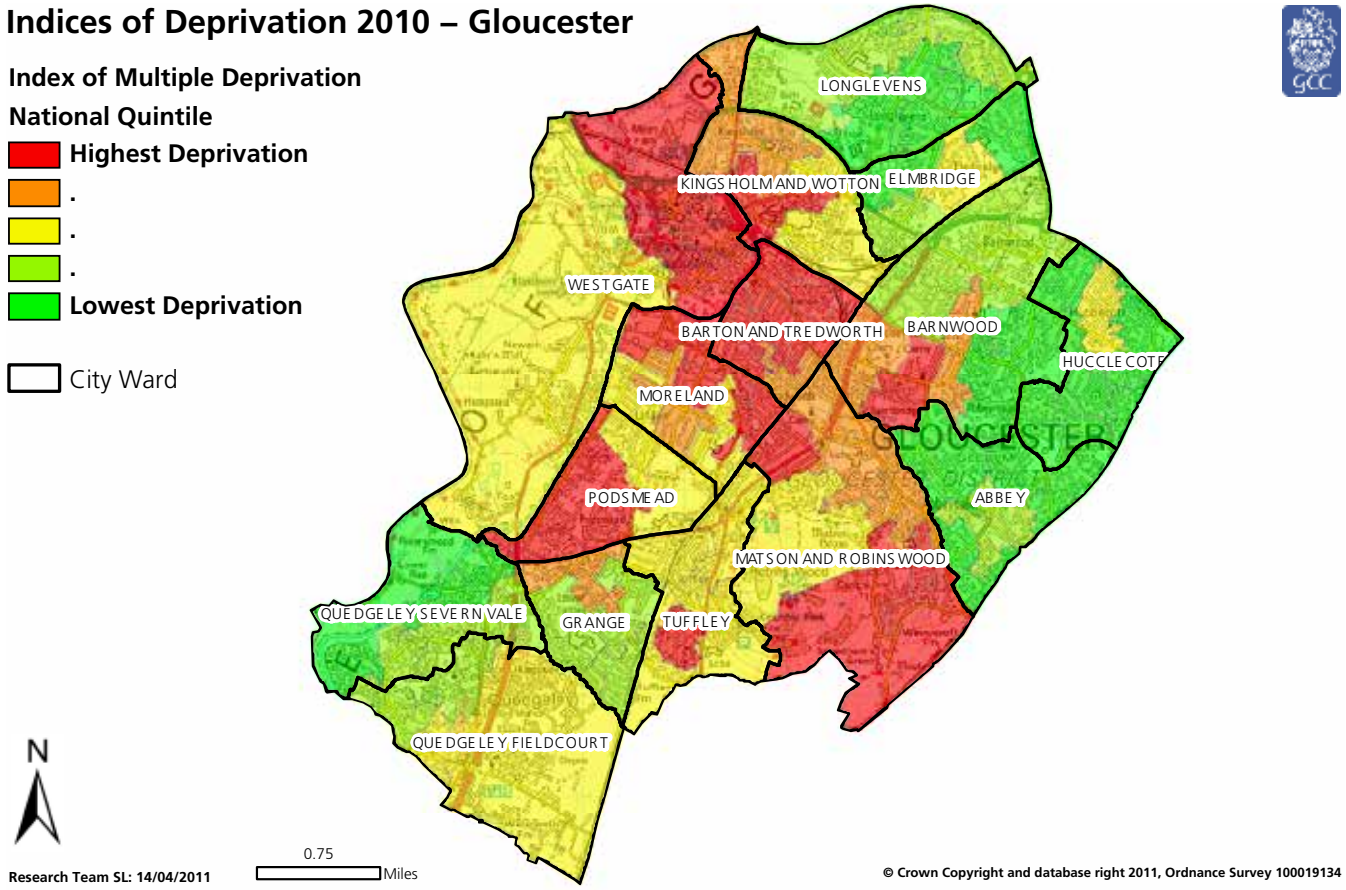
- Income
- Employment
- Health Deprivation and Disability
- Education, Skills and Training deprivation
- Barriers to Housing and Services
- Crime
- Living Environment

The indices use Lower Super Output Areas (LSOA) rather than wards. These are small geographical units covering between 1,000 and 3,000 people and provide a more in-depth appreciation of variations in deprivation at a local level. In Gloucestershire there are 367 LSOAs compared to 142 wards. This helps to identify the small pockets of deprivation that exist alongside some of the less deprived areas. The Indices of Deprivation are not a measure of affluence; all of the indicators used in the index are designed to identify aspects of deprivation, not affluence. Therefore the area ranked as the least deprived is not necessarily the most affluent.

Overall deprivation by district



Based on 2010 figures; with quintile 1 indicating the most deprived and quintile 5 indicating the least deprived, Gloucester City's overall deprivation and specific health deprivation is specified in the graphs on the previous page:



The Gloucester City Locality Executive Group acknowledge that social factors can have a strong influence on an individual's health and well-being, and are fully committed to the advancement of the Social Prescribing scheme for GP surgeries to support patients in the locality.

Source of all graphs in section 5.2.1 – Gloucestershire county council, http://www.gloucestershire.gov.uk/extra/CHttpHandler.ashx?id=45452&p=0 – accessed 30th March 2015

5.2.2 **Demographics**

Additional intelligence from Public Health further informs that:

- Gloucester was the fastest growing district between 2001 and 2011 (up by 10.8% or 11,800 people; nearly double the average growth rate in the county as a whole). Gloucester is again projected to see above average growth through to 2021 which is likely to lead to increased demand for services
- Gloucester locality has a younger age profile than the county as a whole
- As the most populated district in the Gloucestershire, Gloucester city locality has a relatively high number of patients aged 65 plus and 85 plus; with implications for age related long term conditions
- Gloucester locality is the most ethnically diverse locality; with the highest proportion of registered patients describing their ethnicity as 'non white British'
- Amongst the conditions disproportionately affecting the Locality's population, already disadvantaged by deprivation, include higher rates of smoking, child and adult obesity, drug and alcohol-related problems, sexually transmitted diseases and poor mental health

- Gloucester's patients have lower rates of survival from cancer (possibly related to later presentation and lower uptake of screening), with significantly increased morbidity with stroke and ischemic heart disease
- Access to health and social care services can also be more challenging given there are a number of immigrant populations with people speaking English as their second language, together with the associated cultural differences
- Compared to the county as a whole, per head of population, the Locality has a high need for prioritisation of resources in order to tackle health inequalities
- Health inequalities within Gloucester are worse than for the county as a whole. The gap in life expectancy between the most and least deprived neighbourhoods within Gloucester is 11.4 years for men and 9.2 years lower for women
- Gloucester also has the lowest 'Disability Free Life Expectancy' in the county for both males and females.

5.3 Gloucestershire CCG Finance and Information Data

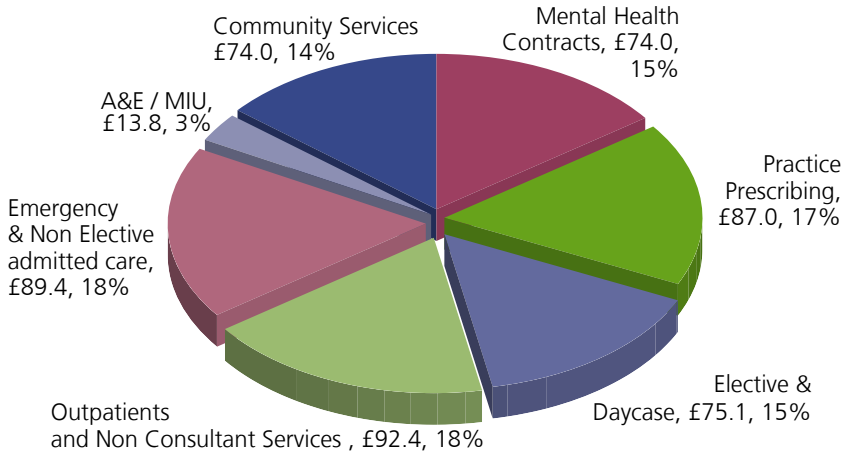
5.3.1 Analysis of NHS resource utilisation demonstrates variation exists not just at a CCG level, but also between and within localities. In addition, the CCG have specific performance issues along with finite financial resources, which, as a membership organisation, the locality can support with.

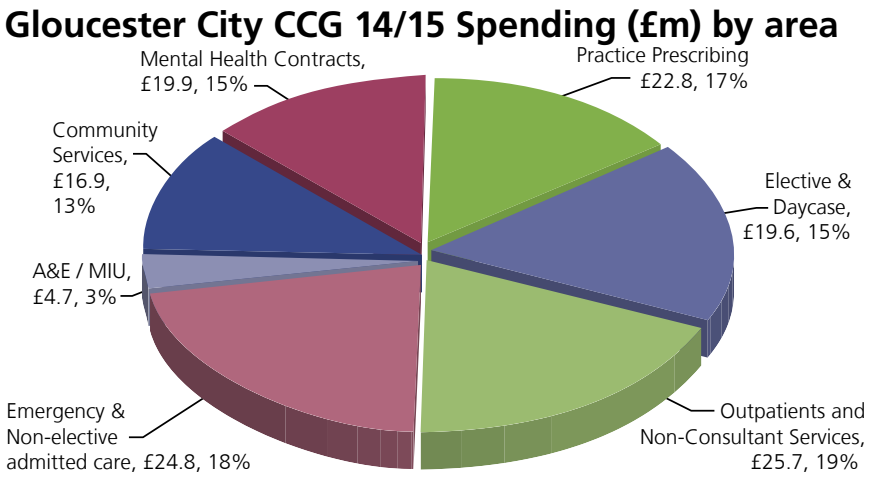
Critically, we face an unprecedented financial challenge over the coming years, at the same time as increased demand for our services, within the context of a fast-ageing population. At present around 17 % of Gloucestershire's population is aged 65 and over; this is expected to grow to 30% over the next 20 years. We will therefore need to provide services that are simple to access, integrated and cost-effective

Given the significant pressures on these services, and considering best services and outcomes for patients, the locality will work alongside countywide CCG programmes of work over the coming two years. The locality will seek to better understand the variation, provide education and communication to all practices on alternative services and determine what other local actions can be taken to support patient urgent care needs.

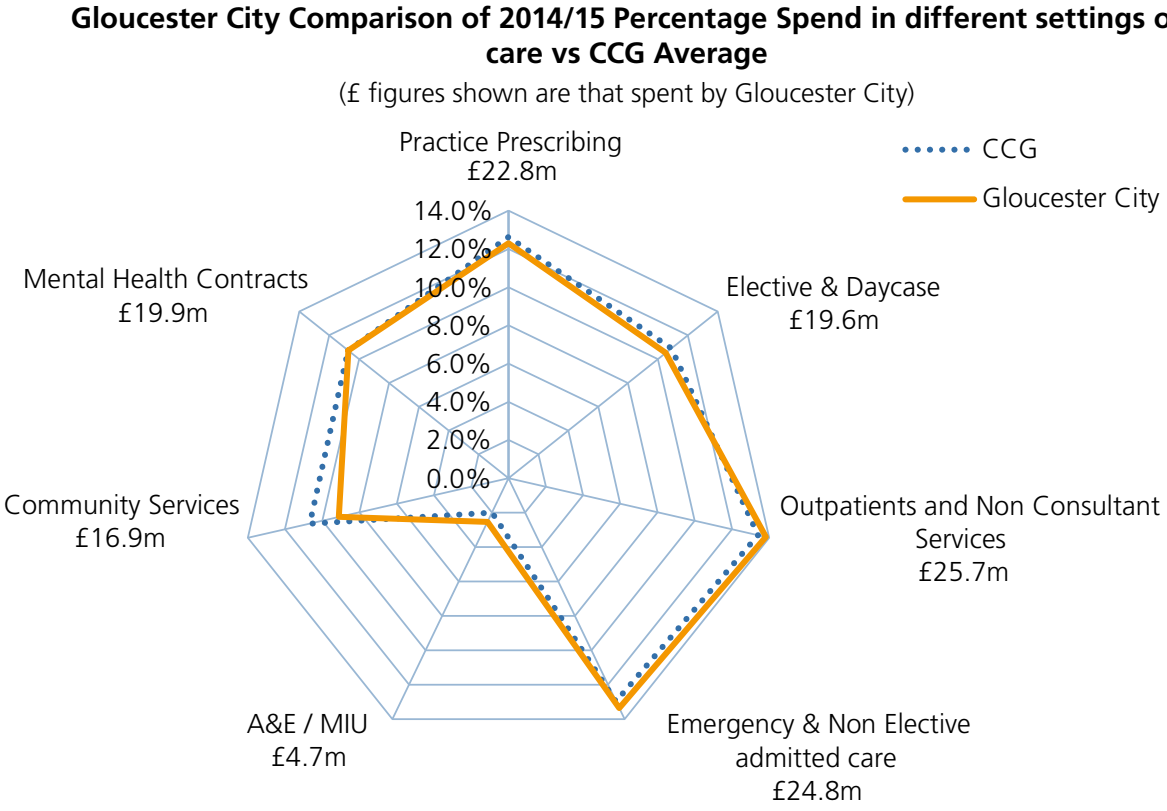
The charts below show the value and proportional split of the key spending themes for both CCG and the locality:

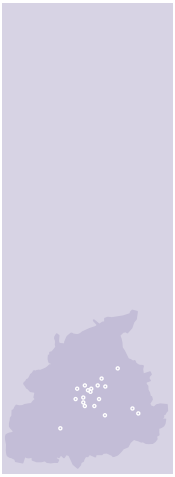
Gloucestershire CCG 14/15 Spending (£m) by area





NOTE: These charts exclude other areas of commissioning spend, such as maternity services, ambulance services, continuing health care, CCG running costs and reserves.

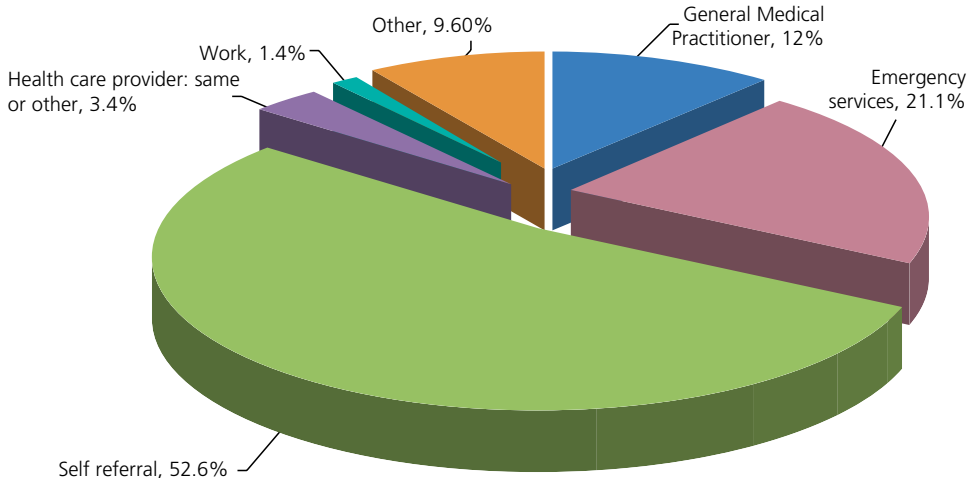




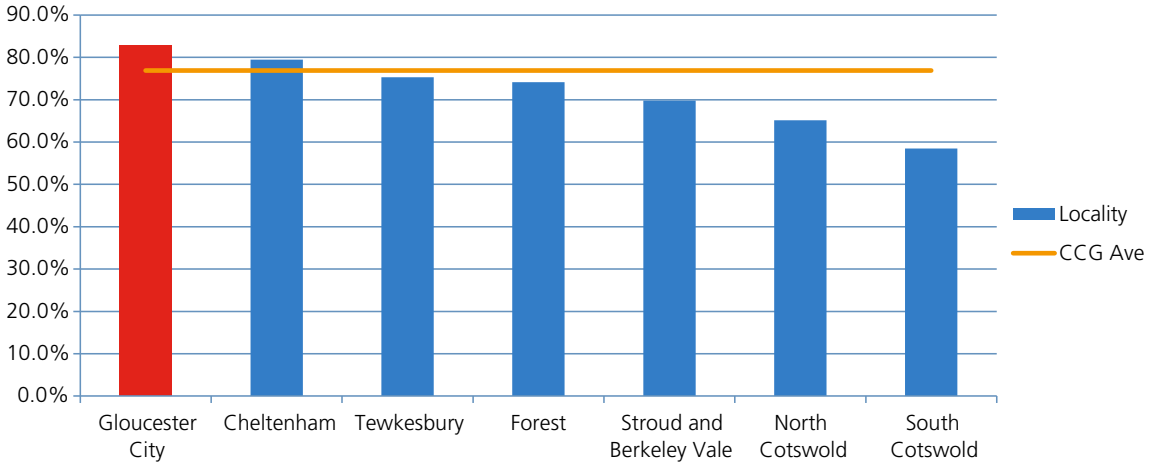
In the context of this wider financial picture CCG business intelligence (finance and information teams) have reviewed activity, performance and finance data from commissioned services to assess where there are significant variances from expected levels. Patients based in the Gloucester locality used the healthcare system approximately 13,688 attendances/admissions more than what was expected (109,199 attendances/admissions). These attendances/admissions have led to additional costs of nearly £2.6 million. This has highlighted areas for further consideration which we will be exploring to understand contributing factors work towards providing solutions which balance cost, value for money, quality and patient experience.

5.3.2 A&E / MIIU attendance

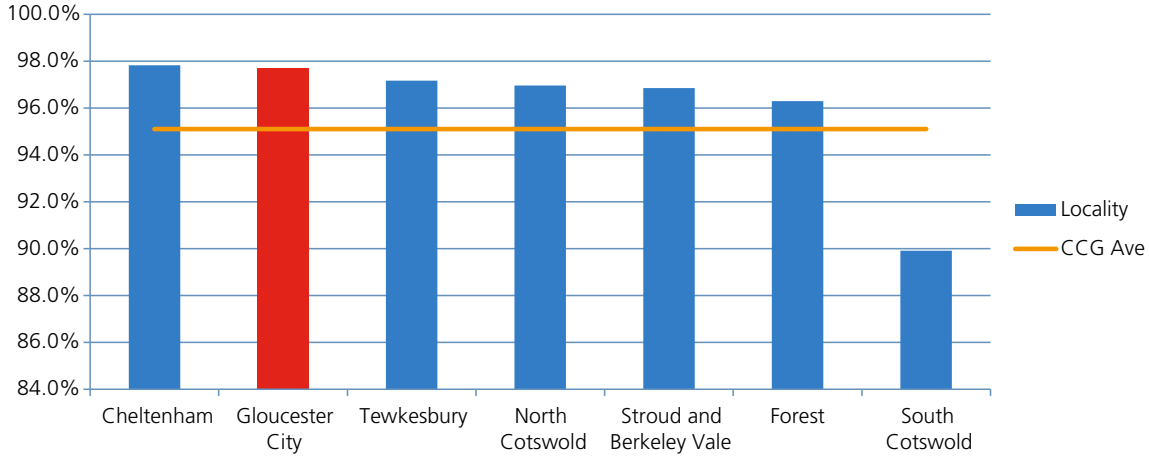
Gloucester City: Source of Referral to A&E/MIIU (All Providers 2014/15)



A&E: Percentage of Patients attending that only required Advice/Guidance (All Providers in 2014/15)



MIIU: Percentage of Patients attending that only required Advice/Guidance (All Providers in 2014/15)



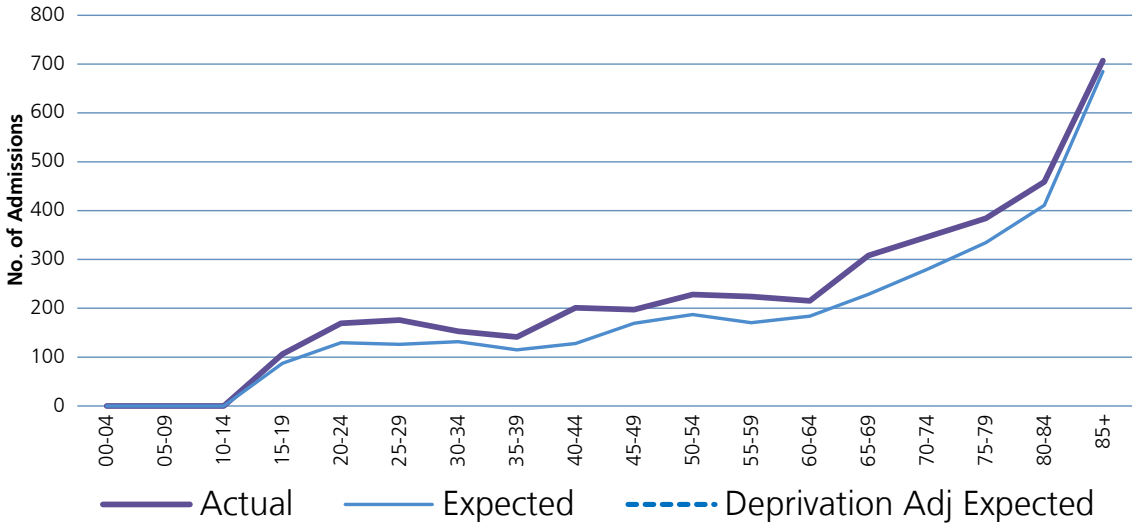
The above graphs demonstrate the utilisation of A&E and MIIU by patients within the Gloucester City locality. The charts suggest a majority of patients attend these services and receive advice and guidance only. The locality will work alongside countywide CCG programmes of work to best understand patient need and ensure appropriate services, engagement and communication is in place.

Gloucester city locality initiatives in this area include:

- Host locality for a successful Choice + pilot which has now expanded county wide across Gloucestershire
- Activity audits for A&E usage
- Supporting the introduction of General Practice at the Front Door to A&E
- Promotion of the ASAP app to practices and patients.

5.3.3 **Emergency General Medicine – admissions**

Practice Level Expected Level Counts v Actual m1-8 2014/15

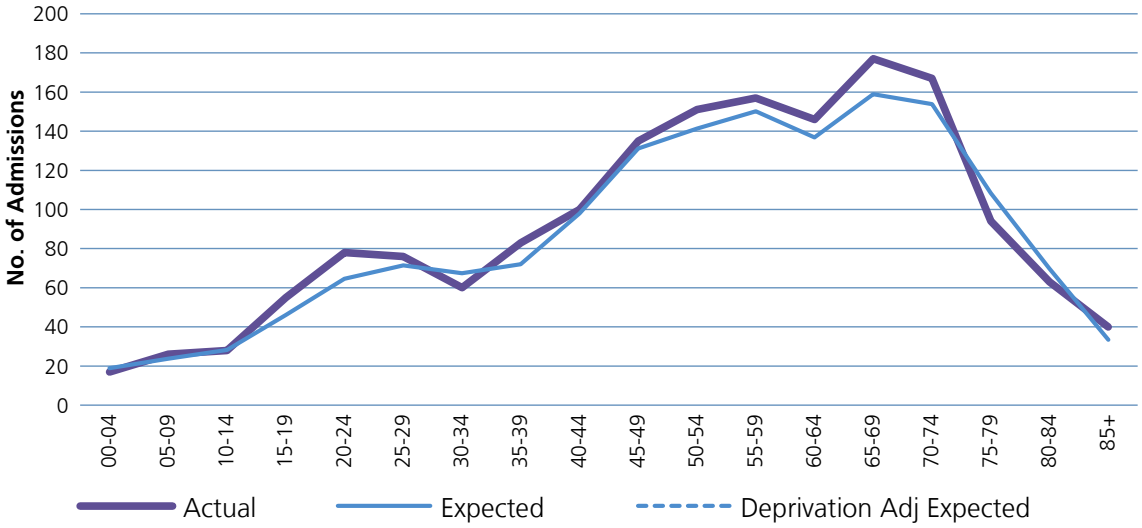


Spend and activity are both above expected levels for general medicine emergency admissions. 5049 admissions were expected in comparison to 6021 admissions (£7.9 million v £9.1 million). Diseases of the respiratory system are one of the largest contributors to this position, with twelve practices in the locality having spent above the expected level on these diseases.

Half of these practices had spent more than £20k more in the first 8 months of 2014/15 with one of them more than £90k above expected levels.

5.3.4 **Elective Trauma and Orthopaedics – Gloucester Locality**

Practice Level Expected Level Counts v Actual m1-8 2014



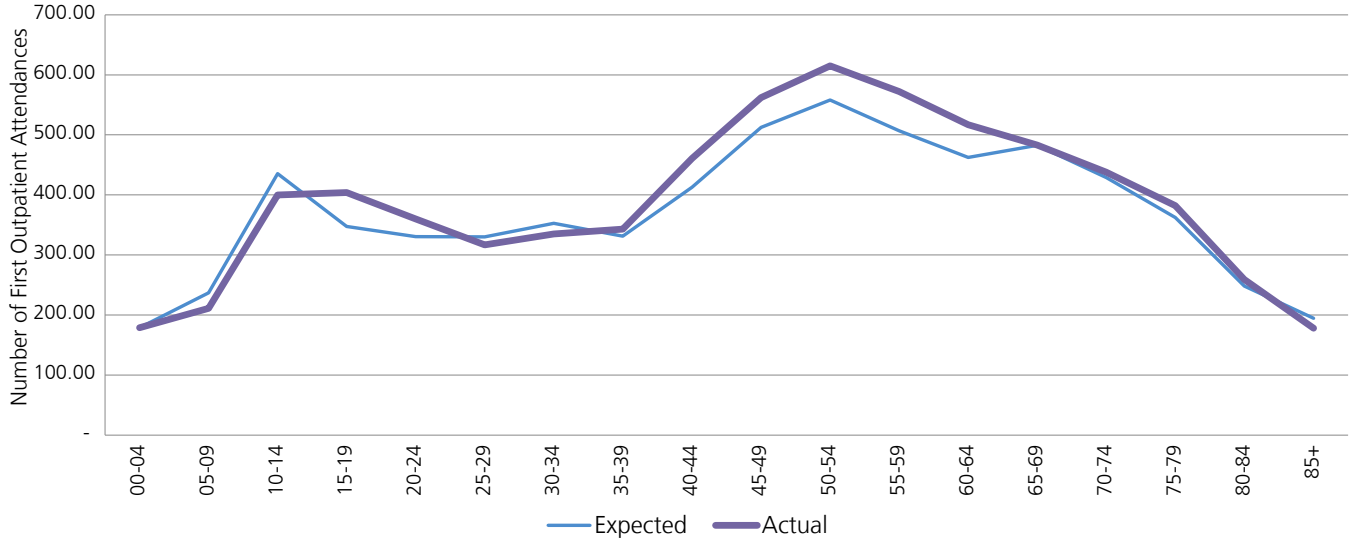
The locality shows higher activity and costs than expected for Trauma & Orthopaedic (T&O), Pain Management and Rheumatology elective admissions. T&O alone had 118 admissions above the expected level, costing £339k more than would be expected for the locality's population. 2362 expected admissions cost £6.53million and there were 2480 actual admissions costing £6.87million.

Thirteen practices in the locality have activity above expected levels, with seven of these being more than 10% above expected levels. This is an issue affecting a significant proportion of the locality's practices.

5.3.5 Outpatient appointments: Trauma & Orthopaedic, Pain Management and Rheumatology

First Outpatient Attendances

Practice Level Expected Level Counts v Actual (M-M8 2014/15)



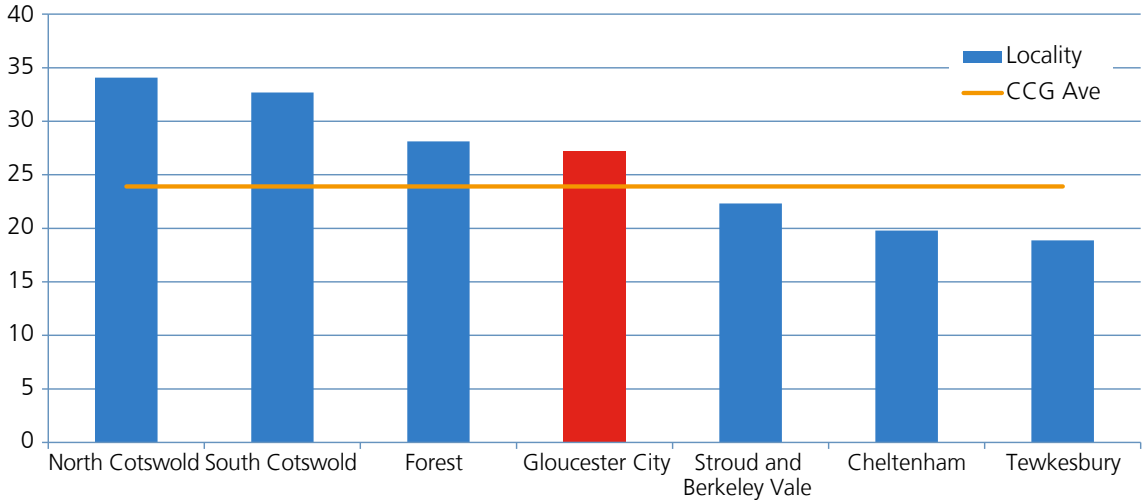
The specialties of Trauma & Orthopaedic, Pain Management and Rheumatology are also above expected levels for outpatient attendances, in addition to the elective admissions already reviewed.

Pain management outpatient attendances are above expected levels in all but two practices in the locality, with fourteen practices more than 10% above expected levels, and nine of them more than 25% above.

5.3.6 Outpatient appointments: Cardiology

GP Referred Outpatient: Cardiology Attendance

Rate per 1000 patients (All Providers 2014/15)



First Outpatient Attendances Cardiology – Gloucester
Practice Level Expected Level Counts v Actual (M1-M8 2014/15)

The trend chart in GP referred OP Cardiology appointments shows a steady trend over the last 2 years, with the locality consistently above the CCG rate.

All age bands over 25 show attendances are above expected levels for first outpatient appointments in the cardiology specialty. This is spread across most practices:

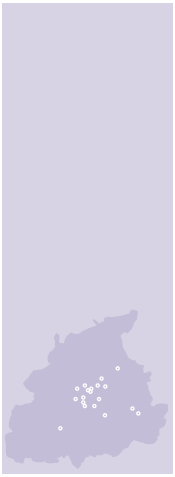
- Twelve practices are above expected levels for first attendances,
- Ten of these practices are more than 10% above expected levels
- Five of these practices are more than 25% above

For follow up appointments, fourteen practices are above expected levels, with nine of these practices more than 10% above expected levels.

5.4 'On the Ground' Feedback

The Gloucester city locality has developed strong relationships with patients through a locality stakeholder reference panel and with GP practices. Locality considerations 'on the ground' are detailed below:

- Access to counselling services in a faster timeline
- Better and faster access to children and adolescent mental health services
- Support for self-harm
- Access to GP appointments when GPs stretched by unprecedented demand levels and increasing chronic disease workload (including the unplanned admissions DES) and increasing work being devolved to primary care
- Obesity management – children and adult
- Long waiting times for cardiology outpatient department
- Stability of district nursing and health visiting teams for continuity and safeguarding
- Complex social challenges affecting health (housing/employment/financial/carer role)
- Increased reablement beds for access to avoid admissions especially frail elderly
- Capacity issues in tertiary centres pathways
- Quality and appropriateness of discharge from secondary care
- Transfer of unfunded work from secondary to primary care



Gloucester City locality GP's and practice managers also felt that it was important for all seven localities across the county to feedback into the CCG and demonstrably influence both clinical and financial priorities.

5.5 The identified priorities have been presented to the Locality Executive Group for them to consider and agree which key themes they would focus on for 2015 - 2017. Below is the plan on a page that has been developed to show the identified priorities initially presented from each contributor:

Gloucester City Locality priority Setting 2015-2017

Work plan delivery – continuing projects	
Social Prescribing	Locality
Immigration LES	Locality
Pharmacy Minor Ailments Scheme	Countywide
GP Front door of A&E	Countywide
ICT's and SPCA	Countywide
District Nursing	Countywide
Elderly Care/CHES	Countywide
GWC and Intermediate Care	Countywide
Better Care Fund	Countywide
Choice +	Countywide

Membership Engagement
Finance and Information reporting
Locality Operating Framework
Education and PLTs
Locality Forum
Practice visits and Feedback into CCG
Workforce development
Infrastructure/Premises Development
Practice Development
Sustainability/Stability of General Practice

Financial Variation
Emergency Admissions
A+E/MIIU attendances
Cardiology pathways
Orthopaedics, Pain management and Rheumatology pathways
Gynaecology

Clinical service developments
Menstrual Disorders
Gynaecology
Domiciliary health care assistants
Dermatology
Glaucoma Monitoring

Agreed priority themes
Glaucoma Monitoring
Locality and Practice financial variation
Health Promotion – Premature mortality CVD and respiratory, Suicide, Smoking, Diabetes and Obesity
Dermatology
Mental Health
Gynaecology – Menstrual Disorders
Domiciliary Health Care Assistants

Public Health Identified Indicators
Premature mortality – CVD
Premature mortality – Respiratory
Suicide – Males
Self harm – Females
Smoking
Obesity – Adults and Children
Diabetes

Locality Considerations
Mental Health – Child, Adolescent and Adult
Obesity Management – Child and Adult
Dermatology
Drug and Alcohol services for 'functioning' people
Primary care workload demand including increasing chronic diseases
Self Harm Support
Cardiology waiting times
Stability of health visiting and district nursing
Complex social issues – employment/carers/housing/finances
Increased requirement for reablement beds
Capacity issues in tertiary centres
Quality and appropriateness of discharge
Transfer of unfunded work from secondary to primary care

New Intelligence from planning session
Existing locality work and projects
Agreed priority themes for 2015-17

6 LOCALITY WORK PROGRAMME FOR 2015/16

6.1 We will be continuing a number of work streams to be rolled forward into 2015-2017, and will be exploring work streams to address some of the local health needs and issues identifying through our information gathering exercise in section five. With our CCG, GP Practice and other colleagues, we will work hard to address identified issues within the resources of the locality.

6.2 The locality work programme will be regularly monitored to assess progress, with a formal review at the CCG's Governing Body meeting every six months.

6.3 Recognising that we need to prioritise our work as a Locality, we have summarised what we aim to achieve in 2015/16 in the work programme below:

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (From CCG or Other Partners)	Expected Outcomes/Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Locality Schemes						
Social Prescribing Continue work with partners to grow and sustain a "Social Prescribing" scheme for Gloucester, offering patients access to a range of services to assist with social need.	Dr Will Haynes	Helen Edwards / Zaheera Nanabawa	• Increased utilisation of identified services in the locality closer to patient homes. • Reduced primary care appointments Improved patient well-being (WEMWBS) • Consistent social prescribing access for patients across the locality.	Gloucester City Council, The Independence Trust Local Voluntary and Community Sector organisations	Trial commenced December 2014 Increase social prescribing hub capacity for delivery September 2015	In current form at least until the end of July 2016
Pharmacy First – Minor Ailments	Dr Joan Nash	Chris Llewellyn	• Appropriate treatment provided to patients, without the requirement to visit GP practices. • Easing pressure on GP practices and A&E	GP practices and Pharmacies in locality, CCG Medicines Management team	Trial commenced November 2014	Trial continuing until March 2016
Patient and Stakeholder Locality reference panel	Dr Bob Hodges/ Dr Rachael Bunnett	Andrew Hughes/ Becky Parish	• Allow local voices to contribute to the development of local health and wellbeing services • To share and inform panel members of progress on projects	Patient participation groups, GP practices in locality, CCG Patient and Public Engagement team, local stakeholders including Politicians, Local Voluntary and Community Sector organisations	Established 2014	Ongoing Planned meetings three times a year

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (From CCG or Other Partners)	Expected Outcomes/Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Review and management of Gloucester City Practices utilisation of commissioned services	Dr Bob Hodges/ Dr Rachael Bunnett	Andrew Hughes	• In-depth analysis of data identified as a significant financial variation for locality and practice including: - Frequent Attenders - Emergency Admissions - Cardiology Pathways - Orthopeadic, pain management and rheumatology pathways - Gynaecology • Development of GP informed client approach to enable better relevance and understanding of data	CCG Business Intelligence, GP practices in locality	Commenced	Ongoing Fortnightly meetings
Review of Ethnic Minority Enhanced Service	Dr Bob Hodges	Andrew Hughes/ Zaheera Nanabawa	• Updating service specification • Assessing GP and patient requirements in relation to cultural diversity • Identify community based health interventions to increase levels of health • Support local GP practices with requirements in relation to diverse populations	GP practices in locality, patient participation groups, local stakeholders including community and voluntary organisations working with diverse individuals	Commenced April 2014	Ongoing
General Practice in the Front Door of A&E	Dr Irene Mawby	Andrew Hughes/Maria Metherall	• Assumed target of treating up to 30% of A&E attendances during operating hours	CCG Urgent Care team	Commenced December 2014	Ongoing
Membership Engagement and Development	Dr Bob Hodges	Andrew Hughes/ Zaheera Nanabawa	• Programme of practice visits with information packs provided to all practices, including variation data. • Understanding concerns and opportunities for practices	GP practices in locality, CCG Business intelligence - Alex Holland and Jeremy Gough	Commenced 2014	Ongoing

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (From CCG or Other Partners)	Expected Outcomes/Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Mental Health Working with existing mental health services to ensure appropriate access for patients in the locality	Dr Joan Nash	Andrew Hughes/ Zaheera Nanabawa	• Improve dialogue between GP's, psychiatrists, psychologists and mental health professionals within the locality. • Improve GP awareness of patient access into relevant mental health services through PLT event • Assess any potential gaps in locality provision for mental health	GP practices in locality, 2gether NHS Foundation Trust, Rethink, Turning Point, Local voluntary and community organisations, Gloucester City Council	April 2015	March 2017
Domiciliary Health Care Assistants For housebound/ temporary home based patients	Dr Joan Nash	Andrew Hughes/ Zaheera Nanabawa	• Practice lists of housebound patients regularly updated • Service requirements in place • Improved access to basic diagnostics such as phlebotomy	GP practices in locality, CCG Business intelligence, Gloucestershire Care Services	October 2015	October 2016
Community Cancer Pilot project for 'Living With and Beyond Cancer'	Dr Sadaf Haque	Sara Mathewson/ Nikki Hawkins	• Supporting Macmillan Community Cancer Care Service around successful implementation of project in the locality	Macmillan, GP practices in locality, Voluntary and community organisations	October 2015	September 2017
Developing Themes						
Health Promotion Exploring a place based approach to tackle health inequalities in a Gloucester city locality	Dr Will Haynes	Andrew Hughes/ Zaheera Nanabawa	• Tackling gender based health inequalities through community based initiatives in a deprived area of the city to reduce: premature mortality from CVD and respiratory illnesses, suicide, smoking, obesity and diabetes.	GP practices in locality, CCG Business intelligence, local voluntary and community organisations	November 2015	November 2016
Glaucoma Monitoring	Dr Bob Hodges	Andrew Hughes/ Zaheera Nanabawa	• Development of a community based Glaucoma monitoring service • Reduce impact on secondary care	GP practices in locality, CCG Business intelligence	April 2015	August 2016

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (From CCG or Other Partners)	Expected Outcomes/Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Dermatology	Dr Irene Mawby	Andrew Hughes/ Zaheera Nanabawa	• Assessing dermatology referrals from Gloucester City locality practices • Exploring use of dermatoscopes in primary care	GP practices in locality, CCG Business intelligence		
Gynaecology	Dr Rachael Bunnett	Andrew Hughes/ Zaheera Nanabawa	• Exploring the impact on secondary care following the closure of a local GP led menstrual disorders clinic in 2014	GP practices in locality, CCG Business intelligence,		
Palliative Community Care	TBC	Andrew Hughes/ Zaheera Nanabawa	• Ensure professionals are aware of overnight 'sitting' service to support patients at risk of admission to hospital • Access to a bed, for example in a specifically identified nursing home(s), when a patient experiences problems with symptom control and/or a 'crisis' • More focused and specific use of the third sector services and support	GP practices in locality, CCG Business intelligence, local voluntary and community organisations		
Workforce Development	Dr Bob Hodges	Andrew Hughes/ Zaheera Nanabawa	• Exploring increased use of physician associates and pharmacists to: • Reduce pressures on GP workload • Encourage a shared skill set approach in practices • Increase efficiency of GP practice resource • Development of practice nurses	Regional universities and accredited bodies, GP's in the locality, Health Education England South West (HEESW)	April 2015	Ongoing

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (From CCG or Other Partners)	Expected Outcomes/Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Physical Activity	Dr Rachael Bunnett	Andrew Hughes/ Zaheera Nanabawa	• Encouraging use of Couch to 5k approach for patients in primary care – by creating awareness of local offers on Health Walks and Park Run. • Working with local partners on the health legacy from the Rugby World cup 2015.	GP practices, Voluntary Organisations, Gloucester City council, Tewkesbury Borough council		
CCG countywide projects Supporting practices to implement CCG projects and work programmes into the locality and influencing those programmes with feedback from the locality.	Dr Will Haynes/Dr Bob Hodges	Andrew Hughes/ Zaheera Nanabawa	Locality GP awareness and implementation of CCG projects including:	Various CCG Lead GPs/ Managers	Ongoing	Ongoing
		Julia Tambini	• Prime Ministers Challenge Fund: Choice +, Skype, e-Consult	Gloucestershire GP provider company (GDoc)		
		Helen Edwards	• Integrated Community Teams • Rapid Response	CCG + Gloucestershire Care Services		
		Andrew Hughes	• Infrastructure/ Premises Development	CCG		
		Bronwyn Barnes	• Variation Programme	CCG		
		Gina Mann	• Care Pathways Website (G-Care)	CCG		
		Dominic Fox	• Joining up Your Information (care record)	Central Southern Commissioning Support Unit		
		Helen Goodey	• Primary Care Offer	CCG		
		Gill Bridgland	• Discharge Reviews			

Dr Bob Hodges Chair – Gloucester City Locality

June 2015

NHS
Gloucestershire
Clinical Commissioning Group

Cheltenham Locality Development Plan 2015-17

Foreword

Over the last 2 years Cheltenham Locality Executive has developed two-way engagement with its member practices, demonstrated by ongoing full attendance at locality meetings, and with our patients through existing Patient Participation Groups. This engagement has been further strengthened for Cheltenham by the appointment of a representative on the Clinical Commissioning Group (CCG) Governing Body – Dr Sadaf Haque who was voted by her peers to become the Liaison Lead between the CCG and the locality.

The Cheltenham Locality Executive has worked openly and collaboratively with all member practices during the past two years to review areas of variation. As a consequence, based on work undertaken by Leckhampton Surgery, the locality decided to carry out an audit across all Cheltenham practices looking into medication reviews following a fall, with the aim of reducing the overall anti-cholinergic load of prescribing in the elderly. This has proven to be extremely successful and beneficial to our patients, and is representative of how Cheltenham practices have come to work together.

The Locality Executive have also arranged a number of learning events for our Cheltenham GPs during the past two years, some of which are mandatory such as Safeguarding for Children and others which are particularly pertinent to the locality such as raising awareness of suicide. We intend to continue this approach during the next two years and have planned the programme.

The locality has taken a holistic approach to supporting our patients and we are working with other organisation's including Cheltenham and Tewkesbury Borough Councils, Public Health through Gloucestershire County Council and a number of voluntary and community sector organisation's to bring a more coordinated approach to the care we provide our patients. This plan takes account of the varied demographics of our population and also reflect and support the wide-spread deprivation across Cheltenham as identified by Public Health.

We expect to see the population of Cheltenham grow significantly over the next 20 years and therefore we recognise that we need to think differently as to how we can deliver and improve services at a local level.

The Cheltenham Locality Executive believe that with the continuing support of the Cheltenham practices, they have been able to localise the commissioning provision of better health care for their population which has enabled them to make a real difference during the last two years. It is our intention to build on this progress for 2015 - 17 and these are described in detail within this document.

Dr Will Miles

Locality Executive Chair

Cheltenham Locality Executive

September 2015

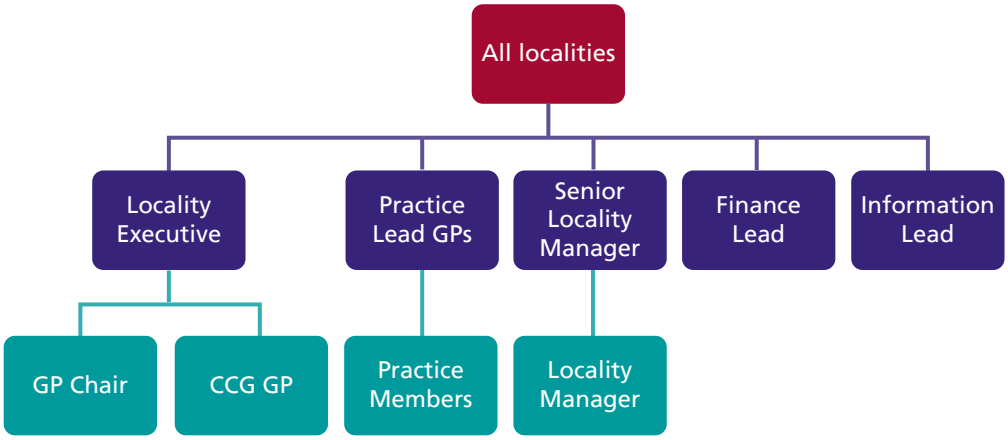
1 Purpose

1.1

This Locality Development Plan has been produced to describe the specific health needs for the population of Cheltenham, and sets out how the Locality Executive Group will lead work to address these needs over the next two years.

