NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 31st March 2016 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 28th January 2016	Chair	Approval
4	Matters Arising	Chair	
5	Patient's Story	Becky Parish	Information
6	Public Questions	Chair	
7	Chair's Update	Chair	Information
8	Accountable Officer's Update	Mary Hutton	Information
9	Performance Report	Cath Leech	Information
10	Operational Plan	Ellen Rule	Approval
11	Budgets 2016/17	Cath Leech	Approval
12	Developing a Sustainability and Transformation Plan for Gloucestershire	Ellen Rule	Information
13	Primary Care Infrastructure Plan 2016 to 2021	Andrew Hughes	Approval
14	West of England Academic Health Science Network Board Report	Mary Hutton	Information
15	Assurance Framework	Cath Leech	Information
16	Integrated Governance and Quality Committee Minutes	Julie Clatworthy	Information

17	Audit Committee Minutes	Colin Greaves	Information
18	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
19	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 26th May **2016** at 2pm in Board Room at Sanger House			

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

NHS
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Governing Body

Minutes of the Meeting held at 2.00pm on Thursday 28th January 2016 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Dr Helen Miller	HM	Clinical Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Dr Caroline Bennett	CBe	GP Liaison Lead – North Cotswolds
Dr Charles Buckley	CBu	GP Liaison Lead – Stroud and Berkeley Vale
Joanna Davies	JD	Lay Member – Patient and Public Engagement
Alan Elkin	AE	Lay Member – Patient and Public Engagement and Vice Chair
Colin Greaves	CG	Lay Member - Governance
Dr Malcolm Gerald	MGe	GP Liaison Lead – South Cotswolds
Helen Goodey	HG	Director of Locality Development and Primary Care
Dr Sadaf Haque	SH	GP Liaison Lead – Cheltenham
Dr Will Haynes	WH	GP Liaison Lead - Gloucester
Cath Leech	CL	Chief Finance Officer
Dr Tristan Lench	TL	GP Liaison Lead – Forest of Dean
Dr Hein Le Roux	HLR	GP Liaison Lead – Stroud and Berkeley Vale
Dr Raju Reddy	RR	Secondary Care Doctor
Ellen Rule	ER	Director of Transformation and Service Redesign
Sarah Scott	SS	Director of Public Health, GCC
Dr Andy Seymour	AS	Deputy Clinical Chair
Valerie Webb	VW	Lay Member - Business
Mark Walkingshaw	MW	Director of Commissioning Implementation and Deputy Accountable Officer
Dr Jeremy Welch	JW	GP Liaison Lead - Tewkesbury
In attendance:		
Andy Ewens (AI 9)	AEw	Emergency Planning and Business Continuity Officer
Caroline Smith (AI 10)	CS	Senior Manager Engagement and Inclusion
Matthew Pearce (AI 13)	MP	Senior Commissioning Manager - Self-Care and Preventative Strategies
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 3 members of the public present.		

1 Apologies for Absence

1.1 Apologies were received from Mary Hutton, Julie Clatworthy and Margaret Willcox.

2 Declarations of Interest

2.1 There were no declarations of interest received.

3 Minutes of the Meeting held on Thursday 26th November 2015

3.1 The minutes of the meeting held on Thursday 26th November 2015 were approved.

4 Matters Arising

4.1 28.05.15 AI 18.2 – Report from West of England Academic Health Science Network (WEAHSN) – MW advised that the Industry Advisory Group meeting had now been postponed until 18th May 2016 and that an update would be provided to the May 2016 Governing Body meeting.

4.2 30.07.15 AI 9.7 – Accountable Officers Report – The engagement activity plan was currently being developed and should be available at the March 2016 Governing Body meeting.

4.3 26.11.15 AI 13.6 – Planning 2016/17 – ER confirmed that the text relating to the commissioning cycle on the planning report had been expanded to explain what it covered. **Complete**

4.4 26.11.15 AI 16.4 – Assurance Framework – HG advised that the risk (Risk No L2) relating to the Quality of Primary Care due to GP practices running at maximum capacity had been reassessed. **Complete**

5 Public Questions

5.1 A question from a member of the public was received.

5.2 **Question:**

Could the CCG provide a response to the recently published book (December 2015) by James Titcombe, entitled Joshua's Story?

Answer:

MAE responded to the question and advised of the following key points:

- the report was publicly available at the GHFT Board meeting held in June 2015 in response to the Morecambe Bay report;
- the maternity services provided by GHFT were scored as good following the CQC inspection;
- the CCG has prepared an assurance report regarding the maternity services in response to this report for NHS England which would be discussed at the next Integrated Governance and Quality Committee (IGQC);
- there were several assurance systems in place to ensure that quality, safe care and patient experience were monitored effectively;
- GHFT had an open approach to sharing information with the CCG and it was noted that the CCG were also involved in their internal meetings;
- GHFT produced data which feeds into the South West Strategic Clinical Network Maternity dashboard in order for GHFT services to be benchmarked against other services in the South West;
- the CCG was represented at the GHFT Women's and Children's Quality meeting and the Quality Committee where any maternity services concerns were discussed;
- the CCG also attends the monthly meeting held by GHFT where serious incidents and complaints were discussed;
- GHFT had initiated high level reviews following four Serious Incidents within the maternity services which had occurred the previous year and to ensure that lessons were learnt and that practice changes were

implemented. It was noted that there were no common themes emerging from these; and

- GHFT had a high focus on the identification and treatment of sepsis. MAE assured members that sepsis was a high priority within the organisation and had been demonstrated by clinical audits within the Trust. This had also been shared with the South West Patient Safety Collaborative.

5.3 HM enquired on the complaints process and queried if all complaints were shared at the monthly GHFT meeting or if it was just serious complaints that were reported. MAE stated that serious complaints and any emerging trends would be considered and that litigation was also considered.

5.4 MAE advised that she recently attended a Regional Nurse Directors' meeting where stories of other families were shared and noted that there were other families in similar circumstances and emphasised on the importance of respecting and supporting family members in these tragic situations.

5.5 WH suggested that an advocacy service could be offered as part of the complaints process. MAE stated that it was good practice to allocate a senior professional as a point of contact for family members. HM queried if GHFT offered this service and MAE agreed to investigate.

5.6 ER highlighted the recent media story regarding the signs being missed from primary care and the NHS 111 service which resulted in the death of a young child from sepsis. ER advised that NHS England had produced an action plan and that this was being implemented locally.

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

6.1 HM presented this report that was taken as read, with a summary of key issues that arose during December 2015 and January 2016 being highlighted.

6.2 HM thanked AS for his work in deputising for her in her absence and thanked the Executive Team for their support.

6.3 The following key areas were highlighted:

- G-Care Website Update;
- Homeless Time to Heal Service;
- Adult Mental Health Update; and
- Respiratory Update.

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

7 Gloucestershire Clinical Commissioning Group Accountable Officer's Report

7.1 MW introduced this report on behalf of the Accountable Officer, which was taken as read, and provided a summary of key issues arising during December 2015 and January 2016.

7.2 MW drew attention to Section 2 of the report regarding engagement and highlighted the work being undertaken to engage with local people in developing the future plans for health services. MW also highlighted the engagement work being undertaken at locality level which was outlined in Section 2.2 of the report and with Healthwatch at Section 2.3.

7.3 Members noted that Gloucestershire had been successful in its bid to become one of five pilot sites across England looking at developing whole systems approaches to obesity.

7.4 The work of the Enabling Active Communities was highlighted and it was noted that this was progressing well.

7.5 MW advised that the CCG recently commissioned a service from GP Care Ltd to provide a community based one-stop assessment and diagnostic service for adults with non-cancerous urological conditions. It was noted that this was a short term contract to help reduce pressure on the urology service at GHFT, as part of a wider plan to improve performance and ensure that constitutional waiting time standards were met for both cancer and non-cancer conditions.

7.6 MW highlighted that there had been an increase in emergency admissions activity above the levels planned and that Section 5 highlighted the work being undertaken to address this.

7.7 An update on the Learning Disability Programme was highlighted. Members were informed that young people with learning disabilities were being offered a structured study programme to support them getting into work through internships.

7.8 MW updated members on the programme of work being undertaken to improve access to GP services and to stimulate innovative ways of providing primary care services.

7.9 Members were informed of the work being undertaken to develop the primary care infrastructure across Gloucestershire and noted that the final plan would be presented to the March 2016 Governing Body meeting.

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

8 <u>Locality Development Plan updates</u>

8.1 HG presented the report which provided an update on the progress of the seven localities against the priorities identified within their plans. HG highlighted that the plans for the seven localities were approved by the Governing Body in September 2015.

8.2 HG advised that localities were focusing on sustainability and the resilience of primary care given the huge challenges being faced. It was noted that the localities were organising events in order to test the future model of primary care and focusing on premises development. Progress on this work would be reported at a future Governing Body meeting.

8.3 HG informed members of the future reporting arrangements and members noted that each locality would have their own Key Performance Indicators hosted on the information portal which would demonstrate progress, aligned to Locality Development Plan priorities.

8.4 HM expressed gratitude to HG and her team for their hard work in developing the localities programme of work.

8.5 CBu requested further information regarding the community based geriatrician service in South Cotswold. MGe advised that this work was an outcome from the reorganisation at Cirencester Hospital and that this was part of the locality wide frailty programme. It was noted that a long term plan was being established. HG advised that a meeting regarding frailty was being held in February 2016 and that any feedback from this meeting can be reported. HG

8.6 <u>RESOLUTION:</u> The Governing Body noted the key highlights of progress and delivery by the seven localities against their Locality Development Plans

9 <u>Emergency Planning, Response and Resilience, Annual Assurance 2015/16</u>

9.1 MAE introduced the report and advised that NHS England had published core standards for Emergency Preparedness, Resilience and Response (EPRR) arrangements. The assurance process required the CCG to undertake a self-assessment against the relevant core standards identifying the level of compliance with each. The CCG was required to report the results of the assessment following Governing Body approval. The submission was attached at Appendix 1 of the report.

9.2 MAE advised that the CCG were compliant with 33 of the 38 core standards. AEw advised that there were five standards where the CCG was not compliant at the date of submission (September 2015). Three of them related to training needs and competencies for on-call managers and directors within the CCG. The appointment of the Emergency Planning and Business Continuity Officer had allowed these items to be addressed and the CCG were now assured against these standards.

9.3 AEw informed members that a standard that was felt to be outside of the remit of the CCG was the provision of and/or receipt of Mutual Aid from another CCG if required. The CCG

were already signed up to a Countywide Health Community Mutual Aid agreement and it was not thought proportionate to step outside of this agreement and engage with other CCGs.

9.4 AEw highlighted that NHS England had stated that these standards must be met and queried how the Mutual Aid issue would be negotiated. MAE advised that she had discussed the standard requirements with NHS England and that they have confirmed that due to the robust local arrangements between health organisations, NHS England were assured that assistance from other CCGs was not required.

9.5 CG queried if any lessons had been learnt from the business continuity training exercise that was held in November 2015 and if any further exercises were being proposed. AEw advised that it was anticipated that exercises would be held every six months in order to sustain the knowledge and experience. CG expressed an interest in attending this training.

9.6 Members noted that the CCG would be responsible for preparing for any emergencies in relation to GP services under the delegated arrangements for primary care. HG assured members that the practices held business continuity plans.

9.7 AEw informed members that the CCG received a further assurance process from NHS England in December 2015 following the tragic incident in Paris and noted that the CCG were fully compliant with the requirements.

9.8 <u>RESOLUTION:</u> The Governing Body approved the report.

10 Open Culture Annual Report 2015

10.1 MAE introduced the report which outlined the work the CCG had undertaken towards meeting its general Public Sector Equality Duty, through engagement with patients, carers, staff and communities.

10.2 The CCG was required to publish an annual report, by 31st January 2016, under the specific equality duty of the Equality Act 2010.

10.3 MAE advised that the report would be available as an electronic document and was accessible on the website via the following link: http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2016/01/Open-Culture-Annual-Report-2015.pdf

10.4 CS advised that the progress report had been combined with the equalities work with examples of innovative practice in engaging and involving the local patients, carers, staff and communities.

10.5 CS advised members of the format of the report and navigated to the website where the Strategy was published. It was noted that the equality page on the website had been divided into key areas which included the strategy, legislation and policy, practical resources, useful links, reports and case studies.

10.6 RESOLUTION: The CCG Governing Body approved the report.

11 Planning 2016/17

11.1 ER presented this report which provided an update on the national planning guidance and outlined the proposed submission regarding planning footprints.

11.2 ER advised that the guidance sets out nine national 'must dos' for every system and explained these. It was also advised that the CCG had a key deadline of the 29th January 2016 to submit and agree a planning 'footprint' for the Sustainability and Transformation Plan (STP).

11.3 Members were informed of the proposals and noted that this would result in Gloucestershire forming the primary footprint in line with the Devolution proposal for Gloucestershire. Alongside this were a number of opportunities for networking clinical services by emerging with partners including Herefordshire, Worcestershire, Swindon and Bristol.

11.4 ER advised that the CCG would continue to focus on the delivery of the core principles set out in Joining Up Your Care

and reinforced in the Five Year Forward View. In order to ensure that the system was joined up around these ambitions, the CCG would work with health and care partners to develop the shared Sustainability and Transformation plan to 2020, focused around the objectives that were being developed through the Gloucestershire Strategic Forum.

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

- **noted the key requirements for the CCG as set out in the national planning guidance and summarised in brief in this paper; and**
- **approved the proposal to submit a response to NHS England that the unit of planning would be Gloucestershire for the purposes of the STP, noting that this position could evolve in the future as clinical networks developed.**

12 Performance Report

12.1 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 December 2015.

12.2 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

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

12.4 Members were advised that there was still further work to undertake in relation to the Ambulance Red 2 performance target and noted that there was a detailed recovery action plan in place with SWASFT.

12.5 MW advised of the achievement of the dementia diagnosis rate target by the member practices following a period of challenging performance.

12.6 Members noted that the 4 hour emergency department target was still an area of challenge. It was highlighted that the year to date performance at the end of December was 89.4%. MW advised that there was an increased pressure at the Gloucestershire Royal site and that this was being worked through with GHFT with a focus on reducing emergency admissions, where clinically appropriate.

12.7 ER updated members on the 62 day cancer performance target and noted that this had been challenging, although improvements were being sustained. ER reported that performance during November was at 81.3% and that the recovery rate was in line with trajectory. ER advised that the recently commissioned Community Urology Service had helped alleviate the pressure.

12.8 ER advised that there had been 549 last minute elective operations cancelled for non-clinical reasons this year. This represented an 11.6% increase from the previous year. ER highlighted that this correlated with the pressures in the Emergency Department and that a detailed review would be undertaken.

Patient Experience

12.9 MAE updated members on patient experience and advised that a programme of clinical case reviews had been developed to support the delivery of emergency care programme. These include reviewing and evaluating emergency admissions to hospital, with particular focus upon admissions which may have been preventable with appropriate support or through accessing alternative pathways to admission

12.10 MAE informed members that there had been two Never Events reported. It was noted that one incident occurred in GCS relating to an incorrect milk tooth being extracted in a community dental service and the other incident occurred in GHFT relating to the misinterpretation of an X-ray for the placement of a naso-gastric tube.

12.11 CBu enquired on the reporting process for Never Events which occurred in private hospitals. It was noted that any

incidents involving private patients would be reported to the Care Quality Commission (CQC) and that NHS funded patients would be reported to the CCG.

12.12 MAE advised that patient surveys were being undertaken to capture patient experience. This included a survey of renal dialysis patients, end of life care, MSK and diabetes. In addition to this, it was noted that GHFT undertook patient experience surveys and shared the results with the CCG.

12.13 MAE advised that the Friends and Family Test (FFT) response rate for Emergency Department continued to decline and was currently at 13.6% during October 2015. MAE informed members that the inpatients response rate was 20% which was below the 25% national target.

12.14 MAE advised that the Patient Experience Team had been undertaking specific work with the Practice Participation Groups (PPGs) and was working with practices to establish these where they were not already in place. Members were informed that a PPG network meeting had been held the previous week and noted that this was a successful meeting.

12.15 HM highlighted the importance of Healthwatch and using their feedback to improve patient experience.

Partnerships

12.16 MW highlighted the success of the social prescribing initiative championed by the Governing Body members.

12.17 MW advised that there was good partnership working in developing the system resilience plan for the winter period including a series of investments to improve system performance this winter.

Finance and Efficiency

12.18 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 in 2015/16. However, due to the CCG receiving a number of allocations which related to both the 2015/16 and 2016/17 financial years, it had been agreed to increase the target to £9.6m to enable the CCG to manage these additional allocations across the year end.

12.19 CL reported that there was significant over performance in emergency activity against contracted levels. CL advised that the CCG had raised contract queries and challenges in a number of areas including emergency, elective and outpatient activity and that the issues were currently being resolved with GHFT.

12.20 CL advised that there were significant cost pressures within the Learning Disability budget, primarily due to three new patients within GCC commissioned activity; one being particularly high cost and backdated.

12.21 Members noted the increased expenditure on prescribing costs (particularly NOACs and Category M Prices). CL highlighted that Category M Prices had just been released which showed a forecast reduction of £740K for the last quarter of 2015/16 and that this has been reflected in the reduction of the forecast overspend.

12.22 CL informed members of the 2014/15 Quality Premium payments and advised that approximately £0.5m had been awarded against a potential £3m allocation. Members noted that this was a result of not achieving three out of the four constitutional indicators.

12.23 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. It was noted that the current year to date performance stands at 97.28% invoices paid by value and 97.13% by volume.

12.24 AE requested that the performance report was considered towards the beginning of the meeting due to the importance of this paper.

12.25 WH felt that the NHS 111 service had adopted performance measures which did not fully measure the success of any quality improvements. MW advised that there was a wider set of quality indicators that were monitored and formed part of the contractual requirements. HM felt that it would be useful to receive a quality assurance report. **MAE**

12.26 MGe expressed concerns regarding the recruitment issues for Band 6 community nursing posts, particularly recognising the increased pressure that this placed on primary care services and sought assurance that this was being addressed. MAE advised that a joint action plan had been developed with GCS and that staffing levels were monitored and reviewed regularly. MAE also advised that the CCG were providing additional investment to enhance the nursing workforce. Members noted that the Band 6 recruitment challenges were a national issue. MAE alerted members to the introduction of a new Band 4 'associate nurse' although the formal notification was still awaited. It was noted that she had met with the University of Gloucestershire to explore a development programme for these roles.

12.27 <u>RESOLUTION:</u> The Governing Body:

- **noted the performance against local and national targets and the actions taken to ensure that performance was at a high standard;**
- **noted the financial position as at month nine;**
- **noted the risks identified in the Finance and Efficiency report; and**
- **noted progress on the QIPP schemes.**

13 <u>Developing our approach to tackle obesity in Gloucestershire</u>

13.1 MP provided a presentation to the Governing Body which updated members on the joint work being undertaken to tackle obesity in the county.

13.2 The presentation covered:

- why is obesity an issue;
- determining factors causing obesity;
- position within Gloucestershire;
- promoting a healthy weight: what works;
- partnership: the key to success;
- developing the strategic approach; and
- next steps.

13.3 ER advised that a stakeholder event was held in December

2015 and that the feedback from the event was detailed in Appendix 2 of the report.

13.4 WH considered that there should be a focus on encouraging healthy schools approaches to promoting health and wellbeing as a way of life and suggested that this was jointly addressed with the educational providers within Gloucestershire. MP advised that schools had received a national funding initiative to promote healthy living.

13.4 JW advised that the NICE Guidance on children's obesity was still awaited.

13.5 <u>RESOLUTION:</u> The Governing Body noted the report and the joint work being undertaken to tackle obesity in the county.

14 <u>West of England Academic Health Science Network Board Report</u>

14.1 MW presented the report which was taken as read. This was the ninth quarterly report produced by the West of England Academic Health Science Network.

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

15 <u>Assurance Framework</u>

15.1 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.

15.2 CL highlighted that the key issues related to:

- risk no Q3 regarding the transfer of specialist commissioning to NHSE;
- risk no C6 regarding the maximum four hour wait in Emergency Department; and
- risk no C5 regarding failure to comply with national and local access targets for planned care.

15.3 <u>RESOLUTION:</u> The Governing Body noted the paper and

the attached Assurance Framework.

16 Integrated Governance and Quality Committee Minutes

16.1 The Governing Body received the minutes of the meeting of the Integrated Governance and Quality Committee held on the 22nd October 2015.

16.2 RESOLUTION: The Governing Body noted these minutes.

17 Audit Committee Minutes

17.1 The Governing Body received the minutes of the meeting of the Audit Committee held on the 29th September 2015.

17.2 CG updated members on the review undertaken by the Committee on the Finance Committee and decided that a Finance Committee was not currently required as functions were carried out through other meetings within the CCG.

17.3 RESOLUTION: The Governing Body noted these minutes.

18 Primary Care Commissioning Committee Minutes

18.1 The Governing Body received the minutes of the meeting of the Primary Care Commissioning Committee held on the 24th September 2015.

18.2 RESOLUTION: The Governing Body noted these minutes.

19 Any Other Business

19.1 CG suggested that a self-assessment was undertaken to reflect on the role of the Governing Body in order to improve processes and identify areas for development where further training was required.

19.2 WH provided a brief update on the Fracture Neck of Femur work programme and advised that work was progressing well.

20 The meeting closed at 16:13.

21 Date and Time of next meeting: Thursday 31st March 2016 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

Item	Description	Response	Action with
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*. *26.11.2015 deferred until May 2016*	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
28.01.2016 Agenda Item 8.5	Locality Development Plan updates	CBu requested further information regarding the community based geriatrician service in South Cotswold. MGe advised that this work was an outcome from the reorganisation at Cirencester Hospital and that this was part of the locality wide frailty programme. It was noted that a long term plan was being established. HG advised that a meeting regarding frailty was being held in February 2016 and that any feedback from this meeting can be reported.	HG

28.01.2016 Agenda Item 12.25	Performance Report	WH felt that the NHS 111 service had adopted performance measures which did not fully measure the success of any quality improvements. MW advised that there was a wider set of quality indicators that were monitored and formed part of the contractual requirements. HM felt that it would be useful to receive a quality assurance report.	MAE

NHS
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Clinical Commissioning Group

Agenda Item 7

Governing Body

Governing Body Meeting Date	**Thursday 31st March 2016**
Title	**Gloucestershire Clinical Commissioning Group Chair's Report**
Executive Summary	This report provides a summary of key issues arising during February and March 2016.
Key Issues	The key issues arising include: • Coombe End Flat Development for Local People with Learning Disabilities • Primary Care Update • Innovative community change model being developed to increase levels of physical activity across Gloucestershire • Cardiology Update • Meetings attended
Risk Issues: **Original Risk** **Residual Risk**	None.
Financial Impact	None.
Legal Issues (including NHS Constitution)	None.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note this report which is provided for information.
Author	Helen Miller
Designation	Gloucestershire CCG Clinical 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 February and March 2016.