2 Background

2.1 The county of Gloucestershire covers a diverse range of populations, from the very deprived to the very affluent, from people living in very rural areas to people living in one of two large urban areas where there are a significant number of immigrant populations. This leads to a countywide population with very different health and social care needs, spread over a large geographic area. In recognition of the need to understand and represent these differences, the CCG has formed seven localities; one of these is for the Cheltenham area. In each locality, lead GPs work alongside key partners to help determine how best to meet the needs of its population, informing the wider work of the CCG; this is known as the Locality Executive Group. The structure of localities is shown below:



For our Locality, these roles are:

- Locality GP Chair — Dr Will Miles
- Locality CCG GP Liaison Lead — Dr Sadaf Haque
- GP Practice Leads:
  - Berkeley Place Surgery — Dr Simon Ryley
  - Corinthian Surgery — Dr Julie Jackson
  - Crescent Bakery Surgery — Dr Mark Trueman
  - Leckhampton Surgery — Dr Martin Nicholas
  - Overton Park Surgery — Dr Julian Wilson
  - Portland Practice (The) — Dr Will Miles
  - Royal Crescent Surgery — Dr Roger Williams
  - Royal Well Surgery — Dr Phil Fielding
  - Seven Posts Surgery — Dr Nick Young
  - Sixways Clinic — Dr Graham Mennie
  - Springbank Surgery — Tbc
  - St Catherine's Surgery — Dr Graham Wilson
  - St George's Surgery — Dr Adam Gillett
  - Stoke Road Surgery — Dr Jim Moore
  - Underwood Surgery — Dr Robin Hollands
  - Yorkleigh Surgery — Dr Andrew Green
  - Winchcombe Medical Centre — Dr Charles Inman

CCG Locality Support

- Senior Locality Manager — Helen Goodey
- Locality Development Manager — Cheryl Ewing
- Finance Lead — Stephen Ball
- Information Lead — Chris Roche/Simon Curtis

The key functions of a locality are:

Planning	Service change delivery	Engagement and relationships
Reviewing health needs, patient insight	Locality specific projects	Utilising/ shaping practice level patient participation groups
Shaping CCG Plans	Local implementation of CCG wide initiatives	Developing links with key community groups
Local delivery plan	Joint initiatives with local partners	Key stakeholders/ partners

Participation	Quality, utilisation and performance	Locality organisational development
Operation of committees, groups and protected learning time	Review locality performance information and take necessary action	Supporting the development of local membership model – e.g. what does greater federation feel and look like
Encouraging wide membership engagement	Understanding variations	Development between localities and the Governing Body
Practice visits and individual membership opportunities	Improving quality and performance	Developing the locality executive

2.2 This document will seek to describe the local health needs for the Cheltenham locality as it is clear that our population has specific health needs to be addressed. The Public Health team within our Local Authority has supported us to identify and understand these needs. The locality is now working to provide positive solutions to meet these needs.

2.3 In accordance with national requirements and working with partners and stakeholders (including patients, carers and the public), the CCG has formulated a five year strategic plan for Gloucestershire – Joining Up Your Care. This is supported by a more detailed two-year operational plan that identifies our more immediate priorities, from April 2014. They remain within the overall umbrella of the Health and Wellbeing Strategy ('Fit for the Future') that sets out the priorities for improving health and outcomes for the people of Gloucestershire from 2012 - 2032.

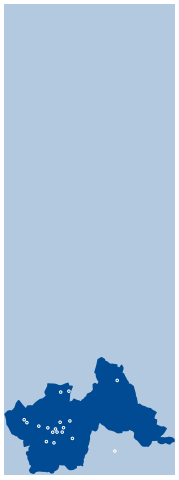
Joining Up Your Care –
Our Shared Vision for the next 5 years:

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

Our Ambitions:

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

2.4 This Locality Development Plan must be seen in the context of these important strategic documents. Projects and initiatives identified will be complementary to this strategic context and the CCG's Operating Plan. This Locality Development Plan therefore fits within this wider context as follows:



2.5 To identify the health needs of the population of the Cheltenham locality, three main sources of information have been identified:

- Public Health Intelligence;
- Activity, performance and financial data on the use of services, highlighting those areas where the locality is significantly at variance. This analysis has included consideration of benchmarking data and information on variation between usage of health care at a GP Practice population level;
- 'On the ground' intelligence – i.e. conversations with local colleagues who are working directly with patients to understand their views about need.

2.6 The Locality Executive Group will work closely with key stakeholders to identify the health and social care needs of the local population, prioritise actions, and provide ideas for how these needs could be addressed. These stakeholders include:

- Local GP Practices and their staff;
- Gloucestershire Care Services;
- Gloucestershire Hospitals NHS Foundation Trust;
- [2]gether NHS Foundation Trust
- Gloucestershire County Council;
- Cheltenham Borough Council;
- Tewkesbury Borough Council;
- Local voluntary organisations;
- Patients and their representatives (through practice Patient Participation Groups);
- CCG colleagues

2.7 Whilst assessing the evidence gathered around local health needs, the Locality Executive Group has also taken into consideration the variety of existing work streams within the CCG's countywide Clinical Programme Groups (CPGs), and the range of projects which encourage improvements in 'Quality, Innovation, Productivity and Prevention' (QIPP) – to ensure locality initiatives are complementary or supporting and influencing countywide schemes. This will allow for a continuous feedback loop where successful learning from locality projects can be embedded into the CPGs, and also from the CPGs into the locality.

3 Key Achievements to date

3.1 Key achievements of the Cheltenham locality from the previous 2013 - 2015 plan are detailed below:

3.1.1 Care Home Zoning

All practices have continued to support care/nursing home zoning whereby each GP practice has been aligned to a number of care/nursing home/s. This has improved the continuity of care and clinical outcomes for those patients in a care/nursing home, and enabled the practices to develop a relationship with care/nursing home staff. Due to the number of care/nursing home/s premises within the Cheltenham locality, this has ensured practices visits are more manageable for GP staff.

3.1.2 Electronic Prescribing

The roll-out of electronic prescribing across all practices working with local pharmacies was completed by end June 2015 when the technical infrastructure was applied to enable prescribers and dispensers to operate the service. Training has been offered to GP practices and pharmacies to ensure business continuity during this change.

On the whole the deployment has gone well from the outset as practices have been pragmatic about understanding the inherent challenges posed by a change in systems and process and will now take forward Phase II of the project during 2015 - 16.

3.1.3 Alcohol Attendances at A&E

A review of alcohol attendances at A&E was undertaken in collaboration between Gloucestershire Hospitals, the Commissioning Support Unit, Public Health and Cheltenham GP practices to understand if any additional support could be provided in primary care.

The GP Project Lead wrote to the five practices identified as having the highest A&E attendances relating to alcohol, offering the opportunity to have in-house appointments for their patients from Turning Point who provide specialist and integrated services for patients needing additional support around their alcohol intake.

3.1.4 Greater Awareness of Suicide

An education programme was developed to support Cheltenham GPs in tackling the relatively high suicide levels in the locality. This involved multi-agency experts including Public Health and [2]gether Trust. This gave an overview of:

- Existing Childrens' & Young Peoples Services;
- National picture of suicide and national factors presented by speakers from [2]gether Trust.

As well as working with [2]gether Trust and Public Health, the Locality Executive has also identified which Voluntary & Community Sector organisations are able to provide extra support in order that practices have the confidence to refer/signpost their patients to those organisations.

3.1.5 Social Prescribing

The Locality Executive developed a joint working approach with Cheltenham Borough Council (CBC) and Cheltenham Partnerships (CP) in the development of a locality social prescribing scheme. The Locality Executive worked collaboratively with CBC and CP to identify and meet with local Voluntary & Community Sector organisation's: namely: Alzheimer's Society, Carers' Gloucestershire, County Community Projects, Gloucestershire Lifestyles, Gloucestershire Rural Community Council and Third Sector Services who had the capability and capacity to support the service user (patient).

The pilot initially ran in 2 GP Practices with roll-out across all practices by the beginning of 2015. Referrals have steadily increased showing the benefits of the scheme, especially for those who received support around social isolation, housing, financial advice and mental health and wellbeing.

Following a countywide evaluation by Public Health it has been agreed by all practices through their GP provider organisation, to adopt an 'in-practice' model going forward whereby practice staff will be able to make a referral to the Social Prescribing Coordinator who will be based in the practice for one/two sessions per week.

3.1.6 Patient Participation Groups (PPGs)

PPGs routinely hear about patients' experiences: perspectives of existing services and about what developments the local community feel would be useful. In the light of this, the Locality Executive sought PPG's thoughts on the priorities in the Locality Development Plan (LDP) for 2013 - 15, along with any issues they would like to highlight, and feedback from patients who may have benefitted from these schemes.

A final report was drafted providing a brief overview of the feedback from those practices who responded which has been reflected within this 2015 - 17 Locality Development Plan.

3.1.7 Locality Executive Engagement

The Locality Executive regularly meet with individual practice leads on a rolling programme throughout the year, as well as organising quarterly meetings whereby all practices send a GP or Practice Manager representative which ensures the voice of local practices are heard and reflected within the work programmes and priorities. The Protected Learning Time events are also seen as an opportunity for GPs to meet and undertake continuous professional development which support the locality priorities.

Locality practice finance and information variation reporting has also been used to inform the Locality Executive's decision making. Member practices have contributed to the countywide clinical programme of work, which through the planning process for 2015 - 17 shows where the locality's focus will be.

3.1.8 Key Relationships

The Locality Executive has developed key relationships and joint working with Cheltenham Borough Council (CBC) through:

- Membership of the Strategic Partnership Board (SPB) which tackles the issues that determine wellbeing and quality of life in the community – such as crime, jobs, education, health, and housing. To support this initiative, representatives from Gloucestershire County Council, the Chief Executive of CBC, Fire & Rescue, Gloucestershire Probation, Gloucestershire Police Authority and businesses have all worked together;
- CBC Strategy & Engagement Manager attends Locality Executive meetings on a quarterly basis;
- CBC have supported and contributed to the Cheltenham Social Prescribing initiative from inception;
- Discussions have been held with the Planning department regarding the Joint Core Strategy for 2012 - 2031, particularly focusing on primary care support.
- Working with the Alcohol Co-ordination Group in order to reduce the harm that alcohol causes in Cheltenham by co-ordinating partnership activity that reduces health harms, crime and disorder and the related harm to families and communities.

3.2 Prime Minister's Challenge Fund

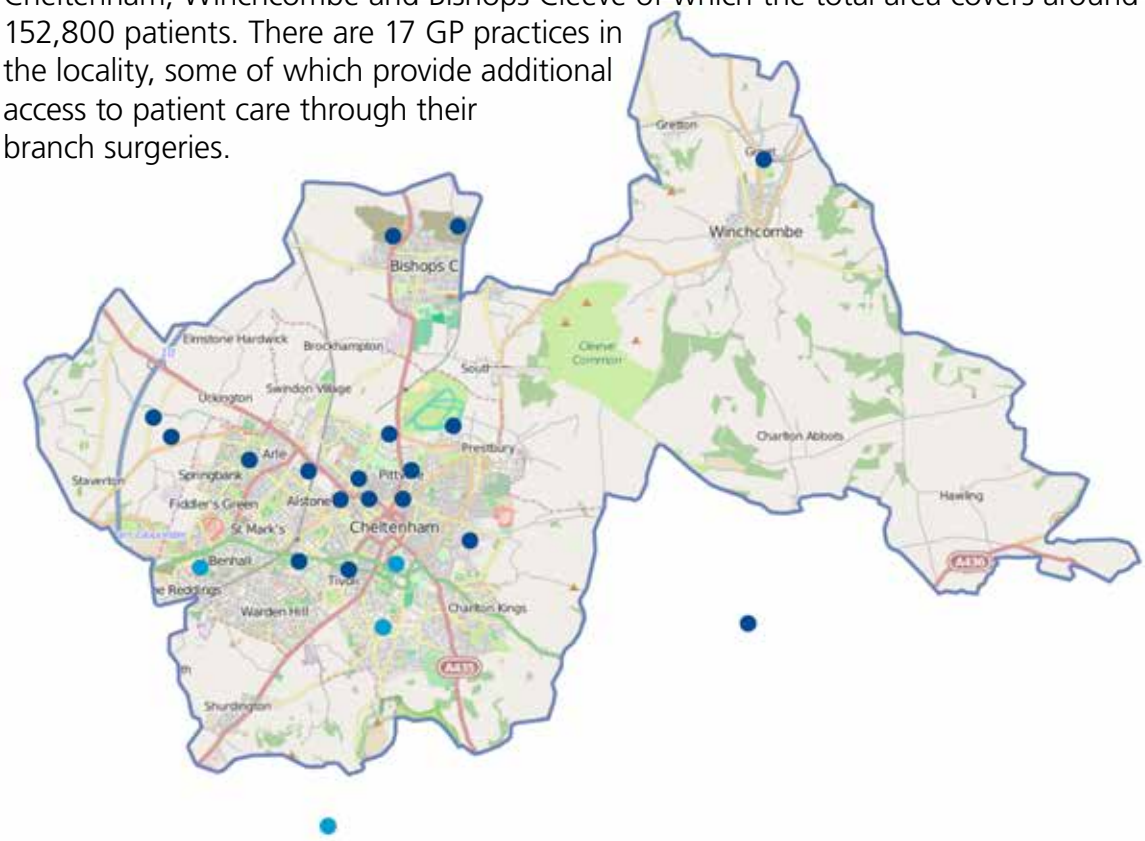
3.2.1 GPs from all localities have been key contributors to a successful application for the Prime Ministers Challenge Fund (PMCF) relating to improving access to general practice, thanks to joint working between the GP provider organisation, Gloucestershire Doctors (G-DOC) and the CCG.

3.2.2 In securing this £4m of additional national funding, localities will be supporting the delivery of providing local people with improved access to GP services in Gloucestershire. This includes the creation of 100,000 appointments a year across all localities to free up time in surgeries to be used on more planned and complex work with patients who have a long term condition. The bid also included greater use of technology, additional specialist nursing, case management and social prescribing.

3.2.3 A Delivery Board has been established to make key decisions and will include representation from each of the seven Gloucestershire localities.

4 Local Service Provision

4.1 The Cheltenham locality covers mainly an urban population comprised of Cheltenham, Winchcombe and Bishops Cleeve of which the total area covers around 152,800 patients. There are 17 GP practices in the locality, some of which provide additional access to patient care through their branch surgeries.



- Berkeley Place Surgery, 11 High Street, Cheltenham GL52 6DA
- Corinthian Surgery, St Paul's Medical Centre, 121 Swindon Road, Cheltenham GL50 4DP
- Crescent Bakery Surgery, St Georges Place, Cheltenham GL50 3PN & Hesters Way Healthy Living Centre, Hesters Way Community Resource Centre, Cassin Way, Cheltenham GL51 7SU
- Leckhampton Surgery, Lloyd Davies House, 17 Moorend Park Road, Cheltenham GL53 0LA
- Overton Park Surgery, Overton Park Road, Cheltenham GL50 3BP
- Portland Practice (The), St Paul's Medical Centre, 121 Swindon Road, Cheltenham GL50 4DP & The Up Hatherley Surgery, Glebe Farm Court Road, Up Hatherley, Cheltenham GL51 5EB
- Royal Crescent Surgery, 11 Royal Crescent, Cheltenham GL50 3DA
- Royal Well Surgery, St Paul's Medical Centre, 121 Swindon Road, Cheltenham GL50 4DP
- St. Catherine's Surgery, St Paul's Medical Centre, 121 Swindon Road, Cheltenham GL50 4DP & Hesters Way Healthy Living Centre, Hesters Way Community Resource Centre, Cassin Way, Cheltenham GL51 7SU
- St George's Surgery, St Paul's Medical Centre, 121 Swindon Road, Cheltenham GL50 4DP
- Seven Posts Surgery, Prestbury Road, Cheltenham GL52 3DD & Greyholme Surgery, Church Road, Bishops Cleeve GL52 8LT
- Sixways Clinic, London Road, Charlton Kings, Cheltenham GL52 6HS & 40 Station Road, Andoversford, Cheltenham GL54 4LA
- Springbank Community Resource Centre, Springbank Way, Cheltenham GL51 0LG & Hesters Way Healthy Living Centre, Hesters Way Community Resource Centre, Cassin Way, Cheltenham GL51 7SU
- Stoke Road Surgery, 4 Stoke Road, Bishops Cleeve, Cheltenham GL52 8RP
- Yorkleigh Surgery, 93 St.George's Road, Cheltenham GL50 3ED
- Winchcombe Medical Centre, Greet Road, Winchcombe, Cheltenham GL54 5GZ
- Underwood Surgery, 139 St. George's Road, Cheltenham GL50 3EQ & University of Gloucestershire, The Park Medical Centre

Other Providers

- Cheltenham General Hospital, Sandford Road, Cheltenham GL53 7AN
- Colbalt Unit, Linton House, Thirlestaine Road, Cheltenham GL52 7AS
- Nuffield Hospital (NHS Services), Hatherley Lane, Cheltenham GL51 6SY
- National Star College, Ullenwood Manor, Ullenwood, Cheltenham GL53 9QU
- Charlton Lane Clinic, Charlton Lane, Leckhampton, Cheltenham GL53 9DZ

4.2 The approximate Practice list sizes are as follows:

Practice Name	Patient List Size as at 1st April 2015
Berkeley Place Surgery	7,692
Corinthian Surgery	8,694
Crescent Bakery Surgery	5,980
Leckhampton Surgery	12,745
Overton Park Surgery	11,611
Portland Practice	13,741
Royal Crescent Surgery	6,988
Royal Well Surgery	6,728
Seven Posts Surgery	10,027
Sixways Clinic	10,871
Springbank Surgery	1,745
St Catherine's Surgery	9,864
St George's Surgery	10,185
Stoke Road Surgery	9,839
Underwood Surgery	10,344
Winchcombe Surgery	6,849
Yorkleigh Surgery	9,023

4.3 In addition to the main acute hospitals in Gloucester and Cheltenham and the GP Practice sites, local NHS health services are also delivered from:

- Charlton Lane Clinic: Elderly Mental Health;
- NHS Services provided by Nuffield Hospital;
- Cobalt Unit: Cancer Services;
- Emersons Green NHS Treatment Centre;
- University of Gloucestershire;
- National Star College; and
- AQP diagnostic providers.

4.4 For patients living in any part of Gloucestershire their health issues are often closely linked to other 'social' factors, such as employment, education, and housing. We are committed to working in partnership with the Local Authority and third sector partners to both find and implement solutions. Therefore, the CCG also commissions a range of services from the local Voluntary and Community Sector.

5 What are the issues we face and how will we address them?

5.1 Overview

Over the last few months' colleagues from across Public Health, Local Councils and the CCGs Finance and Information teams have held planning meetings to work together to identify which potential priorities the locality may want to consider based on relevant data.

5.2 Public Health Information

The Local Authority in Gloucestershire produces a Joint Strategic Needs Assessment (JSNA) – this highlights the medical conditions that particularly affect the population of the county and its localities. It also highlights population changes over the coming 20 years.

It should be noted that two of the Cheltenham locality practices fall within Tewkesbury Borough Council. However, for the purposes of this review, the Public Health data is based on the Cheltenham Borough Council area footprint.

5.2.1 Demographics

Overall the health population of the locality has a slightly younger profile than the CCG average, however, several practices have an older demographic. The locality has the highest number of registered patients aged 65 plus and 85 plus in the county which is likely to mean more patients with age related long term conditions. The locality is projected to see above average growth in 0-17 year olds through to 2021 (15.6% compared to a county average of 9.5%). Compared to the county as a whole, Cheltenham has above average levels of patients from non-white ethnic groups.

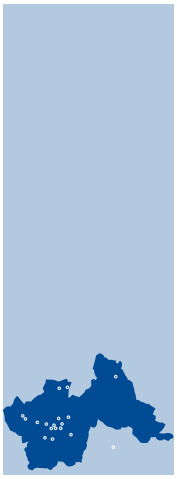
5.2.2 Deprivation

Nine practices have practice deprivation scores above the county average of 14.7; rising to a score of 31. People living in more deprived areas tend to have a greater need for health services.

5.2.3 Public Health Outcomes

The life expectancy gap between the least deprived quintile and the most deprived quintile is 9.2 years in men and 7.3 years in women. This is not altogether unexpected in an urban area with significant pockets of deprivation.

Public Health have also identified excess winter deaths as a priority for the Cheltenham Borough, which the locality will engage with Cheltenham Borough Council and Cheltenham Borough Homes partner organisations to support wherever possible.



5.3 Cheltenham & Tewkesbury Borough Councils

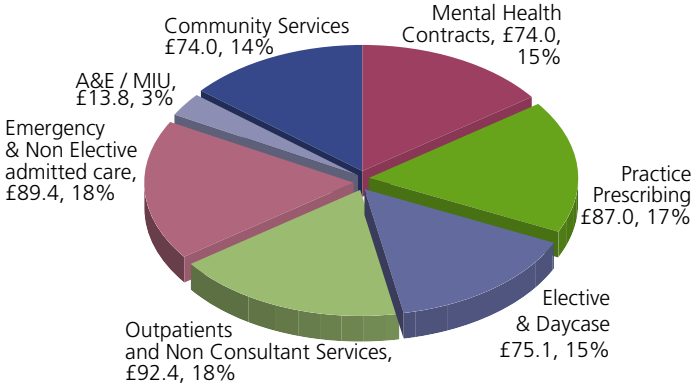
Cheltenham and Tewkesbury Borough Councils contribute to the Joint Core Strategy (JCS) for Gloucestershire to produce a co-ordinated strategic development plan to show how the area will develop during the period up to 2031. Cheltenham will see an additional 9,500 dwellings developed during this period for which the locality GP practices will be required to provide primary care services for a significantly increased population. At present Cheltenham are also attracting a number of Care Home/Assisted Living providers which has the potential to further increase demand on primary care provision.

5.4 CCG Finance and Information Data

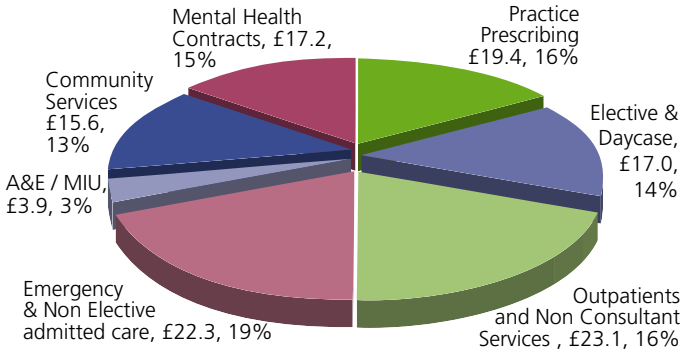
5.4.1 Analysis of NHS resource utilisation demonstrates variation exists not just at a CCG level, but also between and within localities. In addition, the CCG has specific performance issues along with finite financial resources, which, as a membership organisation, the locality can support with.

The charts below show the proportional split of the key spending themes for both Gloucestershire CCG and the locality:

Gloucestershire CCG 14/15 Spending (£m) by area

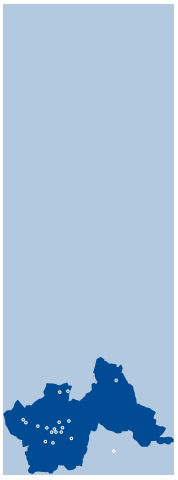


Cheltenham 14/15 Spending (£m) by area



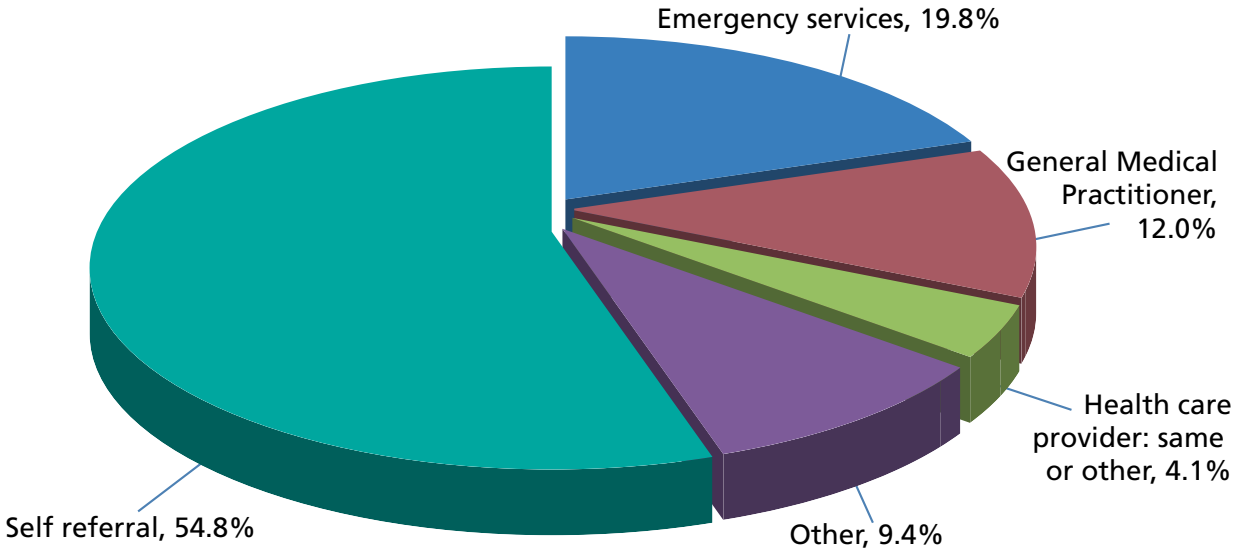
NOTE: These charts exclude other areas of commissioning spend, such as maternity services, ambulance services, continuing health care and placements, acute block contracts, CCG running costs and reserves.

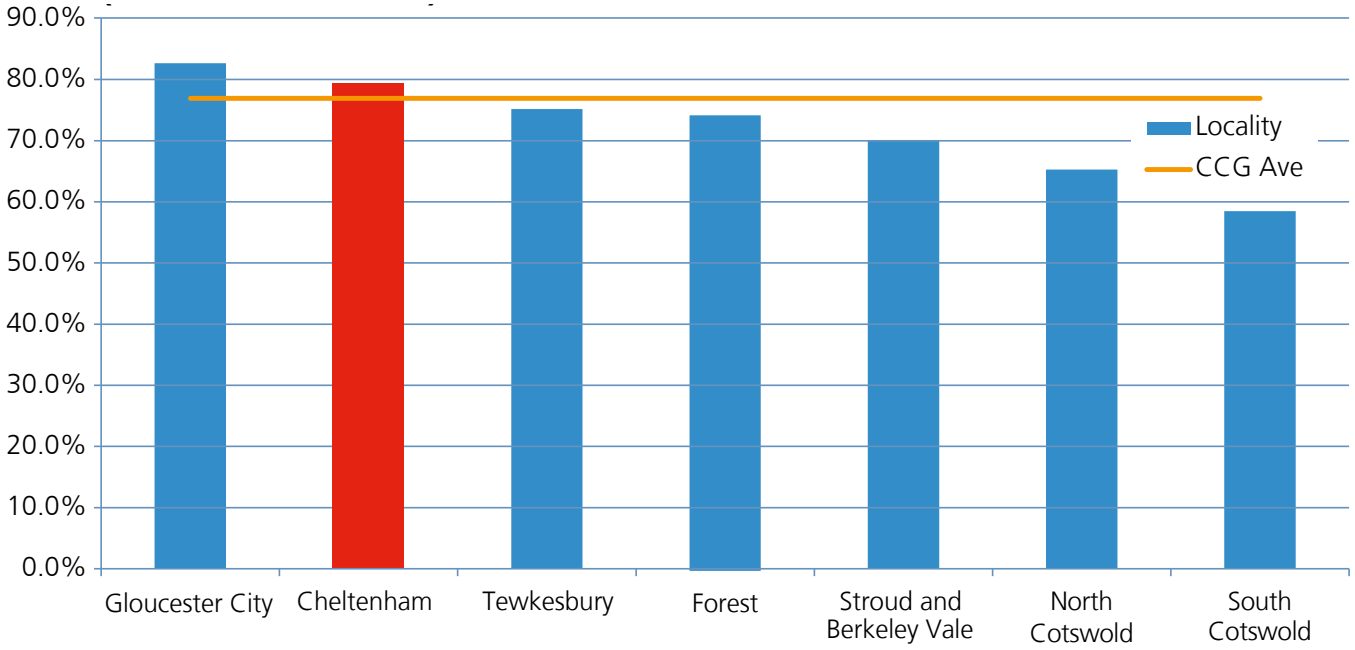
In the context of this wider financial picture, the business intelligence team has reviewed activity, performance and finance data from commissioned services to assess where there are material variances from expected levels, this has highlighted areas for further consideration.



5.4.2 **A&E**

Cheltenham: Source of Referral to A&E (2014/15)



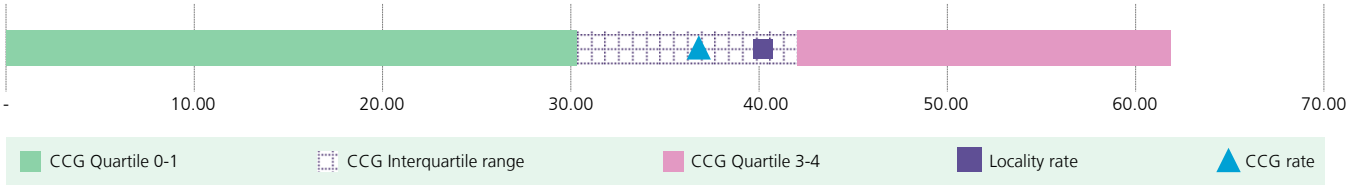


A&E: Percentage of Patients attending that only required Advice/Guidance (All Providers 2014/15)

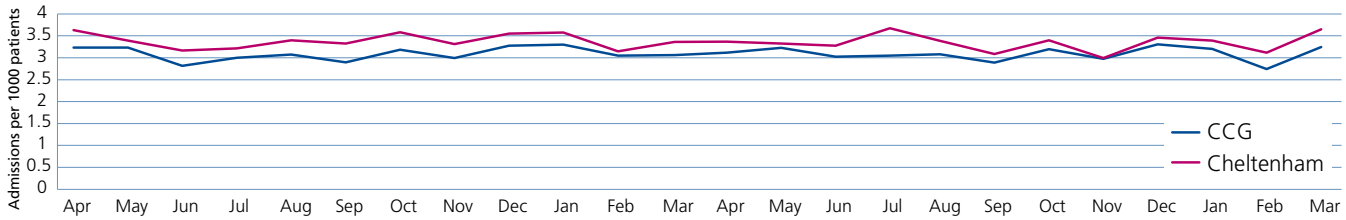
The above graphs demonstrate the utilisation of A&E and MIIU by patients within the Cheltenham locality. The first chart shows that more than 50% of attendances are self referrals by patients, with referral by GP the third largest group. The second chart suggests a majority of patients attending these services receive advice and guidance only. The locality will work alongside the CCG programmes of work to best understand patient need and ensure appropriate services, engagement and communication is in place

5.4.3 Emergency admissions: General Medicine

Cheltenham General Medicine Emergency Admissions rate per 1,000 population comparison (2014/15 All Providers)



Trend Graph of General Medicine Emergency Admissions per 1000 patients April 2013 - March 2015: Cheltenham v CCG



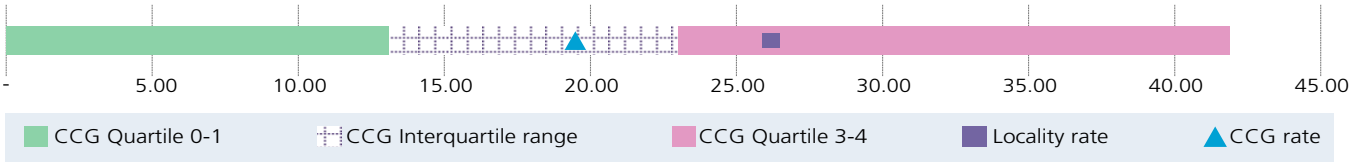
The emergency admission rate for General Medicine in Cheltenham practices, measured per thousand patients, is above the CCG average, with the two year graph suggesting this is a long term trend.

An initial analysis of this data shows that emergency admissions for diseases of the circulatory systems and diseases of the respiratory systems account for more than a quarter of the activity within the General Medicine specialty.

The locality will therefore be continuing work on addressing emergency admissions by working with the Practice Variation Programme to support in-practice audits and developing action plans accordingly.

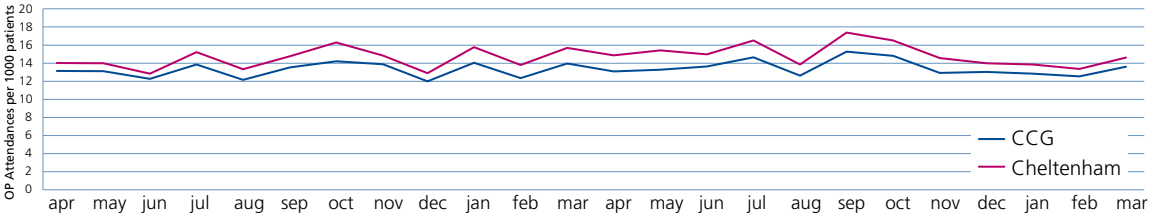
5.4.4 Outpatients: Trauma & Orthopaedics

Cheltenham Trauma & Orthopaedic Outpatient Attendances rate per 1,000 population comparison (2014/15 All Providers)

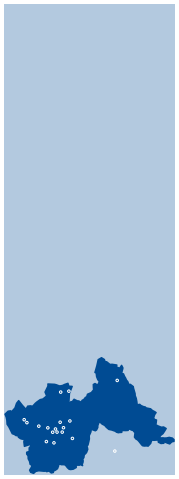


Trend Graph of Trauma & Orthopaedic Outpatient Attendances per 1000 patients April 2013 - March 2015: Cheltenham v CCG

April 2013 - March 2015: Cheltenham v. CCG

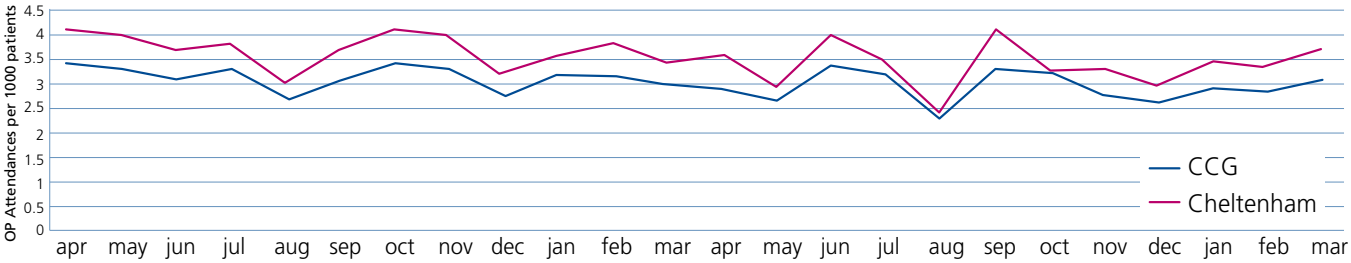


Cheltenham locality spend and activity are both above planned levels for Trauma & Orthopaedic Outpatient attendances. Initial analysis of the data indicates that only one practice in the locality has lower activity than expected whilst one other practice has been identified as a major outlier in Gloucestershire. The Locality Executive will engage with the CPG around this area of work.

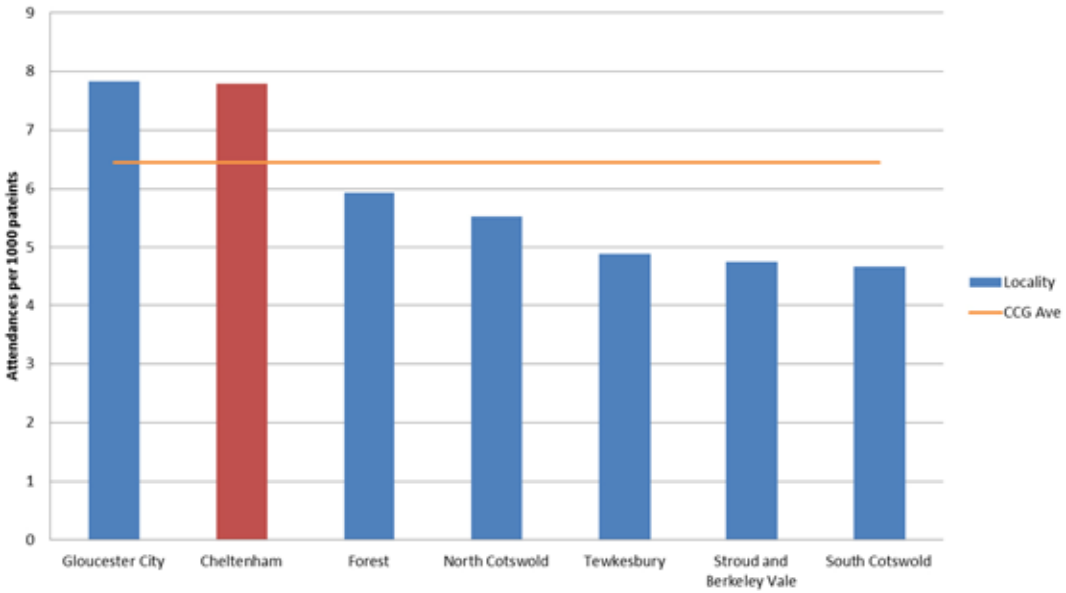


5.4.5 **Outpatients: Paediatrics**

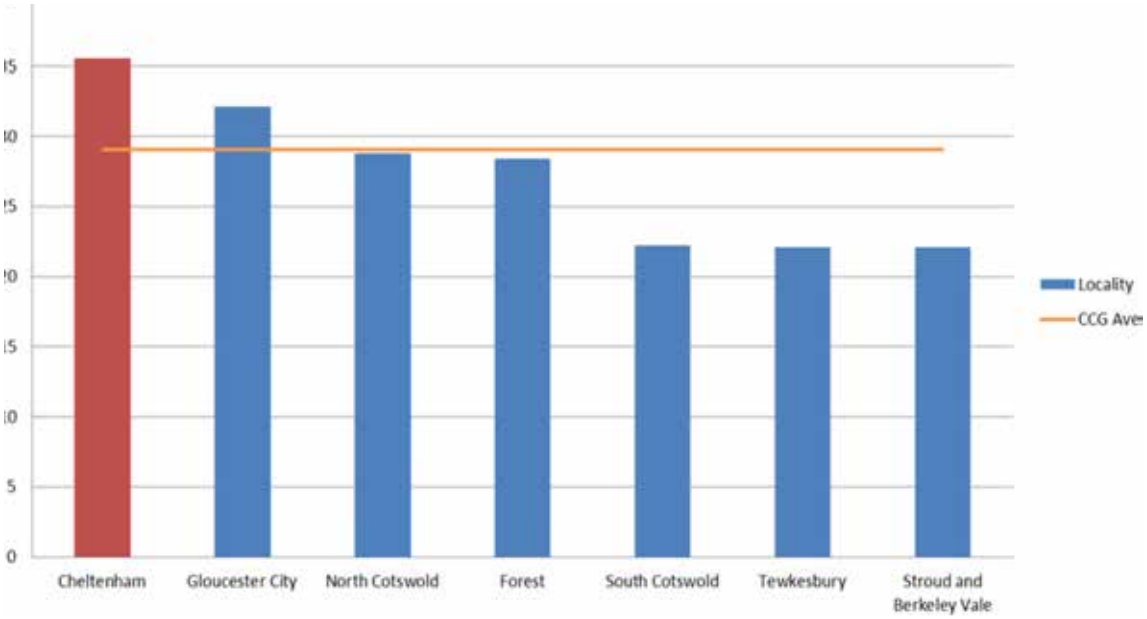
Trend Graph of Paediatric Out patient Attendances per 1000 patients April 2013 - March 2015: Cheltenham v CCG

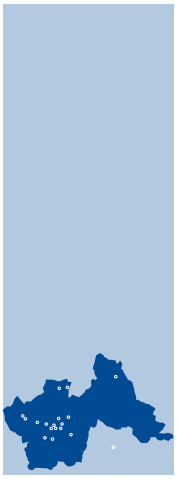


Paediatric Outpatient Attendances per 1000 patients



Paediatric Outpatient Attendances per 1000 patients aged 0-19 (2014/15)





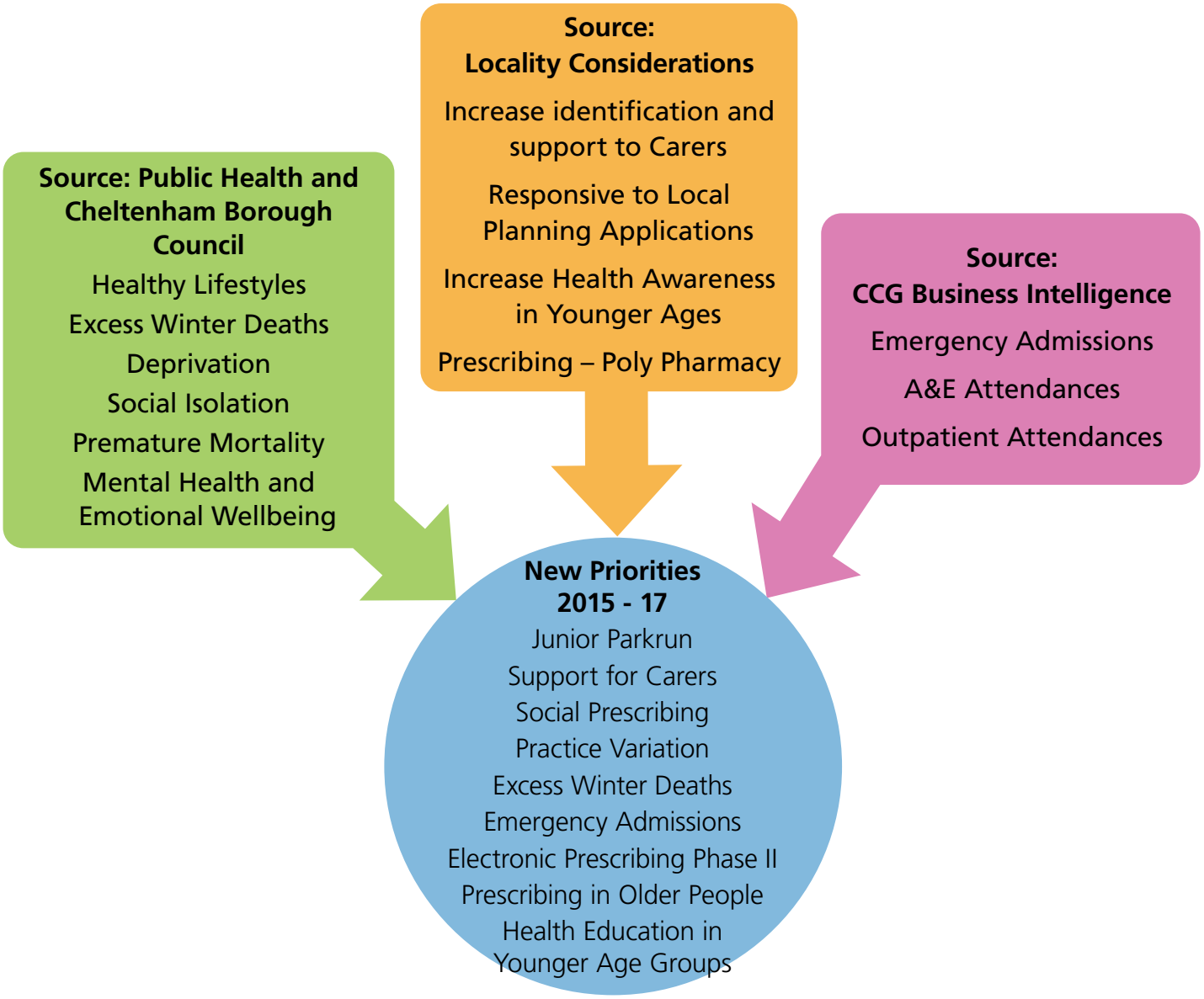
Cheltenham locality have a high rate of Paediatric outpatient attendance per one thousand patients, which has impacted on costs.

These figures were tested by the Finance & Information team to ensure that this position was not generated by the locality having a higher number of registered paediatric patients and reviewed those aged 0 - 19 years.

It can be seen in the second chart that Cheltenham have the highest number of Paediatric Outpatient attendances in comparison to the other localities.

6. Locality Work Programme for 2015 - 16

6.1 The priorities identified above have been summarised below to demonstrate how these have been formulated into our locality work programme.



Projects to be carried forward into 2015 - 17

Care Home Zoning
Electronic Prescribing
Engagement with Patient Participation Groups

6.2 The finer detail of each of these schemes follows in the table overleaf:

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (from CCG or Other Partners)	Expected Outcomes/ Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Existing Work Priorities: 2013-15						
Care Home Zoning Identify new builds in order that appropriate support can be provided	Dr Phil Fielding	Cheryl Ewing CBC	Continuation of priority identified during 2013/15: Align new Care Homes to a GP practice/s	Cheltenham Borough Council	Continuation of 2013 - 15 priority	March 2017
Engagement with Patient Participation Groups (PPGs) Share 2015 - 17 LDP	Locality Exec Group	Cheryl Ewing	Build on engagement started during 2013 - 15 Update PPGs on 6 monthly basis of locality priorities	All locality GP Practices All locality PPGs	Continuation of 2013 - 15 priority	March 2017
Social Prescribing: Adoption of countywide model Adoption of new model across all practices	Dr Julie Jackson	Helen Edwards Cheryl Ewing	To improve the health and wellbeing of those patients referred by healthcare professionals which will be measured through WEMWBS Increase the utilisation of services available within the community Reduce primary care appointments to be measured at 6 months pre and post referral Identify other locations to deliver service for those practices who do not have room availability	All locality GP Practices VCS Lead organisation	Continuation of 2013 - 15 priority	March 2017
Electronic Prescribing Phase II Enable prescribers to send prescriptions electronically to a Dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.	Dr Will Miles	Thoko Owino	Conduct survey to collate EPS feedback Conduct Benefits Realisation meetings with practices and pharmacies Go through utilisation figures and assist practices to increase them Offer refresher training where required Circulate control drugs information once the Practice & Pharmacy system suppliers have updated the systems to process CDs.	Central South Commissioning Support Unit	Continuation of 2013 - 15 priority	March 2017
New Priorities Identified for 2015-17						
Support of Junior Parkrun Support the delivery of free, weekly timed runs for juniors aged 4-14 years within a safe environment.	Dr Will Miles	UoG Parkrun UK Cheryl Ewing	Work with Parkrun UK and University of Gloucestershire to establish Junior Parkrun within locality Promote through GP practices	University of Gloucestershire Parkrun UK	August 2015	September 2015

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (from CCG or Other Partners)	Expected Outcomes/ Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Health Education in Younger Age Groups in schools Engage with primary school age children on issue-based health education initiatives which allows them to develop a holistic understanding of health and illness.	Dr Phil Fielding	Hugh Van't Hoff	Scoping potential work programme	Facts4Life		
Support for Carers Provide additional support for identified Carers	Dr Julie Jackson	Cheryl Ewing	Identify number of Carers in each practice through MIQUEST request Scope potential Carers afternoons within practices linked to social prescribing	All locality GP Practices All locality PPGs PCCAG	September 2015	March 2017
Prescribing in Older People Reduce adverse drug reactions	Dr Julie Jackson	Mark Gregory Ziad Suleiman	Scoping potential work programme Review of medicines management for those patients over 85 yrs prescribed >5 drugs and >10 drugs	Medicines Mgt Team	September 2015	March 2017
Reducing Excess Winter Deaths To improve the health, safety and wellbeing of patients who may be affected by poor housing standards, social deprivation or vulnerability. Link with social prescribing model	Dr Will Miles	Cheryl Ewing Social Prescribing Hub Co-ordinators	Increase the number of referrals to the 'Warm & Well' scheme for those households with members vulnerable to health problems associated with, or exacerbated by poor housing standards, social deprivation or vulnerability.	All locality GP Practices Cheltenham Borough Council Cheltenham Borough Homes Severn Wye Energy Agency		March 2017
Reducing Emergency Admissions (linked to countywide project, although specific to Cheltenham) Improve access to parking in order that home visits can be made by all clinical staff	Dr Julie Jackson	Jim Daniels	Work with GCC to facilitate parking arrangements for clinical staff during home visits.	All locality GP Practices Gloucester County Council	September 2015	December 2015

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (from CCG or Other Partners)	Expected Outcomes/ Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Local Planning Applications Build primary care resilience into new housing and care/ nursing home developments	Dr Phil Fielding	Andrew Hughes Helen Goodey	Linked to Care Home Zoning Work with CBC planning department	Cheltenham Borough Council PropCo	July 2015	Ongoing
Practice Variation Reports Variation reports include elements of variation work programme such as prescribing and paediatric outpatient attendances.	Locality Exec Group	Stephen Ball Bronwyn Barnes Simon Curtis	Scoping of variation identified by Finance & Info Leads	All locality GP practices	1st April 2015	Ongoing
CCG Countywide Projects Supporting practices to implement CCG projects and work programmes into the locality and influencing those programmes with feedback from the locality.	Dr Sadaf Haque and Dr Will Miles	Helen Goodey Cheryl Ewing	Locality GP awareness and implementation of CCG projects including:	Various CCG Lead GPs/ Managers	Ongoing	Ongoing
		Maria Metherall	Urgent care usage reduction – including use of ASAP app, Rapid Response, ICT's, OPAL and SPCA	Various CCG Lead GPs/ Managers		
		Julia Tambini	Prime Ministers Challenge Fund: Choice +, Skype, e-Consult	Gloucestershire GP provider company (GDoc)		
		Helen Edwards	Integrated Community Teams Rapid Response	Gloucestershire Care Services		
		Andrew Hughes	Infrastructure/Premises Development	Various CCG Lead GPs/ Managers		
		Bronwyn Barnes	Variation Programme			
		Gina Mann	Care Pathways Website (G-Care)			
		Dominic Fox	Joining up Your Information (care record)	Central Southern Commissioning Support Unit		
		Helen Goodey	Primary Care Offer	CCG		

Dr Will Miles
Locality Executive Chair
on behalf of Cheltenham Locality
September 2015

NHS
Gloucestershire
Clinical Commissioning Group

Stroud and Berkeley Vale Locality Development Plan 2015-17

Foreword

SIMON OPHER – Chair of the Stroud and Berkeley Vale Executive Group

Stroud and Berkeley Vale Locality has grown over the years into a very diverse but united group. We are blessed with many innovative GPs and practice managers in primary care who tend to see health commissioning not just within the narrow confines of health provision, but as a more holistic type of service. We have embraced public health measures as we see that these will make the most difference to people's wellbeing. Local GPs have championed cycling and healthy eating, as well as trying to avert social isolation through friendship cafes. We have pioneered a unique approach to children learning about health which is attempting to create young individuals who understand health, know how to keep themselves healthy and know, crucially, when they do or don't need medical help. We feel it is important to address the demand for health care as well as setting up an excellent service for patients.

Local practices engage very well with commissioning and this year have delivered considerable cost savings whilst maintaining a very high quality service. Above all we realise that, in the end, the best service for patients is usually also the cheapest as it avoids unnecessary activity.

Lastly, I am very proud of the fact that in our locality, we include all providers in our meetings about health care. The NHS is about far more than commissioning, and we see it as essential that the artificial purchaser provider split does not get in the way of giving the best health care to our population. As Hein has said, we are all in this together and we need to work as a team. Health care should be a collaboration, not a competition

HEIN LE ROUX – CCG GP Liaison Lead

It has been a real privilege for me to be involved with the Stroud and Berkeley Vale locality group as we seek to commission better health care for our local population who we serve. It has been a steep learning curve particularly understanding that the 'money' is real and that we are commissioning based on the needs of our local population which can be complex. This is quite a contrast from how I used to work focusing only on the needs of the patient in front of me and not thinking much about the wider population needs or about the cost of my interventions. I have also come to value the partnership working that inevitably comes with commissioning on behalf of our locality. Specifically, we have patient representatives who are becoming bolder at holding us to account as they better understand the nuances of NHS commissioning. We also have Stroud District Council and Gloucestershire County Council (through public health) representation and it has become clear to me that, if we really are to improve the health and wellbeing of our population, then this is best achieved through collaborative working with other commissioners and providers. In other words, we are all in this together.

For example, we know that our population is ageing and that dementia prevalence is increasing. We also know that people with dementia and their carers are at much greater risk of emergency admissions and ending up in a care home before they might if they were able to make timely plans and get adequate support. Dementia diagnosis was highlighted as a 'need' in our locality plan and through the hard work of primary care we are increasing our diagnosis rates. This makes a huge difference to these vulnerable people with dementia and their carers as post diagnosis education, support and planning can take place. This can safely prolong independence which is very important to most people.

Commissioning makes a difference to real people and I would like to thank my colleagues for their hard work and engagement.

CHARLES BUCKLEY – CCG GP Liaison Lead

We have worked hard as a Locality to try and support more collaboration between member practices; we have looked at a range of wider determinants of health and how we – and a wide range of partners – can help and support people to be physically and psychologically healthier – especially looking at 'social prescribing'; we have supported early years health literacy and awareness; we have looked at ways of improving access to information and advice; we have developed and are refining ways of member practices gaining detailed understanding of commissioned activity and outcomes and encouraging them to be more proactive in framing commissioning ideas and improvements; we have supported the CCG wide developments such as Integrated Community Teams with local enhancements – it has been a very busy and productive year! We all need to join up all our activities and work to deliver better outcomes for all of our local population'.

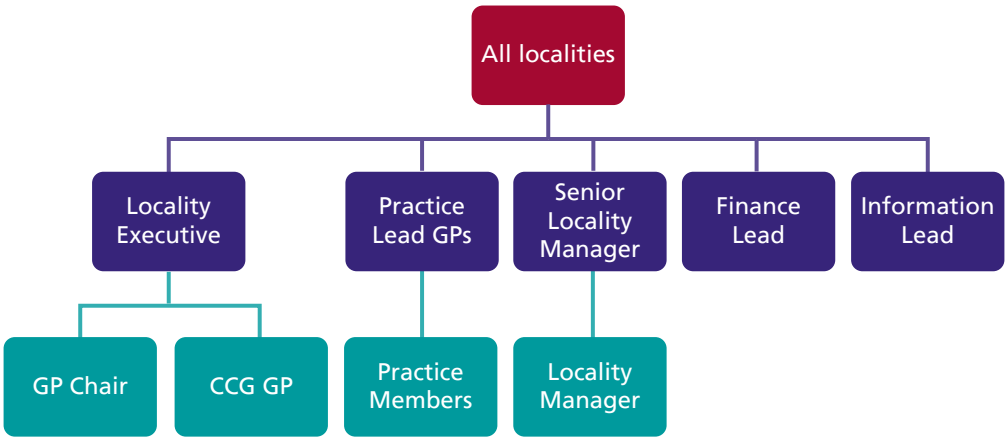
1 Purpose

1.1

This Locality Development Plan has been produced to describe the specific health needs for the population of Stroud and Berkeley Vale and sets out how the Locality Executive Group will lead work to address these needs over the next two years, subject to an annual review.

2 Background

2.1 The county of Gloucestershire covers a diverse range of populations, from the very deprived to the very affluent, from people living in very rural areas to people living in one of two large urban areas where there are a significant number of immigrant populations. This leads to a countywide population with very different health and social care needs, spread over a large geographic area. In recognition of the need to understand and represent these differences, the CCG has formed seven Localities; one of these is for the Stroud & Berkeley Vale area. In each Locality lead GPs work alongside key partners to help determine how best to meet the needs of it's population, informing the wider work of the CCG; this is known as the Locality Executive Group. The structure of localities is shown below:



For our locality, these roles are

- Locality GP Chair: Dr Simon Opher
- Locality CCG GP: Dr Charles Buckley & Dr Hein Le Roux
- Practice Leads:
  - Cam & Uley Surgeries: Dr Stephen Alvis
  - Regent Street Surgery: Dr Hugh van't Hoff
  - Prices Mill: Dr Andrew Sampson
  - Frampton Surgery (Whitminster Lane): Dr Charles Buckley
  - The Chipping Surgery: Dr JJ Kabler
  - Frithwood Surgery: Dr Bridget Jorro
  - Stonehouse Health Clinic: Dr Esmail Esmailji
  - St Lukes Medical Centre: Dr Michael Evans
  - The Culverhay Surgery: Dr Richard Probert
  - Marybrook Medical Centre: Dr Sarah Corston
  - Painswick Surgery (Hoyland House): Dr Rhys Evans
  - The High Street Medical Centre: Dr Victoria Blackburn
  - Walnut Tree Practice: Dr Simon Opher
  - Rowcroft Medical Centre: Dr Richard Waldon
  - Stroud Valleys Family Practice: Dr Christopher Staniforth
  - Beeches Green Surgery: Dr Kieron Bhargava
  - Acorn Practice: Dr Tom Yeburgh
  - Locking Hill Surgery: Dr Ewart Lewis
  - Minchinhampton (Bell Lane): Dr Hein Le Roux

- Senior Locality Manager: Helen Edwards
- Locality Manager: Penny Waters
- Finance Lead: Stephen Ball
- Information Lead: Chris Roche/Simon Curtis

2.4 The key functions of a locality are:

Planning	Service change delivery	Engagement and relationships
Reviewing health needs, patient insight	Locality specific projects	Utilising/ shaping practice level patient participation groups
Shaping CCG Plans	Local implementation of CCG wide initiatives	Developing links with key community groups
Local delivery plan	Joint initiatives with local partners	Key stakeholders/ partners

Participation	Quality, utilisation and performance	Locality organisational development
Operation of committees, groups and protected learning time	Review locality performance information and take necessary action	Supporting the development of local membership model – e.g. what does greater federation feel and look like
Encouraging wide membership engagement	Understanding variations	Development between localities and the Governing Body
Practice visits and individual membership opportunities	Improving quality and performance	Developing the locality executive

2.2 This document will seek to describe the local health needs for the Stroud & Berkeley Vale Locality as it is clear that our population has specific health needs to be addressed. The Public Health team within our Local Authority has supported us to identify and understand these needs. The Locality is now working to provide positive solutions to meet these needs.

2.3 In accordance with national requirements and working with partners and stakeholders (including patients, carers and the public), the CCG has formulated a five year strategic plan for Gloucestershire – Joining Up Your Care which aligns with the Gloucestershire health community. This is supported by a more detailed two-year operational plan, that identifies our more immediate priorities from April 2014. They remain within the overall umbrella of the Health and Wellbeing Strategy ('Fit for the Future') that sets out the priorities for improving health and outcomes for the people of Gloucestershire from 2012-2032.

The Locality development planning process will also take account of the commissioning intentions produced annually by the CCG (focused around acute, community and mental health services), local District Council priorities and the Better Care Fund.

Joining Up Your Care –
Our Shared Vision for the next 5 years:

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

Our Ambitions:

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

2.4 This Locality Development Plan must be seen in the context of these important strategic documents; projects and initiatives in the Plan will be complementary to this strategic context and the CCGs operating plan.

This Locality Development Plan therefore fits within this wider context as follows:

2.5 To identify the health needs of the population of Stroud & Berkeley Vale Locality, three main sources of information have been identified:

- Public Health Intelligence
- Activity, performance and financial data on the use of services, highlighting those areas where the Locality is significantly over or below 'expected' levels. This analysis has included consideration of benchmarking data information and data on variation between usage of health care at a GP Practice population level;
- 'On the ground' intelligence – i.e. conversations with local colleagues who are working directly with patients to understand their views about need.

2.6 The Locality Executive Group has worked closely with key stakeholders to identify the health and social care needs of the local population, to prioritise actions, and provide ideas for how these needs could be addressed. These stake holders are:

- Local GP Practices and their staff
- Patients and their representatives
- Local voluntary organisations and community groups;
- Gloucestershire Care Services;
- 2gether NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust;
- Stroud District Council;
- Gloucestershire County Council
- Lay members
- Local MPs;
- CCG Colleagues

2.7 Whilst assessing the evidence gathered around local health needs, the Locality Executive Group has also taken into consideration the variety of existing work streams within the CCG's countywide Clinical Programme Groups (CPGs) and, the range of Quality, Innovation, Productivity and Prevention (QIPP) projects to ensure locality initiatives and projects are complementary. This will allow for a continuous feedback loop where successful learning from the Locality projects can be embedded into the CPGs, and also from the CPGs into the Locality.

3 Key Achievements to date

3.1 Key achievements of the Stroud & Berkeley Vale Locality from the previous 2013-2015 plan are detailed below.

The CCG has been in operation since 2013 (although in shadow form since 2012). During 2013, seven Locality Development Plans were produced, one for each locality in the county, covering 2013-15. Key achievements of the Stroud & Berkeley Vale Locality since 2013 are as follows:

- **Locality Executive engagement** – The locality executive have regularly met to support two-way engagement between GCCG and membership practices, ensuring the voice of local GPs is heard and reflected within the work programme and priorities. Locality practice finance and information variation reporting has been used to inform the Locality Executive's decision making. Member practices have contributed to the countywide clinical programme of work, which through the planning process for 2015/2017 shows where the locality's focus will be.
- **Information Support Officers in practices** – Information Support Officers (ISOs) have been in post in the majority of Stroud and Berkeley Vale practices during the past two years, analysing practice activity data. For the coming year the ISO model will take a more structured approach as part of the CCG Variation Programme to identify, understand and effect change relating to the under or over utilisation of NHS services.
- **Cycling on prescription scheme commissioned**. This scheme was initially available to the patients of 8 locality Practices and has subsequently been rolled out to all 19 Practices. This is a confidence building programme where individuals are supported by the Road Safety Partnership to return to cycling. The scheme is particularly for people who already own a bike but may not have used it for a while. In addition to confidence building sessions, the individual also receives a free bike maintenance check. People are then linked to local cycling clubs.
- **Social prescribing pilot established** – our social prescribing pilot initially ran in 6 GP Practices in the locality. The most common reason for referral was social isolation, followed by mental health and wellbeing. The scheme was jointly sponsored by Stroud District Council and the CCG. Following an evaluation, an in practice model has been adopted and will roll out during the coming months.
- **Rapid Response roll out** – Rapid Response went live in Stroud and Berkeley Vale in December. Rapid Response practitioners provide a full assessment in a person's home and aim to respond within one hour. People are supported in their own homes for a period of up to 48 hours as an alternative to hospital admission and to support early discharge. Night sitting is also a part of this service offer.
- **Facts4Life** – The locality commissioned the development of this programme which aims to change the attitude of children in key stage 1 to their health and wellbeing. The aim is to promote an understanding of illness as part of normality, helping children to understand how to keep as well as possible and how to manage ill-health effectively. The project helps children to put information in context when making decisions about their health. The Facts4life approach allows children and teachers to start talking about difficult and important personal and family health issues previously regarded as too sensitive to approach. In this way, health problems can be identified more quickly and interventions carried out an earlier stage, without the need for medical involvement. The pre pilot demonstrated positive results and the CCG has now funded the project to enable roll out to 153 schools across the county.

- **Art on Prescription commissioned** – Art on prescription provides primary care health professionals with an alternative prescribing option for a range of health conditions, as a complement and/or alternative to existing traditional prescribing options, particularly when such traditional prescribing options have either not proved helpful or been unsuitable for the patient's needs. This service is delivered by Artlift and the CCG have agreed to commission the service until March 2016.

- **Memory cafes commissioned** – As part of its plans to meet local needs, the Locality Executive funded four memory cafés in Stroud, Cam, Wotton and Berkeley. They are sited within sheltered housing complexes, but are accessible to all patients (and Carers) from Stroud District who have concerns about their memory. The café sessions are run in partnership with a Dementia nurse and Dementia advisors who use the sessions to give support to patients and their carers.The weekly 2 hour 'drop in' sessions, give people the chance to have a chat and a coffee and there are a range of activities for people to enjoy. The project has three key aims:
  - Helping people to feel part of the local community
  - Carer support
  - Access to advice and guidance.

- **On Target programme developed** – On Target 2014/15', is a alternative mini weight management scheme, focusing on mental and physical wellbeing. It was devised and managed by Stroud District Council Sport and Health Development Service and commissioned by the CCG. The scheme provided four blocks of sessions over the year (12 sessions per client) to people who wanted to reduce their weight, consider their mental health and physical activity options in their weight loss journey. The target of achieving 5% weight loss over all was achieved in the first six months and signposting to continued mental health support made available. Numbers were deliberately small with average cohort being 7 to 10 people.

- **Membership Engagement** - Successfully engaging with all practices in the locality, including GP or Practice manager representation at regular Stroud & Berkeley Vale forum meetings – in accordance with the CCG locality operating framework.

3.2 Prime Minister's Challenge Fund

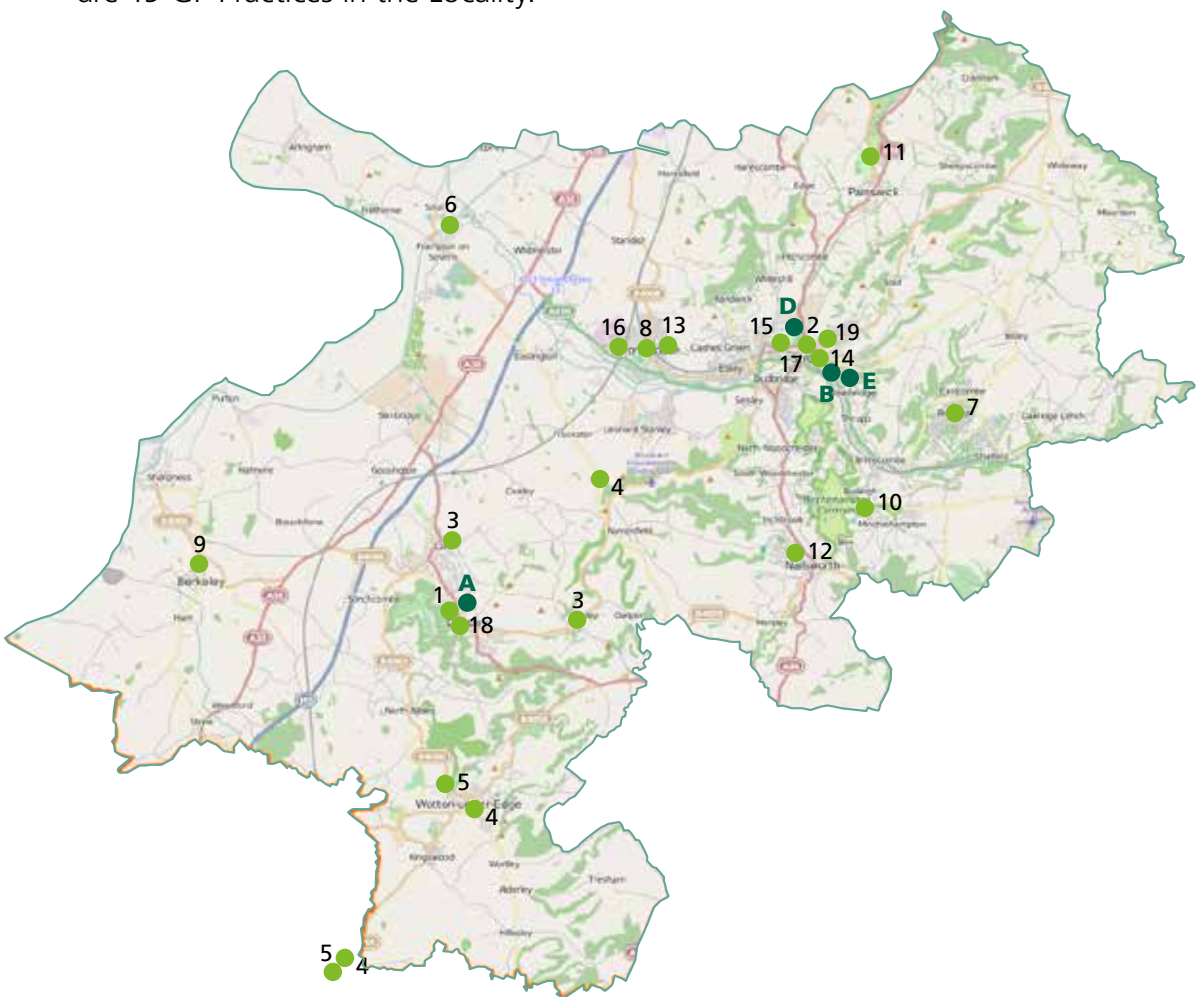
3.2.1 GPs from all localities have been key contributors to a successful application for the Prime Ministers Challenge Fund (PMCF) relating to improving access to general practice, thanks to joint working between the GP provider organisation Gloucestershire Doctors (G-DOC) and the CCG.

3.2.2 In securing this £4m of additional national funding, localities will be supporting the delivery of providing local people with improved access to GP services in Gloucestershire, through a blend of additional appointments and greater use of technology.

3.2.3 A delivery board has been established to make key decisions and will include representation from each of the seven Gloucestershire localities.

4 Local Service Provision

4.1 The Stroud and Berkeley Vale Locality is comprised of Stonehouse, Nailsworth, Frampton-on-Severn, Wotton-Under-Edge, Painswick, Dursley, Stroud, Berkeley, Minchinhampton and Cam] – the total area covers around 121,000 people. There are 19 GP Practices in the Locality.



1 Acorn Practice, May Lane Surgery, Dursley GL11 4JN
2 Beeches Green Surgery, Beeches Green, Stroud GL5 4BH
3 Cam & Uley Family Practice, The Orchard Medical Centre, Fairmead, Cam, Dursley GL11 5NE & 42 The Street, Uley, Dursley GL11 5SY
4 Chipping Surgery (The), Symn Lane, Wotton under Edge GL12 7BD & 1 Avon Crescent, Wickwar GL12 8NL & Bethesda Chapel, Park Street, Hawkesbury Upton, Wotton under Edge GL9 1BA
5 Culverhay Surgery (The), Wotton under Edge GL12 7LS & Bethesda Congregational Chapel, Park Street, Hawkesbury Upton, Badminton GL9 1BA & Community Centre, Avon Crescent, Wickwar GL12 8NL
6 Frampton Surgery, Whitminster Lane, Frampton-on-Severn GL2 7HU
7 Frithwood Surgery, 45 Tanglewood Way, Bussage, Stroud GL6 8DE
8 High Street Medical Centre (The), 31 High Street, Stonehouse GL10 2NG
9 Marybrook Medical Centre, Marybrook Street, Berkeley GL13 9BL
10 Minchinhampton Surgery, The Surgery, Bell Lane, Minchinhampton GL6 9JF
11 Painswick Surgery, Hoyland House, Gyde Road, Painswick GL6 6RD
12 Prices Mill Surgery, Newmarket Road, Nailsworth GL6 0DQ
13 Regent Street Surgery, 73 Regent Street, Stonehouse GL10 2AA
14 Rowcroft Medical Centre, Stroud GL5 3BE

15 St Lukes Medical Centre, 53 Cainscross Road, Stroud GL5 4EX &
St Lukes Medical Therapy Centre, 10 Tuffley Lane GL4 0DT

16 Stonehouse Health Clinic, High Street, Stonehouse GL10 2NG

17 Stroud Valleys Family Practice, Beeches Green Health Centre, Stroud GL5 4BH

18 Walnut Tree Practice, May Lane Surgery, Dursley GL11 4JN

19 Locking Hill Surgery, Locking Hill, Stroud GL5 1UY

Other providers

A Vale Community Hospital, Lister Road, Dursley GL11 4BA

B Stroud General, Trinity Road, Stroud GL5 2HY

C Emersons Green, St Lukes Close, Emersons Green, Bristol BS16 7AL

D Beeches Green Health Centre, Stroud, GL5 4BH

E Weavers Croft Mental Health Clinic, Field Road, Stroud GL5 2HZ

4.2 The approximate Practice list sizes are as follows:

Minchinhampton Surgery	7,187
Rowcroft Medical Centre	11,834
Prices Mill Surgery	8,557
Beeches Green Surgery	7,880
Painswick Surgery	4,791
St Luke's Medical Centre (closing 30/9/2015)	3,985
Stroud Valleys Family Practice	4,149
Frithwood Surgery	6,613
Culverhay Surgery (Wotton)	6,184
Chipping Surgery (Wotton)	8,422
Cam and Uley Family Practice	10,146
Acorn Practice	4,191
Marybrook Medical Centre	5,052
Walnut Tree Practice	4,761
High Street Medical Centre	5,768
Frampton Surgery	4,990
Locking Hill Surgery	9,338
Regent Street Surgery	4,116
Stonehouse Health Clinic	2,742

Correct as at 1st April 2015

4.3 In addition to the main acute hospitals in Gloucester and Cheltenham and the GP Practice sites, local NHS health services are also delivered from:

Stroud General Hospital

The Vale Community Hospital

Hospitals in Bristol

Emersons Green Treatment Centre, which is particularly beneficial to those people living on the South Gloucestershire boarder in Wotton-Under- Edge

Beeches Green Medical Centre

Weavers Croft Mental Health Clinic.

4.4 For patients living in any part of Gloucestershire their health issues are often closely linked to other 'social' factors, such as employment, education, and housing. We are committed to working in partnership with the Local Authority and third sector partners to both find and implement solutions. Therefore, the CCG also commissions a range of services from the local Voluntary and Community Sector.

5 What are the Issues we face?

Overview

Public Health Information

5.1. The Local Authority in Gloucestershire produce a Joint Strategic Needs Assessment (JSNA) – this highlights the medical conditions that particularly affect the population of the county and its Localities. It also highlights population changes over the coming 20 years.

Demographics

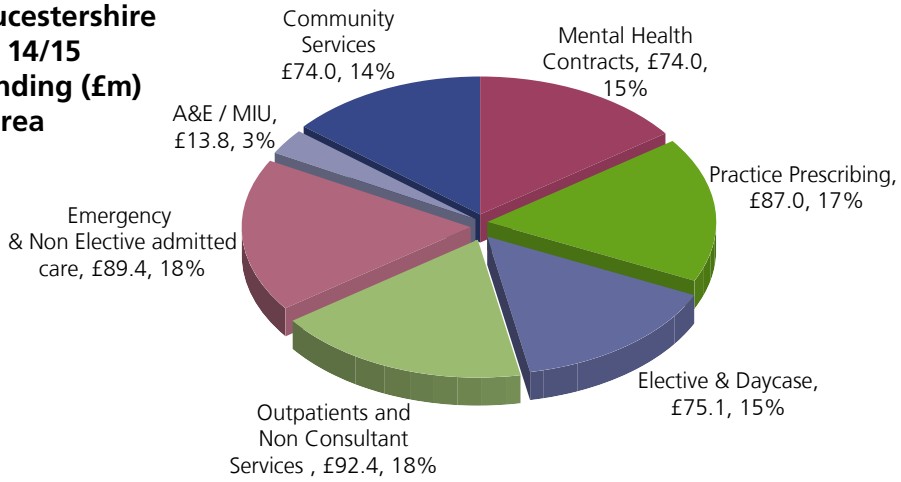
The locality has an older age profile than the CCG average, and a relatively high proportion of patients aged 65 plus (21.9%) and 85 plus (21.9%), with implications for age related long term conditions. The district is projected to see above average levels of growth in the population aged 65 plus and 85 plus through to 2021. With the exception of one practice, all practices are above the average deprivation score for the county.

CCG Finance and Information Data

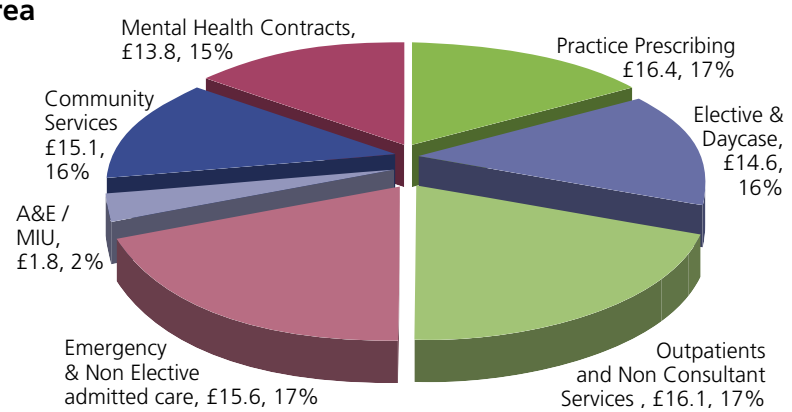
5.2 Analysis of NHS resource utilisation demonstrates variation exists not just at a CCG level, but also between and within localities. In addition, GCCG have specific performance issues along with finite financial resources, which, as a membership organisation, the locality can support with. In addition to the JSNA intelligence, it is vital to consider the wider financial picture.

The below charts show the value and proportional split of the key spending themes for both Gloucestershire CCG and the locality:

Gloucestershire CCG 14/15 Spending (£m) by area



Stroud and Berkeley Vale 14/15 Spending (£m) by area

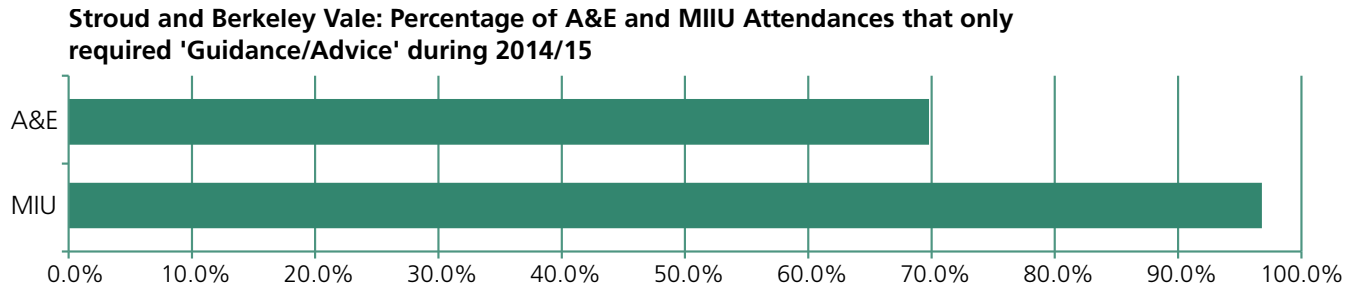


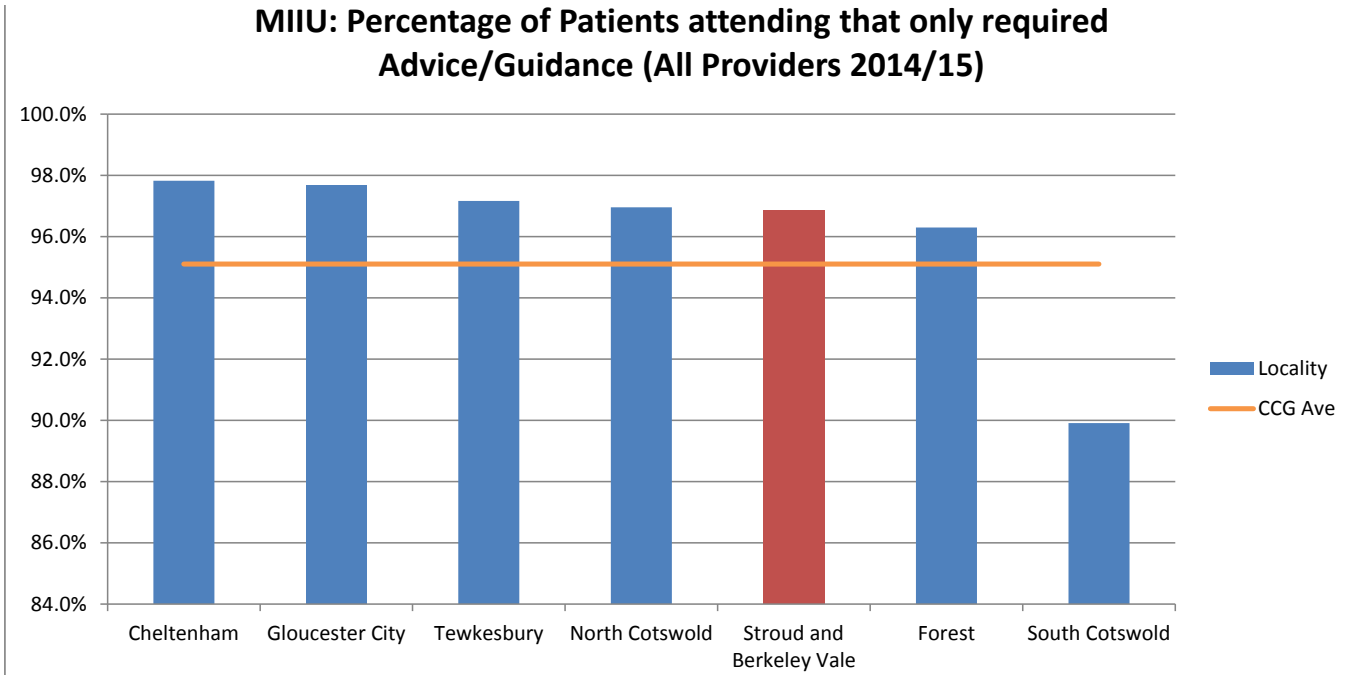
NOTE: These charts exclude other areas of commissioning spend, such as maternity services, ambulance services, continuing health care, CCG running costs and reserves.

Critically, we face an unprecedented financial challenge over the coming years, at the same time as increased demand for our services, within the context of a fast-ageing population. At present around 17 % of Gloucestershire's population are aged 65 and over; this is expected to grow to 30% over the next 20 years. We will therefore need to provide services that are simple to access, integrated and cost-effective.

In the context of this wider financial picture the business intelligence team has reviewed activity, performance and finance data from commissioned services to assess where there are significant variances from the levels expected for the locality; this has highlighted the key areas below for further consideration.

A&E / MIIU attendance

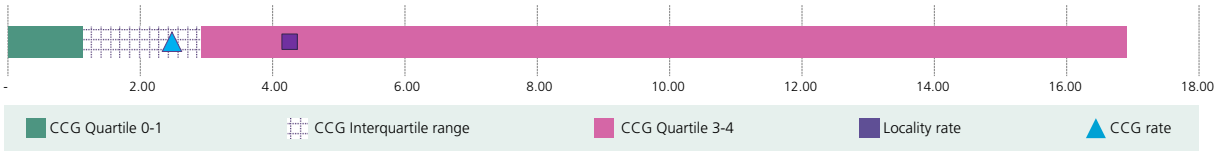




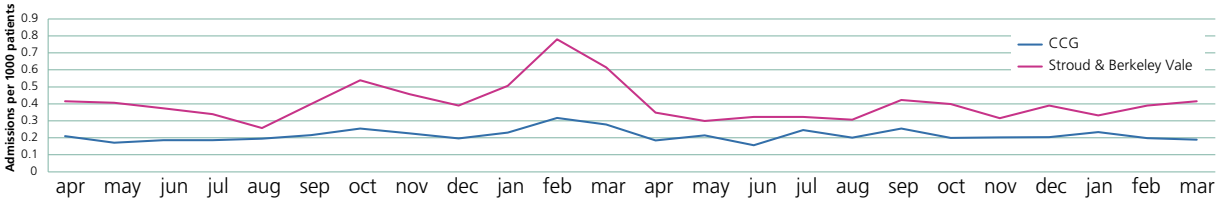
The above graphs demonstrate the utilisation of A&E and MIIU by patients within the Stroud and Berkeley Vale locality. There are a very large proportion of attendances at A&E and MIIU where the outcome for the patients is Guidance/ Advice, either verbal or written. The first chart suggests a majority of patients attend these services and receive advice and guidance only, while the second chart shows that the Stroud and Berkeley Vale locality is above the CCG average for patients who only receive advice and guidance at MIIU. The locality will work alongside countywide CCG programmes of work to best understand patient need and ensure appropriate services, engagement and communication is in place.

Elective admissions: General Surgery

Stroud & Berkeley Vale General Surgery Elective Admissions rate per 1,000 population comparison(2014/15 All Providers)



Trend Graph of General Surgery Elective Admissions per 1000 patients April 2013 - March 2015: Stroud & Berkeley Vale v CCG

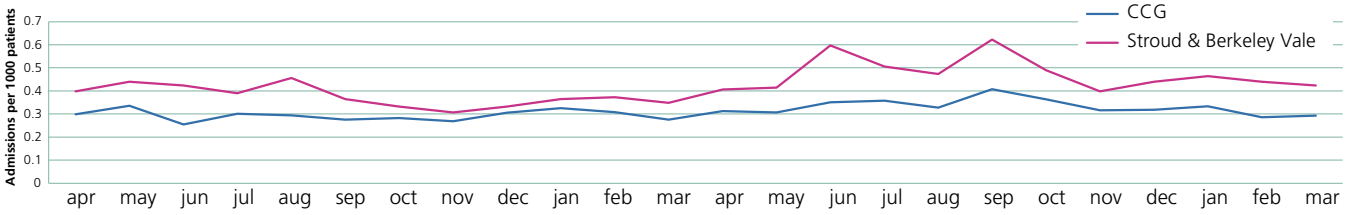


The specialty of General Surgery has actual spend and activity above the expected level for elective admissions, considering the demography of the locality. Fourteen of the nineteen locality practices are above their expected activity level in this specialty. Several of the locality's practices are also outliers in this specialty in comparison to their taxonomy groups.

The age groups from 65 years to 74 years contribute most significantly to the activity being above expected levels.

Elective admissions: Clinical Haematology

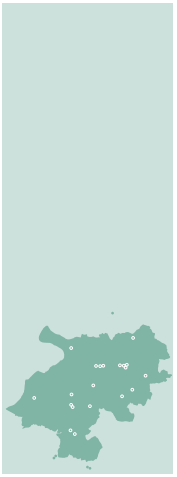
Trend Graph of Clinical Haematology Elective Admissions per 1000 patients April 2013 - March 2015: Stroud and Berkeley Vale v CCG



For elective Haematology SBV had 684 admissions in 14/15 at a cost of £348k, this is the 6th most common specialty with regards to number of elective admissions in the locality (8th for the whole CCG, thus the rate per 1000 being higher in SBV), with activity more than 35% higher than the locality's demography would suggest. To a smaller extent, outpatient and emergency admissions are also high in this specialty for Stroud and Berkeley Vale patients.

5.3 As well as the information provided through the JSNA and CCG activity data, we want to strengthen this with understanding the views of people working alongside our patients in the community and 'on the ground', so we have also worked with our local colleagues (see section 2.6 above) to better understand the needs of our population, and priorities for improvement.

Over the last few months' colleagues from across Public Health, Local Councils and the CCGs Finance and Information team have held planning meetings working together to identify from relevant data, which potential priorities the locality might want to consider.



5.4 The identified priorities have been presented to the Locality Executive Group for them to consider and agree which key priorities they would focus on for 2015 - 2017. Below is the plan on a page that was developed showing all the priorities initially presented from each contributor.

Stroud and Berkeley Vale Locality priority setting 2015-2017

Clinical Service Developments/ Finance and Information
Practice Variation –ISO and prescribing
Emergency Admissions
A+E/MIU attendances
Skin cancer

S&BV Locality Continuing Priorities	
Social Prescribing	Locality/ countywide
ICT Phase 2 (test and learn)	Locality
Practice variation - ISOs	Locality
S&BV Locality Proposed New Priorities	
Practice Variation – Smoking Cessation	Locality
Practice Variation – Reduce Obesity	Locality
Practice Variation – Colorectal cancer early diagnosis	Locality
Localise health service where appropriate to do so – Extend scope of outpatient service	Locality

Locality Partnership working	
Healthy Lifestyle schemes	Working with Stroud District Council/ social care/ education/ VCS
Excess winter deaths – Warm and Well scheme	
Buddy Scheme	
Social prescribing – Model now scaled up across most practices using Asset coordinators aligned to ICT teams	
Reduce Obesity	

All Public Health Identified Indicators
Women's Health outcomes – further analysis
Cancer prevalence – (QOF) Is this related to locality's age profile
Excess winter deaths – Monitor current rising trend
Excess weight in adults – are all practices making the most of the opportunity to refer to slimming world
NHS Healthchecks – an opp to raise questions about lifestyles behaviours and identify risks of CVD/share learning across practices
Secondary prevention in primary care – address variation between practices where relevant
Self harm/suicide

6. Locality Work Programme for 2015/16

6.1 We have set out a range of local health needs/issues in section 5 above. With our CCG, GP Practice and other colleagues, we will work hard to address these. The locality work programme will be regularly monitored to assess progress, with a formal review by the CCG's Governing Body every three months.