2. Coombe End Flat Development for Local People with Learning Disabilities

2.1 The development of Coombe End was first initiated through something called the Estates and Service Strategy: a part of delivering the Brandon Trust contract and thinking about the best way of transforming available housing stock.

2.2 Coombe End used to be a property not fit for purpose. Brandon provided the care and support to the individuals who used to live there and helped us to think through a plan for giving it a major face-lift and delivering support to people very differently. This led to the concept of self-contained flats.

2.3 People living at Coombe End will have their own front door. Often this will be the first time they have had the opportunity to live with the choice and control this offers. They will also have choice over who delivers their support and can change to another provider if they want to. This property can support people with a range of needs, including the most challenging ones.

2.4 At the CCG we talk about the need to be 'person-led' in service design. Sometimes this can sound like a fluffy concept written in papers, rather than a reality. Coombe End gives this real meaning.

2.5 Gloucestershire CCG is totally committed to the Transforming Care agenda that will see people with a learning disability returned from hospital settings far from home to places like Coombe End where they have their own front door, their own place to call home and an opportunity to be part of their community.

3. Primary Care Update

3.1 GCCG have had delegated commissioning responsibilities from NHS England for a year as at the end of March 2016. Delegated commissioning for primary medical care services include responsibility for:

- practice contracts, including PMS reviews;
- enhanced services and local incentive schemes;
- new, merger and closure of practices;
- 'discretionary' payments and Premises Costs; and
- planning GP services and practice performance.

3.2 The first 12 months have been extraordinarily busy in what continues to be a very challenging time for GP practices:

- two practices gave notice on their contract (one which has been re-procured and one which GCCG supported the dispersal of through a dedicated patient advice line);
- two temporary practice list closures; and
- three branch closure requests.

3.3 Furthermore we have seen a succession of practices reporting sustainability, recruitment and premises challenges.

3.4 Along with the effort we are placing on supporting practices with these issues operationally, we are also investing in primary care to support long-term planning. Along with the development of a primary care workforce and primary care estates plan, we are working to produce an overarching Primary Care Strategy. In the meantime, we have announced investment in:

- practice nurse facilitators for each locality;
- additional training places for practice nurses;
- establishing a practice nurse forum;
- increasing investment in GP retainers;
- British Medical Journal (BMJ) advertising package for member practices;
- equipment to enable practices to work remotely; and
- a retiring GP project.

3.5 A countywide primary care strategy event, held on 5 November 2015, was very well attended. Localities have been holding, and continue to hold, local events to capitalise on the energy and enthusiasm generated to consider how they can best adapt to new models of working in future.

4. Innovative community change model being developed to increase levels of physical activity across Gloucestershire

4.1 The CCG are working with Active Gloucestershire, Gloucestershire County Council and Sport England to develop an innovative commissioning model to increase levels of physical activity across the county. Active Gloucestershire were recently successful in securing a development grant from Big Lottery in order to develop a social investment model that will look at implementing whole community programmes and self-sustaining environment of permanent change to physical activity participation. Local data in Gloucestershire indicates that 26.9% of adults in Gloucestershire are 'inactive' (doing less than 30 minutes activity a week). Evidence shows that the health impact of inactivity in terms of coronary heart disease, for example, is comparable to that of smoking and almost as great as that of high cholesterol level. Physical activity has been often described as a 'wonder drug' due to the numerous benefits to individuals and the wider society. A countywide steering group made up of commissioners, providers and national experts has been established to co-develop a model that will aim to coordinate existing activity.

5. Cardiology

5.1 The Cardiology Plan for Gloucestershire is steadily being delivered by the Circulatory Clinical Programme Group and its members, and colleagues across the CCG. The plan is derived from research developments and evidence, an acute pathway walkthrough, and a subsequent stakeholder workshop. The heart failure pathway review element of the plan has been completed and the pathway improvements are already in place or in motion. A forthcoming paper will present the work in more detail. The chest pain pathway review has established a new pathway, but this work is complex and ongoing. A new high sensitivity one hour troponin test to establish the level of risk of an Myocardial Infarction (MI) for individuals with chest pain, will be available for use in the Emergency Department during

2016/17. We have excellent and collaborative engagement from the consultant cardiologists and community services in this work, which has among other things ensured a safe approach with the appropriate clinical management of individuals being considered at all stages.

6. Meetings attended:

- 9 February 2016 - GSF Forward Planning Workshop 4 – National Star College, Gloucestershire
- 11 February 2016 – Opening of Coombe End Flat Development – Hucclecote, Gloucester
- 8 March 2016 - Health Care Overview and Scrutiny Committee – Shire Hall, Gloucester
- 22 March 2016 – Health and Wellbeing Board – Shire Hall, Gloucester

7. Recommendation

7.1 The Governing Body is requested to note this report which is provided for information.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 8

Governing Body

Governing Body Meeting Date	**Thursday 31st March 2016**
Title	**Gloucestershire Clinical Commissioning Group Accountable Officer's Report**
Executive Summary	This report provides a summary of key issues arising during February and March 2016.
Key Issues	The key issues arising include: • update on Transforming Care Programme; • primary Care Infrastructure Plan 2016-2021 and primary Care Transformation Fund; • contracting update; • strategy and prevention; • Clinical Pharmacists in General Practice; and • 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 February and March 2016.

2. Update on Transforming Care Programme

2.1 Transforming care for people with learning disabilities is a programme to improve services for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition.

2.2 On the 8th of February we forwarded our Transforming Care Programme Plan to NHS England. Initial feedback on our plan from John Trevains; Assistant Director of Nursing, Patient Experience and Safeguarding NHS England South (Central) was positive: *"The Glos plan and its presentation was absolutely brilliant. I sung its praises from the rooftops".*

2.3 In essence the Transforming Care Programme (TCP) provides an opportunity not only to focus on the few individuals in secure settings and those whose placement are out of our area (circa 10 individuals) but to change the 'offer' here in Gloucestershire. We are not just outlining a change to services; instead we are implementing a whole system approach. Building on what we know works, we have committed to work together with people of all ages, their families and carers and our partner agencies to build a new offer in Gloucestershire that we can be confident in.

2.4 We know that to achieve the aspirations contained within our TCP plan, we need to implement a system wide culture change.

2.5 Finances

2.5.1 In Gloucestershire we have already commenced our journey to change the offer for this cohort of individuals and currently collectively commission across health and social care services solely for people who may challenge and their carers. Following discussion with NHS

England it was clear that the funding available to support the TCP could only be accessed if there were local 'matched funding'. This included things which have already been, and will continue to be, commissioned.

2.5.2 We therefore asked for matched funding for the following:

- Gloucestershire Clinical Commissioning Group currently funds **£600,000** per annum. This is currently being used for the Learning Disability Intensive Support Service run by 2gether NHFT.
- Gloucestershire County Council (Learning Disability Commissioning) currently funds **£331,000** per annum. This is currently being divided between the Positive Behaviour Support Service, Learning Disability Intensive Support Service, provider and Family Training and Family Support Project.

2.5.3 This provision will enable funding to be secured to implement the other parts of the plan. We anticipate that the matched funding requirements will reduce each financial year. This will be due to the setting up of much of the plan. Additionally, as individuals are returned to Gloucestershire and systems become 'business as usual 'we know that this needs to be sustainable with matched funding. Our bid therefore asked for the following:

- **Year One** (2016/17): Clinical Commissioning Group £600,000; Gloucestershire County Council £331,000;
  Match Funding from NHSE **£995,000**

- **Year Two** (2017/18): Clinical Commissioning Group £600,000; Gloucestershire County Council £331,000;
  Match Funding from NHSE **£700,000**

- **Year Three** (2018/19): Clinical Commissioning Group £600,000; Gloucestershire County Council £331,000;
  Match Funding from NHSE **£500,000**

3 Primary Care Infrastructure Plan 2016 to 2021 and Primary Care Transformation Fund

3.1 Over the last few months, the CCG has been developing a five year

prioritised Primary Care Infrastructure Plan (PCIP) to set out where investment is anticipated to be made in either, new, or extended buildings, subject to business case approval and available funding for the period 2016 to 2021. In summary, the PCIP needs to respond to the following challenges:

- an emerging direction of travel for primary care service provision where bigger, extended teams are providing a greater range of services across 7 days in larger facilities, or networked facilities, across a given area of around 30,000 population to 40,000;
- there will be significant population growth in Gloucestershire over the next 15 years and in a small number of geographical areas, this growth will be exceptional;
- there are a number of practices presently who are providing services in facilities significantly smaller than would be expected. This position worsens over the next ten to fifteen years if there is no investment in new buildings, or extended buildings;
- for a number of practices in Gloucestershire, the current physical conditions and functional suitability of the main surgery building are no longer satisfactory;
- there are a very small number of unique situations which the CCG will need to take account of in prioritising investment; and
- in some instances, the requirement to modernise primary care buildings will be informed by other service strategies, such as the Forest of Dean community services review.

3.2 A draft plan setting out a number of proposed schemes to meet the above challenges, the process for developing these proposals, a high level financial framework for planning processes and a programme timetable has been discussed at the Primary Care Commissioning Committee (PCCC) in January 2016 and sent out to all practices. The final version of the plan is due to be agreed and ratified by the PCCC and the Governing Body at today's March 2016 meetings.

3.3 Members will also be aware that there is a national fund of around £750m managed by NHS England to support premises as well as technology developments called the Primary Care Transformation

Fund (previously the Primary Care Infrastructure Fund). This will be a potential source to reduce some of the capital costs of the proposals. The CCG has already begun the process of working with the identified practices to develop applications ready for submission at the end of April 2016 as well as offering all practices the opportunity to identify small improvement works requirements.

4. Contracting Update

4.1 The 2016/17 Contracting round has begun in earnest, with all our providers. The NHSE draft Standard Contract documentation has been issued for consultation, with responses due by the 16th March. Working in conjunction with our main providers, we are looking to sign our contracts by the 31st March 2016.

5. Strategy and Prevention

5.1 We have been working with clinical programmes to develop a People and Place based approach to transforming care pathways. Each Clinical Programme Group has set out its vision for where services should be delivered from over the next 5 years and this will underpin the development of our Sustainability and Transformation Plan.

5.2 As part of the Sustainability and Transformation Plan, we need to develop a multi-agency prevention and self-care plan. We are working with Public Health to take this forward.

5.3 The county-wide workforce planning group has been developing closer links with the Local Economic Partnership and we are progressing opportunities to work more closely with schools and those needing support following redundancy.

5.4 A strategic action plan to address obesity is being developed to present to the Health and Wellbeing Board on the 22nd March. Four work streams have been identified (adult pathway, children's pathway, physical activity and healthy places). Stakeholders will be invited to take part in these. Gloucestershire County Council is one of the four pilot sites in England working with Leeds Beckett University to look at developing whole systems approaches to tackle obesity. We will be part of the Gloucestershire team visiting Leeds in March with the 3 other pilot sites to explore and learn from best practice.

5.5 The Healthy Individuals Programme Group had submitted a collaborative response to the 'Living a Healthy Life in Gloucestershire' consultation.

5.6 The CCG is participating in the evaluation of the formal close of the national Cultural Commissioning Pilot. The local Gloucestershire Cultural Commissioning Programme is continuing at pace with the roll out of the grant programme.