Recognising though that we need to priorities our work as a Locality, we have summarized what we aim to achieve in 2015/16 in the work programmer below:

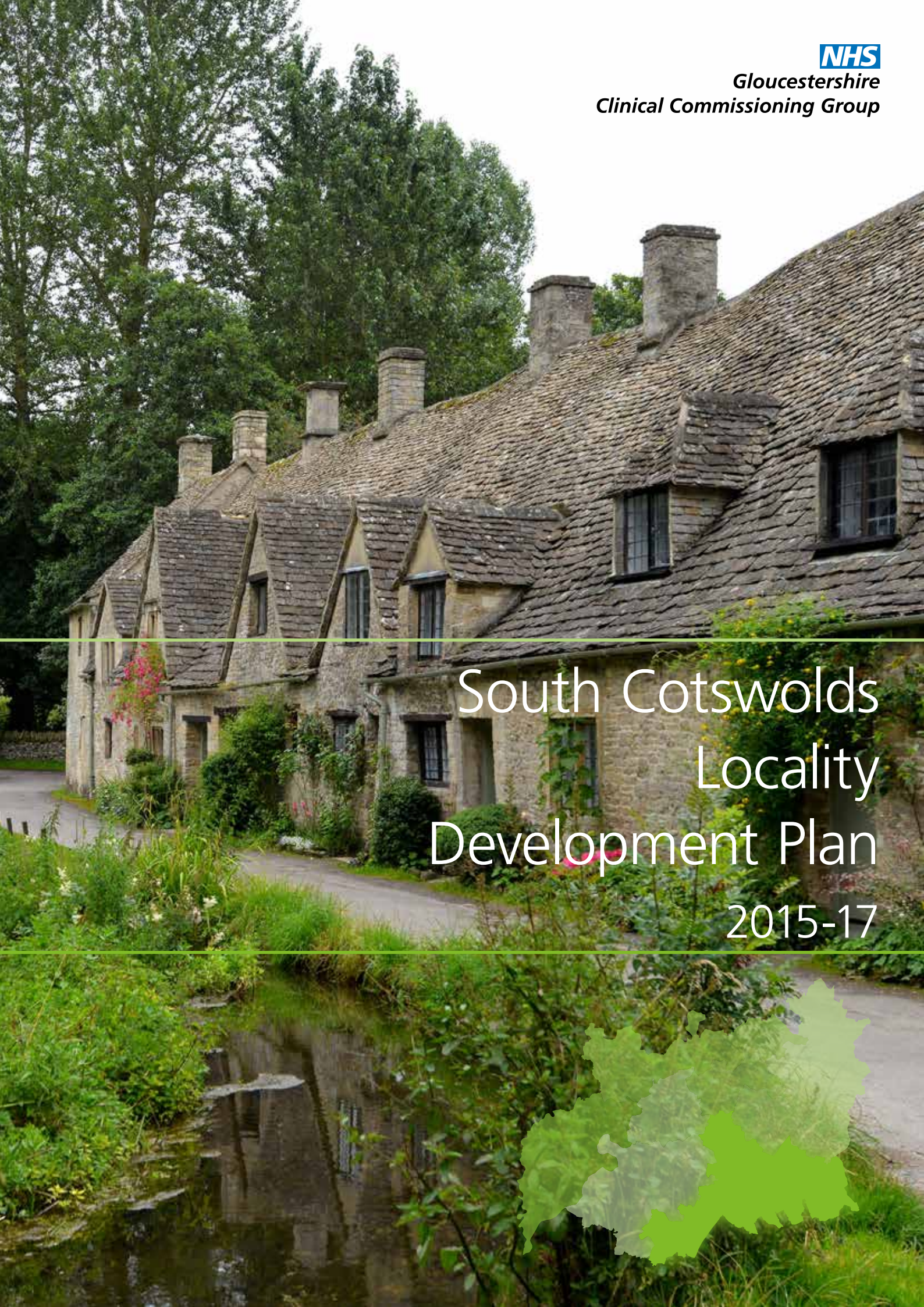
Priority Action Area Proposed Scheme	Lead Locality Gp	Lead Manager (From Ccg Or Other Partners)	Expected Outcomes/ Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Existing Schemes continuing						
Social Prescribing – Scale up in practice model	Dr Simon Opher	Helen Edwards – Senior Locality Manager CCG/Penny Waters Locality Manager	To improve Health & Wellbeing and reduce unnecessary use of primary care. To ascertain impact on use of A&E, emergency medical admissions and outpatients. To promote schemes run by partner organisations for example SDC Healthy Homes loans and countywide Warm and Well Scheme.	Stroud District Council	Continuation of 2013 – 2015 priority	On going
Practice variation – ISO model	Dr Charles Buckley	Bronwyn Barnes – CCG Practice variation Mgr	Reduce expenditure to be in line with peers Detailed practice and individual patients level analysis of variances by practices, as part of the Variance project and ISO work programme, will look for explanations and possible modifiable causes to help reduce unwarranted and poor value variation.		Continuation of 2013 – 2015 priority	On going
ICT phase 2 – continuing priority	Dr Simon Opher	Helen Edwards – Senior Locality Manager CCG	Prevention of some hospital and care home admissions. Less time spent in hospital. Increased identification of people who are at risk of requiring services in the future. Greater clarity on who is involved in a person's care. More focus on the 'goals' and quality outcomes defined by the person. Named key workers. Improved connection to 2gether NHS Foundation Trust staff and wider community based assets.		Continuation of 2013 – 2015 priority	On going

Practice Variation – Reducing Obesity	Dr Simon Opher	Claire Procter – Public Health	Reducing obesity and related conditions such as diabetes, hypertension and coronary heart disease		July 2015	On going
Practice Variation – Smoking cessation	Dr Simon Opher	Claire Procter – Public Health	Reducing smoking and related conditions such as CVD.		July 2015	On going
Practice Variation – Earlier diagnosis of colorectal cancer	Dr Charles Buckley	Claire Procter – Public Health	Practice audit to determine at what stage cancer patients are currently being diagnosed.			
Localise health services where appropriate to do so	Dr Simon Opher	Dawn Porter (GCS), specialty mgrs. From GHFT, Jon Thomas, 2gether	To extend the range and scope of outpatient services provided locally. Priorities for 2015/16 are: oncology and access to the mobile radiotherapy unit at The Vale. Increase from 80% the percentage of local people treated in SGH and VCH. Support the sustainability of both MIUs by running GP sessions from them as part of the Prime Minister's Challenge Fund.		July 2015	On going
CCG countywide projects Supporting practices to implement CCG projects and work programmes into the locality and influencing those programmes with feedback from the locality.	Dr Charles Buckley & Dr Hein Le Roux	Helen Edwards/ Penny Waters	Locality GP awareness and implementation of CCG projects including:	Various CCG Lead GPs/ Managers	Ongoing	Ongoing
		Maria Metherall	* Urgent care usage reduction – including use of ASAP app, Rapid Response, ICT's, OPAL and SPCA.			
		Julia Tambini	Prime Ministers Challenge Fund: Choice +, Skype, e-Consult	Gloucestershire GP provider company (GDoc)		
		Helen Edwards	Integrated Community Teams	Gloucestershire Care Services		
			Rapid Response			
		Andrew Hughes	Infrastructure/Premises Development			
		Bronwyn Barnes	Variation Programme			
		Gina Mann	Care Pathways Website (G-Care)			
		Dominic Fox	Joining up Your Information (care record)	Central Southern Commissioning Support Unit		
		Helen Goodey	Primary Care Offer			

Dr Simon Opher, Stroud & Berkeley Vale Locality Executive Chair, On behalf of Stroud & Berkeley Vale Locality

16 July 2015

NHS
Gloucestershire
Clinical Commissioning Group



South Cotswolds Locality Development Plan

2015-17

Foreword

The South Cotswolds locality has developed into a coherent and effective entity for sharing concerns, ideas and generating solutions between the eight practices, local authority and other locality resources. We have found that by working together across practice boundaries whilst respecting each other's difference we have achieved things that would have been well beyond the scope of any one practice to achieve alone.

The projects that we have successfully implemented include: the establishment of social prescribing hubs within practices supported by the local authority, using Cirencester Hospital as a test bed for innovative community hospital service development, increasing the diagnosis of dementia, developing a county wide complex lower limb service and establishing a new way of identifying the variance of NHS resource utilisation between practices.

The localities ideas for the next two years are exciting; especially our plan to development a locality based consultant led community geriatric service. We also propose to change the way that we use cardiology outpatients by providing more services within each practice, closer to home. Finally we intend to ensure that more mental health services are provided within the locality in a joined up way and much are simpler for practices and patients to access.

Looking to the future the locality faces an increase in its population due to new house building as well as a continued rise in the number of elderly people with multiple long term conditions. We will have to manage the resulting extra pressure in the face of increasingly stretched financial and human resources.

The GP's within the local practices therefore have to ask themselves a fundamental and vital question: Do we keep doing more of the same; with eight practices each striving harder, faster and longer or do we take a step back and genuinely consider the alternative models highlighted in the 'NHS Five Year Forward View', by the RCGP and numerous other reports that have been published?

To this end we do have a decision to make quite quickly: Should the four practices in the town work together to build a primary care infrastructure that accounts for the all of the population and all of the practices needs, or do we follow a more insular, traditional individual practice approach? It's a tough question to answer as it challenges strongly held opinion and traditional orthodoxies, but has to be faced.

I believe the answers that we generate to the above will fundamentally determine the way that primary care is delivered in the locality, its sustainability and indeed vibrancy for decades to come.

Dr Alan Gwynn,
South Cotswolds Locality Commissioning Chair

1 Purpose

1.1

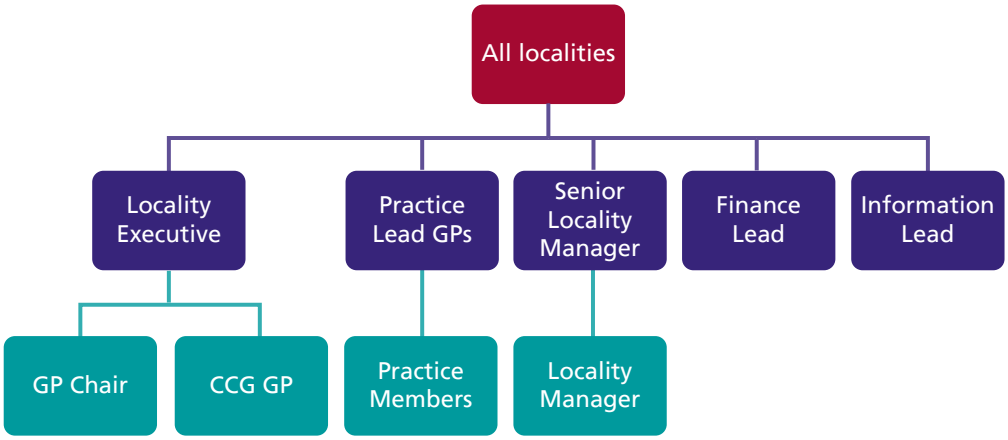
This Locality Development Plan has been produced to describe the specific health needs for the population of the South Cotswold Locality and sets out how the Locality Executive Group will lead work to address these needs over the next two years.

2 Background

2.1 The county of Gloucestershire covers a diverse range of populations, from the very deprived to the very affluent, from people living in very rural areas to people living in one of two large urban areas where there are a significant number of immigrant populations. This leads to a countywide population with very different health and social care needs, spread over a large geographic area.

2.2 In recognition of the need to understand and represent these differences, the CCG has formed seven Localities; one of these is for the South Cotswold area. In each Locality, lead GPs work alongside key partners to help determine how best to meet the needs of its population, informing the wider work of the CCG; this is known as the Locality Executive Group.

2.3 The structure of localities is shown below:



For our locality, these roles are

- Locality GP Chair: Dr Alan Gwynn
- Locality CCG GP: Dr Malcolm Gerald
- Practice Leads:
  - The Park: Dr Julian Tallon
  - Phoenix: Dr Ian Simpson
  - St Peters Road: Dr Martyn Hewett
  - Avenue: Dr Alan Gwynn
  - Romney House Dr Malcolm Gerald
  - Hilary Cottage Dr Graham Wallis
  - Lechlade Dr Henry Stevens
  - Rendcomb Dr Sue Whittles
- Locality Manager: Zaheera Nanabawa
- Senior Locality Manager: Stephen Rudd
- Finance Lead: Chris Trout
- Information Analyst: Chris Roche/ Simon Curtis

2.4 The key functions of a locality are:

Planning	Service change delivery	Engagement and relationships
Reviewing health needs, patient insight	Locality specific projects	Utilising/ shaping practice level patient participation groups
Shaping CCG Plans	Local implementation of CCG wide initiatives	Developing links with key community groups
Local delivery plan	Joint initiatives with local partners	Key stakeholders/ partners

Participation	Quality, utilisation and performance	Locality organisational development
Operation of committees, groups and protected learning time	Review locality performance information and take necessary action	Supporting the development of local membership model – e.g. what does greater federation feel and look like
Encouraging wide membership engagement	Understanding variations	Development between localities and the Governing Body
Practice visits and individual membership opportunities	Improving quality and performance	Developing the locality executive

2.5 This document will seek to describe the local health needs for the South Cotswold Locality. As will be seen, it is clear that our population has specific health needs that need to be addressed in order for us to understand these needs. The Public Health team within our Local Authority has supported this work and will continue to support us in identifying the best way of meeting the needs.

2.6 In accordance with national requirements and working with partners and stakeholders (including patients, carers and the public), the CCG has formulated a five year strategic plan for Gloucestershire – Joining Up Your Care, which aligns with the Gloucestershire Health Community Health and Wellbeing Strategy ('Fit for the Future') that sets out the priorities for improving health and outcomes for the people of Gloucestershire from 2012-2032.

Joining Up Your Care –
Our Shared Vision for the next 5 years:

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

Our Ambitions:

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

2.7 This Locality Development Plan must be seen in the context of these important strategic documents; projects and initiatives in the Plan will be complementary to this strategic context and the CCGs operating plan. This Locality Development Plan therefore fits within this wider context as follows:

2.8 To identify the health needs of the population of the South Cotswold Locality, three main sources of information have been identified:

- Public Health Intelligence;
- Activity, performance and financial data on the use of services, highlighting those areas where the Locality is significantly over or below 'expected' levels. This analysis has included consideration of benchmarking data and information on variation between usage of health care at a GP Practice population level;
- 'On the ground' intelligence – i.e. conversations with local colleagues who are working directly with patients to understand their views about need.

2.9 The Locality Executive Group will work closely with key stakeholders to identify the health and social care needs of the local population, prioritise actions, and provide ideas for how these needs could be addressed. These stakeholders include:

- Local GP Practices and their staff
- Gloucestershire Care Services
- Gloucestershire Hospitals NHS Foundation Trust
- [2]gether NHS Foundation Trust
- Gloucestershire County Council
- Local voluntary organisations
- Cotswold District Council
- Patients and their representatives
- CCG colleagues

2.10 Whilst assessing the evidence gathered around local health needs, the Locality Executive Group has also taken into consideration the variety of existing work streams within the CCG's countywide Clinical Programme Groups (CPGs). This will allow for a continuous feedback loop where successful learning from the Locality projects can be embedded into the CPGs, and also from the CPGs into the Locality. The locality can influence countywide clinical and service improvement projects and enable locality initiatives which are appropriate to the locality population.

3 Key Achievements to date

3.1 Key achievements of the South Cotswold Locality from the previous 2013-2015 plan are detailed below.

3.1.1 **Social prescribing** – The locality has developed and implemented a social prescribing scheme successfully into 4 GP practices in the locality; in partnership with Cotswold District Council and other local voluntary and community organisations. The hub coordinator Sarah Clifton Gould has worked closely with GP practices at St Peters Road, Rendcombe, Lechlade and The Park. Through the hub, patients are signposted to relevant organisations to assist with social issues they are facing. Over 110 patients have been seen through the social prescribing hub since April 2014. A majority of individuals have needs around social isolation and caring responsibilities. The scheme will be rolled out into all practices in the locality by the end of 2015.

3.1.2 **Cirencester Hospital** has been established as an innovation test bed for community hospital service development within the county. With strong input from the Gloucestershire CCG, Gloucestershire NHS Hospitals Foundation Trust and Gloucestershire Care Services a Cirencester Hospital working group has been formed. A range of options for the hospital have been considered with partners including: the best model of medical cover for local patients; increasing outpatient provision; supporting county-wide work on day surgery and diagnostics and working with Wiltshire and Avon CCG's to assess appropriate services after the Care UK contract comes to an end on the 31st of October 2015.

3.1.3 **Dementia** was a priority identified by the JSNA data for 2013-2015 in the South Cotswold locality, as the prevalence levels were lower than expected. A protected learning time event for all South Cotswold GPs, has increased awareness to support dementia diagnosis. This has led to an increase in the recording of dementia cases in the locality, and enabled the implementation of formal memory testing. Prevalence has increased in the locality so that we are now not an outlier. The increase in diagnosis rate has ensured that more patients and their carers have been able to access management and support services.

3.1.4 **Identifying financial variation in practices** – Building on an approach developed by Yorkshire and Humber Public Health Observatory (now Public Health England), the South Cotswold locality chair took the lead in developing an approach which allows comparison to 'similar' practices within taxonomy groups, enabling a comparison not only to locality practices but also to 'practice peers.' Based on the relative position of each practice's registered list against five themes (% of older patients, deprivation, employment, health conditions and carers, lifespan and disease mortality) seven taxonomy groups were created. This approach was put forward for a national innovation award and has been successfully implemented for use across all Gloucestershire CCG localities. This approach will continue to be developed through 2015-17 as part of the newly established variation programme where the key focus will be based on what actions should take place when variance in practices has been identified.

3.1.5 **Complex lower limb service** – With an increasing ageing population, the locality has identified long term condition planning as imperative to the sustainability of the locality in forthcoming years. The locality has worked towards the implementation of a holistic community based complex lower limb wound service – modelled on appropriate community based care closer to home for patients. The developed service is aligned to a social model of care and will enable efficient use of district nurse time. This scheme will begin in the South Cotswold locality and will then be rolled out across countywide locations.

3.1.6 In addition, the locality has also achieved:

- Working with local partners including the Cotswold District Council and South West Energy agency (SWEA) to raise the profile of Excess Winter Deaths and the support available for the residents of the South Cotswold locality to prevent these.
- Improved awareness and provision of Diabetes care into all practices, including audit, training and nurse support
- Increased awareness of managing adult obesity, encouraging referrals into lifestyle services including slimming world and smoking cessation
- Supporting the introduction of integrated community and rapid response teams
- Taking the first steps of establishing a locality based prescribing management scheme
- Supporting and succeeding in a bid for funding to deliver additional primary care capacity within the locality

3.2 Prime Minister's Challenge Fund

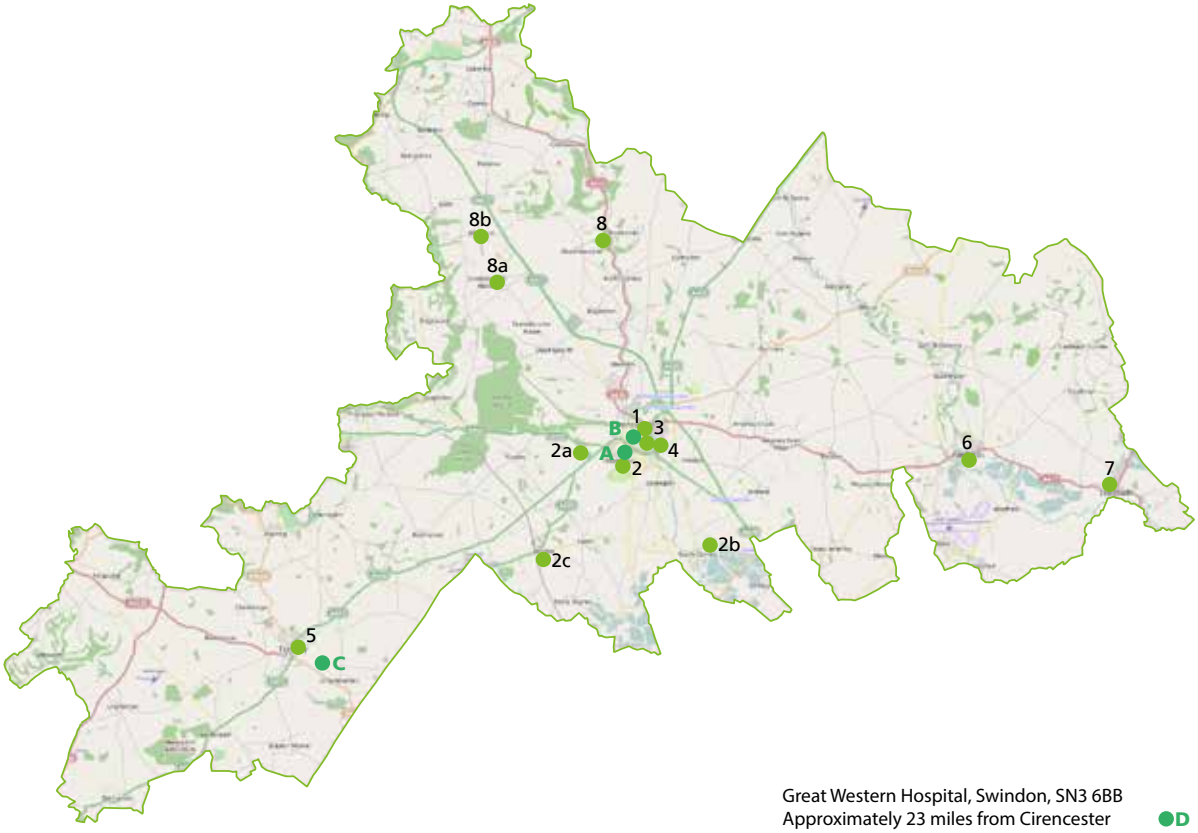
3.2.1 GPs from all localities have been key contributors to a successful application for the Prime Ministers Challenge Fund (PMCF) relating to improving access to general practice, thanks to joint working between the GP provider organisation, Gloucestershire Doctors (G-DOC) and the CCG.

3.2.2 In securing this £4m of additional national funding, localities will be supporting the delivery of providing local people with improved access to GP services in Gloucestershire. This includes the creation of 100,000 appointments a year across all localities to free up time in surgeries to be used on more planned and complex work with patients who have a long term condition. Other innovative delivery approaches include greater use of technology, additional specialist nursing, case management and social prescribing.

3.2.3 A Delivery Board has been established to make key decisions and will include representation from each of the seven Gloucestershire localities..

4 Local Service Provision

4.1 The locality is predominantly rural with population centres in Cirencester, Tetbury, Fairford and Lechlade along with many smaller villages and hamlets. The locality area has neighbouring boundaries with Oxfordshire and Wiltshire – and covers around 57,738 patients. There are 8 GP Practices in the Locality.



1 Park Surgery, Old Tetbury Road, Cirencester, Gloucestershire GL7 1US

2 Phoenix Surgery, Chesterton Lane, Cirencester, Gloucestershire GL7 1XG
2a Royal Agricultural University Branch Surgery, Stroud Road, Cirencester
2b South Cerney Branch Surgery, Clarks Hay, South Cerney, Cirencester GL7 5UA
2c Kemble Branch Surgery, Church Road, Kemble, GL7 6AE

3 St Peter's Road Surgery, 1 St Peter's Road, Cirencester, Gloucestershire GL7 1RF

4 Avenue Surgery, 1 The Avenue, Cirencester, Gloucestershire GL7 1EH

5 Romney House Surgery, 41-43 Long Street, Tetbury, Gloucestershire GL8 8AA

6 Hilary Cottage Surgery, Keble Lawns, Fairford, Gloucestershire GL7 4BQ

7 Lechlade Medical Centre, Oak Street, Lechlade, Gloucestershire GL7 3RY

8 Rendcomb Surgery, Rendcomb, Cirencester, Gloucestershire GL7 7EY
8a Duntisbourne Abbots, Village Hall, GL7 7JN
8b Winstone, Village Hall, GL7 7JZ

Other providers

A Cirencester Community Hospital, Tetbury Road, Cirencester, GL7 1UY

B Cirencester Memorial Hospital, Sheep Street, Cirencester, GL7 1RQ

C Tetbury Hospital, Malmesbury Road, Tetbury, GL8 8XB

D Great Western Hospital, Malborough Road, Swindon, SN3 6BB

Practice List sizes

4.2 The Practice list sizes are as follows:

• The Park	7,583 patients
• Phoenix	12,965 patients
• St Peters Road	6,626 patients
• Avenue	6,688 patients
• Romney House	7,926 patients
• Hilary Cottage	7,333 patients
• Lechlade	4,736 patients
• Rendcomb	3,899 patients
	57,738 patients

Correct as at 1 April 2015 Source: South Cotswold practices

4.3 In addition to the main acute hospitals in Gloucester and Cheltenham and the GP Practice sites, local NHS health services are also delivered from:

- Cirencester Community Hospital
- Care UK at Cirencester Hospital – until October 2015
- Cirencester Memorial Centre
- Tetbury Hospital
- Great Western Hospital
- Any Qualified Provider (AQP) diagnostic providers

4.4 For patients living in any part of Gloucestershire their health issues are often closely linked to other 'social' factors, such as employment, education, and housing. The locality is committed to working in partnership with the Local Authority and third sector partners to both find and implement solutions. The CCG also commissions a range of services from the local Voluntary and Community Sector.

Healthy Marketplace steering committee meeting at Cirencester Hospital - Members of the steering committee discussing details of the project during their meeting in the room which will be used as the Healthy Marketplace - 18.05.15

5 What are the Issues we face?

5.1 Over the last few months' colleagues from across Public Health, Local Councils and the CCGs Finance and Information team have held planning meetings to work together to identify which potential priorities the locality might want to consider based on relevant data.

5.2 Public Health Information

The Local Authority in Gloucestershire produces a Joint Strategic Needs Assessment (JSNA) – this highlights the medical conditions that particularly affect the population of the county and its Localities. It also highlights population changes over the coming 20 years.

The Public Health intelligence demonstrates that the South Cotswold locality performs particular well for its patients. Important outcomes such as life expectancy and premature mortality from major causes of death are very good.

5.2.1 Demographics

The South Cotswold locality has an older age profile than the county as a whole and an above average proportion of patients aged 85 plus, with associated implications for age related long term conditions and use of NHS services. The Cotswold district as a whole is projected to see negative growth (-4.4%) in its working age population (18-64 years) through to 2021. In contrast the over 65 age bracket is projected to grow by 27% in line with the county average.

Loneliness is an issue which impacts strongly on an individual's health and wellbeing. Cotswold District Council have supported a local transport study covering the whole of the Cotswolds area in 2015 across which outlined:

- There are 85,000 residents in the whole of the Cotswolds, 19,000 of whom live in Cirencester
- Of the 85,000 residents, 9,000 residents are over the age of 75
- The older population will increase by more than 10% over the next 10 years and the number of people aged 85 and above living alone is expected to rise by 25% during this time period
- 13% of households across the Cotswolds have no car
- 2,800 pensioners claim credits
- 5,400 people live with a long-term health condition or disability
- Cost of housing is high

Cotswolds Area Transport study (2015). Commissioned in partnership by Cotswold District Council and Gloucestershire Police and Crime Commissioner. The full report including the health and wellbeing impact of loneliness in the Cotswold area can be found at: http://www.cotswold.gov.uk/media/777430/Loneliness-Report.PDF

As part of the Cotswold District local plan there is a proposal to build approximately 2500 additional houses in Cirencester over the next five years adding 6500 patients to the local population. This will lead to additional pressure on community and primary care services.

5.2.2 **Deprivation**

South Cotswold practice boundaries have among the lowest deprivation scores in the county. However there are three Lower Super Output Areas (LSOAs) in Cirencester who rank in deprivation quintile 2 or lower (IMD 2010). The JSNA highlights issues of 'hidden' deprivation for South Cotswolds, potentially causing barriers to housing and services.

LSOA Name	IMD county decile
Cirencester Watermoor 3	1
Cirencester Chesterton 2	2
Cirencester Beeches 1	2
Tetbury 2	3
Cirencester Watermoor 2	4
Moreton-in-Marsh 1	4
Kempsford-Lechlade 3	4
Grumbolds Ash	4
Avening	5
Cirencester Watermoor 1	5
Ermin	5
Chedworth	5
Blockley	5
Ampney-Coln	5
Sandywell	5
Churn Valley	5
Fosseridge	5
Water Park 3	5
Cirencester Park 1	5
Bourton-on-the-Water 1	5
Cirencester Beeches 3	5
Riversmeet	5

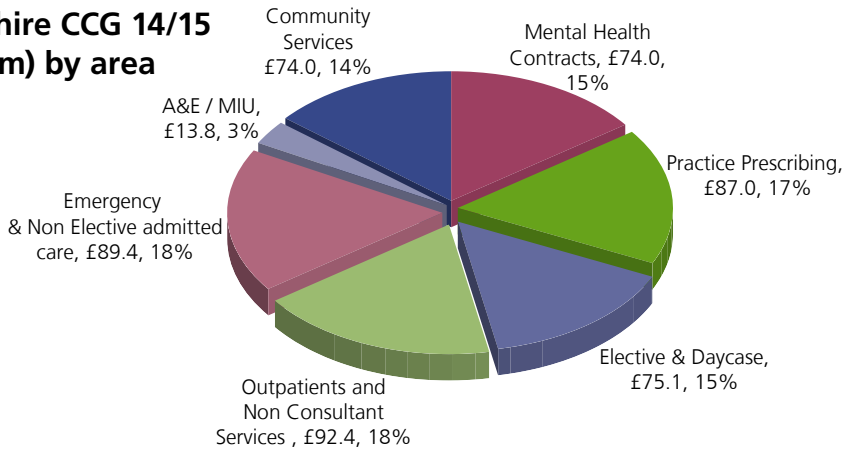
The average deprivation score does not always tell the whole story – There is an assumption of affluence due to the South Cotswolds, however the way in which deprivation data is recorded hide issues such as rurality, localised socio economic deprivation, poor housing stock and difficulties in accessing services.

Deprivation is an important issue as it has an impact on health care funding. Elderly 'wealthy' populations who have multiple age related Long Term Conditionss and subsequent high demand on NHS services and costs are in part discounted in the funding formula due to their low average deprivation score.

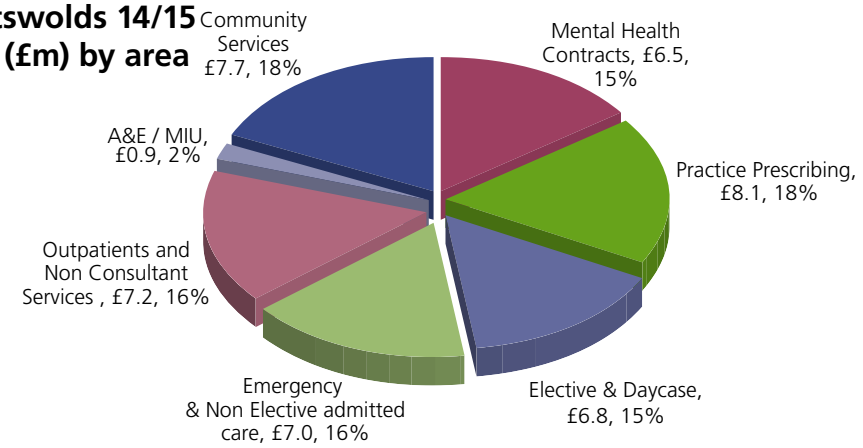
5.3 CCG Finance and Information Data

Analysis of NHS resource utilisation demonstrates variation exists not just at a CCG level, but also between and within localities. The CCG has a finite financial resource that needs to be appropriately distributed and utilised.

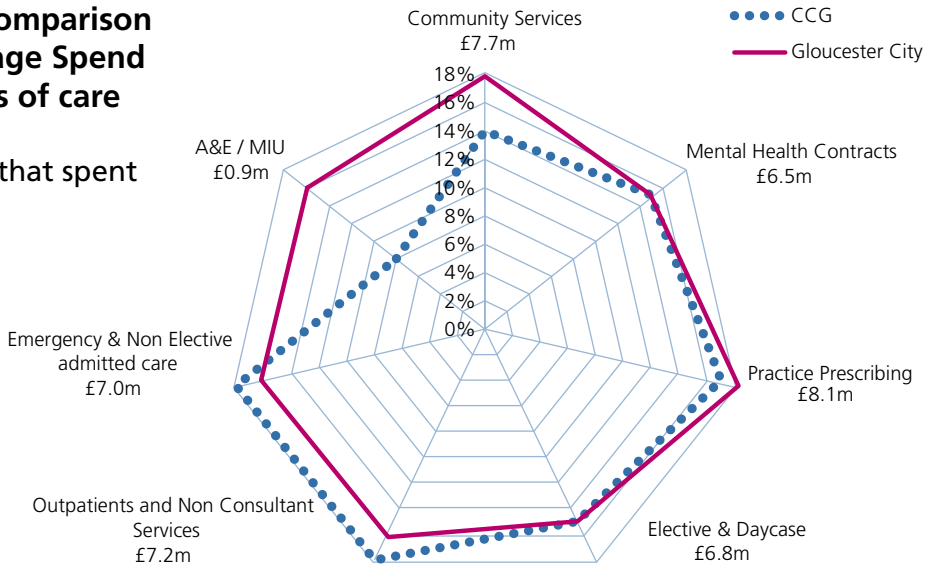
Gloucestershire CCG 14/15 Spending (£m) by area



South Cotswolds 14/15 Spending (£m) by area



South Cotswolds Comparison of 2014/15 Percentage Spend in different settings of care vs CCG Average
(£ figures shown are that spent by South Cotswold)



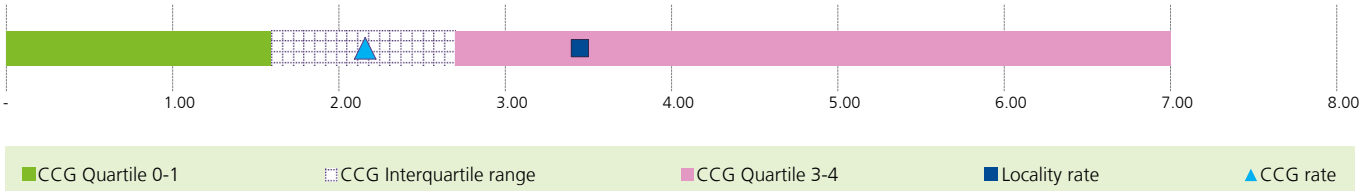
NOTE: These charts exclude other areas of commissioning spend, such as maternity services, ambulance services, continuing health care, CCG running costs and reserves.

In the context of this wider financial picture the business intelligence team has reviewed activity, performance and finance data from commissioned services to assess where there are significant variances from the levels expected for the locality; this has highlighted the key areas for further consideration.

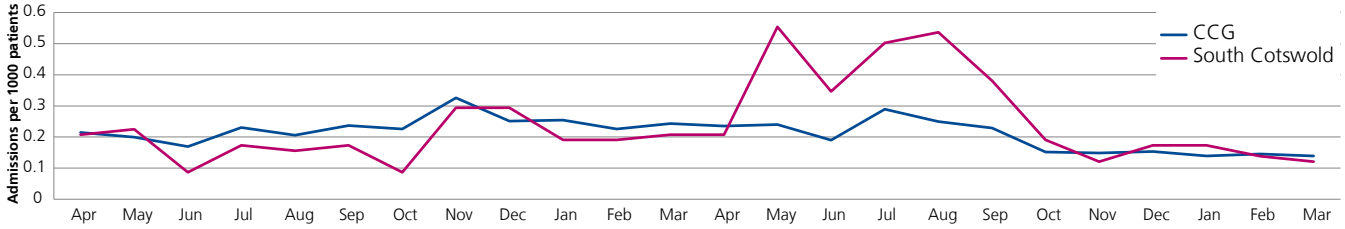
For the development of these key areas the locality proposes a three-pronged approach to each of the highlighted areas: Understand, Educate and Commission.

5.3.1 Emergency Geriatric Medicine admissions

South Cotswold: Percentage of A&E and MIU Attendances that only required 'Guidance/Advice during 2014/15



South Cotswolds A&E / MIU Attendances – Rate per 1,000: All Providers



The South Cotswolds locality contains one of the highest proportions of elderly and very elderly populations within the county. The demographic 'time bomb' often talked about has already exploded and is going to inexorably increase over the next decade. The impact of this can be seen in the data showing the numbers of emergency geriatric admissions from the South Cotswolds population.

The locality shows higher activity for geriatric emergency admissions than expected, with 5 practices within the locality well above expected levels for their age profiles. This issue is of vital importance and forms the basis for many of the work streams that the locality will pursue.

Understand:

Is the admission rate really 'excessive' once you understand the population served? Once we have established this we need to delve deeper. The only way is to go into practices and look at patients notes (this forms the basis of the variance project previously mentioned)

Review case presentations to analyse:	Describe available community services that might avoid admissions including:
• Activity by surgery • Conditions admitted to hospital • Hospital loation • Time of day • Community team engagement • Admissions arranged by in hours or out of hours	• Rapid response • ICTs • Heart failure & Respiratory services, • Community IV service • OPAL • District nurses

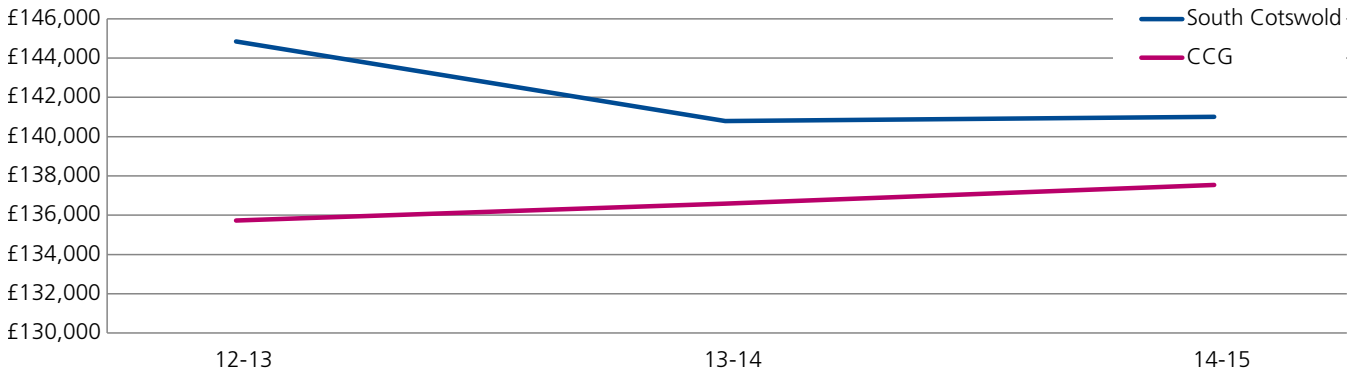
We particularly want to determine the utilisation and effectiveness of the rapid response team within the locality – is it being used appropriately and does it reduce admissions?

Educate: Once we understand the nature of admissions, the services available to avoid admissions, the capacity of those services and the effectiveness of their interventions, we will be in a position to disseminate any learning to the locality to ensure that the services are being used as appropriately as possible. This work will be linked into a CCG project relating to the systemisation of the risk profiling Direct Enhanced Service (DES) – to understand how we can we make the DES really 'work' for patients, practices and the NHS healthcare system.

Commission: The development of a community based geriatric specialist team is the major commissioning intention of the locality for the next two years. It is a service that has been mentioned many times by the practices. The locality has made some difficult decisions and addressed the medical model at Cirencester Hospital, and is now in a realistic position to take this project forwards. We hope to develop an innovative, vibrant, sustainable and effective model of service delivery to maximise benefits for patients and practices. It is hoped any service commissioned will integrate in and out of hospital care by following patients between the two invisibly.

5.3.2 Prescribing

Spend per 1000 patients on Prescribing over past 3 years: South Cotswold vs CCG



Overall the spend rate per 1,000 patients is higher in the South Cotswold locality than in the CCG as a whole. 6 practices are spending more than their taxonomy group average on prescribing and 5 practices have increased spend on prescribing from the previous year. In 2014/15 the locality overspent against its Prescribing budget by 8% (£0.6m). The locality believes that prescribing is an area that we have an element of control over, by changing individual clinical behaviour and practice systems.

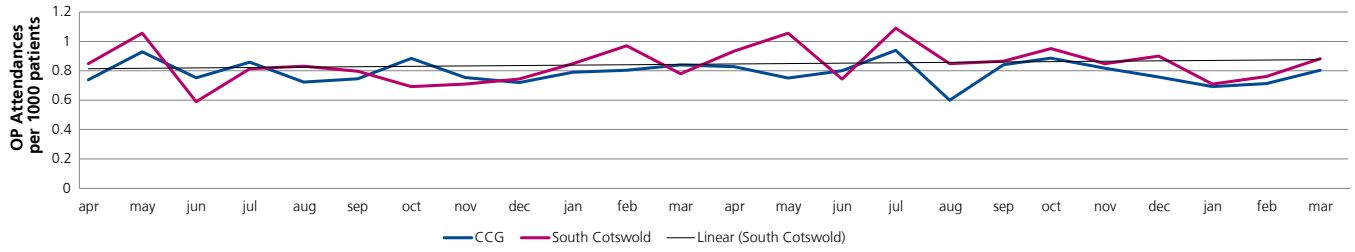
Understand: We have decided to take this issue forward in two ways. The first by devoting additional prescribing resources to one or two practices only (identified by greatest variance in spend and the willingness of practices to engage). We will then use the learning points to share with others. Secondly we intend to look at diabetes prescribing across all of the practices. Diabetes is a well-described condition with nationally agreed, evidence based management protocols. It should therefore be possible to describe an expected spend per diabetic per year based on national guidelines. We can there compare each practices spend against it whilst also comparing proxy measures of outcome such as HBA1C. All projects will be complementary to the existing countywide prescribing improvement plan.

Educate: We will use all of the learning from the individual and cross practice work to write a report and act as the basis for a locality Protected Learning Time event (PLT). The PLT will include expertise from local pharmacists to empower GPs around making appropriate and safe decisions around medicines management. The PLT will also promote best practice in accordance with NICE guidelines, especially with the elderly population.

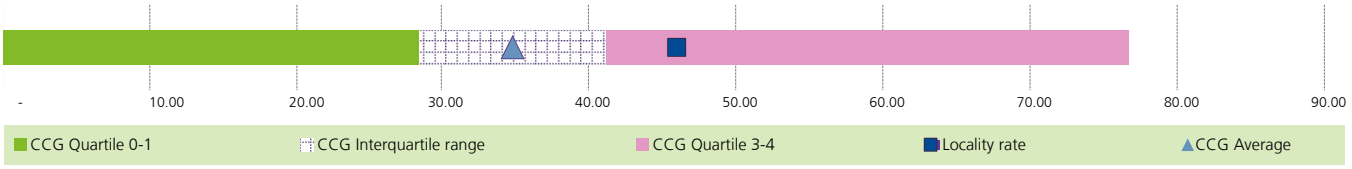
Commission: We want to further explore the development of a locality based Prescribing incentive scheme in the longer term.

5.3.3 **Cardiology – First Outpatient attendance**

Trend Graph of Cardiology GP Referred 1st Outpatient Attendances per 1000 patients April 2013 - March 2015: South Cotswold v CCG



South Cotswolds Cardiology Outpatient attendance rate per 1,000 comparison (2014/15 All Providers)



The above slider chart shows that South Cotswold Locality has more attendances per 1,000 patients than the CCG as whole, with a rate 30% higher than the CCG average. Cardiology outpatients has the highest level of excess activity above the levels that would be expected for the age profile. Including all attendances, activity was circa 600 attendances above expected levels for 2014/15.

As before we intend to use the same three pronged approach to this issue:

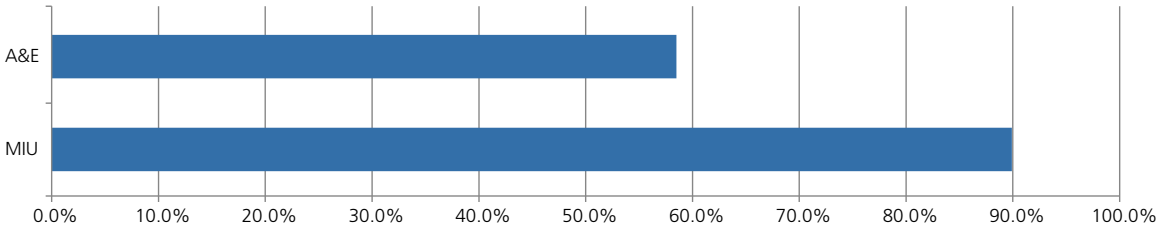
Understand: Through an activity audit analyse which patients are being referred by particular practices into cardiology services, for what reasons. This will help to understand whether all referrals are appropriate or an alternative service provision could help.

Educate: Following the audit, the locality will be able to analyse if certain patients could be managed differently without a referral – are there gaps in local GPs knowledge or in practice systems that can be addressed?

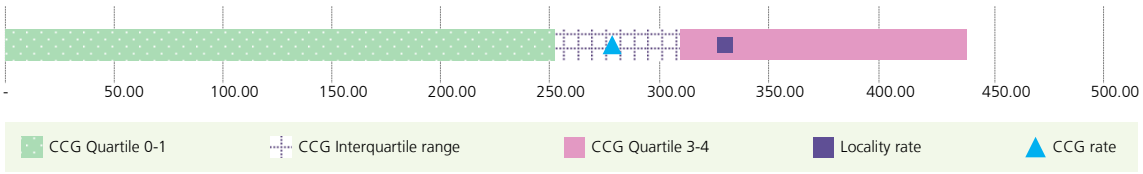
Commission: We are going to explore the viability of establishing a practice based 24hr ECG service or alternative community based palpitation services as we believe on first analysis of the data that this may be the service that is driving the apparent 'excess'.

5.3.4 **A&E / MIIU attendance**

South Cotswold: Percentage of A&E and MIU Attendances that only required 'Guidance/Advice' during 2014/15



South Cotswold A&E / MIIU Attendances – rate per 1,000: All Providers



The graphs on the previous page demonstrate the utilisation of A&E and MIIU by patients within the South Cotswold locality. There are a very large proportion of attendances at A&E and MIIU where the outcome for the patients is Guidance or Advice, either verbal or written. The first chart suggests a majority of patients attend these services and receive advice and guidance only, while the second chart shows that the South Cotswold locality is above the CCG average for utilisation of these services. The locality will work alongside countywide CCG programmes of work to best understand patient need and ensure appropriate services, engagement and communication is in place.

When A&E and MIIU attendance statistics are combined the South Cotswolds has an apparent significant excess in attendance rates. There is also an understandable difference in the outcomes of patient attendances at AE vs MIIU, with the latter dealing with more cases that can appropriately be managed by advice and guidance. Research locally and nationally has shown that the most significant determinant of a patient attending an A&E or MIIU is the proximity of the service to the population. This is reflected in the South Cotswold with attendance rates directly related to how close a patient's practice is to Cirencester and Tetbury Hospital MIIUs. Coupled with the availability of walk –in centres, patient choice could mean that practices have very little influence over a patient's use of MIIU and A&E. The standard belief is that attendance rates at A&E and MIIUs are related to the lack of availability of GP appointments. Is this really true? It is the locality's intention to explore this further.

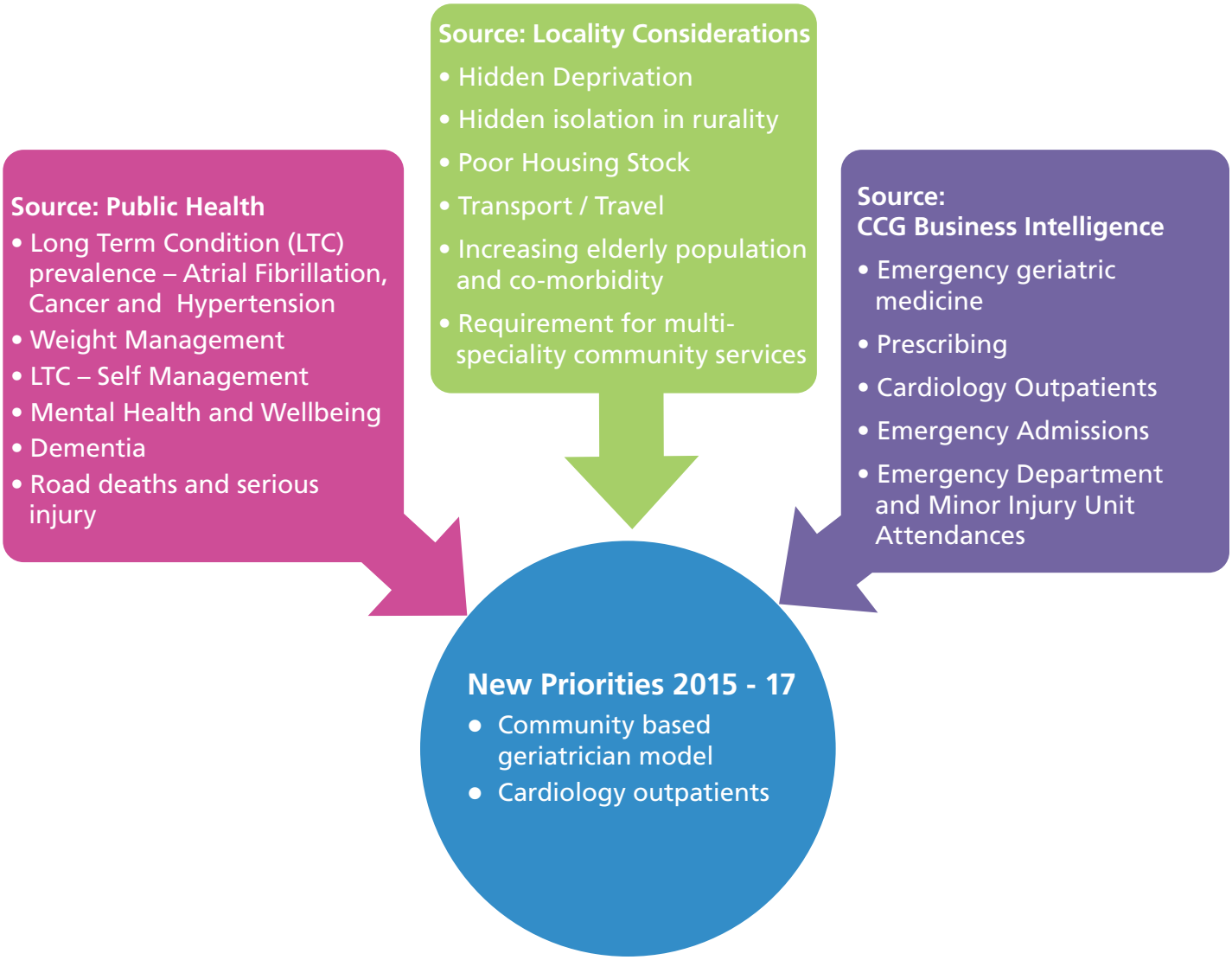
Understand: Collect information on which patients attend different locations at different times of the day. Then analyse if there is a difference in attendances between practices that cannot be explained by geographical distance from the A&E and MIIU location. The analysis will help to understand if initiatives used in particular practices such as 'Doctor First' – where each patient is contacted by a doctor – have an impact on A&E attendances. The skills mix of the workforce within practices will also be explored to understand the best use is being made of all staff according to their skills and knowledge levels.

Educate: Working with CCG colleagues, the locality will encourage patient use of the ASAP app via smartphones to assist them dealing with their condition. It will be promoted through practices and local pharmacies. We will disseminate the findings of the work that we will do at the practice level when we look at individual practice variance in the use of A&E and MIIU.

Commission: The locality will pursue commissioning solutions for any key areas highlighted in the 'understand' stage. This could include specific projects around patient awareness, workforce solutions or system re-design within practices or other provider.

5.4 Priority mapping

The identified priorities have been presented to the Locality Executive Group for them to consider and agree which key themes they would focus on for 2015 - 2017. Below is the plan on a page that was developed showing all the priorities initially presented from each contributor and those prioritised for development.



Projects to be carried forward 2015 - 17

- Social Prescribing
- Cirencester Hospital
- Complex Lower Limb Service
- Locality Collaboration
- Education Federation
- Medicines Management
- Dementia
- Supporting Primary Care within the locality
- Email Patient Photos (Phoenix practice dermatology trial)
- Supporting CCG Countywide Projects

6. Locality Work Programme for 2015/16

6.1 As a locality we will be continuing a number of work streams to be rolled forward into 2015-2017, and we will be exploring work streams which will address some of the local health needs and issues identifying through our information gathering exercise in section five. With our CCG, GP Practice and other colleagues, we will work hard to address identified issues within the resources of the locality.

The locality work programme will be regularly monitored to assess progress, with a formal review at the CCG's Governing Body meeting every six months.

6.2 Recognising that we need to prioritise our work as a Locality, we have summarised what we aim to achieve in 2015/16 in the work programme below:

Priority Action Area Proposed Scheme	Lead Locality GP	Lead Manager (From CCG or other partners)	Expected Outcomes/Impact	Key Contributors	Expected Initiation Date	Expected Completion Date
Locality Schemes						
Community Based Geriatrician Model Exploration of community based support for increasing elderly demographic.	Dr Alan Gwynn	Stephen Rudd/ Zaheera Nanabawa	• Improved access to care closer to home • Reduced emergency admissions and A&E attendances • Increased patient satisfaction and quality of life • Development of appropriate services for existing and projected locality demographic	GP practices in locality, Gloucestershire Care Services, GHNHSFT	September 2015	September 2016 (scoping stage)
Social Prescribing Continue work with CDC to implement and sustain a "Social Prescribing" scheme for the South Cotswolds, offering patients access to a range of services to assist with patients social need – including roll out into all GP practices in the locality.	Dr Sue Whittles / Dr Martyn Hewett	Helen Edwards / Zaheera Nanabawa	• Increased utilisation of identified services in the locality closer to patient homes • Reduced primary care appointments Improved patient well-being (WEMWBS) • Consistent social prescribing access for patients across the locality • Locality based integration of dementia support and physical activity provision	Cotswold District Council, Local Voluntary and Community Sector organisations.	Trial commenced March 2014 Rollout to all practices in locality by October 2015	In current form at least until July 2016

Cirencester Hospital To continue to support the development of Cirencester Hospital as a valuable and viable community hospital through the work of the CCG, Gloucestershire Care Services and the Cirencester Hospital Future Forum.	Dr Alan Gwynn / Dr Malcolm Gerald	Jonathan Jeanes	• Influence the medical model for the benefit of local patients • Consider local commissioning of services wherever viable • Participation in countywide community hospital development programme • Development of Healthy Market Place – which will promote self-help and prevention techniques	Gloucestershire Care Services	Work commenced January 2014	Ongoing
Education Federation Working with local expertise and the South West HEE (Health Education England) to pilot an educational federation for the South Cotswolds locality.	Dr Martyn Hewett	Dr Martyn Hewett	• Increased time and resources for GP registrar training within the locality • Wide coverage of curriculum • Opportunity to visit other GP surgeries • Good-quality clinical teaching • Minimal disruption to working week • Opportunity for GP trainee exposure to management and leadership development	GP trainers in locality GP practices, South West HEE, GP registrar trainees	Work commenced April 2014	Pilot – August 2016

Prescribing – Medicines Management Generate recommendations which influence consistent improvements in prescribing practice at locality and GP practice level.	Dr Alan Gwynn	Stephen Rudd / Zaheera Nanabawa	• Clinically safe prescribing • Assessing factors which allow practices to remain within budget for prescribing expenditure • Assessing consistent approaches for accessing formulary • Working to NICE guidelines • Reduced overspend within prescribing budget for 2015/16 and 2016/17	GP practices in locality, Prescribing support team at CCG.	December 2014	April 2016
Email Photos Trial of specific inbox at Phoenix Surgery for requesting patients, following triage, to email photos of dermatology presentations, e.g. rashes	Dr Peter Hill	Stephen Rudd / Zaheera Nanabawa	• Trial within IG approved process proves compliant and workable • Reduces GP face-to-face appointments, freeing up resource for the practice	Phoenix Surgery initially – to feed back to locality on their innovation	December 2014	December 2015
Moving Care from Secondary to Primary Care Addressing locality financial variance on first outpatient cardiology appointments.	Dr Stephen Jenkins	Stephen Rudd / Zaheera Nanabawa	• Potential financial savings through reduced variation • Subjective quality benefits • Bringing cardiology care closer to home through the use of appropriate technologies	GP practices in locality, Circulatory CPG, potentially Providers (TBD)	July 2015	March 2017

Developing Themes						
Physical Activity Taking a locality place based approach to impact on levels of physical activity, complementary and contributing to the Healthy Individuals clinical programme group.	Dr Alan Gwynn	Stephen Rudd / Zaheera Nanabawa	• Work with local voluntary and community organisations in the locality to map existing physical activity services/ opportunities. • Encourage patient access to existing physical health activities. • Potential use of Healthy Marketplace in Cirencester Hospital for the delivery of condition based physical activity for rehabilitation.	Cotswold District Council, GP practices in locality, Local Voluntary and community organisations.	September 2015	September 2016
Urgent Care Reducing emergency admissions, A&E and MIU attendances	Dr Malcolm Gerald	Stephen Rudd / Zaheera Nanabawa	• Promotion of ASAP smartphone app and website to GP practices and patients through local media campaign. • Encouraging appropriate use of existing mechanisms such as rapid Response, Integrated Community teams (ICT's), Older People's Advice and Liaison (OPAL) and Single point of clinical access (SPCA).	GP practices in locality, CCG communications team, Gloucestershire Care Services, GHNHSFT	Ongoing	Ongoing

Supporting primary care within the locality Exploration of GP practices in locality working in collaboration to develop innovative approaches to meeting local health needs and improving capacity within primary care.	Dr Alan Gwynn	Stephen Rudd/ Andrew Hughes/ Kesh Makesha/ Zaheera Nanabawa	• Sharing resources to increase locality capacity in primary care • Enable an approach for better planning around locality needs for the future demographic of the health population. • Ensuring primary care resources are available to support population growth	CDC, Primary Care team at the CCG, NHS England	Commenced July 2014	Ongoing
CCG countywide projects Supporting practices to implement CCG projects and work programmes into the locality and influencing those programmes with feedback from the locality.	Dr Malcolm Gerald / Dr Alan Gwynn	Stephen Rudd/ Zaheera Nanabawa	• Locality GP awareness and implementation of CCG projects including:	CCG	Ongoing	Ongoing
		Maria Metherall	• Urgent care usage reduction – including use of ASAP app, Rapid Response, ICT's, OPAL and SPCA.	CCG		
		Julia Tambini	• Prime Ministers Challenge Fund: Choice +, Skype, e-Consult	Gloucestershire GP provider company (GDoc) and CCG		
		Helen Edwards	• Integrated Community Teams • Rapid Response	Gloucestershire Care Services and CCG		
		Andrew Hughes	• Infrastructure/ Premises Development	CCG		
		Bronwyn Barnes	• Variation Programme	CCG		
		Gina Mann	• Care Pathways Website (G-Care)	CCG		
		Dominic Fox	• Joining up Your Information (care record)	Central Southern Commissioning Support Unit		
		Helen Goodey	• Primary Care Offer	CCG		

Dr Alan Gwynn

Chair – South Cotswold Locality

June 2015

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 9

Gloucestershire Clinical Commissioning Group
Governing Body

Meeting Date	**Thursday 24th September 2015**
Title	**Approach to Planning 2015/16 – Making it Happen**
Executive Summary	The paper *An Approach to Planning* was approved by the Governing Body on the 30th July 2015. This paper outlined a new approach to planning covering: • A clearly defined planning cycle representing the timings of the commissioning, business case, business planning and engagement cycles that ensures that planning activities occur in a logical order. • An approach to engagement in the planning process which ensures that CCG plans are informed by key stakeholders. • Arrangements to ensure that there is clear alignment between the development of Locality Plans and wider CCG planning. • A Forward Work Plan which will ensure that the 5 year strategy *Joining up Your Care* is widely 'owned', understood, embedded, detailed, localised, coherently delivered and contemporaneous. Having approved this broad approach to planning and engagement this paper has the following aims: i) To list the key activities and dates in the 2015/16 planning round.

	ii) To clarify the process for prioritising business cases including the principles underpinning the decision, the associated weighting and the prioritisation process. iii) To clarify the governance arrangements for prioritising and approving business cases.
Key Issues	This is the start of a refreshed approach to our planning. The implementation of this approach will build and grow in 2015/16 and 2016/17. We will continually learn from our approach and seek to improve it.
Risk Issues: **Original Risk** **Residual Risk**	We are developing our planning approach to be proactive and ready for next year. It is likely that there will be new policy directions and implications for our plans. We do not yet have guidance on the NHS England planning framework for next year. Whilst being prepared we will also need to be flexible in our approach and adapt to national requirements. Developing our approach to planning earlier in the year reduces the risk of undue pressure within the organisation.
Financial Impact	The CCG plans need to be within the CCG's financial envelope. We know that demand for health services is increasing which requires us to look at efficiencies and innovative ways of working to offset this cost. The implementation of the processes set out in the paper is cost neutral. Developing a more systematic approach to planning should ensure more efficient use of staff and clinical time.
Legal Issues (including NHS Constitution)	Our plans do and will continue to set out how the CCG will commission constitutionally compliant health services. As we develop more detailed plans to deliver new models of care we will need to scope out

	any legal implications and requirements.
Impact on Health Inequalities	A key feature of our 5 and 2 year plans is our desire to reduce health inequalities. The public health team are currently developing a Health Inequalities Strategy for the county and the outputs of this will need to feature in the CCG's plans. As part of the engagement in the development of our priorities we need to ensure that the voice of disadvantaged communities is heard. Equality Impact Assessments need to be undertaken for business cases that underpin the CCG's plans. The proposed prioritisation matrix includes a criterion titled 'addressing health inequalities' which will enable proposals that help to reduce health inequalities to be given due weighting within our decision making.
Impact on Equality and Diversity	The recommendations in the paper do not have a specific impact on equality and diversity as they describe mechanisms and processes. The content of our plans and the schemes which make up our plans need to have due consideration for their impact on equality and diversity.
Impact on Sustainable Development	The proposed prioritisation matrix includes a criterion titled deliverability, which includes a focus on sustainability and the impact on the environment. Schemes will need to consider their contribution to sustainable development.
Patient and Public Involvement	The paper proposes that we build engagement into our planning cycle so that it becomes an integral part of our approach. A table of proposed engagement dates is included within the paper and an approach to wider PPI engagement was described in the July Governing Body paper.
Recommendation	To review and act on the recommendations within this paper.
Author	Ellen Rule, Jenny Bowker and Ian Goodall
Designation	Director and Associate Directors
Sponsoring Director (if not author)	Ellen Rule, Director of Transformation and Service Redesign

An Approach to Planning 2015/16

Making It Happen

Contents

1. Overview

The paper *An Approach to Planning* was approved by Governing Body on the 30th July 2015. This paper outlined a new approach to planning covering:

- A clearly defined planning cycle representing the timings of the commissioning, business case, business planning and engagement cycles (*see Figure 1*) that ensures that planning activities occur in a logical order.

- An approach to engagement in the planning process which ensures that CCG plans are informed by key stakeholders.

- Arrangements to ensure that there is clear alignment between the development of Locality Plans and wider CCG planning.

- A Forward Work Plan which will ensure that the 5 year strategy *Joining up Your Care* is widely 'owned', understood, embedded, detailed, localised, coherently delivered and contemporaneous.

Having approved this broad approach to planning and engagement this paper has the following aims:

iv) To list the key activities and dates in the 2015/16 planning round.

v) To clarify the process for prioritising business cases including the principles underpinning the decision, the associated weighting and the prioritisation process.

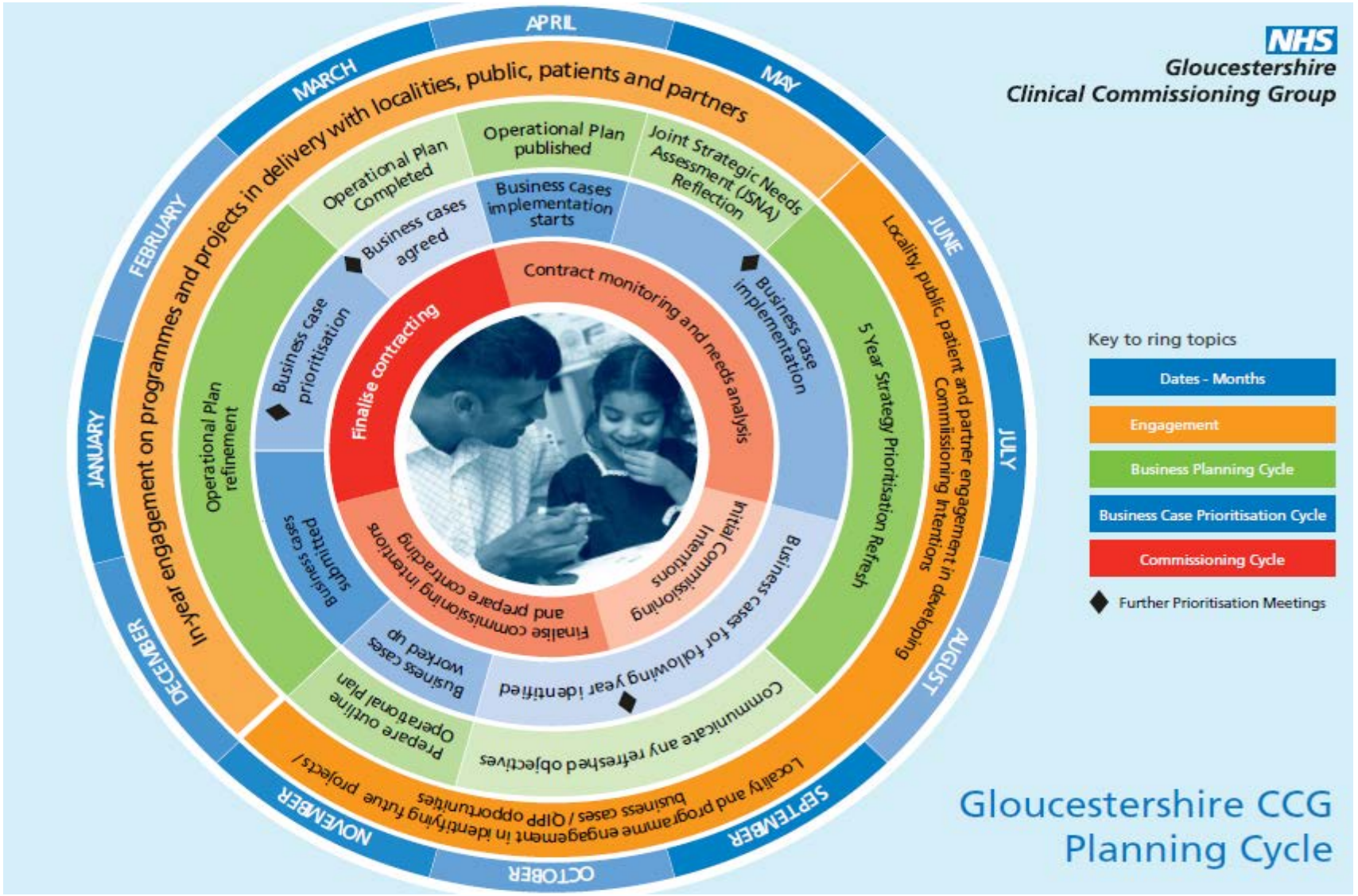
vi) To clarify the governance arrangements for prioritising and approving business cases.

2. The Planning Cycle

The CCG follows a relatively standard cycle of planning activities. It is proposed that this is formalised into the cycle described by the diagram shown at *Figure 1*, to allow for ease of communication with a wide range of stakeholders. The Planning Cycle describes the required planning activities during each month of the year. Each circle represents a different type of planning activity, namely:

- The commissioning cycle
- The business case prioritisation cycle
- The business planning cycle including writing and refreshing our strategic plan JUYC, and the Operational Plan
- The engagement cycle

Figure 1: The Planning Cycle



3. Key Dates in the 2015/16 Planning Round

Shown in *Tables 1-3* are the key dates in the 2015/16 planning round, based around the Planning Cycle. Events are categorised as engagement, business planning/contracting or business case prioritisation and QIPP definition.

Table 1:

Engagement		
Month	**Date**	**Event**
Sept '15	3rd	AGM
Oct '15	22nd 22nd	South Cotswolds Locality Executive Group Engagement Event with key stakeholders – Joining Up Your Care, Our Five Year Forward View (Continuation until Jan '16)
Nov '15	2nd 3rd 10th 11th 18th 23rd TBC TBC	Cheltenham Locality Executive Group Tewkesbury, Newent & Staunton Locality Executive Group Gloucester Locality Executive Group Stroud & Berkeley Vale Locality Executive Group Forest of Dean locality Executive Group North Cotswolds Locality Executive Group VCS Alliance Provider Forum HealthWatch Forum

Table 2:

Planning and Contracting		
Month	**Date**	**Event**
Sept'15	30th	Write to our providers with contract intentions
Oct '15	19th	Outline Commissioning Intentions
Nov '15	26th	Finalise Commissioning Intentions and Governing Body sign-off
Dec '15	21st*	NHSE Publishes Planning Guidance
	31st	Outline activity plan
Jan '16	15th	Updated contract intentions sent to providers
April '16	4th*	Contracts signed
	4th*	Completion of Operational Plan
June '16	30th	Refresh JUYC to respond to 5YFV

Table 3:

Business Case Prioritisation & QIPP Definition		
Month	**Date**	**Event**
Sept '15	TBC	QIPP Development and Monitoring Group
Oct '15	7th	Priorities Committee
	TBC	QIPP Development and Monitoring Group
	30th	High level benchmarking for programme groups
Nov '15	TBC	QIPP Development and Monitoring Group
	30th	Directorates, clinical programmes and localities submit outline business cases
Dec 15	TBC	QIPP Development and Monitoring Group
Jan '16	TBC	QIPP Development and Monitoring Group
	21st	Priorities Committee
	29th	Directorates, clinical programmes, localities sign off draft QIPP schedules
Feb '16	TBC	QIPP Development and Monitoring Group
Mar '16	TNC	QIPP Development and Monitoring Group
	3rd	Priorities Committee
Apr '16	TBC	QIPP Development and Monitoring Group

May '16	TBC 19th	QIPP Development and Monitoring Group Priorities Committee

**Estimated dates subject to change by NHS England*

The Priorities Committee is scheduled throughout the year, although it is intended that that the majority of business cases will be reviewed in January 2016. Additional Priorities Committees are primarily to review ad-hoc business cases that either could not be anticipated or where it is infeasible that they can be developed in January. The QIPP Development & Monitoring Group is a proposed new group (terms of reference to be defined but likely to involve colleagues in the Transformation, Finance, Information and Commissioning Directorates) to define the 2016/17 QIPP schedule, ensure alignment with emerging Commissioning Intentions and provide advice during the development of new business cases to be reviewed by the Priorities Committee. In this way delivery of the 2016/17 QIPP schedule will be maximised and the QIPP Development Group could then assist in the development of QIPP delivery and development of new business cases.

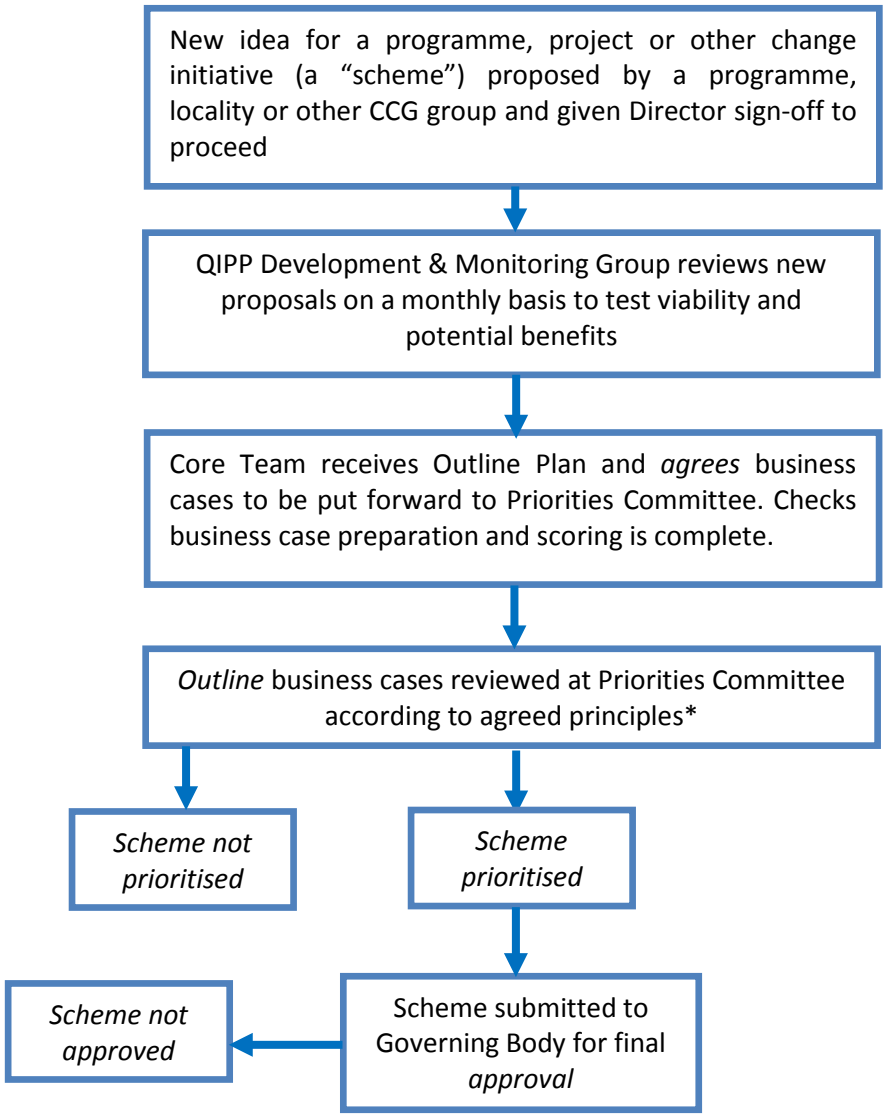
Consultations events are scheduled in order to receive early input into the Commissioning Intentions and well in advance of the production of the Operational Plan or refresh of the clinical strategy. Particular emphasis is placed on localities in order to improve alignment between the Locality Development Plans and wider CCG planning. The proposed engagement activities will involve the following stakeholders:

GP member practices
District Councils
County Council
Gloucestershire Hospitals NHS Foundation Trust
Gloucestershire Care Services NHS Trust
2Gether NHS Foundation Trust
South Western Ambulance Services NHS Foundation Trust
GDoc Ltd
Gloucestershire VCS Alliance
HealthWatch
GFirst LEP
Police and Crime Commission
Fire and Rescue Service

4. Business Case Approval Process

Figure 2 below shows the governance arrangements for the approval of new, and ratification of existing, business cases (including QIPP schemes). *Table 4* outlines, in broad terms, the role of each group in this process.

Figure 2: Business Case Approval Process



**Full business cases will subsequently be reviewed on a monthly basis by the QIPP Development & Monitoring Group following approval of the outline business case by Governing Body to ensure that the detailed proposals are realistic and will deliver the intended benefits.*

Table 4: Roles of Groups

Group	Role
Governing Body as Priorities Committee	Prioritises *Outline* Business Cases for new schemes according to the Prioritisation Matrix *(see section 6 below).* Reviews existing schemes and recommends whether they should proceed into following year.
Core Team	Approves the Outline Plan of schemes to be put forward to Priorities Committee. Assures business case preparation and scoring is complete prior to submission to Priorities Committee.
Governing Body	Provides final approval for Outline Business Cases.
QIPP Development & Monitoring Group	Reviews new proposals arising from CPGs, localities, Programme Boards or elsewhere to test viability prior to developing Outline Plan for Core Team. Defines 2016/17 QIPP schedule through liaison with other departments in CCG and linked to emerging Commissioning Intentions. Reviews full business cases that are developed subsequent to the approval of outline business cases to ensure they are consistent with the aims of the approved outline business case. Monitors QIPP delivery in 2016/17.
Localities, Programme Boards and CPGs	Conceive of new projects and schemes in order to meet CCG objectives

5. Prioritisation of Business Cases

The role of the *Priorities Committee*, as described above, is to review and prioritise outline business cases to determine which should be supported to proceed. *Table 5* below shows the Prioritisation Matrix which forms the basis of this process and the aspects of each outline business case that should be reviewed.

The detailed process to be followed by the Priorities Committee is as follows:

i) Outline Business Cases for new 2016/17 schemes sent to Priorities Committee members in advance of January 2016 meeting.

ii) Members read and score each Outline Business Case and submit scores electronically to PMO.

iii) Priorities Committee meets on 21st January 2016 and reviews collated scores for each business case. Any amendments are made to scores based on any further information received or misunderstandings.

iv) Schemes are prioritised and a proposal made for those that should go forward.

v) Priorities Committee reviews existing schemes and, based on feedback regarding effectiveness to date, make a proposal as to whether these schemes should continue.

vi) The recommendations of the Priorities Committee are sent to Governing Body for final approval.

Table 5: Prioritisation Matrix

Factor		Scale			Score	Weight	Mark
Mandatory (Core to confirm status)	DO NOT SCORE FURTHER						
	Detail	Low (0-3)	Mid (4-7)	High (8-10)			
Strategic Fit	Supports delivery of Gloucestershire priorities, Joining Up Your Care, national policy, managing access (care closer to home/reduced waiting times and LOS) and reducing variation, reputational or other imperative (e.g. procurement)	Does not address the objectives of Joining Up Your Care or meet national/local priorities. Does not improve access or reduce variation. No risk to reputation or other imperative.	Partially addresses one or more of the objectives set out in Joining Up Your Care or national/local priorities. Makes some contribution to improving access or reducing variation. Some risk if not delivered.	Fully supports one or more of the objectives set out in Joining Up Your Care or national/local priorities. Significant improvement to access or significant reduction in variation. High risk if not delivered.		1	
Addressing Health Inequalities	Reduces identified health inequalities, proportionate universalism	Little contribution towards reducing health inequalities or needs identified in JSNA / Health Inequalities delivery plan	Some contribution towards reducing health inequalities or needs identified in JSNA / Health Inequalities delivery plan	Significant contribution towards reducing health inequalities or needs identified in JSNA / Health Inequalities delivery plan		1	
Quality and Outcomes	Clinical evidence base, patient experience, measurable impact on health and wellbeing outcomes and/or life expectancy, negative impact on care if not delivered	Limited benefit to patients is demonstrated	Some Benefits demonstrated	Significant and measurable benefits to patients		1	
Deliverability	Do-ability, Workforce, Sustainability, Environmental Impact	Significant questions of deliverability, resourcing or sustainability, adverse environmental impact	Some questions of deliverability, resourcing or sustainability, neutral or evidence of some positive impact on environment	Clear evidence of deliverability, resourcing or sustainability. Significant positive impact on the environment		1	
Cost Effectiveness	Return on Investment expected (supporting schedule - can be quantified or qualitative assessment), investment vs benefits delivered, use of resources and Value for Money	Limited evidence of return on investment, investment vs benefits and significant questions about value for money	Some evidence of return on investment, investment vs benefits, some questions about value for money	Clear evidence of return on investment, investment vs benefits and clear value for money		1	0
					TOTAL		
					Maximum		50
Cost (£)							£0.00
Cost (£) per point							£0.00

Weighting

The development of a new prioritisation matrix requires careful consideration of the relative impact of the individual criterion. This new framework has initially been set with all criteria offering equal weight. The approach will be tested through an exercise applied to existing approved business cases to determine if relative weights need to be adjusted for future application. This process will be led

by the QIPP Development and Monitoring Group and the results will be shared with the Governing Body for approval at the November session.

6. Key Recommendations

The key recommendations for consideration are as follows:

No:	Recommendation:
1	To note the key planning dates (Tables 1-3)
2	To approve the business case approval process (Figure 2)
3	To approve role of groups in the planning process (Table 4)
4	To approve the Prioritisation Matrix (Table 5) in principle, pending a review of the weighting

NHS
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Agenda Item 10

Governing Body

Governing Body Meeting Date	**Thursday 24th September 2015**
Title	**Performance Report**
Executive Summary	This performance framework report provides an overview of Gloucestershire CCG performance against organisational objectives and national performance measures for the period to the end of August 2015. The performance report format is currently being reviewed. Some of the agreed changes from the review have been included within this report, others are still under development.
Key Issues	These are set out in the executive summary within the report.
Risk Issues: **Original Risk** **Residual Risk**	All risks are identified within the relevant sections of this report.
Financial Impact	This report gives detail on the financial position to the end of August
Legal Issues (including NHS Constitution)	These are set out in the main body of the report.
Impact on Health Inequalities	Not applicable.
Impact on Equality and Diversity	There are no direct health and equality implications contained within this report.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	These are set out in the main body of the report.
Recommendation	The Governing Body is asked to: • Note the performance against local and national targets and the actions taken to

	ensure that performance is at a high standard. • Note the financial position as at month 5. • Note the risks identified in the Finance & Efficiency report. • Note the progress on the QIPP.
Author & Designation	Sarah Hammond, Head of Information & Performance Andrew Beard, Deputy CFO Ian Goodall, Associate Director of Strategic Planning
Sponsoring Director (if not author)	Cath Leech, Chief Finance Officer

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Gloucestershire CCG

Performance Report

1.0 Executive summary

1.1 Introduction

The performance report is broken down into the five sections of the GCCG performance framework:

- Clinical Excellence
- Finance and Efficiency
- Patient Experience
- Partnerships
- Staff

A full summary of performance against all national and local standards is included within the relevant scorecard for that section of the report. An overarching GCCG performance dashboard is included as a supporting appendix; providing an overview of all key national and local targets. A further supporting appendix is provided in relation to the update on 2015/16 budgets.

Whilst inevitably this report focuses on areas of concern it should be noted that Gloucestershire is currently achieving the majority of the local and national performance standards.

1.2 Balanced scorecard 2015/16 – up to 31st August 2015

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

1.2.1 **Clinical Excellence – Amber**,

Clinical excellence - Perspective highlights:

- Strong progress is being reported across all active clinical programme groups with good clinical engagement across the system
- GCCG will be a 'Beacon CCG' becoming one of the first CCG's to commit to the 'Sign up to Safety' campaign
- The Quality Team, in conjunction with the Information Team have produced a draft Quality Assurance Framework which spans in-county NHS providers allowing for benchmarking of indicators across providers. Development of this assurance tool will continue

Good performance:

- SWAST wide Red 1 ambulance target achievement
- Reduction in handover delays compared to 2014/15 levels
- Improved Incomplete RTT performance, with the 92% incomplete standard
- Continued achievement of Cancer 31 day targets and improved performance against the 2 week wait standard
- No urgent operations cancelled for a second time for the year to date

Challenging performance:

- Red 2 Ambulance response times following the introduction of the Dispatch on Disposition pilot. SWAST trajectory to reach 70% for Red 2 by Q3 is in place. It is recognised that the ambulance service are operating the Dispatch on Disposition pilot which has had an impact on this performance
- A&E 4 hour target. The YTD performance at the end of August was 92.0%
- 62 day cancer waiting times
- 6 week diagnostic waiting times
- Planned endoscopy waiting times
- Cancelled operations

Patient experience – Green.

Patient Experience - Perspective highlights:

- The Patient Experience and Safety Team have planned visits to all main providers to ensure patient engagement/information is comprehensive and utilised effectively to support service change

- CCG Patient Engagement and Experience Teams continue to support a wide range of GCCG projects. Key activities in the last period include:

  - Eye Care and Muskulo-skeletal workshops
  - supporting the development of the Gloucestershire Shared Care Records Project communications and engagement campaign for summer 2015
  - development of Personal Health Budgets (PHB) Stakeholder Engagement
  - production of a patient survey to capture patient experience (including patient transport) of Renal Dialysis; and improving experience of End of Life care in community hospitals

Good performance

- FFT CQUIN Targets achieved in Q4 2014/15
- Comprehensive experience and engagement activity supporting CCG work programme

Challenging performance:

- Results of Maternity, Emergency & elective inpatient surveys remain amber

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

Partnerships - Perspective highlights:

- Full sign up to collaborative commissioning agreement and contract performance of all health and social care services in the community provided by Gloucestershire Care Services
- Better care fund metrics are now included within the report, progress against the ambitions set within the Gloucestershire health and well-being board plan will be reported within the partnerships perspective.
- Development of system wide Operational Resilience and Capacity Plan (ORCP)

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

Staff - Perspective highlights:

- Monthly turnover in August was 1%
- Staff sickness levels in 2015/16 equates to 2.2%
- A new organisational development programme of work is underway which is led by a group with membership from all CCG teams

Finance and efficiency – Green

Finance and Efficiency - Perspective highlights:

- The overall assessment for the finance and efficiency perspective against the NHS England criteria is amber. The CCG has significant financial pressures emerging

Good performance

- The CCG is forecasting to deliver a surplus of £7.3m
- The better payment practice code performance for the year to date (for non-NHS invoices by volume) is 97.2% which is in line with the targeted figure

Challenging performance:

- Prescribing expenditure is significantly above budgeted level, primarily NOACs
- Emergency activity at GHFT is above plan
- There is slippage against the QIPP programme

1.3 GCCG Performance Framework Overview

The sections below provide an overview of each domain. Each of the sections is broken down into success criteria which when combined provide an overall rating for the domain. The development of the partnerships section is ongoing as this is an area of development for the CCG.

All indicators are RAG rated, based on the 2015/16 NHS England planning thresholds. Key national and local indicators are given an overall rating by weighting their importance to the organisation. Indicators which feature in the NHS constitution, Quality Premium and CCG assurance framework receive the highest weighting with local targets being given a lesser value. The overall rating is then derived from the combined score of those targets rated Amber and Red.

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

Performance framework

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

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

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

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

2.1 Clinical Excellence

2.1.1 Clinical Excellence – Period up to 31st August 2015

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

PERSPECTIVE 1	Clinical Excellence	Green
Success criteria: *1. Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.*		G
Key performance indicators		
A robust process to timely monitor compliance with NICE, which provides assurance that all NICE publications are considered and Technology Appraisals are implemented within 90 days (or to have a valid reason if not which has gone through appropriate governance process).		G
Clinical Quality Review Groups meet quarterly and provide assurance to the Governing Body through the production of a bi-monthly provider quality report. Ad-hoc meetings take place with providers on specific concerns.		G
Success criteria: 2*. The Organisation has a culture where clinical effectiveness underpins decision-making, through considering up to date evidence and horizon scanning.*		G
Key performance indicators		
CPGs have a portfolio of clinical evidence which informs and supports their decision-making.		G
Success criteria: 4*. Key local and National standards relating to Patient Experience*		A
Key performance indicators		
Achievement of key local and National standards relating to Clinical Excellence – see section 2.2 to 2.8		A

2.1.2 **Success criteria 1: Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.**

The Quality Team has established quarterly Clinical Quality Review Groups (CQRG) chaired by the Executive Nurse and Quality Lead. These are held for Gloucestershire's main providers, namely Gloucestershire Hospitals NHSFT, 2gether NHSFT, Gloucestershire Care Services Trust and a further CQRG for Care Homes. These meetings report directly to the relevant NHS Gloucestershire CCG/Provider contract boards, and provide a focused opportunity for quality to be discussed between provider and commissioner.

Bespoke datasets are reviewed at the quarterly Clinical Quality Review Group meetings for each of the provider organisations, as well as further CQRG's for Care Homes and Primary Care

CQRG's have the ability to escalate any issues to the full contract board, and where necessary to the regular wider Quality Surveillance meetings. Updates and minutes from CQRG's are routinely reported to IGQC for assurance purposes.

The Quality Team, in conjunction with the Information Team have produced a draft Quality Assurance Framework which spans in-county NHS providers allowing for benchmarking of indicators across providers. Development of this assurance tool will continue.

In addition to the CQRG meetings the Quality Team has recently established a programme of bi-annual Quality Summits for the three main Providers. These Summits bring together Commissioners across the range of services to highlight issues or concerns and identify areas of good practice. The intention is that issues raised will be used to inform the commissioning intentions for the year 2015/16.

2.1.3 **Success criteria: 2. The Organisation has a culture where clinical effectiveness underpins decision-making, through considering up to date evidence and horizon scanning.**

Continued work between CPG team, information team, public health and the quality team, to consider the outcomes of the NICE CCG Outcome Indicator Set 2014/15 – 2018/19, and how the clinical outcomes can contribute to the implementation of the CCG two year delivery plan.

A small contract has been agreed with the CSU to provide the CCG with access to their clinical effectiveness updates and NICE implementation impact assessments on a monthly basis. This information will be shared with clinical leads and CPGs.

2.2 Reporting of key local and national standards – Clinical Excellence

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

Issues identified in the following areas:

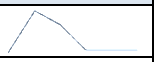
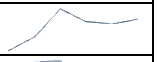
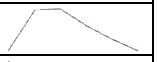
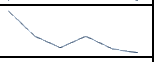
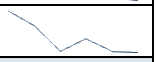
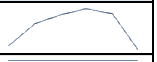
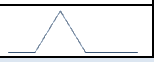
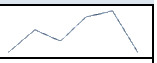
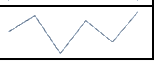
- Red 2 Ambulance response times
- 12 hour trolley waits in A&E
- A&E 4 hour target
- Stroke performance targets
- RTT 52 week waits
- Cancer waiting times
- 6 week diagnostic waiting times
- Planned endoscopy waiting times
- Cancelled operations

Areas of good performance include:

- Red 1 ambulance achievement
- Reduction in handover delays
- Incomplete RTT performance
- Cancer 31 day targets
- Improvements to patient transport service targets

2.3 Unscheduled care:

The dashboard below provides a more complete position statement for Unscheduled care. Each of the Amber and Red rated indicators are reported on by exception in section 2.3.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Local and National standards relating to Clinical Excellence							
Unscheduled care	Threshold	Month	Performance		YTD performance		6 month trend
SWAST Ambulance indicators							
Cat A RED 1 Ambulance incidents	75%	July	75.3%	●	76.2%	●	
Cat A RED 2 Ambulance incidents	75%	July	66.6%	◆	66.8%	◆	
Cat A 19 min response Ambulance incidents	95%	July	90.5%	■	91.5%	■	
Over 30 minute ambulance handover delays (GHNHSFT)	<2014/15	July	37	●	223	●	
Over 1 hour ambulance handover delays (GHNHSFT)	<2014/15	July	3	●	21	●	
A&E							
4-hour A&E target GHNHSFT	95%	August	85.8%	◆	92.0%	■	
4-hour A&E target GCS MIU	95%	July	99.8%	●	99.8%	●	
12 hour trolley waits	0	August	0	●	1	◆	
Enhancing quality of life for people with long-term conditions							
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	80%	July	64.9%	◆	76.0%	■	
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	60%	June	58.7%	■	50.0%	◆	

2.3.1 SWAST Ambulance indicators

Ambulance targets are monitored at a South Western Ambulance Trust wide aggregate level.

The introduction of the Dispatch on Disposition has resulted in the prioritisation of responses to Red 1 incidents. As part of the changes to the dispatch process call handlers are provided with extra assessment time for all other classification of 999 calls (including Red 2 incidents).