5.7 The West of England Academic Health Science Network (AHSN) is working with a range of partners, including the CCG, to develop a 'Diabetes Digital Coach' test bed in the South West. The CCG has played a pivotal role in developing the regional bid to become an NHSE Test bed site. The key aim of the Test Bed will be for people with diabetes and frontline health and care workers to pioneer and evaluate opportunities of using remote monitoring and coaching technology. This will bring together mobile health self-management tools (such as wearable sensors and supporting software) with the latest developments in connecting monitoring devices – the Internet of Things (IoT). The Test Bed will enable people with Type 1 or Type 2 diabetes to 'do the right thing at the right time' to self-manage their condition, and will encourage more timely and appropriate interventions from healthcare professionals. This is part of a £40 million, three-year Government programme in collaboration with Innovate UK. As part of Phase 1 of the project, Gloucestershire has selected to work with two providers; Map My Health and Ki Performance. Map My Health will be piloting an online diabetes self-management programme that is accredited against NICE. Ki Performance will be working alongside a number GP practices to test out a 12-week digital therapy programme that optimises physical activity for disease prevention and management.

6 Clinical Pharmacists in General Practice

6.1 The CCG is pleased to report that five clinical Pharmacists have joined five Gloucestershire GP practices as part of the recent initiative that NHSE, HEE, BMA and RCGP announced in Summer 2015 called the 'Clinical pharmacists in General Practice'. The scheme is focused on the engagement of 250 clinical pharmacists across England to work with and support general practitioners by providing additional clinical

pharmacists based in general practice to work with patients and the wider primary care workforce. This will utilise the knowledge and skills of pharmacists to deliver care to patients in General Practice and support long term transformation of the primary and community workforce. It is expected to help address the pressing workforce challenges facing general practice.

6.2 The practices in Gloucestershire that are taking advantage of this initiative are College Yard/Highnam, Churchdown, Church St, St Catherine's and Cam/Uley.

6.3 Practices that are part of the pilot will be expected to participate in a team based development programme. Up to four sessions will be provided to support practices with aspects of organisational development and exploring new ways of working.

6.4 The key outcome of this work will be improved care and health outcomes for patients with better access to care in general practice. Pharmacists will support patients to self-manage their well-being and long term conditions, through optimising medicines. This will enable improved medicine related communication between general practice, hospital and community pharmacy e.g. on admission and discharge and at other interfaces of care.

6.5 The pilot is built on current evidence on healthcare redesign, established theories and models for the improvement of quality and safety. It forms an integral part of GP Workforce 10 Point Plan described in "Building the Workforce – the New Deal for General Practice' (NHS England January 2015).

7. Meetings

7.1

4th Feb	Board to Board with Gloucestershire Care Services
9th Feb	Systems Resilience Group (SRG)
9th Feb	Gloucestershire Strategic Forum (GSF) Workshop
9th Feb	West of England Academic Health Science Network (WEAHSN) – Diabetes Digital Coach Test Bed Launch, Bristol
10th Feb	Enabling Active Communities (EAC) Commissioning Group Meeting, Shire Hall
18th Feb	Whole System Healthy Weight Pilot, Shire Hall

24th Feb	Personality Disorder Meeting, Cheltenham
25th Feb	Optum – New Models of Care Event, London
29th Feb	GHFT Quality Risk Summit, Swindon
1st Mar	Quarter 3 Partners meeting with Healthwatch Gloucestershire, Gloucester
8th Mar	Health & Care Scrutiny Committee, Shire Hall
10th Mar	Gloucestershire CCG Q3 Assurance meeting, Chippenham
15th Mar	Enabling Active Communities (EAC) Commissioning Group meeting
29th Mar	Gloucestershire Strategic Forum (GSF)
31st Mar	Leadership Gloucestershire, Shire Hall

8. Recommendation

8.1 The Governing Body is requested to note this report which is provided for information.

NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Agenda Item 9

Governing Body Meeting Date	**Thursday 31st March 2016**
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 February 2016.
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 February
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 ten. • Note the risks identified in the Finance and

	Efficiency report. • Note progress on the QIPP schemes.
Author & Designation	Sarah Hammond, Head of Information and Performance Andrew Beard, Deputy CFO Ian Goodall, Associate Director of Strategic Planning
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

NHS
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Clinical Commissioning Group

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 29th February 2016

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

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
- The CCG has had 100% sign up from Gloucestershire practices to its primary care offer which includes a strong focus on improving quality in primary care
- The primary care clinical quality group has been set up and is developing a set of indicators of primary care quality at practice level

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
- Improvements to patient transport service targets
- Dementia Diagnosis performance above target at 68.2%

Challenging performance:

- Red 2 Ambulance response times
- A&E 4 hour target. The YTD performance at the end of February was 87.5%%.
- 62 day cancer waiting times below constitutional off trajectory – new trajectory being agreed.
- Cancelled operations

Patient experience – **Green**.

Patient Experience - Perspective highlights:

- The case review programme has now been finalised and the programme of case reviews started, the immediate priority is urgent care.
- A Practice Participation Group network has been established with over 50 practices represented at the first meeting.
- Patient Engagement and Experience continues to develop across a wide range of GCCG projects. Key activities in the last period include:
  - During a two week period at the end of November/beginning of December, the CCG Information Bus carried a Stay Safe and Well campaign. Much of the information targeted older people promoting home safety checks, falls prevention and podiatry services.
  - Attended health and wellbeing events at two secondary schools in Cheltenham locality to gather feedback on the appeal of various website styles. This will be used to inform the development of a Gloucestershire website – a request from young people and stakeholders who contributed to our local Transformation Plan.

Good performance

- Comprehensive experience and engagement activity supporting CCG work programme
- The national GP practice patient satisfaction survey shows Gloucestershire practices to be above average.
- To date all GP practice inspected by CQC are good or outstanding.

Challenging performance:

- FFT - Results remain amber. Particular concern is the low response rate by patients attending the ED.
- GHFT have been requested to undertake focused work on patient experience for people using urgent care services in the Trust as this has not previously been systematically monitored.

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

Partnerships - Perspective highlights:

- As a part of the CCG's prevention and self-care agenda, we have worked with G.Doc and a range of third sectors partners and community groups to develop an innovative social prescribing model. Social prescribing now covers the entire county with the scheme available to all GP Practices in the county and referrals also accepted from staff in the counties 21 Integrated Community Teams (ICTs) and staff in community hospitals. As at the end of January there had been 1345 referrals. The scheme is currently being evaluated by the University of the West of England. The CCG will fund social prescribing for the year 2016/17 subject to evaluation.

- A system resilience plan has been agreed for the winter period including a series of investments to improve system performance this winter.

- A cross system enabling active community groups is meeting regularly.

- The VCS Alliance has been instrumental in the development of a kitemark for social prescribing. To date 50 organisations have completed the questionnaire which seeks assurance in areas such as staff training and support, policies and procedures and insurance.

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

Staff - Perspective highlights:

- Staff sickness levels remain below the upper threshold of 3%

- A working group is progressing the organisational development plan in 2015/16 and will complete a refresh for 2016/17.

Finance and efficiency – Amber

Finance and Efficiency - Perspective highlights:

- The overall assessment for the finance and efficiency perspective against the NHS England criteria is amber.

Good performance

- The CCG had been planning to deliver a surplus of £7.3m in 2015/16, however due to the CCG receiving a number of allocations which relate to both the 2015/16 and 2016/17 financial years it was agreed with NHS England to increase this target to £9.6m to enable the CCG to manage these additional allocations across the year end.

- The better payment practice code performance for the year to date (for non-NHS invoices by value) is 97.0% which is in line with the targeted figure.

- Detailed plans for 16/17 were submitted to NHS England on the 2nd March which reported a £7.5m surplus in line with the anticipated control total. There is a further submission for the 11th April.

Challenging performance:

- Prescribing expenditure is significantly above budgeted level, primarily NOACs, although there are indications that the rate of overspend may be decreasing.

- Activity, primarily emergency, at GHNHSFT is significantly above planned levels

- There continues to be some slippage on QIPP schemes within the current financial year. Slippage for the year to date is £2.9m

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 29th February 2016

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

PERSPECTIVE 1	Clinical Excellence	Amber
Success criteria: *1. Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.*		Green
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).		Green
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.		Green
Success criteria: 2. *Commissioning high-quality primary care services through the utilisation of exercising Delegated Commissioning responsibilities within a robust governance structure*		Green
Key performance indicators		
Commission all Gloucestershire practices through a 'Primary Care Offer' enhanced service for 2015/16 that focuses on clinical quality improvement, reduces variation, tackles health inequalities and promotes innovation		Green
Set-up and implement a Primary Care Clinical Quality Review Group (CQRG) and develop a set of indicators to measure primary care quality		Green
Success criteria: 3. *Progress in developing and implementing locality plans*		Green
Key performance indicators		
Reporting progress on implementation of the seven Locality Development Plans for 2015-2017.		Green
Success criteria 4. Progress to develop outcomes for CPGs *CPG success criteria & KPIs Outcomes – CPG programme/timelines in outline in appendix, KPis re staying to timetable, output etc, narrative to focus, in brief, on one CPG area per month*		In development

***Success criteria: 5**. Key local and National standards relating to Patient Experience*	Amber
Key performance indicators	
Achievement of key local and National standards relating to Clinical Excellence – see section 2.2 to 2.8	Amber

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. In addition extraordinary CQRGs are held with providers to focus on specific service issues. An example of this is the recent meeting to consider staffing issues at GHNHSFT

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 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 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 2016/17.

2.1.3 **Success criteria: 2: Commissioning high-quality primary care services through the utilisation of exercising Delegated Commissioning responsibilities within a robust governance structure.**

GCCG transitioned the commissioning of primary care services from NHS England in April 2015, using a robust project management approach. We have established a governance infrastructure, including a Primary Care Commissioning Committee, Primary Care Operational Group and commenced the establishment of work streams relating to workforce, estates, quality and innovation.

Since April 2015, in addition to commencement of the development of strategic objectives, we have also managed a number of operational contractual issues, including two GP providers serving notice on their GMS contracts resulting in one GCCG managed dispersal and one procurement, with extensive patient engagement for both. In addition, list closure and branch closure requests have also been received and managed within this period too, all within a good governance process that minimised real or perceived conflicts of interest.

The Primary Care Offer for 2015/16 builds on the success of the 2014/15 scheme, with four 'building blocks' across the enhanced service for practices to choose from. The new additions this year include quality indicators relating to antibiotic prescribing, improving Atrial Fibrillation (AF) diagnosis and use of anticoagulants, and identifying patients at risk of Acute Kidney Infection (AKI). The four blocks and the elements they include is summarised in the table below:

For the second year running, we have achieved 100% sign-up to the Primary Care Offer, with all practices agreeing to undertake all four building blocks.

The Primary Care Offer 'Improving Quality' will form the basis of reporting through the year, particular with regards to the following elements:

- **Cancer education**
  - GP practices to give significant event consideration to all cancer diagnoses in the practice during 2015/16. To select one case per 2,000 head of population for conducting an in-depth Significant Event Audit
  - GP practices to participate in an education programme, consisting of Macmillan GP "Lunch/Supper & Learn" Master Classes and/or a full-day Cancer PLT.

- **Practice variation**
  - CCG to provide a practice variation report. The report will provide activity and performance detail across urgent care, planned care and referrals
  - Each practice to pick two areas where they are an outlier (e.g. T&O referrals) to review.
  - Practices to aim to reduce any unexplained variation
  - Each practice will be provided with a refreshed practice variation report at quarter three 2015.
  - Practices to discuss internally and develop an action plan in order to reduce unexplained variation in their two identified domains

- **Local Quality Improvement Indicators**
  - The CCG has developed four quality indicators as set out below, GP practices to review the benchmarking data and agree a practice action plan to improve the benchmarked position. This will involve peer discussion at locality level.

    - Smoking – recording status and advice given
    - Antibiotics Prescribing - (Antimicrobial Stewardship)
    - Improving Atrial Fibrillation (AF) diagnosis rates and use of Anti-coagulants
    - Identifying patients at risk of Acute Kidney Injury (AKI) (Package of measures and further clarity to follow).

Initial work has commenced on the design of the Primary Care Offer for 2016/17.

2.1.4 A Primary Care Clinical Quality Review Group (CQRG) has been established, reporting to the Integrated Governance Quality Committee (IGQC). The Group are now working to develop the indicators and processes that will be used to measure primary care quality, drawing on the Primary Care Offer, the Primary Care Web Tool, the Patient Survey, patient complaints and other relevant data sources to determine a Primary Care Quality Framework.

2.1.5 **Success criteria 3. Progress in developing and implementing locality plans**

All seven CCG localities have developed two year Locality Development Plans for 2015 – 2017. Each plan was developed after working with their member practices, CCG colleagues and local stakeholders including Public Health colleagues and representatives from the district and borough councils to understand the influencing factors on health and wellbeing within each locality. These have been shared with a wide range of stakeholders across the county, including practice Patient Participation Groups (PPGs).

Progress against all seven Locality Development Plans is being reported six monthly to the GCCG Governing Body.

Across the county, the GCCG Primary Care and Localities Directorate are currently also supporting localities in formulating the vision for primary care in the future. Given the current resilience and sustainability issues being experienced within General Practice, along with the latest national policy direction of primary care working 'at scale' to lead an integrated out-of-hospital care system, the locality infrastructure is well placed to organise and co-ordinate events to help develop the ideas locally. These are being held through January – March 2016, with the support of the Localities team.

All localities have also been working on the implementation of the Prime Minister's GP Access Fund projects, such as Choice+, to pilot the schemes within their areas

2.1.6 **Success criteria 4. CPG success criteria & KPIs Outcomes – CPG programme/timelines in outline in appendix, KPs re staying to timetable, output etc. narrative to focus, in brief, on one CPG area per month (timetable re which CPG each month)**

Please see section 3.1.6

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

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
- Proportion of people at high risk of Stroke who experience a TIA

- 6 week diagnostic waiting times
- Cancelled operations
- Cancer 62 day GP referral

Areas of good performance include:

- 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	Dec-15	Jan-16	Feb-16	Month	Latest Performance		YTD performance		6 month trend
SWAST Ambulance indicators										
Cat A RED 1 Ambulance incidents	75%	75.3%	72.0%		Jan	72.0%	◆	75.2%	●	
Cat A RED 2 Ambulance incidents	75%	63.9%	61.0%		Jan	61.0%	◆	66.2%	◆	
Cat A 19 min response Ambulance incidents	95%	90.3%	89.0%		Jan	89.0%	◆	91.1%	■	
Over 30 minute ambulance handover delays (GHNHSFT)	<2014/15	82	92		Jan	92	●	687	●	
Over 1 hour ambulance handover delays (GHNHSFT)	<2014/15	20	5		Jan	5	●	79	●	
A&E										
4-hour A&E target GHNHSFT	95%	82.7%	80.1%	76.3%	Feb	76.3%	◆	87.5%	◆	
4-hour A&E target GCS MIU	95%	99.7%	99.8%	99.9%	Feb	99.8%	●	99.8%	●	
12 hour trolley waits	0	1	2	0	Feb	0	●	4	◆	
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%	82.4%	81.8%		Jan	81.8%	●	83.7%	●	
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	60%	25.0%	27.7%		Jan	27.7%	◆	36.5%	◆	

2.3.1 SWAST Ambulance indicators

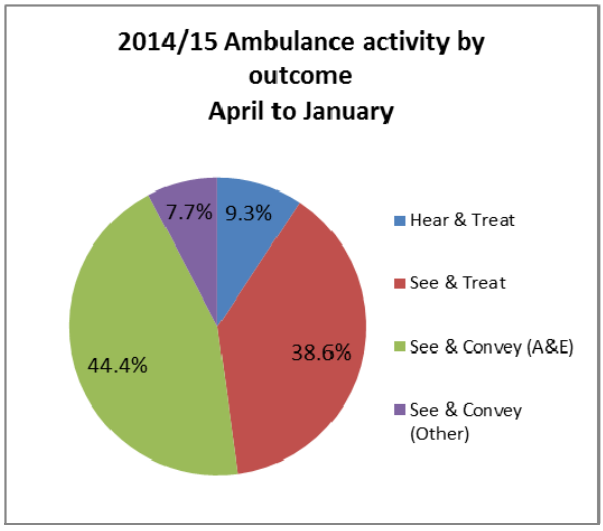
Ambulance targets are monitored at a South Western Ambulance Trust wide aggregate level.

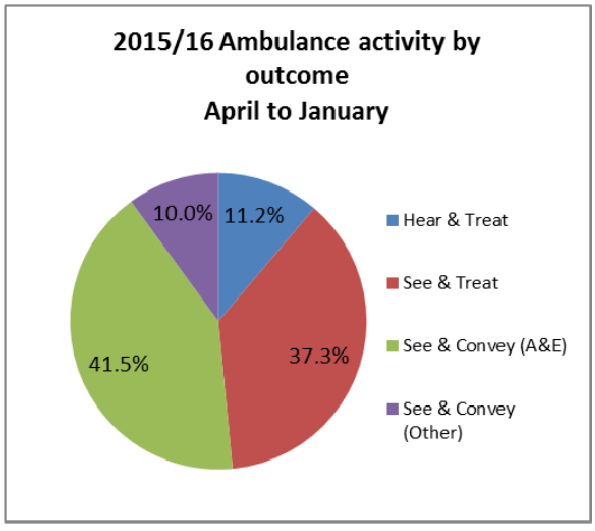
The introduction of the Dispatch on Disposition (DoD) has resulted in the prioritisation of responses to Red 1 incidents. As part of the changes to the dispatch process call handlers are provided with extra assessment time for all other classification of 999 calls (including Red 2 incidents).

Current year to date (April to January) performance is 75.2% at a Trust level and 66.0% at a Gloucestershire area for Red 1. For Red 2 performance at a Trust level is 66.2% and at a Gloucestershire level is 64.9%. For A19 performance at a Trust level is 91.1% and at a Gloucestershire level is 90.1%.

During the first 10 months of 2015/16, incidents with response in Gloucestershire have been 1.5% above contracted levels, which equates to 1125 incidents, approx. 94 per month. These additional incidents are from public calls into the 999 service.

When analysed by case type/ outcome, the profile of Ambulance activity has changed. The percentage of Hear and Treats has increased from 9.3% to 11.2% for the period April to January 2014/15 to 2015/16, with the number of patients conveyed to A&E departments has seen a reduction from 44.4% to 41.5%.





SWAST performance has been affected in recent months by the introduction of a new computer aided dispatch (CAD) system in the north division, which was bought in to match the systems used in the south division. There have also been changes to the Ambulance quality indicators (AQI) by NHS England which have changed the way some RED call can be recorded, such as the use of defibrillators.

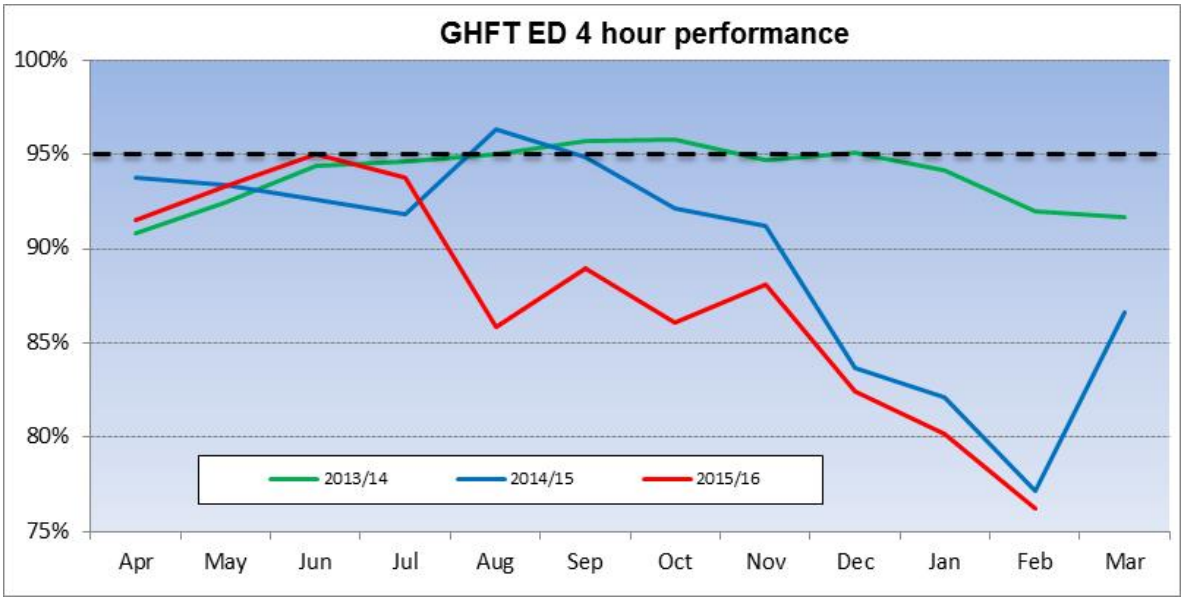
SWAST have a plan to ensure there is full establishment in the North division by the 1st April 2016, this follows commissioner investment into paramedic bursaries. They are also in the process of building a storyboard to identify all significant events which have taken place over the last few years and their impact on performance. This is being presented to commissioners, along with highlighted areas of concern which will be further investigated and action plans produced to address them. Commissioners (Gloucestershire as lead) have requested an extraordinary meeting with SWASFT as the performance prior to the CAD in the area was also deteriorating for Red 1 and Red 2. Within April, new performance indicators are planned to be implemented according to NHS England.

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 February was 76.3%. Performance at Cheltenham General was 88.7% and Gloucestershire Royal was 69.0%.

The year to date performance for 4 hours has decreased to 87.5% at Gloucestershire Hospitals NHSFT (GHNHSFT); the all type performance (combined GHNHSFT, Gloucestershire Care Services MIU and Primary care in A&E) is 92.8%. A 4 hr recovery plan is agreed and monitored as a system response to the delivery of the 4hr target and this reports to System Resilience Group.



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. As a result of continued poor performance, Monitor have undertaken a programme of 'heightened surveillance' at GHFT.

2.4 Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (target 60%).

Performance indicator relates to high-risk transient ischemic attacks (TIA) patients need to be assessed by experts and, wherever possible, scanned using magnetic resonance imaging (MRI) within 24 hours of experiencing symptoms. Compliance against this target continues to be of concern with performance year-to-date of 36.5%.