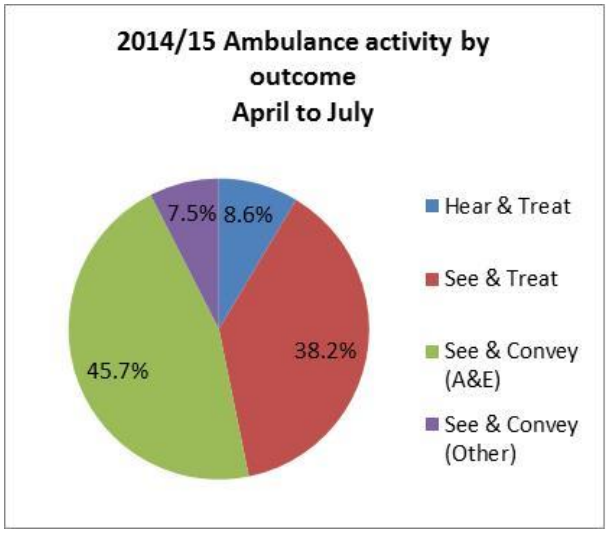
Current year to date performance is Green rated (76.2%) for Red 1; however, performance against the Red 2 and Red 19 minute targets is currently red rated.

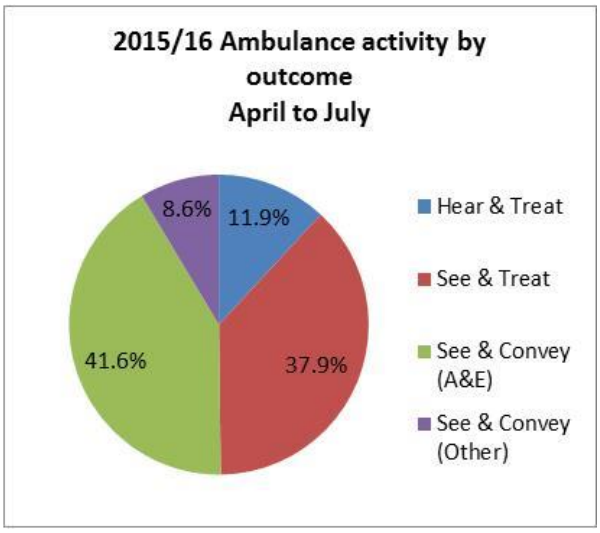
It is estimated that impact there has been a 5% reduction in Red 2 performance due to the introduction of the discharge on disposition pilot. On this basis commissioners have received a trajectory from SWAST to reach 70% for Red 2 by the end of December 2015.

During the first 4 months of 2015/16, incidents with response in Gloucestershire have been 2.8% above contracted levels, which equates to 806 incidents, approx. 200 per month.

When analysed by case type/ outcome, the profile of quarter 1 Ambulance activity has changed.

The percentage of Hear and Treats has increased from 8.6% to 11.9% for the period April to July 2014/15 to 2015/16, with the number of patients conveyed to A&E departments has seen a reduction from 45.7% to 41.6%.



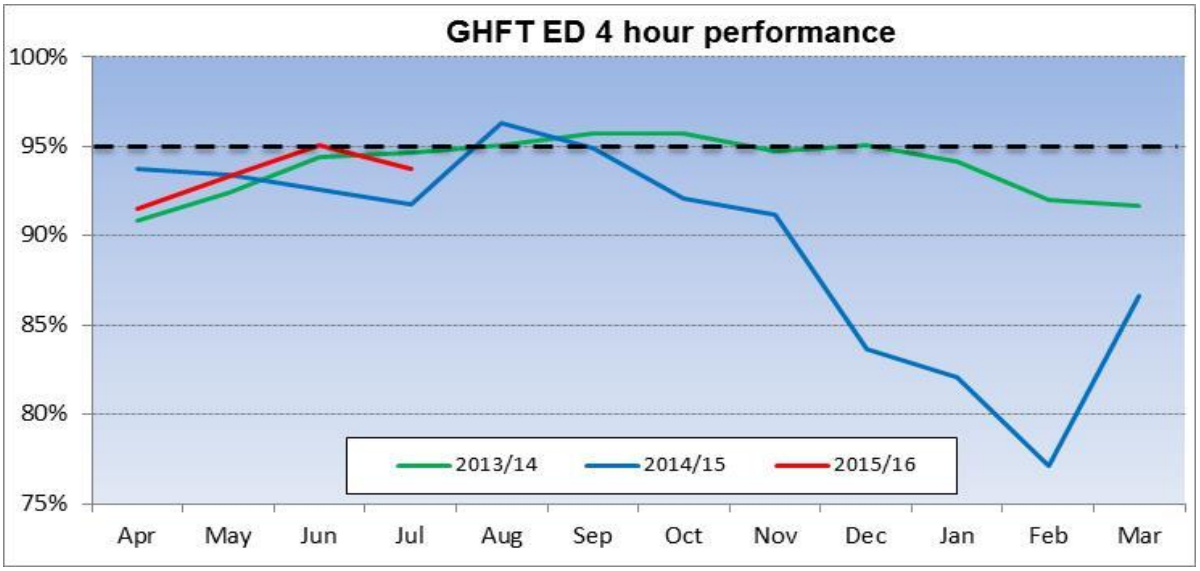


4-hour A&E target - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge.

Threshold – at least 95% of patients should be transferred, admitted or discharged within 4 hours.

Performance in August is 85.8%. Performance at Cheltenham General was 92.1% and Gloucestershire Royal was 82.2%.

The year to date performance for 4 hours has decreased to 92.0% at Gloucestershire Hospitals NHS FT (GHNHSFT); the current year to date all type performance (combined GHNHSFT, Gloucestershire Care Services MIU and Primary care in A&E) is 96.0%.



The CCG continues to implement a programme to increase urgent and emergency care system resilience to ensure that the system can cope with peaks in demand. These actions are set out in our system resilience plans and focus upon self-care, signposting, admission avoidance, in-hospital care, hospital discharge and community services.

12 hour trolley wait – Gloucestershire Royal Hospital

A 12 hour trolley wait occurred at Gloucestershire Royal Hospital on the 13th May. A detailed root cause analysis has been received and GHFT and GCCG are reviewing the incident and implementing mitigating actions/ recommendations.

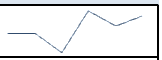
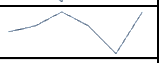
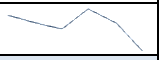
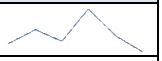
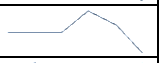
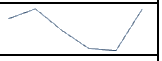
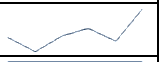
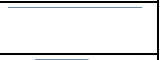
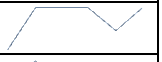
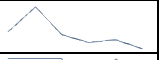
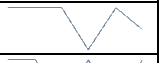
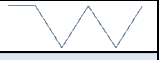
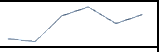
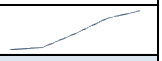
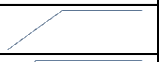
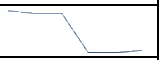
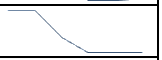
Stroke targets

The proportion of patients spending the required amount of time on a specialist stroke unit decreased to 76% due to red rated performance in July. Compliance against the TIA's target increased to 58.7%.

Plans to increase stroke capacity are underway, plus review of admission pathway and discharge delays.

2.4 Planned care:

The dashboard below provides a more complete position statement for Planned care. Each of the Amber and Red rated indicators are reported on by exception in section 2.4.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Planned care	Threshold	Month	Performance		YTD performance		6 month trend
Referral to treatment (RTT)							
% of admitted pathways treated within 18 Weeks	90%	July	90.5%	●	90.0%	●	
% of non - admitted pathways treated within 18 Weeks	95%	July	95.8%	●	95.6%	●	
% of incomplete Pathways that have waited less than 18 Weeks	92%	July	92.1%	●	92.2%	●	
Zero RTT pathways greater than 52 weeks	0	July	17	◆	64	◆	
Cancer waiting times							
% of patients seen within 2 weeks of GP referral for suspected cancer	93%	July	89.0%	■	90.9%	■	
% of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected	93%	July	90.5%	■	94.0%	●	
Cancer - first definitive treatment within 31 days of a cancer diagnosis	96%	July	100.0%	●	99.1%	●	
Cancer - subsequent treatment for cancer within 31 days - surgery	94%	July	100.0%	●	96.1%	●	
Cancer - subsequent treatment for cancer within 31 days - Drug Regime	98%	July	100.0%	●	100.0%	●	
Cancer - subsequent treatment for cancer within 31 days - Radiotherapy	94%	July	100.0%	●	99.7%	●	
Cancer - first definitive treatment within 62 days GP referral	85%	July	68.7%	◆	71.2%	◆	
Cancer - first definitive treatment within 62 days screening service	90%	July	96.7%	●	98.5%	●	
Cancer - first definitive treatment within 62 days upgrade	90%	July	100.0%	●	71.4%	◆	
Diagnostic waiting times							
% of patients waiting more than 6 weeks diagnostic test	1%	July	5.2%	◆	5.1%	◆	
% of patients waiting more than 6 weeks for a Planned/ Surveillance diagnostic test from their to be seen date – Endoscopy procedures	1%	May	58%	◆	58.0%	◆	
Local community waiting times							
% referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	95%	July	85%	◆	92.5%	■	
% referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	95%	July	100%	●	100.0%	●	
% referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	95%	July	100%	●	100.0%	●	
% referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	95%	July	96%	●	94.8%	■	
% referred to the Podiatry Service who are treated within 8 Weeks	95%	July	98%	●	98.5%	●	
% referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	95%	July	85%	◆	88.8%	◆	
% referred to the Adult Physiotherapy Service who are treated within 8 Weeks	95%	July	90%	■	90.8%	■	
% referred to the Parkinson Nursing Service who are treated within 8 Weeks	95%	July	100%	●	100.0%	●	
% referred to the Diabetic Nursing Service who are treated within 8 Weeks	95%	July	96%	●	99.0%	●	

2.4.1 **Referral To Treat (RTT) incomplete pathways and Referral to treatment (RTT) pathways greater than 52 weeks**

Following advice from the NHS IMAS (Interim management and support) Intensive support team (IST), GHNHSFT changed their RTT processing in December 2013. This has resulted in a greater number of RTT pathways being reported.

17 incomplete pathways of 52+ weeks reported in July 2015. Of these, 16 were at North Bristol Trust (112 in Trauma and Orthopaedics, 4 in Neurosurgery, 3 Neurology) and 1 at GHNHSFT (Urology).

During the first 4 months of the year there have been 81 incomplete pathways of 52+ weeks reported to the CCG.

The majority (72) of the breaches have occurred within the Trauma and Orthopaedic specialty; the CCG is aware of capacity issues particularly for complex spinal services across a number of providers.

GCCG are having discussions with commissioners who manage the out of county acute contracts on behalf of GCCG to identify and understand the operational issues that contributed to these waiting times and agreed plans for the identification and active management of any other likely breaches for Gloucestershire patients.

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

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

Performance in the first three months of the year has been Red rated:

85% Target	62 day target - GP Referral		
	Patients treated	Over 62 day breaches	% within 62 days
April	121	32	73.6%
May	102	29	71.6%
June	138	39	71.7%
July	150	47	68.7%
2015/16 Total	361	147	72.3%

Of the 147 breaches, 98 have occurred at Gloucestershire Hospitals NHS FT (GHNHSFT).

The majority of breaches have occurred in the following specialties:

Urology – 66 breaches

Lower Gastrointestinal – 15 breaches
Head & Neck – 13 breaches
Upper Gastrointestinal – 12 breaches

GCCG are coordinating actions with the main providers to ensure that performance improves, with sustainable delivery during 2015/16; however, concerns remain with capacity issues in key specialties.

The CCG is co-ordinating a working group which is working with local providers to understand the impact of the NICE referral guidance for suspect cancer. GHNHSFT and GCCG are also actively engaged in working with the IMAS Intensive Support Team to aid improvements in performance.

Percentage of patients waiting more than 6 weeks for a diagnostic procedure

The proportion of patients waiting over 6 weeks for a diagnostic procedure has increased in 2015/16. Performance in July (5.2%) was adversely affected by delays for Endoscopic and Echocardiogram tests at GHNHSFT.

The most significant number of breaches during 2015/16 has been due to pressure for Echocardiogram tests at GHFT.

The number of Endoscopy breaches at GHFT decreased in line with the agreed clearance trajectory.

GHNHSFT has a detailed action plan and trajectory to improve endoscopy performance by the end of August 2015, some of the key actions include:

- Review of elective capacity within key specialties
- Recruitment of additional clinical staff
- Implementation of greater management controls

Improved performance within Cardiology is anticipated to improve by October 2015.

2.5 Elective cancellations:

The dashboard below provides a more complete position statement for Elective cancellations. Each of the Amber and Red rated indicators are reported on by exception in section 2.5.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Elective cancellations	Threshold	Month	Performance		YTD performance		6 month trend
Cancelled operations - 28 day breaches	0	July	2	◆	19	◆	
Urgent operations cancelled for a second time	0	June	0	●	0	●	

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

The current year-to-date position shows that so far in 2015/16, 19 patients have been cancelled on the day of admission for non-medical reasons and patients have not been provided with another date within 28 days; the threshold is zero.

There were 206 last minute elective operations cancelled for non-clinical reasons during quarter 1. The number of cancellations was 2.8% lower than in the same period in 2014/15.

2.6 Mental Health:

The dashboard below provides a position statement for Mental health indicators. Each of the Amber and Red rated indicators are reported on by exception in section 2.6.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

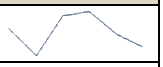
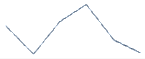
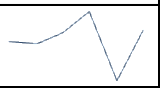
Mental health indicators	Threshold	Month	Performance		YTD performance		6 month trend
Dementia diagnosis rate	56%	Mar-15	64.6%	■	64.6%	■	
Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	95%	Q1 15/16	98.0%	●	98.0%	●	
The proportion of people who have depression and or anxiety discorders who receive psychological therapies	3.5%	Q4 14/15	16.9%	●	16.9%	●	
The proportion of people who complete therapy who are moving towards recovery	50%	Q1 15/16	43.0%	◆	43.0%	◆	
IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	75%	June	91.0%	●	89.5%	●	
IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	95%	June	99.0%	●	99.3%	●	

2.6.1 Dementia diagnosis rate

Dementia diagnosis increased by 10.2% during 2014/15. The final year end position was 64.6%, making GCCG performance is the highest within the BGSW area; however, the CCG fell short of the 66.7% NHSE target.

2.7 Patient transport:

The dashboard below provides a position statement for Patient transport. Each of the Amber and Red rated indicators are reported on by exception in section 2.7.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Patient transfer services	Threshold	Month	Performance		YTD performance		6 month trend
Arrival within 45 minutes before, to 15 minutes after, booked arrival time	95%	July	83.4%	◆	85.4%	◆	
Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey	85%	July	81.0%	■	82.5%	■	
Where booked on the day of travel, patients not to wait more than 4 hours for their (outbound) journey (within two hours for end of life patients)	85%	July	83.9%	■	82.8%	■	

2.7.1 **PTS 04 - Arrival within 45 minutes before, to 15 minutes after, booked arrival time – Target 95%**

Inbound on-time is an area where performance has been challenging. Improvements have been seen; however, further work is required in order for the target to be achieved on a sustainable basis. July's reports show 83.4% of patients arriving with KPI timescales.

PTS 05 - Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey – Target 85%

The response timeframe for these is one hour from the time the patient is 'made ready'. Analysis for July shows that 81.0% were achieved within the one hour compared to the target of 85%. Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys.

PTS 06 - Where booked on the day of travel, patients not to wait more than 4 hours for their (outbound) journey (within two hours for end of life patients) – Target 85%

This is generally being achieved or just below target. The response timeframe for these journeys is four hours from the time the patient is 'made ready'. Analysis shows for July that 83.9% of on-day booked journeys are achieved within 4 hours.

The longer period for on-the-day bookings recognises that PTS is a finite resource, across various vehicle types, to support different patient mobilities (from walking to wheelchair to stretcher), travelling between multiple collection and destination points. As a result, on-the-day bookings have to be integrated into the existing pre-planned programme as effectively as possible. Clearly, it follows that the higher the proportion of total activity that is booked on the day, the more challenging it becomes to ensure effective and efficient use of the resources, the greater the likelihood of all resource being fully utilised (but not necessarily optimally), and the harder it becomes to achieve the Key Performance Indicator standards. The service is seeing high numbers of on- day bookings from the hospitals, particularly during the recent urgent care pressures, which has a detrimental impact on overall performance.

Overall PTS performance has improved since service implementation. Further improvement is required in order to achieve all performance targets on a sustainable basis.

2.8 Clinical quality:

The dashboard below provides a more complete position statement for Clinical quality. Each of the Amber and Red rated indicators are reported on by exception in section 2.8.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Clinical quality	Threshold	Month	Performance		YTD performance		6 month trend
Infection control							
Number of MRSA infections (Health Community)	0	July	0	●	3	◆	
Number of MRSA infections (GHNHSFT)	0	July	0	●	3	◆	
Number of C.diff infections (Health Community)	157	July	10	●	55	●	
Number of C.diff infections (GHNHSFT)	37	July	4	●	12	●	
Mixed sex accommodation							
Mixed-sexed accommodation breaches	0	July	0	●	0	●	
Other quality indicators							
Number of Never Events	0	July	1	◆	1	◆	
Cardiology correspondence backlog	n/a	June	0	●	0	●	
Radiology reporting delays	n/a	June	0		0		
Outpatient follow-up pending lists	n/a	July	18,347		18,347		

2.8.1 Number of MRSA infections (Health Community)

Year to date performance is Red rated with 3 reported cases against a threshold of zero.

GCCG are investigating the cases reported in Q1; for CCG actions please see GCCG Quality report to the Integrated Governance Quality committee (IGQC).

Number of total C. diff infections (Health Community)

The threshold for 2015/16 has decreased from 201 to 157 cases in line with NHS England guidance.

Year to date performance is green rated with 55 cases against a year to date

threshold of 55.

Never events

There was a never event reported at GHNHSFT in July, a full investigation is underway.

Other Key Performance Issue:

Cardiology correspondence delays

There has been some positive progress with the backlog of cardiology outpatient letters, with actions taken to increase secretarial support. Quarterly reports are provided on the position of all outpatient letters to ensure that performance across all specialities is closely monitored. There is concern regarding capacity for ECHOs and the time to test results being reviewed by the consultants. At a joint meeting in June several further actions were agreed to mitigate these issues, however, as concern remains about the service this will remain on the risk register with the information updated to reflect the current position.

Outpatient follow-up pending list

In line with new information sharing request set out in the contract agreement with Gloucestershire Hospitals NHS Foundation Trust (GHFT), detailed information regarding outpatient follow up pending lists was received in October and will now be reported monthly in the CCG performance reporting framework. Initial data received has highlighted a need for further data validation to correctly assess the position with regards to patients who may be overdue a follow up appointment, as the pending list currently may report all patients who are waiting for their follow up including those for whom the expected follow up date has not yet been reached. In some specialties, the follow up pending list may at this stage also include patients who are not actually waiting for a follow up appointment, but who have an arrangement to self-refer in to see a consultant should an issue with their on-going care arise. An example of this is for respiratory patients who are on long term treatment with Continuous Positive Airway Pressure (CPAP), Bi-level Positive Airway Pressure (BPAP) or Nebulisers. We have agreed with GHFT that we will work together to complete the assessment of the position, and will now receive weekly update reports at a specialty level as we do this. Where a problem is identified, we will work together to agree a specialty level action plan to improve the position that will focus on service redesign of pathways where this is required.

District Nursing

Gloucestershire CCG and Gloucestershire Care Services (GCS) continue to work together to understand and address the specific concerns raised in relation to the District Nursing function within Integrated Care Teams across Gloucestershire.

GCS continues to focus on recruitment to community nursing vacancies. In relation to Band 5 posts GCS currently has a vacancy rate of 6.15 WTE substantive posts against a funded establishment of 151.55 WTE across the county. It is noted that the equivalent of 8 WTE applicants have been offered posts and are now going through the recruitment process. Successful completion of these recruitments will mean that GCS is over-established for Band 5 posts. This over-recruitment was planned to enable the release of Band 5 staff to complete Specialist Practitioner Qualifications (SPQ) with a view to upskilling members of this staff group to Band 6 roles.

The funded establishment for Band 6 District Nurses in the county is 57.59 WTE. Currently GCS has 15.99 WTE substantive vacancies for this staff group. 3 WTE Band 6 posts have been offered to applicants and these are going through the recruitment process.

The CCG continues work closely with GCS with regards to District Nursing recruitment, meeting with the GCS HR team on a fortnightly basis to monitor progress.

Work continues to monitor and evaluate the effectiveness of the service through Datix incident reporting. Both GCS and CCG are working together to address concerns raised by Primary Care and identify themes and trends.

3.1 Patient experience

3.1.1 Patient Experience – Period to 31st August 2015

PERSPECTIVE 3	Patient Experience	Green
Success criteria 1: *Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.*		**G**
Key performance indicators		
Outcomes measures for patient safety have been developed based on the CCG Outcome framework and sign up for safety initiative.		**G**
Quality Impact Assessments are undertaken for all new proposed initiatives and service developments. This is considered by the QIPP assurance board before decisions are made to support new initiatives. Mitigation is planned where necessary to ensure patient safety.		**G**
Success criteria 2: Reporting: *Improve reporting of patient experience including FFT*		**G**
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in patient and staff Friends and Family Test		**G**
Qualitative feedback including that from surveys, FFT, 4Cs and Healthwatch		G
All lproviders of NHS funded services commissioned by GCCG participating in National Patient Survey programme (2015/16)		G
Success criteria 3: Staff Involvement: *Improve staff reporting if three domains of quality: safety, effectiveness and experience*		G
Key performance indicators		
Review the systems for the management of Serious Incidents and Never Events and develop mechanisms to identify themes, ensure lessons are learnt and feedback is provided to member practices and service providers		G
Success criteria 4: Effecting change based on patient experience feedback : *Staff recognise the value of patient experience in their commissioning role*		G
Key performance indicators		
Use patient stories to monitor the quality of commissioned services		G
Use individual patient experience to inform the wider decision making in improving services		G
Constructively respond to requests for specific engagement on themes identified through feedback		G

3.1.2 Success criteria 1: Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.

The CCG has a strong focus on patient safety and this forms a standing item on the agenda of the Clinical Quality Review Groups. In addition the CCG is

fully involved as an active member of the South West Patient Safety Collaborative.

GCCG will be a 'Beacon CCG' becoming one of the first CCG's to commit to the 'Sign up to Safety' campaign. GCCG's support of this campaign is indicative of the high level of commitment the organisation places on improving harm free care and supporting staff in speaking up when things do go wrong.

A formal launch to GCCG Staff happened on 30th July. A briefing to the Governing Body was delivered on 30th July 2015.

The five Sign up to Safety pledges are

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. **Continually learn**. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are
3. **Being honest**. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. **Collaborating**. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. **Being supportive**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress

- We commit to turn our actions into a safety improvement plan (including a driver diagram) which will show how the CCG intends to save lives and reduce harm for patients over the next 3 years
- Committing to turn these actions into a Safety Improvement Plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
- Identify the patient safety improvement areas we will focus on within the safety plans.

- Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community

- Make public our plan and update regularly on our progress against it.

An early benefit of this collaborative work is the networking that has evolved, sight of other provider initiatives and joining up of work streams. For example the South West ambulance service is developing a CQUIN to support roll out of NEWS across the South West.

3.1.3 **Success Criteria 2: Reporting – Improve reporting of patient experience and the use of feedback to influence commissioning intentions (Green).**

CCG monitoring of FFT

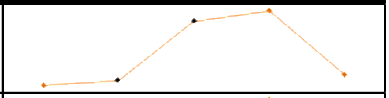
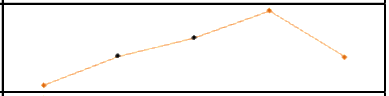
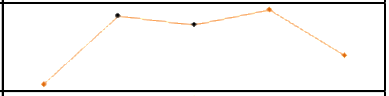
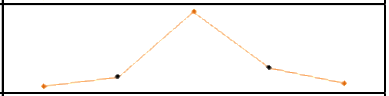
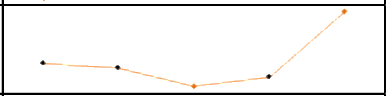
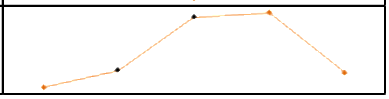
Although the Friends and Family test has been removed from national and local CQUIN schedules, it has been retained as core within the national contract for providers.

We will continue to monitor the Friends and Family test data. The CCG will focus on the qualitative information it providers as well as the quantitative.

PALS and the provision of Information and Advice

Public contact has increased year on year, but numbers for Quarter One are unlikely to match the height of Quarter Four. However, the type of contact we are experiencing is requiring additional time to resolve with queries and questions becoming more complex.

Overall complaint numbers have risen, particularly about providers. However, this is due in part to a change in how complaints are recorded. New reporting requirements, which include providers and commissioners, mean that at the end of each quarter we will submit a return to the Health and Social Care Information Centre (HSCIC), which has standardised the way issues should be recorded.

Type	Quarter 1 14/15	Quarter 2 14/15	Quarter 3 14/15	Quarter 4 14/15	Quarter 1 15/16 (to date)	Sparkline
Advice or information	41	47	138	154	57	
Comment	1	4	6	9	4	
Compliments	9	3	3	3	5	
Concerns	3	48	42	52	22	
Complaints aboubt the CCG	1	4	26	7	2	
Complaints against provider	10	9	5	7	22	
TOTAL CONTACTS	**83**	**115**	**220**	**232**	**112**	

As demonstrated in the figures, requests for advice have made up majority of the Experience Team workload. The type of advice sought ranges from how to plan for end of life care, information about Village Agents and Pharmacy First as well enquiries about social prescribing.

The Experience Team has also been able to take the service out of Sanger House. On two occasions in the last month, members of the team have gone out to patients to live up to our ambition to be 'Commissioners on the Ground'.

3.1.4 **Success criteria 3: Staff involvement – Improve staff reporting of three domains of quality: safety, effectiveness and experience (Green).**

Staff Friends and Family - NHS England have now reported the Staff Friends and Family test results for Quarter Four. The CCG is yet to understand why GHNHSFT response rate appears so low in comparison to others. This will undoubtedly affect results and so they cannot be compared to previous quarters. This will be discussed at the next scheduled GHNHSFT Clinical Quality Review Group.

Org Name	Total Responses	HSCIC Workforce Headcount	Percentage Recommended - Work	Percentage Not Recommended - Work	Percentage Recommended - Care	Percentage Not Recommended - Care
England	151,605	1,155,066	61.7%	18.9%	77.2%	7.5%
2GETHER NHS FOUNDATION TRUST	339	1,974	62%	19%	77%	8%
GLOUCESTERSHIRE CARE SERVICES NHS TRUST	532	2,693	49%	25%	81%	4%
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	90	7,416	37%	43%	72%	9%

3.1.5 **Success criteria 4: Effecting change based on patient experience feedback – staff recognise the value of patient experience in their commissioning role (Green).**

In the last Performance Report a full update was provided on engagement activities linked to Clinical Programme Groups. A summary of individual project work CCG Engagement and Experience staff supported during Q4 and the early part of Q1 (2015/16) together with an update on Healthwatch Gloucestershire activity is reported in the Accountable Officer Report to the Governing Body

4.1 Partnerships

4.1.1 Partnerships – Period to 31st August 2015:

PERSPECTIVE 4	Partnerships	PERSPECTIVE 4
Success criteria 1: Building effective partnership working by putting in place a joint planning and governance framework to improve outcome for the Gloucestershire population		**Green**
Key performance indicators		
Develop a 5 year commissioning plan agreed with key providers		**G**
Development and maintenance of system wide forum encompassing all providers across heath & social care, independent and voluntary sector		**G**
Success criteria 2: *Delivery of the Health & Well Being plan*		**G**
Key performance indicators		
Increase the range and volume of services commissioned jointly with both GCC and District Councils.		**G**
Increase the range and volumes of services commissioned jointly with the third sector on a locality basis within which the agenda of early intervention and prevention are woven into a range of local statutory health and social care services.		**G**
Success criteria 3: *Effective urgent care pathway to enable more patients to stay in their own home*		**Amber**
Key performance indicators		
Effective relationships across adult social and health care to enable: i) Reduce non-elective admissions which can be influenced by effective collaboration across the health and care system.		G
ii) Reducing inappropriate admissions of older people (65+) in to residential care		G
iii) Rehabilitation / reablement, increase in effectiveness of these services whilst ensuring that those offered service does not decrease		G
iv) Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.		A
v) To develop a system which measures patient experience of integration over time, allowing any improvements to be demonstrated.		**Year-end assessment**
vi) Enhancing quality of life for people with care and support needs.		**Year-end assessment**

4.1.2 **Success criteria 1: Building effective partnership working by putting in place a joint planning and governance framework to improve outcome for the Gloucestershire population (Amber)**

In April of this year Gloucestershire submitted a Better Care Fund (BCF) plan which was underpinned by a shared programme of work. It is timely to remember that the shared programme of work associated with the BCF reflected our system wide commitment to the precepts underpinned Joining Up Your care. The six metrics associated with the BCF each had a plan of service re-design and development.

As a system we had implemented new engagement methodologies in order to move forward, such as the BCF Providers Forum. Wherein we could engage and co-design system change with our provider partners

4.1.3 **Success criteria 2: Delivery of the Health & Well Being plan (Green)**

The CCG has a long established history of collaborative and joint commissioning with the local authority both on a county and district level, a key example of how we work in partnership would be the Joint Commissioning Partnership. The Joint Commissioning Partnership between Gloucestershire County Council (GCC) and Gloucestershire Clinical Commissioning Group is a key element of the Governance arrangements that support joint commissioning. The scope and role of the JCP is includes:

- Assessing policy impact - mapping and interpretation leading to directing development of new commissioning strategies
- Scoping, testing and prior approval of joint commissioning strategies
- Implementation of joint commissioning strategies including performance oversight
- Oversight of joint funding arrangements - approval and assurance

The JCP consists of an Executive made up of Chief Officers/Senior officers from both organisations and a Board (JCPB), drawn from GCC Cabinet and CCG Governing Body. The role of the JCPB is to set policy direction, and to assure themselves that joint commissioning is carried out with due regard to each organisation's statutory roles and responsibilities, including service quality, performance and outcomes. The role of the Executive is to develop and implement joint commissioning strategies, policies and plans, to draw to the attention of the Board any issues arising from current joint commissioning that require resolution, and to keep the Board informed of likely future developments.

In support of joint commissioning, the CCG and GCC jointly fund a small number of Joint (or Lead) Commissioner posts:

- Mental Health
- Children and Young People

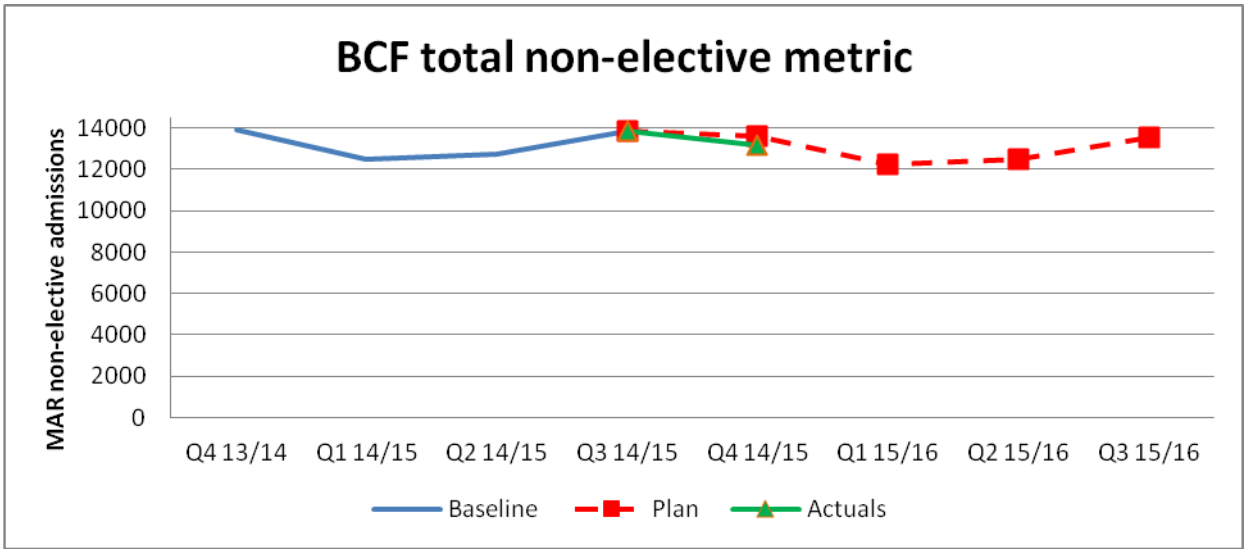
- Older People / Long Term Conditions
- Learning Disabilities
- Physical Disabilities

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

As part of the Better Care Fund submission, Gloucestershire health and well-being board (H&WB) have committed to delivering a number of key indicators/ outcomes for the residents of Gloucestershire:

Total non-elective admissions (general and acute)

Avoidance of hospital admissions helps to ensure the most effective management of social care requirements. Minimising delayed transfers of care and avoidable admissions transforms the quality of care of individuals, enabling service users to receive the most appropriate care in the most appropriate location. During quarter 4 of 2014/15 performance against plan showed a position of -3.6%, pressures were seen in the system but the overall admissions were lower than planned levels.



Reducing inappropriate admissions of older people (65+) into residential care

Indicator is part of the Adult Social Care outcomes framework (ASCOF). The number pf permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.

The overall level of ambition was to reduce the growth in admissions by 2.6% per year. Provisional data for 2014/15 shows a 16.3% decrease on 2013/14 and 9.9% below the planned level.

Rehabilitation / re-ablement, increase in effectiveness of these services whilst ensuring that those offered service does not decrease

Indicator is part of the ASCOF. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services.

The H&WB ambition factored through increased provision of the re-ablement/ rehabilitation services resulting in an annual increase of 3.3% in year 1 and a further 3.7% in year 2.

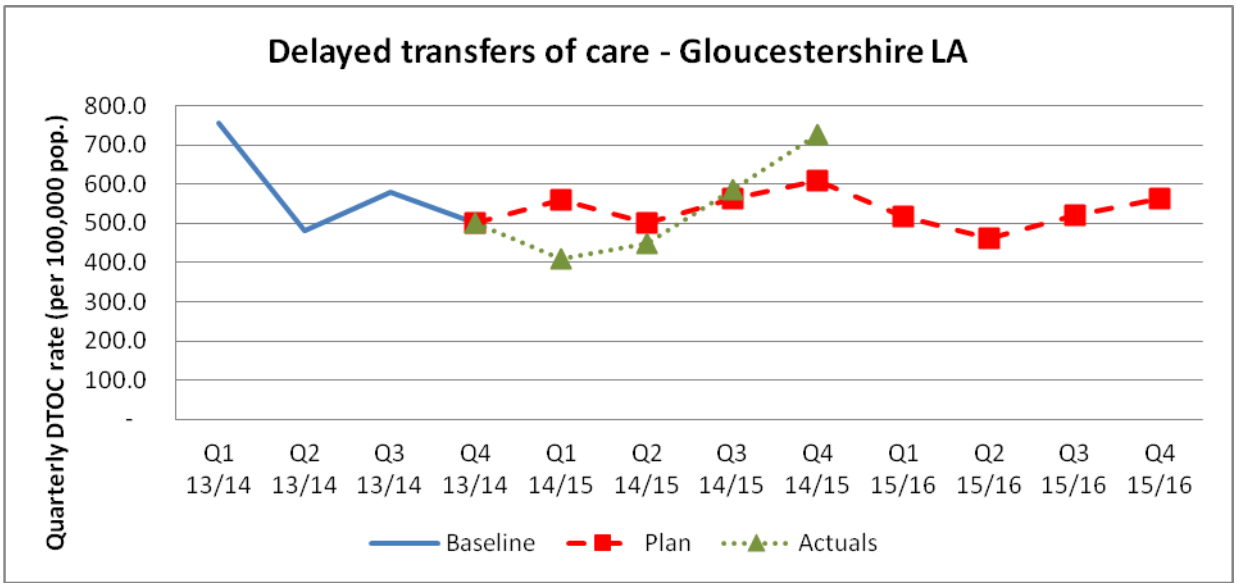
2014/15 provisional performance shows a 4.3% increase on 2013/14.

Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

This indicator is based on the ASCOF Delayed transfers of care from hospital per 100,000 population metric.

During 2013/14 delayed transfers of care reduced significantly from those reported in 2012/13 (37% decrease).

The ambition was to further reduce delayed transfers by 2.8% in 2014/15 and 7.0% in 2015/16 from the 2013/14 baseline.



To develop a system which measures patient experience of integration over time, allowing any improvements to be demonstrated.

This is a locally set metric based on the Gloucestershire Care Services Integrated Community Teams Rapid Response Experience Comment Card.

The expectation is that this metric will assess the services ability to look at individual patient needs and improved health and social care outcomes.

Enhancing quality of life for people with care and support needs.

Locally selected measure which is part of the ASCOF. The indicator is based on responses to 6 questions within the Adult Social Care Survey.

Ambitions against the above indicators have been set by Gloucestershire Health and well-being board. Health community QIPP schemes have been mapped to each of the relevant indicators to assess the impact and progress made against these ambitions.

Assessment against the Gloucestershire ambitions is being developed and will report by exception in this section of the performance framework report.

5.1 Staff

5.1.1 Staff – Period to 31st August 2015:

PERSPECTIVE 5	Staff	Green
Success criteria 1: *Attracting and retaining high quality staff aligned to the CCGs vision and values*		**G**
Key performance indicators		
Turnover - % of employees leaving the organisation		**1%**
Number of current Vacancies in structure		**14**
Success criteria 2: *Personal development processes that are linked to the strategic plan*		**RAG**
Key performance indicators		
All staff should have a PDP by the end of Oct (90% target) and should have had an appraisal in the last 12 months		**In progress**
Percentage of staff who have completed their mandatory training in the last 12 months		**Quarterly update**
Success criteria 3: *Staff are Happy and Motivated*		**G**
Key performance indicators		
Staff sickness levels		**2.2%**
Staff Survey		**Annual**
Completion of OD plan by 31st March 2016		**Due 31st March 2016**

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

Monthly turnover in August was 1%. The number of leavers since the 1st April is 12, giving a monthly average of 2.4 leavers per month.

There are 6 jobs live on NHS Jobs and 8 are in the recruitment process.

5.1.3 **Personal development processes (PDP) that are linked to the strategic plan**

The CCG has commenced the collection of staff PDPs. Once collated a review against strategic objectives will take place.

5.1.4 **Staff are Happy and Motivated**

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

Staff sickness levels up to the 31st August have equated to 2.2% which is below the GCCG target of less than 3%. Sickness levels show a decrease on the figure reported at the end of 2014/15.

2.2% equates to 621.9 full time equivalent (FTE) working days or 2.7 working days per employee since the 1st April 2015. The sickness absence rate is calculated by the total number of FTE days lost divided by the total number of working days.

6.1 Perspective 2. Finance and Efficiency

6.1.1 Finance and efficiency – Period to 31st August 2015

Summary:

Perspective 2	Finance & Efficiency	Amber

Success critieria: To ensure a financially viable commissioning organisation with an underlying recurrent surplus			A
	Threshold	Lower threshold	RAG
Underlying recurrent surplus (%age)	2%	1%	A
Surplus - year to date variance to planned performance (%age)	0.10%	0.50%	G
Surplus - full year variance to planned performance (%age)	0.10%	0.50%	G
Running costs year to date (variance to running costs allocation)	Within RCA		G
Running costs forecast outturn (variance to running costs allocation)	Within RCA		G
BPPC performance on non-NHS invoices by value (year to date)	95%	80%	G
Cash drawdown in line with planned profiles (%age variance)	2%	5%	G
Success critieria: QIPP Full year Forecast			**A**
	Threshold	Lower threshold	RAG
QIPP - full year forecast delivery to planned performance (%)	95%	75%	A

- The CCG is forecasting to deliver a surplus of £7.3m; this is dependent on access to a non-recurrent surplus drawdown of £1.2m.
- Known risks and pressures have been fully assessed and included within the CCG's forecast position, with mitigating actions where appropriate.
- There is currently slippage on QIPP schemes for the financial year.
- Financial risks are monitored through a continuous review of budgets and proposed investments and the use of the CCG's contingency and activity reserves.
- The better payment practice code performance for the year to date (for non-NHS invoices by volume) is 97.60% which is in line with the targeted figure.
- Key risks:
  - Provider contracts over perform in excess of those levels provided within the year end forecast
  - Increased expenditure on prescribing (particularly NOACs)
  - Increased slippage on QIPP schemes (noting that the current RAG ratings are embedded within current financial forecasts)

The overall assessment for the finance and efficiency perspective is amber for which more detail is provided in the following sections. However, this assessment should be read in conjunction with those risks outlined within paragraph 3.9.

6.2 Resources

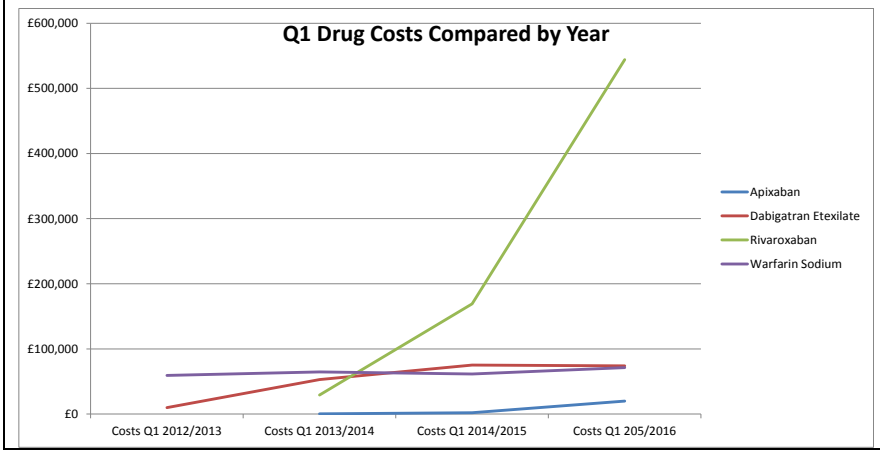
The CCG's current anticipated resource limit (see Appendix 2) is £810m. This includes all Primary Care co- commissioning designated budgets totalling £76.8m. There was an additional non recurrent allocation this month relating to eating disorders totalling £319k which is the initial allocation released by NHSE to support Childrens' and Young People's Mental Health and Wellbeing.

6.3 Expenditure

The financial summary as at 31st August 2015 shows a year to date surplus of £3.04m and a forecast surplus of £7.3m, which are both in line with plan. Further detail is shown at Appendix 3. Key budget areas with either a financial risk or forecast outturn variance are highlighted below:

Key ↑ Indicates a favourable movement in the month ↓ Indicates an adverse movement in the month	**Trend**	**Forecast Over/ (Under) Spend £'000**
Gloucestershire Hospitals NHS FT		
Performance in Emergency activity continues to over perform by 868 spells within gastroenterology and medical specialities. Variable non PbR contract lines are above plan driven by costs within excluded drugs; the growth in Lucentis, in particular, being above those levels anticipated. Under performance in outpatient and elective activity within trauma & orthopaedics (T&O), urology, gynaecology and anaesthetics is marginally offsetting this position. A number of contract queries have been raised, these need to be finalised prior to an agreed position. It is likely that this contract will overperform in this financial year based on current projections. The CCG and Trust are to shortly meet in order to progress the sign-off of quarter 1 performance.	→ ←	£0
Winfield Hospital		
The position remains static from the previous month with elective activity being below plan. T&O and spinal being the main contributors with underperformance of 58 and 43 patient episodes respectively. The waiting list position is anticipated to improve from September 2015, partly due to additional sessions being offered in Spinal Surgery.	→ ←	(£400k)
Oxford University Hospitals NHST		
Elective procedures are higher than the previous year for interventional radiology (IR), vascular interventional Radiology (VIR) and hip & knee procedures. Non PbR	→ ←	£361k

contract lines continue to see an increase in devices and drugs from plan. A contract query has been sent to the provider to request further detail to support this increase.		
North Bristol NHS Trust		
Indicators are highlighting this contract will continue to underspend within the area of elective inpatients in hip & knee procedures, non elective and outpatients in T&O. Non PbR is over performing in mental illness and T&O where a local tariff is used. A query regarding this has been raised with the trust this month. There has been pressure in the delivery of RTT performance targets within the trust with twenty 52 week incomplete waiters; some procedures are scheduled to take place in September. This position is being monitored closely.	↓	(£202k)
Great Western Hospitals NHSFT		
The underperformance is continuing in inpatient activity within T&O, general medicine and obstetrics. Non elective activity is also under the planned contract level due to respiratory system, T&O and paediatric medicine. A contract query has been raised relating to the position in T&O and general surgery specialties.	↑	(£200k)
Royal United Hospital Bath NHSFT		
Non elective inpatients are extremely high due to emergency cases in General Surgery, T&O and respiratory medicine where a patient with septicaemia is continuing treatment. Elective inpatient activity is also over performing in T&O for reconstructive procedures without critical care and major foot procedures for trauma. . Non PbR high cost drugs and devices within rheumatology continues to be over contracted levels; this has been queried with the provider.	↓	£189k
Worcestershire Acute Hospital NHST		
Non elective activity continues to show a downturn in activity with a reported under performance within general medicine. Non PbR is over spending on drugs which mitigates some of the above under spend.	↑	(£96k)
Clinical Assessment & Treatment Centre		
Current performance at the ISTC still indicates a reduction in activity over last year. The current contract comes to an end at the end of October 2015. The CCG is re-procuring this activity under an Any Qualified Provider (AQP) contract	→←	(£177k)
Planned Care		
The enteral feed contract continues to over perform with costs still averaging £96k a month which is higher than the budgeted growth of 6%, due mainly to a growth in patient numbers. Further feedback from GHNHSFT is that numbers	↓	£225k

have gone up in excess of the 6% predicted. Further analysis of the information is being undertaken to understand this increase.		
Oxford Fertility – the new IVF policy has only just been ratified and is therefore unlikely to lead to a significant financial effect until next year, however the budget has been set based on uptake from the beginning of this year.	↑	(£231k)
Learning Difficulties		
There has been one (high cost) directly commissioned patient in the year to date compared to four this time last year. The s256 recharge from Gloucestershire County Council has seen two new patients however this has been more than offset by a decrease in fees.	↓	(£117k)
Continuing Healthcare		
Due to further investigation into the current performance of adult joint funded placements, the position has been reduced to reflect anticipated backlog of claims that will come through in the later part of the year. The forecast is based on figures supplied by Gloucestershire County Council and further detailed analysis is being undertaken to understand this variation.	↓	(£753k)
Prescribing		
Prescribing expenditure continues to show increased pressure with growth in excess of 6% above the same period in 2014/15. Increased costs from Rivaroxaban (a Novel Oral Anticoagulant drug where growth significantly exceeded the national average) and the additional costs of category M drugs are the main drivers. Further analysis is currently underway to assess to what extent the increase is due to increase in volume and what is change in cost per unit. The change in anticoagulant drug costs over the first quarter of the last four financial years is shown below.  	↓	£3,100k

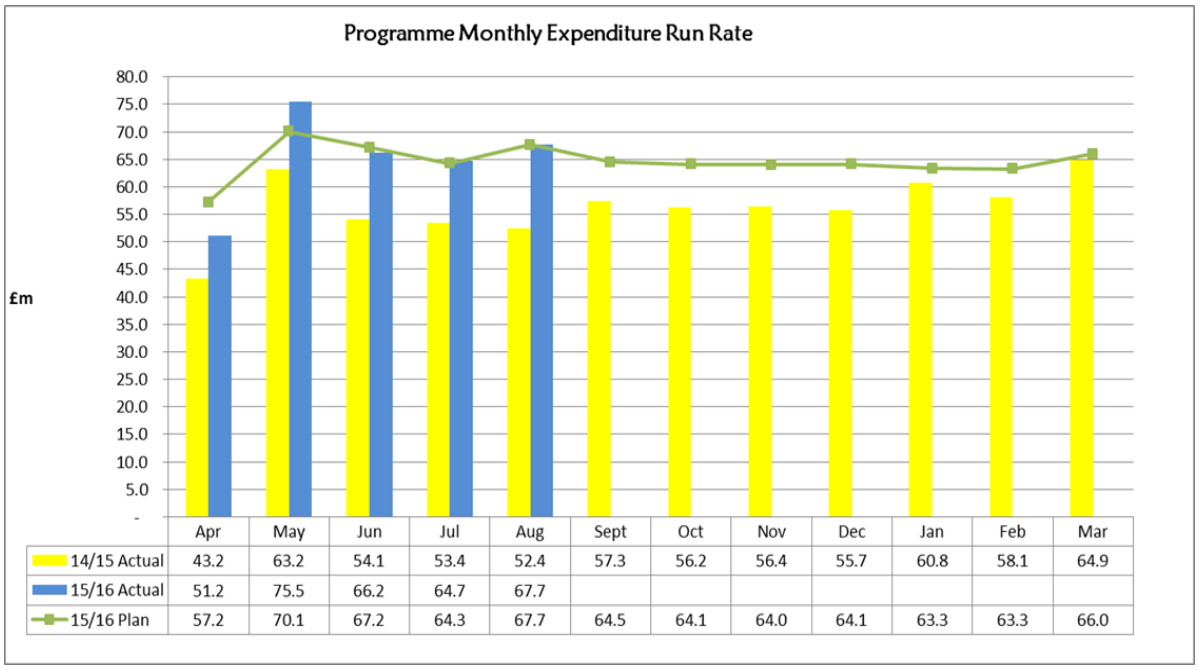
Cost increases in other drug areas are also contributing to the forecast overspend and these are currently under review to assess their impact.		
Running costs		
The underspend is predominantly due to slippage on appointment to vacancies which is not anticipated to carry on throughout the year. There are current pressures within other areas to offset the majority of the underspend, property services being one of them.	↑	(£37k)

6.4 **QIPP**

The CCG has a £17m QIPP target that has fully identified plans to achieve this. Delivery against the plan is currently forecast to under achieve by an estimated £2.3m. Additional programmes are continually being reviewed to mitigate any shortfall.

Recognising that all forecasts have been based only on information available at the end of August, Appendix 4 reports the extent of QIPP performance against programme areas whilst Appendix 5 highlights scheme reports by exception.

6.5 **Run Rate**



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
14/15 Actual	43.2	63.2	54.1	53.4	52.4	57.3	56.2	56.4	55.7	60.8	58.1	64.9
15/16 Actual	51.2	75.5	66.2	64.7	67.7							
15/16 Plan	57.2	70.1	67.2	64.3	67.7	64.5	64.1	64.0	64.1	63.3	63.3	66.0

The graph above highlights the expenditure relating to Programme budgets for this and last financial year, compared to the resource available for Programme excluding any reserves and the surplus. August is showing that programme is in line with anticipated spend

6.6 **Cash (Appendix 6)**

By the end of August, the CCG has drawn down 42.74% of the total cash limit which is in line with the straight line profile. The cash balance at the end of August was £802k.

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

It is a national target that requires the CCG to pay 95% of non-NHS trade creditors within 30 days of receipt of goods or a valid invoice. The current year to date performance stands at 98.28% invoices paid by value and 97.60% by volume; both being in line with the target.

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

The position shown includes the audited opening balances from the 2014/15 Annual Accounts as a reference point.

6.9 **Financial Risk**

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

- Contract Performance
  A large number of the CCG's contracts are variable and there is a risk of over performance against the contracted value, which in turn may create risk in further years.

- Prescribing
  The CCG has received prescribing data for April to June that highlights a potential significant overspend in this area. Although the CCG has now received the first nationally developed forecast (which is in line with initial local assumptions), the CCG is currently using historical data to further analyse local trends and underlying detail to clarify the robustness of these early indicators.

- Better Care Fund performance
  Performance under the conditions of the Better Care Fund is being reviewed on an ongoing basis in order to gauge whether conditions for release of the Performance Fund have been met (this necessitated a 2% reduction in non-elective admissions when compared with the previous financial year).

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

- Properties
  Under the charging regime for NHS Property Services the CCG will be charged for any void space in properties owned or managed by NHS Property Service. The CCG should be invoiced on a quarterly basis and will continue to challenge

any erroneous charges but as yet have not been informed of the anticipated charge for 2015/16 or received the Q1 invoice.

- National position
  All NHS organisations are being monitored closely by Monitor, TDA and NHS England. A national "deep dive" exercise in September will focus on the robustness of financial forecasts and current reported positions for individual NHS bodies.

Appendices:

Ref	Description
1	GCCG Dashboard 2015/16
2	Resource Limit Position
3	Summary Financial Position
4	QIPP Programme
5	QIPP scheme reports by exception
6	Cash
7	Better payment practice code
8	Statement of financial position

Gloucestershire CCG 2015/16 Integrated Performance Scorecard

Target	Principal Delivery Targets		2014-15 Outturn	Apr-15	May-15	Jun-15 / Q1	Jul-15	Aug-15	Sep-15 / Q2	Oct-15	Nov-15	Dec-15 / Q3	Jan-16	Feb-16	Mar-16 / Q4	Year / Quarter to date	Year End Forecast	Perf. Measured	Director	Responsible Manager
Unscheduled Care																				
Accident & Emergency																				
E.B.5	**4-hour A&E target** - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C	Mark Walkinshaw	Maria Metherall
		GRH	88.1%	89.4%	92.2%	93.7%	92.3%	82.2%									0.00%			
		CGH	93.3%	95.2%	95.8%	97.2%	96.2%	92.1%									0.00%			
		GHNHSFT total	90.0%	91.5%	93.5%	95.0%	93.7%	85.8%									0.00%			
		GCS - MIU	99.8%	99.8%	99.8%	99.8%	99.8%										0.00%			
E.B.S.5	**12 hour trolley waits** (no A&E attender should wait more than 12 hours from the decicision to admit to admission)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		GRH	0	0	1	0	0	0												
		CGH	0	0	0	0	0	0												
		GHNHSFT total	0	0	1	0	0	0												
		GCS - MIU	0	0	0	0	0													
Ambulance																				
E.B.15.i	**Cat A 8 min response** - The percentage of Category A **RED 1** incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	C	Mark Walkinshaw	Maria Metherall
		SWASFT	75.2%	79.0%	75.1%	75.3%	75.3%									76.2%	76.2%			
		Glos only	66.4%	72.7%	69.8%	64.9%	62.4%									67.6%	67.6%			
E.B.15.ii	**Cat A 8 min response** - The percentage of Category A **RED 2** incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%			
		SWASFT	71.4%	68.3%	66.3%	65.9%	66.6%									66.8%	66.8%			
		Glos only	66.4%	64.8%	62.3%	65.2%	61.9%									63.5%	63.5%			
E.B.16	**Cat A 19 min response** - The percentage of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%			
		SWASFT	93.6%	92.7%	91.8%	91.1%	90.5%									91.5%	91.5%			
		Glos only	91.5%	90.2%	89.8%	89.7%	89.1%									89.7%	89.7%			
E.B.S.7	Ambulance handover delays - 30 to 60 mins (GHNHSFT)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		Actual	1,038	51	85	50	37									223	223			
E.B.S.7	Ambulance handover delays - over 60 mins (GHNHSFT)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual	141	4	10	4	3									21	21			
E.B.S.8	Clear up delays of over 30 minutes	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		Actual	1,201	142	159	179	187									667	667			
E.B.S.8	Clear up delays of over 1 hour	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual	105	13	20	12	16									61	61			
Delayed Transfers of Care (DTOC)																				
Local	Average number of Delayed Transfers of Care for acute patients in the month	GHNHSFT target		14	14	14	14	14	14	14	14	14	14	14	14	14	14	C	Mark Walkinshaw	Maria Metherall
		GHNHSFT actual	10.9	13.2	9.5	11.3	19.6	14.5								13.6	13.6			
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	GHNHSFT	0	0	0	0	0	0								0	0			
Local	Average number of Delayed Transfers of Care for non-acute patients in the month	GCS target		10	10	10	10	10	10	10	10	10	10	10	10	10	10	M		
		GCS actual	2.3	5.2	3.0	2.0	1.8	1.8								2.8	2.8			
Harmoni 111																				
Local	Calls answered within 60 seconds	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	M		
		Actual	90.0	97.6%	96.5%	95.9%	94.8%	96.7%												
Local	Calls abandoned after 30 seconds	Target		5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%			
		Actual	2.6%	0.4%	0.6%	0.7%	1.0%	0.7%												
Local	Calls triaged	Target		60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%			
		Actual	79%	81.0%	82.2%	81.9%	82.1%	80.7%												
Local	% calls referred to ED	Target		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%			
		Actual	5.8%	5.1%	4.9%	6.0%	6.2%	5.9%								5.6%	5.6%			
Local	Calls warm transferred	Target		98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%			
		Actual	55.8%	41.3%	34.7%	38.3%	31.4%	38.7%												
Local	Longest wait for an answer	Target		00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00			
		Actual	-	00:05:45	00:10:11	00:07:11	00:09:34	06:49:00												
Local	Longest wait for a call back	Target		00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00			
		Actual	-	00:16:24	00:30:09	00:06:45	01:03:06	08:14:00												
Planned Care																				
Acute Care Referral to Treatment																				
E.B.1	Percentage of admitted pathways treated with in 18 Weeks	Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	C	Ellen Rule	Annemarie Vicary
		Actual	90.4%	88.6%	90.8%	90.1%	90.5%										0.0%			
E.B.S.4	Number of completed admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual	-	6	2	6	8										0			
Local	Number of specialties where admitted standard was not delivered	Actual	-	8	7	7	8													
E.B.2	Percentage of non - admitted pathways treated within 18 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%			
		Actual	95.4%	95.8%	95.6%	95.2%	95.8%										0.0%			
E.B.S.4	Number of completed non-admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		Actual	-	0	3	3	2										0			
Local	Number of specialties where non-admitted standard was not delivered	Actual	-	6	4	4	6													
E.B.3	Percentage of incomplete Pathways that have waited less than 18 Weeks	Target		92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%			
		Actual	92.0%	92.1%	92.2%	92.2%	92.1%										0.0%			
E.B.S.4	Number of incomplete pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		

Gloucestershire CCG 2015/16 Integrated Performance Scorecard

Target	Principal Delivery Targets		2014-15 Outturn	Apr-15	May-15	Jun-15 / Q1	Jul-15	Aug-15	Sep-15 / Q2	Oct-15	Nov-15	Dec-15 / Q3	Jan-16	Feb-16	Mar-16 / Q4	Year / Quarter to date	Year End Forecast	Perf. Measured	Director	Responsible Manager
E.B.S.4	Number of incomplete pathways greater than 52 weeks	Actual	-	20	23	21	17									81	81			
Local	Number of specialties where incomplete standard was not delivered	Actual	-	8	8	9	8													
Cancelled Operations																				
E.B.S.2	**Cancelled operations** - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Ellen Rule	Annemarie Vicary
		Actual	-	6	6	5	2													
E.B.S.6	**Urgent operations cancelled for a second time** - number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual	-	0	1	0														
Diagnostics																				
E.B.4	Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests	Target		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	C	Ellen Rule	Annemarie Vicary
		Actual breaches		464	568	365	512									1909	1909			
		Actual Perf		5.0%	6.3%	3.9%	5.2%										0.0%			
Cancer Waits																				
E.B.6	Percentage of patients seen within 2 weeks of an urgent GP or GDP referral for suspected cancer	Target		93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C	Ellen Rule	Annemarie Vicary
		Actual breaches	1,290	137	81	131	180									529	529			
		Actual Perf	92.0%	90.3%	94.1%	90.8%	89.0%										0.0%			
E.B.7	Percentage of patients seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Target		93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C		
		Actual breaches	287	14	4	10	25									53	53			
		Actual Perf	87.8%	93.9%	97.8%	95.3%	90.5%										0.0%			
E.B.8	Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis	Target		96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	C		
		Actual breaches	25	2	3	4	0									9	9			
		Actual Perf	99.2%	99.2%	98.6%	98.5%	100.0%										0.0%			
E.B.9	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	Target		94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C		
		Actual breaches	21	3	2	3	0									8	8			
		Actual Perf	96.2%	94.5%	96.0%	93.5%	100.0%										0.0%			
E.B.10	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regime	Target		98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	C		
		Actual breaches	0	0	0	0	0									0	0			
		Actual Perf	100.0%	100.0%	100.0%	100.0%	100.0%										0.0%			
E.B.11	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment	Target		94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C		
		Actual breaches	4	0	0	1	0									1	1			
		Actual Perf	99.6%	100.0%	100.0%	98.9%	100.0%										0.0%			
E.B.12	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Target		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	C		
		Actual breaches	266	32	29	39	47									147	147			
		Actual Perf	82.7%	73.6%	71.6%	71.7%	68.7%										0.0%			
E.B.13	Percentage of patients receiving first definitive treatment for cancer within 62 days from an NHS Cancer screening service	Target		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C		
		Actual breaches	18	0	1	0	1									2	2			
		Actual Perf	93.2%	100.0%	93.8%	100.0%	96.7%										0.0%			
E.B.14	Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	Target		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	C		
		Actual breaches	3	1	--	1	0									2	2			
		Actual Perf	93.5%	50.0%		50.0%	100.0%										0.0%			
Long Term conditions																				
Local	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit (GHT Only)	Target		80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	C	Ellen Rule	Annemarie Vicary
		Glos		70.6%	82.6%	86.0%	64.9%													
Local	Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (GHT Only)	Target		60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%			
		Glos		52.3%	38.1%	58.7%														
E.A.S.1	Dementia diagnosis rate (Annual)	Target														66.7%	66.7%	C		Helen Vaughan
		Glos																		
Community Care Referral to Treatment (GLOUCESTERSHIRE only)																				
Paediatric																				
Local	Percentage of patients referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		Helen Ford
		Actual	97.9%	96.0%	99.0%	90.0%	85.0%									92.5%	92.5%			
Local	Percentage of patients referred to the Paediatric OccupationalTherapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual	99.4%	100.0%	100.0%	100.0%	100.0%									100.0%	100.0%			
Local	Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual	97.7%	100.0%	100.0%	100.0%	100.0%									100.0%	100.0%			
Adult																				
Local	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		Debbie Clark
		Actual	91.5%	93.0%	91.0%	99.0%	96.0%									94.8%	94.8%			
Local	Percentage of patients referred to the Podiatry Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual	90.3%	98.0%	99.0%	99.0%	98.0%									98.5%	98.5%			
Local	Percentage of patients referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual	99.8%	99.0%	86.1%	84.9%	85.0%									88.8%	88.8%			
Local	Percentage of patients referred to the Adult Physiotherapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual	96.9%	93.0%	90.0%	90.0%	90.0%									90.8%	90.8%			
Specialist Nurses																				
Local	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		Debbie Clark
		Actual	99.3%	100.0%	100.0%	100.0%	100.0%									100.0%	100.0%			
Local	Percentage of patients referred to the Diabetic Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual	98.0%	100.0%	100.0%	100.0%	96.0%									99.0%	99.0%			

Gloucestershire CCG 2015/16 Integrated Performance Scorecard

Target	Principal Delivery Targets		2014-15 Outturn	Apr-15	May-15	Jun-15 / Q1	Jul-15	Aug-15	Sep-15 / Q2	Oct-15	Nov-15	Dec-15 / Q3	Jan-16	Feb-16	Mar-16 / Q4	Year / Quarter to date	Year End Forecast	Perf. Measured	Director	Responsible Manager
Mental Health and Learning Disabilities																				
Adults of Working Age																				
E.B.S.3	Proportion of those patients on a Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	Target	95%			95.0%			95.0%			95.0%			95.0%	95.0%	95.0%	C	Mark Walkinshaw	Eddie O'Neill
		Glos	97.7%			98.0%										98.0%	98.0%			
Improving Access to Psychological Therapies (IAPT)																				
E.A.3	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Glos target				15.0%			15.0%			15.0%			15.0%	15.0%	15.0%	C	Mark Walkinshaw	Eddie O'Neill
		Glos actual	16.9%														0.0%			
E.A.S.2	The proportion of people who complete therapy who are moving towards recovery	Glos target				50.0%			50.0%			50.0%			50.0%	50.0%	50.0%	C		
		Glos actual	48.1%			43.0%											0.0%			
E.H.1_B1	The proportion of people that wait **6 weeks** or less from referral to their 1st IAPT treatment appointment against the no. of people who enter treatment in the reporting period.	Glos target				50.0%			52.7%			57.0%			75.1%	75.1%	75.1%			
		Glos actual	-			89.0%											0.0%			
E.H.1_B2	The proportion of people that wait **18 weeks** or less from referral to their 1st IAPT treatment appointment against the no. of people who enter treatment in the reporting period.	Glos target				60.0%			63.0%			72.0%			95.1%	95.1%	95.1%			
		Glos actual	-			99.0%											0.0%			
Quality																				
Quality Indicators																				
E.B.S.1	Eliminate mixed-sexed accommodation breaches at all providers sites	GHT	0	0	0	0	0											C	Marion Andrews-Evans	Kay Haughton
		Care Services	0	0	0	0	0													
		2gether	0	0	0	0	0													
	Number of Never Events	GHT	3	0	0	0	1											C	Marion Andrews-Evans	Kay Haughton
		Care Services	0	0	0	0	0													
		2gether	0	0	0	0	0													
		SWAST	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
	Percentage of all adult inpatients who have had a VTE risk assessment	Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	C	Marion Andrews-Evans	Kay Haughton
		GHNHSFT		94.3%	93.9%	95.5%														
		GCS		97.0%	97.8%	90.9%	91.0%													
Cleanliness and HCAIs																				
Methicillin Resistant Staphylococcus Aureus (MRSA)																				
E.A.S.4	Number of MRSA infections (Health Community)	Glos HC target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Marion Andrews-Evans	Teresa Middleton
		Glos HC actual	11	2	1	1	0	1									5			
	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		GHNHSFT actual	10	2	1	0	0	1									4			
Clostridium Difficile (C.Diff)																				
E.A.S.5	Number of total C Diff infections (Health Community)	Glos HC target	162	15	12	12	16	16	8	12	10	9	16	16	15	71	157	C	Marion Andrews-Evans	Teresa Middleton
		Glos HC actual	153	15	14	16	10	9								64	64			
	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target	52	3	3	3	4	4	2	3	2	2	4	3	4	17	37	C		
		GHNHSFT actual	37	4	4	0	4	4								16	16			

Appendix 2

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position as at 31st August (Month 05)

AS AT Month 05 2015/16	R	2015/16 NR	TOTAL	Cash Limit
	£000	£000	£000	£000
2015/16 baseline excl growth	**678,642**		**678,642**	**678,642**
Growth	28,774		28,774	28,774
B/f surplus		8,494	8,494	8,494
BCF	11,596		11,596	11,596
ETO Funding		2,300	2,300	2,300
Co -Commissioning	69,377		69,377	69,377
GPIT		1,622	1,622	1,622
Co-commissioning Premises	7,425		7,425	7,425
Risk Share Agreement RTT		1,430	1,430	1,430
Planned Surplus				(7,300)
MCD Adjustment				(1,427)
Waiting List review		22	22	22
Last month total	**795,814**	**13,868**	**809,682**	**800,955**
Adjustments in month				
Eating disorders and planning in 2015/16		319	319	319
Adjustments actioned in month		**319**	**319**	**319**
TOTAL NATIONALLY REPORTED LIMIT	**795,814**	**14,187**	**810,001**	**801,274**

Appendix 3

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Summary Financial Position

Overall financial position as at 31st August 2015 (Month 05)

	Year to Date			Forecast Outturn		
	Budget	Actual	(Under)/Over spend	Annual Budget	Forecast Outturn	(Under)/Over spend
	£000	£000	£000	£000	£000	£000
Acute services						
Acute contracts -NHS (includes Ambulance services)	145,998	144,985	(1,013)	344,459	344,524	65
Acute contracts - Other providers	6,667	6,904	237	16,002	15,415	(587)
Acute - NCAs	2,782	2,783	1	6,681	6,681	
Pass-through payments						
Sub-total Acute services	**155,447**	**154,672**	**(775)**	**367,142**	**366,620**	**(522)**
Mental Health Services						
MH contracts - NHS	31,669	31,744	75	76,006	76,038	32
MH contracts - Other providers	1,308	1,280	(28)	3,243	3,185	(58)
Sub-total MH services	**32,977**	**33,024**	**47**	**79,249**	**79,223**	**(26)**
Community Health Services						
CH Contracts - NHS	34,792	34,792		82,156	82,156	
CH Contracts - Other providers	(532)	(497)	35	(1,277)	(1,277)	
CH - Other						
Sub-total Community services	**34,260**	**34,295**	**35**	**80,879**	**80,879**	
Continuing Care Services						
Continuing Care Services (All Care Groups)	10,127	9,369	(758)	22,690	22,667	(23)
Local Authority / Joint Services	1,671	1,121	(550)	4,010	3,458	(552)
Free Nursing Care	3,964	3,789	(175)	9,515	9,337	(178)
Sub-total Continuing Care services	**15,762**	**14,279**	**(1,483)**	**36,215**	**35,462**	**(753)**
Primary Care services						
Prescribing	38,178	39,531	1,353	91,627	94,727	3,100
Enhanced services	34,362	34,126	(236)	83,606	83,566	(40)
Other	4,045	4,019	(26)	9,707	9,657	(50)
Sub-total Primary Care services	**76,585**	**77,676**	**1,091**	**184,940**	**187,950**	**3,010**
Other Programme services						
Re-ablement funding	872	872		2,093	2,093	
Other	10,414	10,350	(64)	24,983	24,960	(23)
Sub-total Other Programme services	**11,286**	**11,222**	**(64)**	**27,076**	**27,053**	**(23)**
Total - Commissioned services	**326,317**	**325,168**	**(1,149)**	**775,501**	**777,187**	**1,686**
Specific Commissioning Reserves (Inc headroom and Contingency)	2,503	3,941	1,438	13,666	12,016	(1,650)
Total - Programme Costs (excl Surplus)	**328,820**	**329,109**	**288**	**789,167**	**789,203**	**36**
Running Costs (incl reserves)	5,638	5,350	(288)	13,534	13,498	(36)
Total - Admin Costs (excl Surplus)	**5,638**	**5,350**	**(288)**	**13,534**	**13,498**	**(36)**
Surplus	3,042		(3,042)	7,300		(7,300)
Total Application of Funds	**337,500**	**334,459**	**(3,042)**	**810,001**	**802,701**	**(7,300)**

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Appendix 4

QIPP Programme 2015/16

Theme	Planned Gross Savings 2015/16 £'000	Forecast £'000	Variance £'000	Theme RAG	Savings RAG	Recurrent / Trend RAG
Urgent Care	7,433	5,685	(1,748)	A	A	A
Planned Care	2,910	3,110	200	A	A	A
Community	1,200	700	(500)	A	A	A
Prescribing	4,070	3,694	(376)	G	G	A
Transactional	1,430	1,530	100	G	A	A
Unidentified	0	0	0			
Grand Total	**17,043**	**14,720**	**(2,323)**			
Additional Schemes			0	**n/a**	**n/a**	**n/a**
Additional QIPP / Slippage / Contingent resources / Application of QIPP rule		2,323	2,323			
Grand Total	**17,043**	**17,043**	**0**			

The report provides information on all 2015/16 QIPP schemes **Appendix 5**

Urgent Care Schemes

Project	Integrated Community Teams (ICT)	

The programme team is now working closely with the service provider to ensure that anticipated throughput is realised in line with requirements. The CCG is currently waiting for proposals from GCS as to how they will be increasing throughput. Expected throughput is 60 cases per week however actual activity is 30-40 cases per week. Rapid Response have been carrying out in-reach into hospital to pull out a target of 5 patients per day. The CCG has agreed the staffing and financial model for Rapid Response and is finalising revised interim clinical coding so that transition and service management into business as usual arrangements can take place. The case review process has been finished and will start shortly.

Project	Older People's Assessment Liaison (OPAL)	

The OPAL service is available at both GRH and CGH. A full time Consultant is due to start in September 2015 and recruitment for additional staff continues. A position statement of the current OPAL service to inform the development of the service going forward has been developed by GHFT, and the requirement for a new service model business case is being discussed. A separate business case for the Frailty Unit's Older People's Assessment Unit (OPAU) element of OPAL is expected shortly. GHFT are also considering operating a virtual OPAL service. Performance to date has been at or above planned activity levels.

Project	Integrated Discharge Team (IDT)	

A new IDT service specification was written and signed off by GHFT and GCS. Recruitment and interviews have been underway for a band 3 and 6 (frequent attender post). A number of actions are being implemented to improve the medically stable numbers including further data being added to Alamac around length of patient delays and turnover.

Project	Ambulatory Emergency Care (AEC)	

The AEC Business Case proposal was originally signed off by QIPP Assurance Group and Core Team in January 2015, however a new version has been signed off since which includes revised financials and a medical model to cover 14 hour days, 5 days per week. Pathways for group 1 have been completed with pathway groups 3 & 4 reforecast for delivery in 2016/17 . Pathway Group 2 on track for delivery in December 2015. Evening opening times will in be place by January 2016.
The GRH AEC is to remain on the ground floor of Gallery Wing in the interim until a permanent Streamlining Urgent Care solution has been agreed. A location for the CGH AEC is still to be agreed. Recruitment ongoing and challenging.

Project	Urgent Care Respiratory Pathways	

Scheme is being aligned to AEC pathway with links to service under exploration with GHFT. Urgent Care pathways being developed and a Project Initiation Document has now been drafted. An Asthma action plan has been agreed and sent out with 'What's New This Week'. Work continues on a Chronic Obstructive Pulmonary Disease (COPD) bundle and a meeting took place between providers in Gloucestershire on Friday 21st August to refresh the pathway and ensure it reflects recent COPD-related service developments ahead of the critical winter period. Work is being undertaken to review the pneumonia guidelines for primary care and care homes ahead of the winter period.

Project	Primary Care (Prime Minister's Challenge)	

Choice+ in Gloucester is now live with 7 day working over 2 sites. In Cheltenham the Health Living Centre will go live on 9th September and St Pauls on 14th September. Subject to N3 connection, the service will go live in Tewkesbury at the end of September. Around 350,000 patients are now covered by Choice+.
Social Prescribing implementation on track with accelerated implementation in the Forest of Dean and Gloucester.
Ask My GP is in the process of being procured and being extended to cover around 260,000 patients.
Additional Rapid Response support has been finalised and is planned to be implemented in time for the winter period.
A Nurse Manager in now in post and recruiting nurses for the Specialist Nursing Services.
ASAP has 1400 downloads with additional communications and marketing planned for the winter period.
Video Consultations are being reviewed based on lessons learned from the pilot.

Project	Primary Care in ED (PAU element)	

Service operational 7 days a week and performance is being monitored.

Project	DVT	

The new DVT Enhanced Service was launched in April 2014. 74 out of 84 GP practices have expressed an interest in providing the community DVT service and GPs have started providing the service. Referrals into the acute hospital are being monitored and there is already evidence that the numbers are decreasing. The DVT services at Cirencester and Berkeley Vale are being monitored with a view to decommissioning the services there.

Project	Mental Health Liaison	

The Mental Health Liaison service specification has been agreed.
Crisis Team have successfully recruited band 6 staff for the Crisis Team to provide 24 hour coverage and capacity to cover a lowered age range (>12). These are due to commence their roles in August 2015 which is ahead of plan. The night service within ED has commenced. Discussions are ongoing regarding the co-location of the MH Crisis service at Police HQ (Waterwells).

Project	Care Homes Enhanced Service	

Implementing the enhanced service as business as usual. Close to 100% coverage of all care homes. A small number of returns are awaited from GPs. Maintaining delivery of continuing reduction in ED admissions and attendances. Plans for roll out of some components of the ES to LD and PD homes are being developed. A business case for specialist pharmacist support for care homes is anticipated at QIPP Assurance Group on 10/09/15 which is based on 3 successful pilots in care homes.

Project	Community Hospitals	

Transforming Community Hospitals Group (TCHG), who provides overall direction and strategic development of Community Hospitals, has identified 7 work streams: Ambulatory Care, Bed Usage & Rehabilitation, Clinical Care Model, Discharges, Estates, Healthy Market Place and Urgent Care. A number of activities have taken place with regard to the 7 work streams, including a workshop for ambulatory care which will continue on a montly basis with findings to be considered in Jan 16, implementation of the revised medical model at Cirencester Hospital, and the launch of the Healthy Market Place on 23rd August 2015. SystmOne is due to be in place across all community hospitals by November 2015. A listening event will begin in the Forest of Dean in September that will examine every aspect of community care including community hospitals. MiU at Cirencester will move to the ENP led service from 1st October.

Project	Maternity Triage	

Commencement of pilot delayed until 1st September 2015. Midwives have been recruited and were released on the 1st August. The Contract Variation order is being taken forward. It has been agreed that the investment will be split over two years to carry out the full pilot. Discussions are taking place regarding the evaluation of this pilot.

Project	Signposting	

The signposting scheme is currently delivering a 6% disposition to ED with a KPI target of 5%. Work to ensure delivery of this target is being undertaken as part of the resilience planning. There are 8 high impact actions to review how as a CCG we can support delivery of action 2 (999/111 dispositions). MIU attendances are up on last year by 4.9%.

Project	Single Point of Clinical Access (SPCA)	

The service spec is complete and has been reviewed and approved by GCS. This will now go through Contract Board for approval via contract variation, however, it has been raised through Urgent Care Delivery Group that the service specification does not currently allow Care Homes or Residential Homes access to SPCA. Discussions will now take place to make a decision on this and whether an amendment is made to the specification. Whole system audit to take place; delivery of this has slipped from the original plan.

Project	Falls and Bone Health	

The CCG Development Group approved the plan on a page and aims of the enhanced falls service. A business case is being written for additional falls resource whilst a longer-term strategy is developed and implemented to shift the focus of care to earlier in the pathway. The PM is working closely alongside urgent care to agree how best to develop the falls service and this is expected at QIPP Assurance Group in September 2015. Business case is being prepared.
A meeting has been arranged between the CCG and the Fire Service to look at pick up services with falls awareness training already being undertaken by the fire service and a Fracture neck of femur workshop has been arranged for October.

Project	Paediatric Urgent Care Pathway	

Training sessions on the Big 6 attended by SWAST, GPs and GCS staff. SWAST have agreed to direct booking slots into OOHs for GPs so that children can be followed up in the OOHs service following a GP appointment.

Planned Care Schemes

Project	Care Pathways	

G-Care website was launched on 13 July and initial response has been positive. Videos of 'how to use the site in practice' are being used in communications.
Content Guidance has been agreed to aid managers and clinicians when providing information for the website and a Pathway Template (including flowchart) and guidance to help authors of new pathways has been created. Template used to develop the Dementia pathway to be used as an example. The Business Case was agreed at QIPP Assurance on 28/5.

Project	Direct Access Diagnostics	

The draft evaluation is now complete. Certain elements will be shared with providers. The evaluation was signed off by Core Team in July and went to a Development session on 6th August.
Results from the evaluation to be shared with providers in order for next steps to be worked on.

Project	ISTC Utilisation (Part Year Effect up to Sept 15)	

A small number of waiting list transfers are taking place and are now happening in outpatients as well as inpatients for Urology. There has been a slight drop in the weekly GP referrals however communications through What's New This Week and the launch of G-Care (which includes information about Care UK) should encourage GPs to continue referring to Care UK. On track to deliver QIPP target currently.

Project	Diabetes Enhanced Service	

Communications have been sent to practices regarding the Enhanced Service and requirements for repatriation. An educational programme for primary care is ongoing.

Project	Respiratory Pathways	

Top tips for intractable cough are being developed by GHFT and a service specification is in development for a revised Pulmonary Nodules pathway. Business Case from GCS for Pulmonary Rehab is still awaited; this will provide capacity for the repatriation of some bronchiectasis activity as well as increasing the capacity of the Pulmonary Rehabilitation service.

Project	Eye Health	

Community Eye Care Service Specification and Voluntary Sector Eye Care Service Specification in draft and ready for consultation. A School Vision Screening Workshop has been held and agreement to investigate moving some services into the community was gained. An Eye Health Panel has been arranged for 3rd November and Terms Of Reference for the group agreed. The group will meet to review the Community Eye Health Proposal.

Project	MSK	

7 workshops have now been held and recommendation reports produced. Commitment has been received from all stakeholders to reduce the Orthopaedic follow-up rate. 10 conditions/surgical procedures have been identified and meetings arranged to determine plan. The PM has been liaising with ICE to ensure that relevant test panels are set up to assist with referrals. The link between SystmOne and Choose and Book is also being investigated. The STarTback tool has now been implemented by the GCS and GHFT physiotherapy departments to ensure appropriate and timely interventions for patients with back pain. The IFRs have now been agreed and an initial set of information has been uploaded onto G-Care. A new integrated MSK service model has been developed based on feedback from the workshops, patient feedback and the evidence base. This was discussed at the CCG Development session on the 13th August 2015.

Project	Follow Ups	

An action plan was received from GHFT for Paediatrics, Neurology and Dermatology along with an Implementation Timetable. A monthly information report to be generated by GHFT to assess the effectiveness of the action plan for each speciality. GCCG Commissioning Manager to liaise with GHFT Project Manager around implementation.
Discussions with reference to telephone consultations and the current tariff agreement for consultant-led consultation continue.

Project	Individual Funding Reviews (IFR)	

Group 1 policies have been signed off by Integrated Governance and Quality Commission (IGQC). A number of policies were signed off by IGQC including Eye Health. Discussions regarding the terms of reference for the CBA audit are ongoing with GHFT.
A challenge of £200k has been made, based on assumed non-compliance with CBA. Interventions Not Normally Funded (INNF) and Prior Approval (PA) compliance process has now been embedded. The April process challenged £179,242 which following GHFT review has been reduced to £116,939. The May process challenged £126,155 which is currently with GHFT for review and final amount to be confirmed.

Project	Irritable Bowel Syndrome (IBS)	

A service specification has been drafted and is currently with GCCG for comment around amendments to patient pathway.
GP education programme and implementation dates to be confirmed. Some discussions regarding CCG proposal are still ongoing.

Project	Cancer (Living with and Beyond)	

A CQUIN has been agreed for Risk Stratified Pathways, Treatment Summaries and Holistic Needs Assessments & Care Plans within breast, colorectal and prostate cancers. GHFT have successfully appointed a Macmillan Programme Manager to oversee this project, due to start in September 2015.
Risk Stratified Pathways and Treatment Summaries: Workshops were run in June/July for breast, colorectal and prostate cancer to look at the future pathways and the structure of the Treatment Summaries. These were run with attendees from primary care and secondary care so that all aspects within each pathway were fully understood and worked through. Actions from these workshops are currently being worked through and follow up meetings are being arranged.

Project	Dermatology	

Project team established to include data and information lead, finance lead, Public Health, PPE lead, Programme Manager, Project Manager. An evidence base review has been completed and a needs assessment is underway. Potential areas of savings have been identified and are to be explored.
A data and information report is underway. Furthermore, a patient questionnaire has been created and process maps have been developed. The service description and directory is currently being developed as well as condition specific pathways and a workshop is planned for the 8th September.
Teledermatology pre-procurement work is underway.

Project	ISO - Stroud and Berkeley Vale	

All 19 practices have now signed up to the "Addressing Practice Variation in Stroud and Berkeley Vale" service specification. The first meetings with Variation Auditors (previously called ISOs), practice managers and practice representatives have been held. These meetings were an opportunity to confirm the work programme and expectations, answer any questions or concerns, and provide a forum for sharing best practice. Feedback about the more structured approach the project will take as part of the Variation Programme this year was positive, as was the more consistent approach with templates and Practice Variation Reports. Meetings will be held every two months to monitor progress and begin the evaluation process. During July most of the Variation Auditors completed the practice profile sections of their Practice Variation Reports. Following this each will receive the updated version of their Practice Variation Report with key variations identified along with supporting data, in advance of the first scoping meeting. This meeting, attended by the Variation Auditor, a GP, the CCG Variation Project Manager and a representative form the CCG Finance and Information team will be to review the Practice Variation Report and agree the scope and parameters for the first audit. A few of these meetings have now taken place, and the audits at these practices can now commence.

Community Schemes

Project	Rehabilitation Pathways	

Project manager has been appointed and approval of business case is underway.

Project	Continuing Health Care	

3 x Band 3 posts recruited into. Checking of Rates Cards with individual providers on care track has commenced to enable validation of the invoices. These posts have been extended until September 2015.

Project	LD Joint Funding	

Joint Placements: The remaining 38 placements are all residential care placements. Re-negotiations of these amounts await the implementation of a new Tool Price for LD residential care which is currently under negotiation with the Gloucestershire Care Providers Association (GCPA).

Project	Leg Ulcers	

A meeting with patients and volunteers took place at the Lindsay Leg Club in Cirencester on 22/7/15 ahead of the 'lift and shift' of this element of the service into Cirencester Hospital in August. Recruitment ongoing. Contingencies are currently being assessed by GCS.

Prescribing Schemes

Project	Primary Care	

Prescribing Improvement Plan (PIP) topics completed by all practices to a high level of participation.

Project	Home Oxygen	

A saving of £88k has been identified for this scheme. A contract variation and updated service specification has been sent to GCS for sign off. A robust dataset was included within these documents in order to enable the capture of savings attached to the service. Regular contract monitoring meetings have been set up to receive and review the data. Additional funding will be transferred upon the appointment of staff. It is anticipated that these staff will be effective from 1st December 2015 so 4 months savings were agreed to be included within the budget.

Project	Centralised Continence Supplies	

A decision is still to be made as to whether GCCG go through a tendering process or award to incumbent provider. This will depend upon the decision of another CCG.

Project	Care Home Pharmacist medication reviews	

Care Home Pharmacists now attending higher priority care homes and delivering medicines optimisation services with close liaison with the attending GPs. Pilot 3 is continuing and findings have provided input to the business case for the next phase. The business case is being re-presented to QIPP assurance group in early September.

Project	Secondary Care Partnership (specials/homecare)	
Discussion of increasing availability of Low Molecular Weight Heparins underway. Discussion about provision of a range of lesser used higher cost medications (repatriation to hospital service) being considered, where overall costs are lower than provision within primary care, where patient convenience is not negatively affected (e.g. if attending outpatient clinic for routine follow up anyway).		

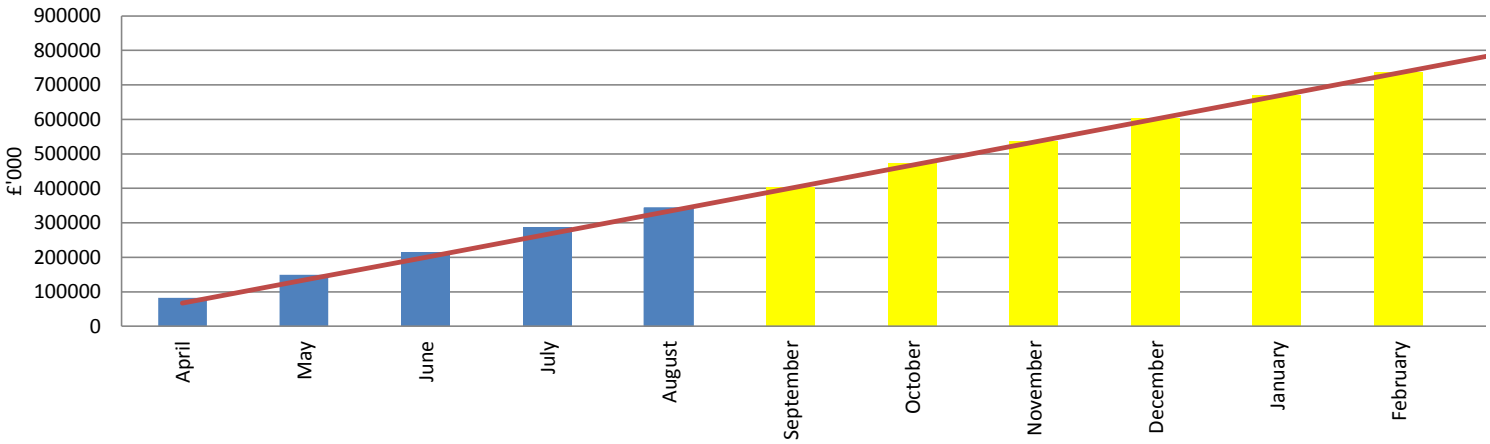
Appendix 6

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 31st August 2015 (Month 05)

		Actual/Forecast Charges in Month							YTD	CASH	Mth end	Cash Limit
Month	Status	Drawn £000	Prescribing £000	Home Oxygen £000	Advance Drugs Payments £000	co Commissioning	CHC Risk pool contribution	Capital Allocation	TOTAL £000	TOTAL £000	LIMIT £000	Balance £000
April	Act	70,000	6,364	82	80	6,244			82,770	82,770	66,773	1,460
May	Act	50,000	7,149	89	(107)	9,169			66,300	149,070	133,546	2,429
June	Act	51,000	6,887	91	93	6,385	1,154		65,610	214,680	200,319	1,133
July	F'cast	60,000	6,756	87	(36)	6,232			73,039	287,719	267,091	3,735
August	F'cast	46,000	7,147	91	19	1,460			54,717	342,436	333,864	802
September	F'cast	49,000	7,147	91		5,906			62,144	404,580	400,637	
October	F'cast	55,000	7,147	91		5,906			68,144	472,724	467,410	
November	F'cast	52,566	7,147	91		5,906			65,710	538,434	534,183	
December	F'cast	52,566	7,147	91		5,906			65,710	604,144	600,956	
January	F'cast	52,566	7,147	91		5,906			65,710	669,854	667,728	
February	F'cast	52,566	7,147	91		5,906			65,710	735,564	734,501	
March	F'cast	52,566	7,147	91		5,906			65,710	801,274	801,274	



Overview of current position

At the end of August £342m had been drawn down (42.7%) of the anticipated cash limit against 41.7% on a straight line basis for August.