Planned care:

The dashboard 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	Dec-15	Jan-16	Feb-16	Month	Latest Performance		YTD performance		6 month trend
Referral to treatment (RTT)										
% of non - admitted pathways treated within 18 Weeks	95%	91.9%	91.3%		Jan	91.3%	■	94.1%	■	
% of incomplete Pathways that have waited less than 18 Weeks	92%	92.3%	92.5%		Jan	92.5%	●	92.3%	●	
Zero RTT pathways greater than 52 weeks	0	19	17		Jan	17	◆	207	◆	
Cancer waiting times										
% of patients seen within 2 weeks of GP referral for suspected cancer	93%	89.9%	87.8%		Jan	87.8%	■	91.3%	■	
% of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected	93%	94.6%	93.7%		Jan	93.7%	●	93.6%	●	
Cancer - first definitive treatment within 31 days of a cancer diagnosis	96%	99.6%	100.0%		Jan	100.0%	●	99.5%	●	
Cancer - subsequent treatment for cancer within 31 days - surgery	94%	100.0%	97.0%		Jan	97.0%	●	97.9%	●	
Cancer - subsequent treatment for cancer within 31 days - Drug Regime	98%	100.0%	100.0%		Jan	100.0%	●	100.0%	●	
Cancer - subsequent treatment for cancer within 31 days - Radiotherapy	94%	100.0%	100.0%		Jan	100.0%	●	99.9%	●	
Cancer - first definitive treatment within 62 days GP referral	85%	79.5%	78.6%		Jan	78.6%	◆	76.1%	◆	
Cancer - first definitive treatment within 62 days screening service	90%	96.9%	84.0%		Jan	84.0%	◆	95.2%	●	
Cancer - first definitive treatment within 62 days upgrade	85%	100.0%	85.7%		Jan	85.7%	●	91.7%	◆	
Diagnostic waiting times										
% of patients waiting more than 6 weeks diagnostic test	1%	2.0%	2.0%		Jan	2.0%	◆	4.0%	◆	
% of patients waiting more than 6 weeks for a Planned/ Surveillance diagnostic test from their to be seen date – Endoscopy procedures	1%	34.6%	45.6%		Jan	45.6%	◆	46.9%	◆	
Local community waiting times										
% referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	95%	98.0%	85.0%		Jan	85.0%	◆	93.9%	■	
% referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	95%	100.0%	100.0%		Jan	100.0%	●	99.7%	●	
% referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	95%	100.0%	97.3%		Jan	97.3%	●	99.5%	●	
% referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	95%	93.6%	94.5%		Jan	94.5%	■	95.2%	●	
% referred to the Podiatry Service who are treated within 8 Weeks	95%	99.0%	98.3%		Jan	98.3%	●	98.2%	●	
% referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	95%	90.0%	82.0%		Jan	82.0%	◆	86.7%	◆	
% referred to the Adult Physiotherapy Service who are treated within 8 Weeks	95%	94.6%	93.7%		Jan	93.7%	■	91.4%	■	
% referred to the Parkinson Nursing Service who are treated within 8 Weeks	95%	100.0%	100.0%		Jan	100.0%	●	100.0%	●	
% referred to the Diabetic Nursing Service who are treated within 8 Weeks	95%	97.0%	97.3%		Jan	97.3%	●	97.7%	●	

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

17 incomplete pathways of 52+ weeks were reported in January 2016. Of these, 15 at

North Bristol Trust - 7 in Trauma and Orthopaedics, 4 in Neurosurgery and 3 in Neurology, and 2 at GHFT in Urology. The CCG continues to closely monitor progress for its patients with the Trust. Overall recovery is above trajectory, which is positive.

During the first 10 months of the year there have been 207 incomplete pathways of 52+ weeks reported to the CCG. The majority with NBT, the breaches have occurred within the Trauma and Orthopaedic specialty; there are capacity issues particularly for complex spinal services across a number of providers within the South West. All patients have been clinically reviewed and offered alternatives where clinically appropriate.

The CCG regularly receive updates on the progress of treatment for Gloucestershire patients at out of county providers. Performance management is being undertaken in conjunction with the lead commissioner for planned care. As an associate commissioner, we receive the monthly performance position highlighting the issues and have an opportunity to challenge progress.

2.5 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

Delivery of cancer targets has been challenging throughout 2015/16 to date in the face of significantly increased demand, particularly in the services of urology, colorectal, upper GI, lung and gynaecology. Demand has in part been fuelled by the 'Be Clear on Cancer' and other awareness campaigns.

Performance against the 2-week wait target was 87.8% in January; reducing the year to date position to 91.3%. Referral volumes were particularly high in November and December.

Performance against the 62-day wait target was 78.6% in January which was below the target of 85%. The GHFT position was 77.4%, which is 3.0% below the GHFT recovery trajectory. Overall CCG performance is running at 76.1% for the year to date.

Urology remains the speciality of most concern with 50% of patients being treated beyond 62 days in December and January. The majority of breaches relate to waits for diagnostics tests.

There were 6 over 104 day breaches reported at the end of January. 5 were in Urology and 1 was in Upper GI, all 6 pathways started and finished at GHFT.

85% Target	62 day target - GP Referral		
	Total	Breaches	%
Apr-15	121	32	73.6%
May-15	102	29	71.6%
Jun-15	138	39	71.7%
Jul-15	150	47	68.7%
Aug-15	128	18	85.9%
Sep-15	136	38	72.1%
Oct-15	140	29	79.3%
Nov-15	128	24	81.3%
Dec-15	122	25	79.5%
2015/16 Total	**1,165**	**281**	**75.9%**

The majority of breaches have occurred in the following specialties:

Urology – 120 breaches
Lower Gastrointestinal – 41 breaches
Lung – 32 breaches
Upper Gastrointestinal – 26 breaches

GCCG have an agreed recovery action plan in place with GHFT. In addition we have provided additional CCG support to GHFT to support the recovery plan process 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 has commissioned additional capacity within urology to support this tumour site area's activity. This has acted to take transfers direct from GHFT and is now operating as a one stop shop to all new referrals since January 2016 through independent provider, GP Care.

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

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

The performance for patients waiting over 6 weeks for a diagnostic procedure has remained static in January (2.0%) from the position in December (2.0%).

Issues within Neurophysiology have been identified and a remedial action plan agreed with GHNHSFT.

There has been an increase in MRI breaches in January (59) from December (14). This is

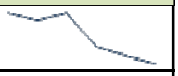
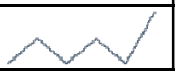
due to a delay in the procurement of new equipment.

Other areas for concern are Urodynamics.

Recovery plans relating to Endoscopy have been implemented, with improved performance since September 2015

2.5.2 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	Jan	2	♦	51	♦	
Urgent operations cancelled for a second time	0	Jan	2	♦	6	♦	

2.6 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.

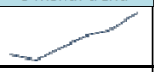
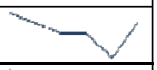
The current year-to-date position shows that so far in 2015/16, 51 patients have been cancelled on the day of admission for non-medical reasons and patients have not been provided with another date within 28 days; the threshold is zero.

There were 784 last minute elective operations cancelled for non-clinical reasons this year. The number of cancellations was 716 in the same period in 2014/15 (9.5% increase).

The CCG has requested and received additional information and assurance in respect of cancelled operations. This is reviewed as part of the contractual framework with GHNHSFT.

2.6.1 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		6 month trend
Dementia diagnosis rate	67%	Jan	68.2%	●	66.1%	●	
Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	95%	Q3 15/16	96.4%	●	97.0%	●	
The proportion of people who have depression and or anxiety disorders who receive psychological therapies	3.5%	Q3 15/16	14.0%	●	14.0%	●	
The proportion of people who complete therapy who are moving towards recovery	50%	Q3 15/16	25.0%	◆	32.0%	◆	
IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	75%	Jan	88.0%	●	88.0%	●	
IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	95%	Jan	99.0%	●	99.0%	●	

2.6.2 Dementia diagnosis rate

The PCCAG dementia case finding audit in Q3 had 100% practice compliance and the activity identified a cohort of patients not recorded on the Dementia Register. Based on the audit findings shared with practices in order to update their Dementia Registers, PCCAG have indicated that the DDR for Feb 2016 has increased to 68.2%. We have agreed with NHSE, a trajectory for 16/17 with a target to reach 70% DDR by the end of Q4 2017. Alongside this, the local primary care dementia pathway will be reviewed during 16/17 to ensure that post diagnostic services can support the rising DDR and anticipate that this will be an area of interest to stakeholders and NHSE going forward.

2.7 The proportion of people who complete therapy who are moving towards recovery

There are known discrepancies between nationally reported recovery figures and local reported figures from 2gether NHS FT (2G).

2G have an on-going programme of work that will help ensure better understand of the variances in reporting of data. 2G Staff are being briefed and trained on the issues to ensure that true clinical performance of the service can be reflected within the national dataset, and a new care pathway has been introduced.

Throughout the improvement programme 2G are using a reliable improvement rate (local indicator), showing those people who have made an improvement. This indicator is showing a reliable improvement rate of 55%.

A member of the National IAPT Team is supporting 2G. They have also had an on-site visit from the NHSE Intensive Support team, and their initial findings will be available by the end of March for review. An improvement plan is in place to improve the recovery rate by the end of Quarter 4.

2.7.1 **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%	Jan	88.2%	♦	84.3%	♦	
Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey	85%	Jan	85.6%	●	82.1%	■	
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%	Jan	90.2%	●	84.3%	■	

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. January's report shows 88.2% 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 January shows that 85.6% 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 January that 90.2% 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 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	Jan	0	-	7	-	
Number of MRSA infections (GHNHSFT)	0	Jan	0	-	1	-	
Number of C.diff infections (Health Community)	157	Jan	17	◆	129	■	
Number of C.diff infections (GHNHSFT)	37	Jan	6	◆	33	■	
Mixed sex accommodation							
Mixed-sexed accommodation breaches	0	Jan	49	◆	111	◆	
Other quality indicators							
Number of Never Events	0	Jan	0	●	2	◆	
Cardiology correspondence backlog	n/a	Q1	0	●	0	●	
Radiology reporting delays	n/a	Q1	0		0		
Outpatient follow-up pending lists	n/a	Sept	18,034		18,034		

2.8.1 Number of MRSA infections (Health Community)

Year to date performance is 8 reported MRSA bacteraemia cases. 7 of these cases were identified as pre 48 hr, with the patients being admitted to hospital having already

acquired MRSA in the community, 1 case acquired in hospital. On further investigation these were all found to be unavoidable. As per the NHS England Post Infection Review guidance all of these cases were investigated by multi-disciplinary teams.

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.

YTD performance is amber rated with 129 cases against a YTD threshold of 126.

In January there was an increase (17 cases) of C.Diff in the community. The CCG has undertaken RCA on all cases and has found no underlying cause for this increase. This situation will continue to be monitored.

Never events

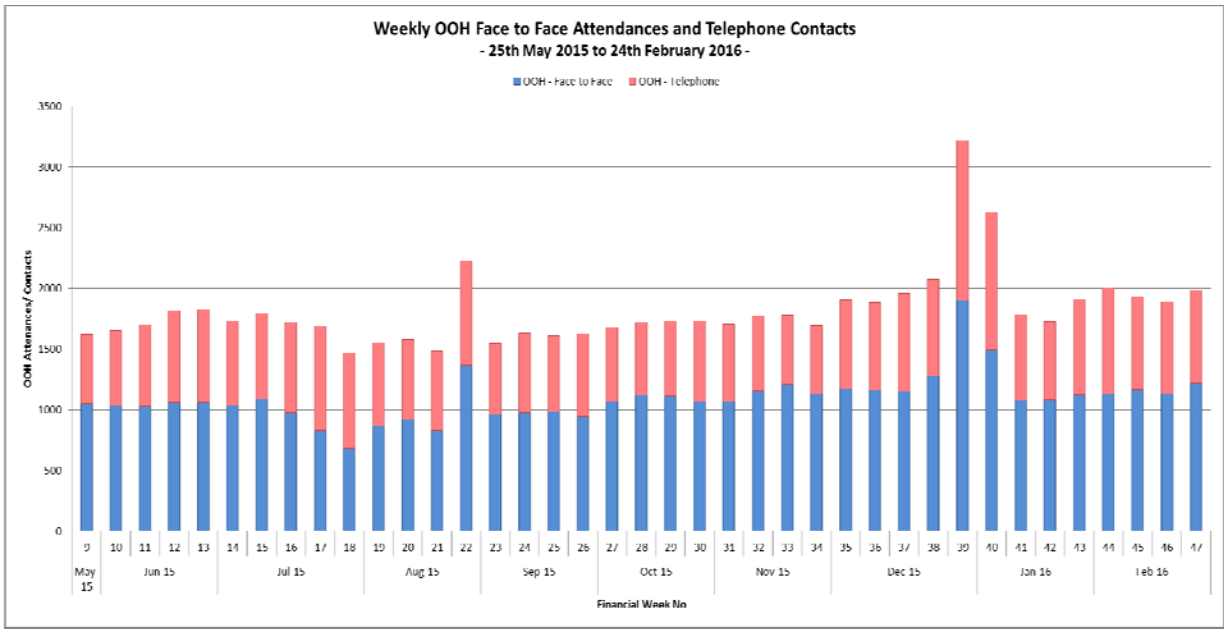
In January a Never Event was reported by Winfield Hospital operating as an NHS AQP. This related to wrong side surgery on a spinal procedure.

Gloucestershire Care Services have reported a Never Event also in January relating dentistry. This service is commissioned by NHS England and is therefore not reported via CCG systems.

Out of Hours (OOH)

The SWAST Out of Hours Service commenced on 1st April 2015; there have been 90,0021 OOH contacts made from start of service to 24th February 2016.

The graph below shows the total number of weekly OOH contacts split by face to face and telephone; face to face contacts predominantly include Treatment Centre, Home Visit and ED/MIU Referral contacts. The peaks in activity co-incide with bank holidays.



Excluding the bank holiday weeks, contacts remain consistent with the predicted rise in activity through the winter months.

In Q3 reported performance across a number of national and local service quality indicators did not meet the required standard and a Performance Notice has been issed to SWASFT. SWASFT are submitting a remedial action plan to address the issues and outline the actions required to raise performance to the required levels.

The dashboard below provides performance data for a number of key quality indicators.

National Quality Requirements

			Jan 16	Year to Date Compliance
Requirement 10: (Walk in)	All immediately life threatening conditions to be passed to the ambulance service within 3 minutes following face to face clinical assessment in PCC	Number of emergency cases passed to the ambulance service within 3 minutes following face to face clinical assessment took place in a PCC	0	0
		Total number of emergency cases passed to the ambulance service where a face to face clinical assessment took place in a PCC	0	0
		Percentage Compliance	**100%**	**100%**
Requirement 10a: (Adult Walk in)	For urgent adult patients - % definitive face to face clinical assessments started within 20 minutes of arrival in PCC.	Number of urgent adult patient cases where face to face clinical assessments started within 20 minutes of patient's arrival in PCC	9	85
		Total number of adult cases with urgent need presenting at a PCC	14	117
		Percentage Compliance	**64.29%**	**72.65%**
Requirement 10a: (Children Walk in)	Children, who are ill and have an urgent OOH need, will receive definitive clinical assessment within 15 minutes of arrival in PCC	Number of children (0-16) cases with urgent need started definitive clinical assessment within 15 minutes of arriving at PCC	3	16
		Total number of children (0-16) with urgent need cases presenting at a PCC	10	37
		Percentage Compliance	**30.00%**	**43.24%**
Requirement 10b: (Walk in)	Definitive clinical assessment for less urgent cases presenting at PCC to start within 60 minutes	Number of less urgent patient cases where definitive face to face clinical assessments started within 60 minutes after the patient arrived at PCC	365	2,258
		Total number of less urgent patient cases presenting at PCC	371	2,401
		Percentage Compliance	**98.38%**	**94.04%**

National Quality Requirements

			Jan 16	Year to Date Compliance
Requirement 12 (Presenting at PCC) - Priority assigned on triage	Emergency face to face consultations started within 1 hours of completion of the last telephony definitive clinical assessment	Number of Emergency Consultations	7	23
		Number within 1 Hour	3	18
		Percentage Compliance	**42.86%**	**78.26%**
	Urgent face to face consultations started within 2 hours of completion of the last telephony definitive clinical assessment	Number of Urgent Consultations	773	4,430
		Number within 2 Hours	728	4,165
		Percentage Compliance	**94.18%**	**94.02%**
	Less urgent face to face consultations started within 6 hours of completion of the last telephony definitive clinical assessment	Number of Less Urgent Consultations	2,068	23,076
		Number within 6 Hours	2,017	22,702
		Percentage Compliance	**97.53%**	**98.38%**
Requirement 12 (Presenting at PCC) - Priority following F2F PCC Assessment	Emergency face to face consultations started within 1 hours of completion of the last telephony definitive clinical assessment	Number of Emergency Consultations	18	149
		Number within 1 Hour	11	100
		Percentage Compliance	**61.11%**	**67.11%**
	Urgent face to face consultations started within 2 hours of completion of the last telephony definitive clinical assessment	Number of Urgent Consultations	444	4,034
		Number within 2 Hours	348	3,270
		Percentage Compliance	**78.38%**	**81.06%**
	Less urgent face to face consultations started within 6 hours of completion of the last telephony definitive clinical assessment	Number of Less Urgent Consultations	2,553	24,556
		Number within 6 Hours	2,493	23,902
		Percentage Compliance	**97.65%**	**97.34%**
Requirement 12 (Home Visit) - Priority assigned on triage	Emergency face to face consultations started within 1 hours of completion of the last telephony definitive clinical assessment	Number of Emergency Consultations	5	40
		Number within 1 Hour	3	28
		Percentage Compliance	**60.00%**	**70.00%**
	Urgent face to face consultations started within 2 hours of completion of the last telephony definitive clinical assessment	Number of Urgent Consultations	288	2,464
		Number within 2 Hours	249	2,155
		Percentage Compliance	**86.46%**	**87.46%**
	Less urgent face to face consultations started within 6 hours of completion of the last telephony definitive clinical assessment	Number of Less Urgent Consultations	504	4,466
		Number within 6 Hours	447	4,097
		Percentage Compliance	**88.69%**	**91.74%**
Requirement 12 (Home Visit) - Priority following F2F home visit assessment	Emergency face to face consultations started within 1 hours of completion of the last telephony definitive clinical assessment	Number of Emergency Consultations	9	126
		Number within 1 Hour	1	51
		Percentage Compliance	**11.11%**	**40.48%**
	Urgent face to face consultations started within 2 hours of completion of the last telephony definitive clinical assessment	Number of Urgent Consultations	206	1,730
		Number within 2 Hours	143	1,306
		Percentage Compliance	**69.42%**	**75.49%**
	Less urgent face to face consultations started within 6 hours of completion of the last telephony definitive clinical assessment	Number of Less Urgent Consultations	582	5,116
		Number within 6 Hours	536	4,798
		Percentage Compliance	**92.10%**	**93.78%**

Local Quality Requirements

			Jan 16	Year to Date Compliance
LI1	All calls to the OOH clinical service must be answered within 60 seconds	Number of calls answered within 60 seconds following the end of a voice message lasting no longer than 20 seconds	3,265	28,315
		Total number of incoming calls	4,002	35,616
		Percentage Compliance	**81.58%**	**79.50%**
	For calls prioritised as emergency: Timely calls backs within 1 hour of notification from the NHS 111 service where a call back is required	Number of emergency cases have clinical assessment within1 hour following the receiving of the case at OOH service	817	7,642
		Total number requiring a call back within 1 hour	909	8,164
		Percentage Compliance	**89.88%**	**93.61%**
LI2	For calls prioritised as urgent: Timely calls backs within 2 hours of notification from the NHS 111 service where a call back is required	Number of urgent cases have clinical assessment within 2 hours following the receiving of the case at OOH service	1,515	8,656
		Total number requiring a call back within 2 hours	1,957	10,225
		Percentage Compliance	**77.41%**	**84.66%**
	For calls prioritised as less urgent: Timely calls backs within 6 hours of notification from the NHS 111 service where a call back is required	Number of less urgent cases have clinical assessment within 6 hours following the receiving of the case at OOH service	1,409	18,014
		Total number requiring a call back within 6 hours	1,837	20,268
		Percentage Compliance	**76.70%**	**88.88%**
LI5	Qualified response to urgent paramedic requests for advice within 20 minutes of the request	Number of urgent paramedic requests receiving definitive consultation within 20 minutes after the call has been picked up by call takers/clinicians	287	2,572
		Total number of urgent paramedic calls received	428	4,102
		Percentage Compliance	**67.06%**	**62.70%**
LI8	Transfers to Emergency Departments	Number of patients transferred from the OOH Service to an Emergency Department	380	2,981
		Total number of patient contacts	9,531	82,258
		Percentage Compliance	**3.99%**	**3.62%**

NHS 111

NHS 111 Summary	Target	Dec-15		YTD	
		Calls	%	Calls	%
Calls Offered		16551		103869	
Weekday calls answered in 60 seconds	>=95%	7087	97.80%	57856	96.60%
Weekend calls answered in 60 seconds	>=95%	7895	91.60%	62558	93.10%
Total calls Referred to ED	<=5%	994	6.30%	7512	5.90%
Total Ambulance Dispatched	<=10%	1660	10.50%	13797	10.90%
Calls Transferred to 111 Clinical Advisor		3865	28.30%	28475	26.90%
Warm transferred	>=98%	1763	45.60%	11224	39%
Call backs in 10 minutes	>=95%	1221	58.10%	7717	45%

Over the Christmas and New Year Period the answered in 60 seconds key performance indicator (KPI) was achieved, apart from 28th December when National Contingency was invoked which meant the call demand was significantly higher as Care UK supported other providers. Care UK have recently introduced a new role within the call centre which is a Service Advisor who support patients who are awaiting call backs from Clinicians within NHS111 and Out of Hours (OOHs). Care UK are currently reviewing how this role may be extended in the future and intend that this will provide a pool of staff who may convert to Health advisors in the future.

Prior to Christmas Care UK re-configured the appointment booking process for patients that were required to be contacted by a GP within 12 or 24 hours. This has had a positive impact upon patient experience, the OOHs service and productivity within NHS111

During December Care UK reported a significant downward trend in attrition for both Health Advisors (HA) and Clinical Advisors (CA). Currently recruitment of CA is being prioritised with the appointment of a dedicated CA Resourcing manager which has significantly improved suitable applicants into this role. A recent review of the CA rota has ensured that shift patterns reflect service demand, ensuring patient experience and performance are enhanced.

There has been a positive downward trend in the disposition to 999. A clinical validation line has been introduced, supported by staff from South Western Ambulance Service Trust (SWAST) which has focussed upon providing clinical intervention and validation to the green ambulance dispositions. The validation line is in place between 7am -11pm, 7 days a week.

Care UK undertake robust internal audit of calls taken and ensure that individuals staff are provided with the necessary support and training and key learning is shared and appropriately actioned.