Appendix 7

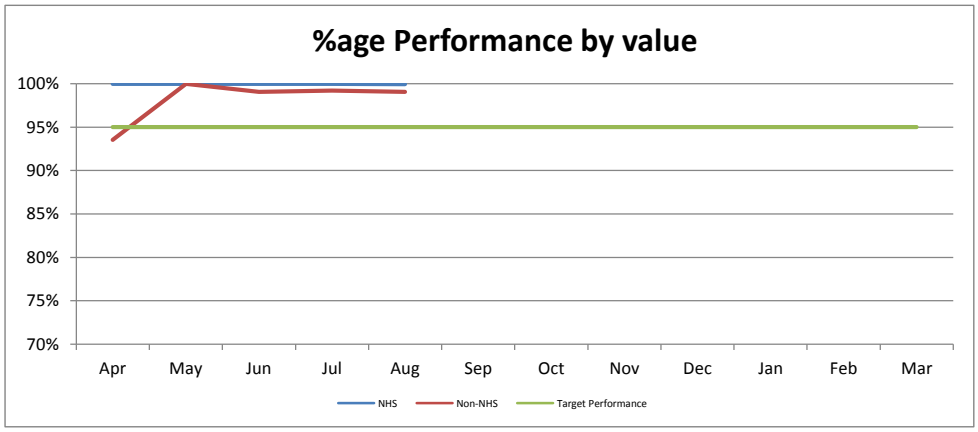
NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

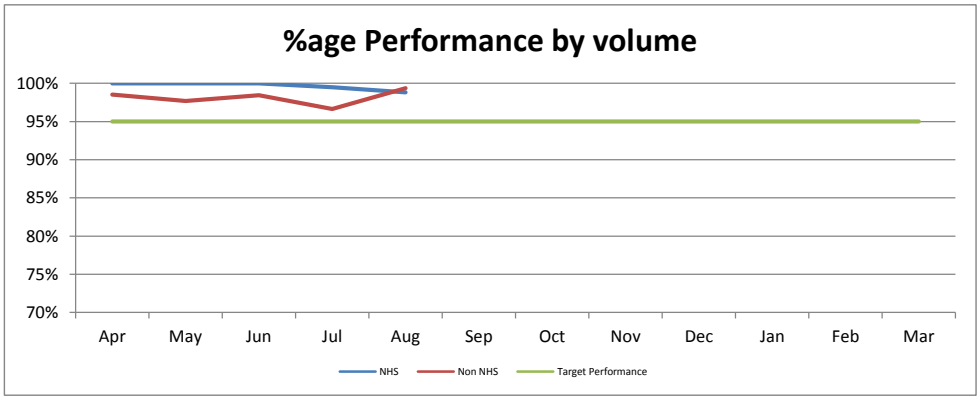
Performance against better payment practice code

As at 31st August 2015 (Month 05)

	In Month		Year to Date	
	NHS	Non NHS	NHS	Non NHS
By volume				
Total number of invoices	249	624	1,418	3,333
Number paid within target	246	620	1,413	3,253
Performance	**98.80%**	**99.36%**	**99.65%**	**97.60%**
By value				
Total value of invoices (£'M)	34.83	3.30	208.25	20.36
Value paid within target (£'M)	34.82	3.27	208.24	20.01
Performance	**99.97%**	**99.09%**	**100.00%**	**98.28%**

The target performance level is 95%





Appendix 8

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

As at 31st August 2015 (Month 05)

	Audited Position as at 31 March 2015	Current Month end Position	Forecast Position as at 31 March 2016
		£000	£000
Non-current assets:			
Premises, Plant, Fixtures & Fittings	188	167	143
IM&T		0	0
Other		0	0
Long Term Receivables		0	0
Total non-current assets	**188**	**167**	**143**
Current assets:			
Inventories		0	0
Trade and other receivables	6,150	19,478	6,000
Cash and cash equivalents	104	802	1
Total current assets	**6,254**	**20,280**	**6,001**
Total assets	**6,442**	**20,447**	**6,144**
Current liabilities			
Payables	(40,361)	(48,139)	(40,000)
Provisions	(863)	(848)	0
Borrowings		0	0
Total current liabilities	**(41,224)**	**(48,987)**	**(40,000)**
Non-current assets plus/less net current assets/liabilities	**(34,782)**	**(28,540)**	**(33,856)**
Non-current liabilities			
Trade and other payables		0	0
Other Liabilities		0	0
Provisions		0	0
Borrowings		0	0
Total non-current liabilities		**0**	**0**
Total Assets Employed:	**(34,782)**	**(28,540)**	**(33,856)**
Financed by taxpayers' equity:			
General fund	(34,782)	(28,540)	(33,856)
Revaluation reserve			
Other reserves			
Total taxpayers' equity:	**(34,782)**	**(28,540)**	**(33,856)**

Agenda Item 11

Gloucestershire Clinical Commissioning Group
Governing Body

Governing Body Meeting Date	**Thursday 24th September 2015**
Title	**Assurance Framework 2015/16**
Executive Summary	The attached Assurance Framework for 2015/16 provides details of the assurances that will be 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 high-level 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 minimise the effect of 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 Inequalities	None

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

Agenda Item 11

Governing Body

Thursday 24th September 2015

Assurance Framework 2015/16

1. Introduction

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

- focus on those high-level risks that could compromise achievement of the organisational objectives;
- map out the key controls in place to manage the objectives;
- 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 six summary objectives outlined in the 2 Year Plan for 2014/16.

2.2 The document outlines the principal high-level 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.

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

3. Recommendation

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

4. Appendix

Appendix 1: Assurance Framework

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
Objective 1: Develop strong, high quality, clinically effective and innovative services.								
L2	Risk to the Quality of Primary Care due to GP practices running at maximum capacity and certain practices not being financially viable.	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. Delegated Commissioning from 1 April 2015.	Primary Care Commissioning Committee, Risk and issues log for all member practices.		Ongoing monitoring, appointments made within Senior Management of Primary Care team, Investment to support unplanned admissions DES to practices, new ways of working pilot, funding identified in ORCP plan to support Primary Care initiatives.
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.	Kathryn Hall/Simon Bilous	12 (3x4)	16 (4x4)	Monitoring service provision with local providers and feedback to Area Team. Issue raised in CQC review report.	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)
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	9 (3x3)	6 (2x3)	Communications and Engagement Strategy, 4Cs Policy and Procedure, Provider Clinical Quality Review Groups, HSOSC, Healthwatch Gloucestershire (HWG) comments.	Commissioning for Quality Report, Outcome of Engagement/Consultation Reports, CPGs and other programme groups		Maintain mechanism for 'feeding back' impact of patient, carer public experience data.
Q11	Failure to implement Deprivation of Liberty Safeguards (DoLS) as per recent judicial review.	Helen Crystal/Mary Morgan	12 (4x3)	6 (2x3)	Adult Safeguarding Board and provider Clinical Quality Review Groups (CQRGs) in place to monitor.	Adult Safeguarding Board and CQRG meetings.		General awareness to be raised across the whole organisation with emphasis on Continuing Health Care (CHC) and Mental Health services (Oct 2014). Expansion of the CCG Safeguarding team will allow greater focus on training and support across the health community

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
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 remaining in hospital exceeds agreed target.	Maria Metherall	16 (4x4)	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.		Whole system recovery plan agreed with focus upon ED staffing and rotas, bed capacity and flow, community capacity and weekend discharges. Daily monitoring of performance plan underway via whole system escalation calls.
C6	(Acute Care) Non-delivery of the Constitution standard for maximum wait of 4 hours within the Emergency Department.	Maria Metherall	12 (3x4)	16 (4x4)	GSRG, Weekly GHT, ECB, 7 day service 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.		Whole system recovery plan agreed with focus upon ED staffing and rotas, bed capacity and flow, community capacity and weekend discharges. Daily monitoring of performance plan underway via whole system escalation calls.
C15	Failure to comply with national and local access targets for planned care; including 2ww, over 52ww, 62 day cancer target, diagnostic 6-week target, planned follow-ups could result in inadequate and/or delayed care.	Annemarie Vicary	12 (3x4)	12 (3x4)	Acute provider contracts, including AQP.	Performance Reports		Performance calls in place to monitor action plans and trajectories with focus on services under pressure. Additional capacity is being sought from other providers for April 2015/16 contracts including both elective and diagnostic options. Locality training planned for practice secretaries September 2015. Ongoing work to assist with the transfer of patients to ISTC. Cancer CPGs actively working on patient pathways.
F11 - F16	Failure to deliver financial targets.	Cath Leech	12 (3x4)	12 (3x4)	Robust financial plan aligned to commissioning strategy.	Budgets approved by the Governing Body. Monthly reporting to CCG Governing Body.		Ongoing work to ensure financial commitments are affordable and CCG is achieving a recurrent balance (at least quarterly). Work on 5 year financial plan underway.
					Robust contract management and activity monitoring and validation (particularly at GHFT)	Monthly performance dashboard for larger contracts with robust out of county contract monitoring reflected within performance reports.		Monthly performance meeting which reviews all contracts (including out of county) together with Contract Boards and Finance & Information Groups for larger contracts.
					Financial procedure being refreshed.	Internal audit plan in place and internal audit reports and recommendations to be reported to Audit Committee.		Procedures are constantly under review and work is currently ongoing re: financial delegation limits (Sep 15)

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
C26	There is a risk that the scale, complexity and unavoidable time constraints associated with the implementation of the agreed service model for strengthened health and social care integrated community teams across Gloucestershire means that the financial savings target allocated to this programme as part of 2013/14 Annual Operation Plan and prior to the completion of the case for change and return of investment are not realised along with the service objectives (given the significant change in the model of service delivery required).	Kim Forey/Andrew Hughes	12 (3x4)	12 (3x4)	ICT Programme Group, QIPP Board Reports, GCCG Board Reports	Report to IGC and Governing Body, ICT Steering Group	Implementation of integrated case management and model; Delivery of HIS functionality as part of day to day service. Finalised financial model. Impact of current DN working on programme development. Throughput of Rapid Response cases.	Rapid Response now fully operational. Agreed trajectory in place. with target of 60 cases per week. Regular performance meeting with Provider. Weekly discharge in first quarter of 2015/ 2016 at around 40 cases per week. Additional plans have led to increased throughput. Since July 2015, now increased to over 50 per week. Reviewing on weekly basis. Service and financial model agreed, clinical coding Interim service specification finalised, KPIs developed as part of new wider ICT service specification. Integrated cased management not implemented and HIS not integrated into day to day team work. QIPP risk share in place to incentivise delivery. Not rolling out HIS until model working well across Gloucester, Cheltenham and Tewkesbury (around 60% of County) and new project in place to drive this. Also new governance arrangements in place. Overall full functionality not in place- full benefits delayed and estimated to not be achieved until 2016/ 2017
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.		Most services are now being provided in-house and the remaining CSU services are subject to a tender (lead provider framework) with any new arrangement being implemented from 1 April 2016)
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. Monitoring of budgets.		Due Diligence undertaken prior to submission. Budgets will be monitored through 2015/16.

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
Objective 5: Work together with our partners to develop and deliver ill health prevention and care strategies designed to improved the lives of patients, their families and carers.								
A1	Failure to build positive relationships with the local health community and other commissioners could impact on joined-up service delivery and transformation.	Mary Hutton, Helen Miller	12 (3x4)	8 (2x4)	Joint 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 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 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, briefing 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)	6 (2x3)	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, Bimonthly C Difficile working group, Strategic Countywide HCAIs group.		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 practice 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).

Risk	Principal Risks	Risk Owners	Original Risk Ratings (LxC)	Current Risk Ratings (LxC)	Key Controls	Sources of Assurance	Gaps in Controls or Assurance	Action and Target Date
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 service (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 Bilous	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 progress reports.	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).

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Governing Body

Governing Body Meeting Date	**Thursday 24th September 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 June 2015.
Key Issues	The following principal issues were discussed: • Experience and Engagement Report • Quality Report • Primary Care Clinical Audit Report • Effective Clinical Commissioning Policies • Non-Emergency Patient Transport Policy • Health and Safety Policy • Risk Register • Assurance Framework • Information Governance Update • Suicides and Attempted Suicides
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
Clinical Commissioning Group

Integrated Governance and Quality Committee (IGQC)

Minutes of the meeting held on Thursday 18th June 2015, Board Room, Sanger House

Present:		
Julie Clatworthy	JC	Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Caroline Bennett	CBe	GP - North Cotswolds Locality
Dr Charles Buckley	CBu	GP – Stroud Locality
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Colin Greaves	CG	Lay Member – Governance
Mary Hutton	MH	Accountable Officer
Dr Tristan Lench	TL	GP - Forest of Dean Locality
Dr Helen Miller	HM	Clinical Chair
Mark Walkingshaw	MW	Deputy Accountable Officer
Valerie Webb	VW	Lay Member - Business

In Attendance:		
Becky Parish	BP	Associate Director Patient and Public Engagement
Caitlin Lord	CLo	Patient Experience Co-ordinator
Helen Ford	HF	Senior Commissioning Manager - Children, Young People and Maternity Commissioning Team
Ellen Rule	ER	Director of Transformation and Service Redesign
Richard Thorn	RT	Commissioning Manager (Planned Care)
Sarah Riordan-Jones	SRJ	Primary Care Clinical Audit Manager
Gill Bridgland	GB	Commissioning Implementation Manager
Cate White	CW	Project and Business Manager Quality Team
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator

1. Apologies for Absence

1.1 Apologies were received from Cath Leech and Sarah

Scott.

2. Declarations of Interest

2.1 JC declared an interest in Agenda Item 9.1, Varicose Veins Policy, as she was a member of the Quality Standards Advisory Committee of NICE which developed the Quality Standard for Vascular Disease.

3. Minutes of the meeting held on 14th May 2015

3.1 The minutes of the meeting were accepted as a true and correct record.

4. Matters Arising

4.1 **IGQC97 Information Governance Update**
MH requested that the Information Governance training for the Governing Body members was arranged by AP.
AP advised that CL was reviewing the contextual learning material to be used for the training and was in the process of being arranged. CG reminded members that the online training module also required completing.

4.2 **IGQC99 Quality Report**
AE highlighted the increase in suspected suicides and was told that a briefing report would be presented at the next Committee meeting on the activity being undertaken on suicide prevention.
This was covered under Agenda Item 14. **Item Closed.**

4.3 **IGQC104 Individual Funding (IFR) Annual Report**
CBe proposed that a scoring system process for differentiating between a minor and significant change should be developed to ensure that any request above a certain score was presented to the Committee.
MW advised that a scoring approach was being developed and that an update would be presented at the next Committee meeting.

4.4 **IGQC105 Experience and Engagement Report**
RM advised that the engagement activity could be

inaccurate and would clarify if engagement was undertaken in other localities.
BP advised that further engagement was undertaken with the South Cotswold Locality and that it was proposed to establish a Patient Reference Group. The Clinical Programme Groups in the North Cotswold Locality were also approached regarding the changes following delegated commissioning arrangements. BP clarified that the engagement activities would be included in the engagement plan. **Item Closed.**

4.5 **IGQC106 Quality Report**

HM enquired on the membership for the Gloucestershire Research and Development Consortium Team. KH agreed to circulate the membership.
Action had been completed. **Item Closed.**

4.6 **IGQC107 Quality Report**

AE suggested that a paragraph was inserted to indicate the specific actions identified for the CCG and highlighted that the Serious Case Reviews could be accessed and that a link to the reviews could also be included within the report. It was also agreed that the actions were explicitly defined to clarify lead and action date.
Action had been completed. **Item Closed.**

4.7 **IGQC108 Quality Report**

HM suggested that the Mental Health presentation that was presented to the Gloucester City Locality at Gloucester Rugby Club was circulated to other Localities.
AP advised that the presentation was being tracked. CBu requested that this was added to the CCG Live website.

4.8 **IGQC109 Quality Report**

JC reiterated the Committees wish to move towards a quality performance dashboard which would provide a system wide view using comparative data across providers.
Action had been completed. **Item Closed.**

4.9 **IGQC111 Quality Report**

JC requested that a clinical audit report was presented at the next Committee meeting.

This was covered under Agenda Item 8. **Item Closed.**

4.10 **IGQC113 Assurance Framework**

It was agreed that the presentation relating to Impact of Care Act 2014 and Impact of Children and Families Act 2014 could be discussed at Locality meeting and could also be linked in the 'What's New This Week' email.

Action had been completed. **Item Closed.**

4.11 **IGQC114 Records Management Policy**

JC requested clarity on the information received from Facebook and Twitter and where that information should be stored.

AP confirmed that further clarity would be included in the Policy. **Item Closed.**

4.12 **IGQC115 Safeguarding Children Policy**

HC explained that there was an emerging national guidance yet to be published and would cross reference against the requirements and agreed that she would report the requirements of the non-executive director back to the Committee.

VW stated that the revised policy was forwarded to her for approval, however, the Policy required tracked changes. VW highlighted that a number of amendments were not actioned. The Committee agreed that the final version should be presented at the next IGQC meeting.

4.13 **IGQC119 Health and Safety Policy**

JC highlighted the requirement for Health and Safety to be a standing agenda item at staff meetings within the CCG and requested that it was further specified which meetings Health & Safety would be discussed.

This was covered under Agenda Item 10. **Item Closed.**

4.14 **IGQC120 Capability Policy**

MW agreed to feedback to the CSU regarding the timing process for the dismissal on the grounds of

failing to demonstrate the required capability.
MW advised that this was aligned to national requirements although managers would be informed that the Policy stated the maximum timescales.

4.15 **IGQC121 Assisted Conception Policy**
The Committee requested that the consultation report and the financial comparison for frozen vs fresh cycle, the Equality Impact Assessment and consultation views were available for the June Committee meeting.
MAE advised that an Equality Impact Assessment was being undertaken and that further details would be presented at the Priorities Committee.

4.16 **IGQC124 GHFT Dr Foster Mortality data**
JC requested that a formal response from Public Health was sought regarding this report.
The Public Health response was received on the 17/06/2015. **Item Closed.**

5. Patient's Story

5.1 CLo provided a patient's story presentation relating to Maternal Mental Health.

5.2 The presentation covered:

- experience of diagnosis/getting help;
- treatments/therapies that helped;
- community support; and
- lessons to be learnt

5.3 RECOMMENDATION: The Committee noted the presentation.

VW left at this point

6. Experience and Engagement Report

6.1 BP introduced the report which provided an overview of key experience and engagement activity undertaken by the CCG during 2014/15 Quarter 4 and the first part of 2015/16 Quarter 1. The report was taken as read.

6.2 BP highlighted the concept regarding the 'Commissioners on the Ground' initiative which included the Quality Team visiting the provider organisations to talk to patients and staff. It was noted that this was a positive development. BP also highlighted that the Complaints and Patient Advice and Liaison (PALs) Team were reviewing internal processes within the GHFT Complaints Team in order to streamline the CCG process.

6.3 BP informed members that the Friends and Family Test (FFT) had changed from being a national CQUIN to a standard local requirement for providers. However, it was noted that it would be a requirement for Primary Care to implement the FFT and that the scope was being reviewed with the Locality Development and Primary Care Team.

6.4 The Committee discussed the summary of patient and public feedback from Healthwatch which contained summary information of public views and experience collected in Quarter 4 2014/15 (January to March 2015) and felt that it would be useful to know actual number of people who fedback as well as the percentage. BP advised that the issues were previously raised and that it was envisaged that further input from Healthwatch could be acquired from the detailed task groups.

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

7. Quality Report

7.1 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.

7.2 Members were informed that the report included the Quality Dashboard which provided an overview of

performance within the provider organisations. MAE highlighted that this was a developing framework and requested that any feedback was forwarded to CW.

7.3 MAE highlighted Section 4 of the report in relation to Gloucestershire CCG 'Sign up to Safety' and advised that a formal sign up would be undertaken at the Governing Body meeting on the 30th July 2015. It was noted that this programme was supported by the Academic Health Science Network and that Dr Hein Le Roux would be engaging with his primary care colleagues in order to encourage sign up.

7.4 MAE stated that Kay Haughton was appointed as a 'Q fellow' by the Academic Health Science Network together with Andrew Seaton and Dr Sally Pearson of GHFT.

7.5 MAE advised that a meeting was held with the Chair of the Adults Safeguarding Board to discuss Serious Incidents. It was indicated that Healthwatch had raised safety concerns. MAE agreed that at a future Adults Safeguarding Board the CCG would present its approach to patient safety. The IGQC noted the update on the serious incidences.

7.6 MAE highlighted section 9.3 of the report relating to the Dr Foster Mortality Report. It was noted that a small working group was being established with GHFT to review the mortality rates.

7.7 MAE reported that a draft report from the CQC inspection of GHFT that took place in March 2015 would be received at a formal CQC summit planned for the 18th June. A scheduled Care Quality Commission (CQC) inspection of GCS was due to take place on the 23rd – 26th June 2015. It was understood that the CQC had concerns regarding quality and lack of information provided by GCS. It was also noted that 2gether were scheduled a CQC inspection at the end of October 2015. Feedback from the recent CQC visit of GHFT would be reported at the August IGQC meeting. MAE

7.8 MAE provided an update on Norovirus and advised that a Health Protection meeting led by Public Health was held. It was reported that there was a significant increase in Norovirus in hospitals during the previous winter period. MAE emphasised that steps needed to be taken in order to control Norovirus entering the hospital premises. Public Health England had been requested to prepare a report on Norovirus regarding clinical presentation and prevention. Members were informed that there would be a particular focus on care homes and that workshops for care homes were being organised in September to train staff on managing patients with diarrhoea and vomiting symptoms. There would also be a focus on promoting the uptake of flu injections.

7.9 The Committee discussed the Public Health response to the Dr Foster Mortality which was circulated on the 17th June 2015. JC advised that she had responded to Public Health as she felt that the report did not provide sufficient assurance. It was agreed that Public Health would be requested to provide an action plan. SS

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

8. Primary Care Clinical Audit Report

8.1 SRJ presented the report which highlighted the work of the Primary Care Clinical Audit Group. The report was taken as read.

8.2 SRJ highlighted that she and CBu were closely working with the Clinical Audit Network Group to try and build audit relationships with providers.

8.3 JC considered that the CCG should sign off the annual audit plans of providers.

8.4 The Committee commended the work of the Primary Care Clinical Audit Group and thanked SRJ for her efforts.

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

9. Policies for Approval

9.1 Effective Clinical Commissioning Policies

9.1.1 ER presented the Effective Clinical Commissioning Policies (ECCP) and provided a background context underpinning the review to the policies on the current ECCP list.

9.1.2 The Committee were presented with a proposal for 23 policies which had been reviewed in the first stage of the process. ER provided details of the review process which was outlined in section 3 of the report.

9.1.3 The policies had been reviewed in collaboration with consultant colleagues at GHFT. The process involved an initial clinical review of the current policy content by a GP and appropriate consultants, alongside review of neighbouring CCG policies to test consistency with other areas.

9.1.4 ER advised that the policies were adapted to align with the new policy format and were separated into categories. The policies detailed the commissioning decision, policy statement, rationale, plain English summary and evidence base. It was noted that the policies also included consultation and sign off details.

9.1.5 ER advised that there were no changes to the current commissioning criteria on 9 policies, minor changes to 6 existing policies which primarily involved rewording elements to improve clarity, significant changes to 7 policies that alter the commissioning criteria and adopting 1 additional policy for a procedure identified through the first stage of the review process.

9.1.6 JC queried if the review process included a stakeholder analysis and if patient's views were included. RT advised that the process was subject to the views from the patients' representatives reporting to the groups

that were consulted. MW considered that a robust process was in place which could be demonstrated through the Clinical Programme Groups. The Committee felt that as these were specialist treatments, it would be challenging to target specific stakeholder groups due to the potential conflict of interests. MH suggested that a methodology for defining and identifying best practice should be established.

9.1.7 CG highlighted that the policy format did not include the review dates or page numbers and suggested that these should also be included. CG also queried the logistics for the publication of these policies. ER confirmed that the review date will be added once the policies were agreed and considered that the majority of the review dates would be two years. ER also confirmed that policies would be published under specific headings on the website and on the G-Care website.

9.1.8 The 9 policies where no changes were proposed to the current criteria was approved by the Committee. These were:

- Grommet insertion in children;
- Surgical intervention for snoring;
- Tongue tie in breast fed infants;
- Voicebox surgery;
- Asymptomatic gallstones;
- Aesthetic surgery – general principles;
- Abdoninoplasty and apronectomy;
- Body contouring procedures; and
- Other breast procedures.

9.1.9 The Committee reviewed the following policies where amendments and additions were proposed. These were:

9.1.10 Varicose Veins

9.1.10.1 JC queried if there was any local evidence to indicate that varicose veins led to limb loss.

9.1.10.2 CBe highlighted that there was inconsistency in compliance with the current policy within GHFT and requested that implementation of the policy should be imposed. ER advised that the approach had been shared with senior clinicians within GHFT and noted that there was an action plan in place to manage the wider implementation process.

9.1.10.3 RT advised that the prior approval requirement was removed and that the policy was contingent to criteria based access referrals. CBu stated that the referral criteria should be stringent and should be documented within the referral letter. ER advised that an audit to monitor compliance would be required. HM requested that a standard mechanism for referrals was established i.e. using a template.

9.1.10.4 RECOMMENDATION: The Committee approved the Policy subject to the above amendments.

9.1.11 Breast augmentation and insertion of breast implants

9.1.11.1 RT advised that the policies were split in order to provide greater clarity in relation to post-cancer treatment.

9.1.11.2 RECOMMENDATION: The Committee approved the Policy.

9.1.12 Facial procedures

9.1.12.1 It was noted that the clarification of the process for Rhinoplasty for non-cosmetic reasons had been received.

9.1.12.2 RECOMMENDATION: The Committee approved the Policy.

9.1.13 Male breast reduction for gynaecomastia

9.1.13.1 CBe enquired on who should apply for the funding and it was advised that this was the responsibility of the consultants. It was agreed that this would be corrected within the policy.

9.1.13.2 RECOMMENDATION: The Committee approved the Policy subject to the above amendment.

9.1.14 Removal and replacement of breast implants

9.1.14.1 RT advised that the policy combined two previous policies (removal and replacement of breast implants and removal of breast implants) into one policy.

9.1.14.2 RECOMMENDATION: The Committee approved the Policy.

9.1.15 Skin and subcutaneous procedures

9.1.15.1 CBu highlighted that this policy recognised that procedures could be done under the Minor Surgery Direct Enhanced Service, and that this approach was more cost effective than secondary care so should be applied where appropriate.

9.1.15.2 RECOMMENDATION: The Committee approved the Policy.

9.1.16 Adenoidectomy

9.1.16.1 It was advised that this policy was being removed.

9.1.16.2 RECOMMENDATION: The Committee approved the Policy.

9.1.17 Tonsillectomy

9.1.17.1 RT advised that the existing policy was reviewed and that the proposal was to adopt the Bristol policy. It was noted that the Bristol policy was recently reviewed and was felt to provide greater clarity than the existing Gloucestershire policy.

9.1.17.2 RECOMMENDATION: The Committee approved the removal of the Policy.

9.1.18 Haemorrhoids

9.1.18.1 RT advised that the prior approval requirement had been removed and that funding would be provided for patients who meet the defined criteria.

9.1.18.2 RT explained the conservative treatment options information had been simplified and updated to increase relevance and that the requirement for haemorrhoids to be recurrent and irreducible was removed. It was also noted that the requirement for the patient's symptoms to be present for at least three months was included.

9.1.18.3 RECOMMENDATION: The Committee approved the Policy.

9.1.19 Hernias in adults

9.1.19.1 RT advised that the criteria were amended following a review of the existing policy. JC queried if the NHS England guidance was used and was advised that the criteria contained in the NHS England guidance had not been adopted. CBu stated that following discussions with the consultants, it was felt that the guidance was challenging to assess and measure. CBu articulated that the process followed incorporated the consultants' views and comprised clinical logic.

9.1.19.2 Members were informed that the policy included recommendations asking patients to adhere to rigid regimens that included weight management and smoking cessation.

9.1.19.3 RECOMMENDATION: The Committee approved the Policy.

9.1.20 Breast reconstruction post cancer surgery

9.1.20.1 RT advised that following discussions with the consultants, it was felt that surgery should be limited to a maximum of 3 procedures in a 5 year period post cancer. Any further surgery would be subject to prior approval from the CCG. CBu explained the rationale supporting this and considered that there was a disparity in managing the existing process as some patients were offered infinite procedures. The Committee expressed concerns and felt that this was a quality issue.

9.1.20.2 RECOMMENDATION: The Committee approved the

Policy.

9.1.21 Developmental asymmetry

9.1.21.1 RT advised that the changes related to increasing the BMI threshold for patients to <30 and the removal of the requirement for the largest breast to be at least a D cup.

9.1.21.2 RECOMMENDATION: The Committee approved the Policy.

9.1.22 Female breast reduction

9.1.22.1 RT advised that the changes related to increasing the BMI threshold for patients from <27 to <30. The Committee requested that the threshold of <27 was retained.

9.1.22.2 RECOMMENDATION: The Committee approved the Policy subject to the above amendment.

9.1.23 Anal Skin Tag

9.1.23.1 It was noted that this was a new policy and an Individual Funding Request application form would need to be submitted in order to request funding from the CCG. This was identified as a procedure of little clinical value by local specialists. The proposed policy was consistent with other local CCGs.

9.1.23.2 RECOMMENDATION: The Committee approved the new Policy.

9.2 Non-Emergency Patient Transport Policy

9.2.1 MW introduced and provided a brief context to the Policy. MW advised that the Policy provided clarity on the CCG's responsibilities regarding NHS funded patient transport. The Policy was taken as read.

9.2.2 MW advised that the Policy reiterated the eligibility criteria for NHS funded transport which was based on national guidance and ensured that staff, patients and service providers had clear guidelines to the entitlements and that it was applied consistently.

9.2.3 CG noted that this was a joint procurement in 2013 and queried if this Policy was aligned with other commissioners who were involved with the procurement exercise. GB advised that the new policy was shared with other commissioners and they were considering adopting this Policy.

9.2.4 CBe highlighted the NHS Funded and Community Transport Matrix on page 26 and queried what the arrangements were for transporting patients travelling from hospices. GB advised that this would be covered under the Non-Emergency Patient Transport Policy Procedures.

9.2.5 JC drew attention to section 10 of the policy relating to consultation and requested that further statistics of percentage of users views obtained were added for future reference. It was agreed that a formal letter to Healthwatch was sent acknowledging their feedback. MW

9.2.6 JC highlighted section 2.15.5 and requested that this was further clarified on the requests for transport within normal working hours.

9.2.7 RECOMMENDATION: The Committee approved the Policy.

MH left at this point.

10. Health and Safety Policy

10.1 The Health and Safety Policy was presented to the Committee for approval. The Policy was taken as read.

10.2 MAE advised that a Staff Forum was being established where Health and Safety would be a standing agenda item.

10.3 JC recognised that a risk assessment would be reviewed annually. However, it was queried who would undertake the assessment and where these would be reported. MAE advised that the Health and Safety Lead

would undertake the assessments and that they would be monitored by the IGQC.

10.4 JC highlighted section 3.4 and requested that the precise location of the Accident Reporting book was specified.

10.5 JC requested that section 3.5 regarding the reporting of injuries, diseases and dangerous occurrences was explicit to state who reported these incidents to the Health and Safety Executive (HSE).

10.6 JC highlighted the training requirements for the Executive Lead and that policy should specify the time period for update training. MAE agreed that she would confirm with the CSU. MAE

10.7 JC requested that section 4.5 relating to fire safety also included visitor arrangements.

10.8 JC also requested that section 4.6 included where the first aid box was located.

10.9 CG highlighted that the Core Team was not a term used in the Constitution and should therefore be explained in the Policy.

10.10 RECOMMENDATION: The Committee approved the Policy subject to the above amendments to be agreed by Chair electronically.

11. Risk Register

11.1 AP presented the Risk Register which provided details of those risks identified by the responsible managers that currently face the CCG and which could affect the achievement of the organisational objectives.

11.2 The Risk Register currently comprises a total of 41 risks, two of which are graded as ‘red’ as outlined in Appendix 1.

11.3 AP confirmed that details of all risks for consideration

to be removed from the Risk Register had been provided at Appendix 2. These were Risk No F10 and F3.

11.4 RECOMMENDATION: The Committee

- **noted the paper and the attached Risk Register; and**
- **approved the closure of the two risks listed on Appendix 2.**

12. Assurance Framework

12.1 AP presented the Assurance Framework for 2015/16 which provided details of the assurances that will be provided to the Governing Body regarding the achievement of the CCG's Objectives. The paper was taken as read.

12.2 JC drew attention to Risk No F8 and highlighted that this should be removed from the Risk Register now that the risk rating had reduced. AP

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

13. Information Governance Update

13.1 The paper provided an update on the organisation's information governance arrangements. The paper was taken as read.

13.2 JC queried section 5 regarding the proposed patient consent model and the governance arrangements for approving the model. It was agreed that an update would be provided at the next Committee meeting. CL

13.3 RECOMMENDATION: The Committee:

- **noted the 10th June 2015 minutes from the Information Governance Group meeting; and**
- **noted the contents of this report.**

14 Briefing on Suicides and Attempted Suicides

14.1 This paper was presented to the Committee which was provided for information. The paper was taken as read.

14.2 It was agreed that this item was carried forward to the next meeting. MAE

15. Any Other Business

15.1 CBu advised that new revised guidelines were being issued by NICE regarding Cancer around the 2 week and 62 days target and felt that this would place significant pressure on the diagnostic service. It was noted that this issue was identified in the draft CQC report of GHFT.

16. The meeting closed at 12.00pm.

Date and time of next meeting: Thursday 20th August 2015 in the Board Room at 9am.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 13

Governing Body

Governing Body Meeting Date	**Thursday 24th September 2015**
Title	**Primary Care Commissioning Committee (PCCC) minutes**
Executive Summary	The attached minutes provide a record of the inaugural meeting of the PCCC held on the 7th May 2015.
Key Issues	The following principal issues were discussed: • Committee Terms of Reference • Delegation Agreement • National Updates • Primary Care Overview • Primary Care Governance Structure • Primary Care Operational Group Terms of Reference • Primary Care Co-Commissioning Budget • Quality Report
Risk Issues: **Original Risk** **Residual Risk**	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note

	these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Alan Elkin PCCC Chair and Lay Member

NHS Gloucestershire Clinical Commissioning Group (CCG) Primary Care Commissioning Committee

Minutes of the Inaugural Meeting held on Thursday 7th May 2015 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Alan Elkin	AE	Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Colin Greaves	CG	Lay Member - Governance
Julie Clatworthy	JC	Registered Nurse
Mary Hutton	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Andy Seymour	AS	Deputy Clinical Chair
In attendance:		
Debra Elliott	DE	Director of Commissioning, NHS England
Nikki Holmes	NH	Head of Primary Care, NHS England
Claire Feehily	CF	Chair of Healthwatch Gloucestershire
Cllr Dorcas Binns	DB	Chair of the Health and Wellbeing Board
Helen Goodey	HG	Associate Director Locality Development and Engagement
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 3 members of the public present.		

1 Welcome and Introductions

1.1 AE welcomed the Primary Care Committee and members of the public to the inaugural meeting.

2 Apologies for Absence

2.1 There were no apologies received.

3 Declarations of Interest

3.1 AS declared that his GP practice was a member of the GP Provider Company.

4 Terms of Reference

4.1 The Terms of Reference were presented which outlined the roles and responsibilities of the Committee. It was noted that the Terms of Reference were appended to the revised CCG Constitution that was considered by the Governing Body on the 29th January 2015 and subsequently approved by NHS England on the 6th February 2015.

4.2 RESOLUTION: The Committee noted the Terms of Reference

5 Delegation Agreement

5.1 The Delegation Agreement was introduced by AE and was taken as read.

5.2 AE drew attention to the executive summary of the report which specified that the Delegation Agreement was subject to further variation in the future and felt that it would be helpful to understand what areas were being considered. DE responded that the areas being discussed were the premises function, finances, dental, pharmacy, ophthalmology and specialist commissioning. It was indicated that the CCG had the capacity to support these commissioning functions in the future. MH advised that the Agreement could be varied if it was required.

5.3 CF queried the reporting mechanisms to the Adults Safeguarding Board in terms of the commissioning of GP services. DE confirmed that this would be reported by the CCG under delegated arrangements, although NHS England retained overall responsibility through the Secretary of State. MAE stated that she was a member of the Adults Safeguarding Board and highlighted that a designated nurse was also closely working with NHS England.

5.4 AE highlighted section 2.6 of the agreement which relates to the need for the CCG to provide a plan on the exercise of the functions by the end of May 2015 and queried if a national template was available considering the stipulated timescales. DE

advised that a detailed plan had been drawn up which demonstrated all the functions that exist under commissioning General Medical Services that were being jointly managed with HG's team. DE advised that regular meetings were held to review the transfer process and that NHS England would continue to support the CCG to deliver independently and until the plan's actions were fully exhausted, accepting that this could be an extensive process. HG thanked NHS England for the support during this process.

5.5 CG advised that there was a requirement to implement the staffing model within 6 months and requested that this was formally agreed. MH advised that Model 3 (Employment) was selected as stated in section 2.11 of the report. DE recognised that due to the complexity of the arrangement, it could also be reasoned that whilst working through the detail, elements of Model 1(Assignment of NHSE staff) could also be included in order to support the CCG. It was agreed that the arrangement required a formal confirmation. **MH**

5.6 DB enquired about the rationale for selecting Model 3. MH explained that Gloucestershire was the only local CCG that had selected delegated commissioning and felt that the next year would be busy for NHS England as other areas had selected joint commissioning. MH recognised that there was already a huge pressure within primary care which required a vigorous approach. MH explained that Model 1 was also explored but due to the limited resources available, it was practical to select Model 3. MH advised that the resource issue had been acknowledged by NHS England and that the decision was a mutual agreement.

5.7 <u>RESOLUTION:</u> The Committee noted the Delegation Agreement.

6 National Updates

6.1 DE provided a verbal update on national subjects. These were:

- Prime Minister's Challenge Fund;
- Specialised Commissioning; and
- Primary Care Infrastructure Fund

6.2 DE advised that the work to implement the Challenge Fund was

progressing. A meeting had been held with the national team and G-Doc (Gloucestershire GP Provider Company) where a due diligence was undertaken and discussions held on initiating the elements of the project further.

6.3 DE advised members of the proposed approach to the commissioning of specialised services and the opportunities for the CCG to play a greater role. MH advised that an impact analysis would need to be undertaken.

6.4 DE advised that the Primary Care Infrastructure Fund was a four year investment programme to accelerate improvements in GP premises and infrastructure. DE highlighted that Gloucestershire was in a good position due to the number of schemes that had been initiated during the PCT period. MH suggested that a premises report would be presented at the next Committee meeting. DE agreed that she would also prepare a short presentation. **DE**

6.5 CF enquired what the communication intentions were for the Challenge Fund in terms of the sharing of information with the public, particularly if it could result in the redesign of the current system. AS responded that the Associate Director of Communications was involved in the implementation process and that communication was embedded within the wider process.

6.6 CF also enquired about the prioritisation process for the infrastructure fund and the mechanism to distribute it equitably to ensure that it was aligned with the countywide commissioning strategy. DE articulated that there was a framework underpinning this scheme. DE advised that work was being carried out with the local planning authorities to ensure that spatial planning took account of the health needs of the population, for example, the development of significant housing developments. Property surveys were also undertaken of practice accommodation which established the condition, age, defects and whether they were DDA compliant. DE advised that this would be adopted as a tool to prioritise funding on any applications received.

6.7 <u>RESOLUTION:</u> The Committee noted the verbal update.

7 <u>Primary Care Overview</u>

7.1 AS introduced a presentation to the Committee which provided a local context to the primary care strategic priorities and the primary care offer.

7.2 The presentation covered:

- Our vision
- Strategic integration
- Context
- Summary of the challenges
- Pressures on primary care
- Opportunities for primary care
- What will success look like?
- Consistent primary care offer - the Gloucestershire model
- Progress so far
- Prioritisation
- Primary care strategic priorities
- Reducing variation and improving quality in primary care enhanced service

7.3 JC reminded members of the inherent risks posed by workforce challenges particularly in terms of nurses and felt that there could be possible risks to delivery. The Committee acknowledged the challenge. DE informed members that discussions were being held with the University of the West of England to explore training programmes for nurses.

7.4 <u>RESOLUTION:</u> The Committee noted the presentation.

8.1 <u>Primary Care Governance Structure</u>

8.1.1 HG provided a presentation that outlined the Primary Care Governance Structure which represented the CCGs response to ensuring that there was a robust governance structure for Primary Care Co-Commissioning.

8.1.2 HG felt that the structure represented an excellent model to deliver the strategic and operational requirements to meet the needs of taking delegated authority for co-commissioning of primary care medical services.

8.1.3 HG advised that a number of primary care workstreams had been established under the Primary Care Operational Group who would be responsible for the development of the primary care strategy.

8.1.4 The workstreams included the following:

- Quality Improvement
- Estates
- Innovation
- Workforce and Education
- Enhanced Services
- IM&T Strategy

8.1.5 JC felt that it would be challenging to address the issue of innovation and queried how this would be managed. HG advised that the innovation group was clinically led and that a number of themed questions would be posed to GP practices in order to obtain their views. This would inform the innovation agenda going forward. MAE felt that Research and Development was also vital to improving innovation in primary care and advised that meetings had been held with the Gloucestershire Research Consortium where resources had been commissioned for primary care.

8.1.6 DB enquired why nurse education and the availability of training was at low level in Gloucestershire and was advised that this was a historical issue and that responsibility for training had transferred to the GPs as part of the 2004 GMS contract. The individual practices were responsible for continuing the support of practice nurses. HG indicated that Gloucestershire was the only regional area where nurse training was not structured and facilitated. It was noted that other regional areas utilised the LMC for facilitating the training.

8.1.7 AE requested that the primary care and localities team structure was presented at the next Committee meeting. **HG**

8.1.8 <u>RESOLUTION:</u> The Committee noted the Primary Care Governance Structure

8.2 Primary Care Operational Group Terms of Reference

8.2.1 The Primary Care Operational Group (PCOG) Terms of Reference was presented to the Committee. The paper was taken as read and views were invited from members.

8.2.2 CF requested clarification on the group that held the responsibility for the process of engagement with the public and it was advised that the IGQC held overall responsibility. An action plan was required and this would be developed with the input of the lay membership and would be tested with the PCCC prior to sign off.

8.2.3 CG highlighted that the structure diagram did not correlate with what was indicated in the report and requested that this was corrected.

8.2.4 <u>RESOLUTION:</u> The Committee approved the Primary Care Operational Group Terms of Reference

9 <u>Primary Care Co-Commissioning Budget</u>

9.1 CL introduced the report which provided a summary of the primary care budget. CL reported that the CCG's 2015/16 delegated budget for primary care totals £76.8m. However, the potential financial risk around this budget had been recognised in the overall CCG budgets and reflected as a financial risk.

9.2 CL advised that the budget set included the application of the NHS England business rule in terms of the achievement of a 1% surplus, a contingency reserve of 0.5% and a headroom reserve of 1%.

9.3 Budgetary limits for expenditure will be as per the current CCG Detailed Scheme of Delegation which was outlined in Appendix 2. There was ongoing work between the CCG and NHS England finance teams to finalise the actual expenditure relating to the baseline and also to ensure that all commitments for 2015/16 have been identified. This will then inform the forecast for the primary care budgets going forward.

9.4 CL informed members that the CCG Finance and Primary Care

teams had been, and were continuing, to work with NHS England to ensure that there were robust financial procedures in place around the validation of claims and the processing of payments. This work will continue through the year as roles within NHS England change and systems such as Exeter become available to the CCG.

9.5 <u>RESOLUTION:</u> The Committee noted the report.

10 <u>Quality Report</u>

10.1 MAE introduced the 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.

10.2 MAE provided a background context to the development of quality in primary care. It was noted that the change to delegated commissioning for the CCG had clarified the responsibility for quality assurance and provided the organisation the opportunity to lead the development of quality, safe services in GP primary care.

10.3 MAE informed members that the formal system of quality assurance will be undertaken by the development of a new Clinical Quality Review Group (CQRG) for primary care which would report to the Integrated Governance and Quality Committee. The Terms of Reference for this Group were outlined in Appendix 1 of the report.

10.4 MAE emphasised that one of early initiatives for primary care would be a drive to encourage GP practices to '*Sign up to* Safety'.

10.5 CG highlighted that the Terms of Reference stated that the CQRG would report to the Integrated Governance and Quality Committee (IGQC). However, the governance structure indicated a dual reporting line to the PCOG as well and requested that this was clarified. It was felt that there should be a link to the PCOG although the CQRG reports directly to the IGQC.

10.6 MAE updated the Committee on practice nurse education and development and how the CCG was proposing to take it forward.

10.7 MAE advised that it was proposed to have a role in the CCG of a Practice Nurse Education and Development Manager and to support this work; the CCG was planning to establish a Practice Nurse education group, with representatives of experienced practice nurses from each locality.

10.8 <u>RESOLUTION:</u> The Committee noted the report.

11 <u>Any Other Business</u>

11.1 There were no items of any other business.

12 The meeting closed at 13:30.

13 Date and Time of next meeting: Thursday 30th July 2015 in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Primary Care Commissioning Committee:

Signed (Chair):_____ Date:_____