Warm Transfer rates remain a challenge. The recruitment into vacant CA posts will positively impact upon performance within this area and work is also underway to introduce clinical prioritisation which will ensure the safe and appropriate prioritisation for warm transferring of patients.

2.9 Other Key Performance Issue:

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 is now being received.

The monthly updates are reviewed to ensure that progress against follow-up backlog clearance is on track. There are indications that the overall follow-up pending list has grown in recent month; however, the number of very long waits in excess of 1 year have reduced.

District Nursing

In response to concerns initially raised by Primary Care, the CCG and GCS committed to jointly understand and address the specific concerns raised in relation to District Nursing

and a joint action plan was subsequently developed .The joint CCG/GCS 2014-15 District Nurse action plan has been refreshed with a new plan developed for the next 18 months. The refreshed plan is aligned with the recently published NHSE commissioning framework for community nursing whilst recognising some of the challenges that are specific to Gloucestershire. To support the development of the Community Nursing Service the CCG has recently agreed to release £500K to fund more nursing posts.

The funded establishment for Band 6 DN's across Gloucestershire is: 57.59 WTE. The current vacancy is: 18.95 WTE (this includes 2.96 WTE temporary vacancies). All Band 6 vacancies are currently advertised.

The funded establishment for Band 5 Community Staff Nurses across Gloucestershire is: 154.54 WTE. The current vacancy is: 22.99 WTE (this includes 12.90 WTE temporary vacancies).

5.80 WTE of the vacancy rate is in the active recruitment phase whilst the remaining balance of vacancies is being advertised.

In relation to HCA positions it should be noted that there are minimal vacancies and the HCA workforce remains stable.

When compared to 18 months ago, the band 6 position remains relatively unchanged but the band 5 position has significantly improved.

All localities have vacancies across both bands but particular hotspots are: Cheltenham, South Cotswolds and Gloucester.

In the Cheltenham Locality, GCS have identified that the current vacancy position and lack of senior staff has manifested in some significant operational issues. In response to this, GCS have deployed additional professional lead resource from 2 other localities alongside additional operational management for a period of 3 months to stabilise the situation. The CCG have requested to see the detailed action plan and are also keen to understand what impact this will have on other localities that have similar issues.

The CCG have been provided with evidence that there is a clinical escalation process in place for staff to use if they assess that patient safety and quality of care is compromised as a result of staffing/skill mix issues. However, CCG Quality Alerts suggest that the process is not clearly understood by all staff and being utilised appropriately. Via the refreshed joint CCG/GCS action plan, the CCG have asked for this to be addressed as a priority. Monthly meetings between the CCG Quality lead for GCS, Professional Head of DN at GCS and GCS quality manager will take place in order to triangulate data and review all of the CCG Quality Alert's and GCS Datix in relation to DN.

3.1 Patient Experience

3.1.1 Patient Experience – Period to 29th February 2016

PERSPECTIVE 2	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.*		Green
Key performance indicators		
Outcomes measures for patient safety have been developed based on the CCG Outcome framework and sign up for safety initiative.		Green
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.		Green
Success criteria 2: Reporting: *Improve reporting of patient experience including FFT (Marion Andrews-Evans)*		Green
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in patient and staff FFT		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average in patient and staff FFT score		Amber
All providers of NHS funded services commissioned by GCCG participating in National Patient Survey Programme (2015/16)		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average results in National Patient Survey Programme (2015/16)		Green
Success criteria 3: The CCG has a programme of case reviews in place across urgent care reporting into system resilience to influence service redesign including CPGs.		Green
Key performance indicators		
CCG has a programme of case reviews across urgent care, which feed into System resilience / clinical programme groups as appropriate.		Green
Focus on emergency admissions and discharge.		Green
Success criteria 4: *National targets-PROMs*		Green
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in PROMs (2015/16)		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average PROMs results (2015/16)		Green
Success criteria 5: *All active Clinical Programme Groups are working with patients to ensure experience is incorporated into the programme and outcomes*		Green

Key performance indicators	
All CPGs have regular 'lay' input	Green
All CPGs receive and review patient experience data	Green
Work to ensure PE is incorporated within QIPP schemes	TBC
Success criteria 6: *Develop patient experience work within primary care through working with PPGs to help inform and influence commissioning across the whole spectrum*	Green
Key performance indicators	
PPGs are informing countywide priorities and Locality developments	Green
All GP practices in Gloucestershire have a PPG by 31 March 2015	Green

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 is a 'Beacon CCG' 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 along with a briefing to the Governing Body was made 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. The CCG has established with other healthcare organisations across the county a Gloucestershire Patient safety Forum.

To further highlight the Sign up to Safety (SU2S) campaign and engage CCG member practices, a safety page has been developed on CCG live. This page will share learning from significant events and serious incidents across Gloucestershire. It will publish themes and trends from Quality Alerts and give examples of actions taken when issues have been resolved. There will also be links to the national SU2S website and the local Academic Health Science Network (AHSN) and other national programmes such as Sepsis Six.

3.1.3 Success Criteria 2: Improve reporting of patient experience including FFT

The Friends and Family test no longer has a CQUIN attached and has become part of the national contract for all providers.

The data included in this report has been taken from the NHSE FFT website. All FFT data (including current and historic acute and staff FFT data) can now be found at: https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

The table (Table 1) below sets out the latest FFT results for December 2015, by service type across all main providers, response rates and performance. Results have been RAG rated against national performance. Previously reporting of FFT has focussed on the acute provider (GHNHSFT). We are keen to provide patient experience data regarding primary care providers, and for completeness will from now on routinely provide FFT data from the community services provider (GCSNHST) and the mental health and learning disabilities provider (2GNHSFT).

		July		August		September		October		November		December		January	
		Provider	Nat Ave	Provider	Nat Ave	Provider	Nat Ave	Provider	Nat Ave	Provider	Nat Ave	Provider	Nat Ave	Provider	Nat Ave
GHT Inpatients	Response Rate	36.30%	27.60%	17%	25.50%	17.80%	25.10%	20.60%	25.10%	18.20%	25.10%	15.70%	23.40%	13.80%	24.30%
	% Recommend	95.00%	95.90%	95%	96%	95%	96%	94%	96%	95%	96%	96%	96%	95%	96%
	% Not	1.00%	1.40%	1%	1%	1%	2%	1%	1%	1%	1%	1%	2%	1%	1%
GHT A&E	Response Rate	2.60%	15.20%	1%	14%	1.50%	14.10%	2%	13.60%	2.40%	13%	1.90%	12.70%	0.70%	12.90%
	% Recommend	76.00%	88.20%	65%	88%	75%	88%	74%	87%	79%	87%	76%	87%	54%	86%
	% Not	13%	6%	20%	6%	19%	6%	21%	7%	14%	7%	11%	7%	31%	7%
GCS	Response Rate														
	% Recommend	96.00%	95.00%	96%	96%	94%	95%	95%	95%	95%	95%	95%	95%	95%	95%
	% Not	2%	1%	2%	1%	3%	2%	1%	2%	2%	2%	2%	2%	1%	3%
2g	Response Rate														
	% Recommend	93.00%	87.00%	77%	88%	89%	86%	87%	87%	96%	87%	81%	88%	94%	87%
	% Not	3%	5%	5%	4%	6%	5%	4%	4%	0%	5%	6%	4%	0%	5%

GHNHSFT: Performance at GHNHSFT remains below the national average, however, with such small numbers the statistical accuracy cannot be guaranteed. FFT remains an item for discussion at the GHNHSFT CQRG and the CCG will be working with GHNHSFT to develop an action plan to increase response rates, particularly in ED. Due to the poor performance in relation to ED FFT the Trust have been asked by the CCG to undertake further patient experience work to understand what the service user experience is like for those patients flowing through the urgent care pathway.

GCSNHST: GCSNHST FFT results for December 2015 are exactly at national average. No response rates are available.

2GNHSFT: 2GNHSFT FFT results for December 2015 have dipped below the national average % recommend score for the first time since August 2015. No response rates are available.

Primary Care (GP services): GP FFT results for the CCG area as a whole are above the national average for % recommend (92%) compared to 88% nationally in December 2015. The FFT results for GP Practices present a

mixed picture. However, it should be noted that in most cases the response rates are very low and therefore cannot be considered to be statistically significant when looking at one month's data. The FFT data for each practice is reviewed on an ongoing basis to look for any trends by the Primary Care Clinical Quality Review Group

3.1.4 Success criteria 3: Programme of case reviews

A programme of clinical case reviews has been developed to support the delivery of urgent/emergency care programme.

These include reviewing and evaluating emergency admissions to hospital, with particular focus upon admissions which may have been preventable with appropriate support or through accessing alternative pathways to admission.

This is in addition to a programme of work to review the management of discharge from hospital. This includes a focus on the quality of discharge information.

These case studies are being undertaken with input from Governing Body GPs and localities and are being carried out in partnership with provider organisations.

3.1.5 Success Criteria 4: National targets-PROMs

In the latest PROMS data release (February 2016) GHNHSFT is recorded as 'not an outlier' for all PROMs procedures across all measures.
http://www.hscic.gov.uk/catalogue/PUB19824

GHNHSFT	April - Sept 2015 (pub. Feb 2016)
Groin Hernia (EQ5D index)	Not an outlier
Groin Hernia (EQ-VAS)	Not an outlier
Hip Replacement Primary (EQ5D index)	Not an outlier
Hip Replacement Primary (EQ-VAS)	Not an outlier
Hip Replacement Primary(Oxford hip Score)	Not an outlier
Knee Replacement (EQ5D Index)	Not an outlier
Knee Replacement (EQ-VAS)	Not an outlier
Knee Replacement (Oxford Knee Score)	Not an outlier

Varicose Vein (all measures)	Insufficient data for GHNHSFT for the February 2016 publication (similar position for other providers for this publication)

3.1.6 **Success criteria 5: All active CPGs are using working with patients to understand their experience, to inform the programme**

In Q3, Healthwatch Gloucestershire collected one comment from a member of the public regarding their experience of diabetic footcare. The key issue was that as a result of the normal procedure to examine the legs and feet of diabetic patients regularly not being followed, the individual lost part of his leg and as a result become almost totally immobile relying on a wheelchair for transport.

The CCG is currently developing a Diabetic Foot CQUIN with GHNHSFT. This will included a patient experience element in the form of a patient experience feedback survey.

3.1.7 **Healthwatch Gloucestershire (HWG) representation on GCCG programmes and projects**

HWG continue to participate in many CCG programmes and projects. These include Clinical Programme Groups (above), Locality Reference Groups and specific groups, such as Joining Up Your Information. The HWG Chair is a non-voting member of GCCG Primary Care Commissioning Committee (PCCC).

Success criteria 6: Overarching Patient experience, developing working relationships with Patient Participation Groups (PPG) in GP Practice (HG & BP)

The CCG has established the Gloucestershire Patient Participation Group (PPG) Network. The first meeting was held on 22 January 2016 and was attended by 50+ patient representatives and Healthwatch Gloucestershire.

A recent audit has shown that over 90% of practices in Gloucestershire have an established PPG. The CCG is supporting the remaining practices, with advice about recruiting members, developing constitutions and considering work plans.

4.1 Partnerships

4.1.1 Partnerships – Period to 29th February 2016

PERSPECTIVE 3	Partnerships	Green
Success criteria 1: *Building effective partnership working by putting in place a joint planning and governance framework to improve outcomes for the Gloucestershire population*		Amber
Key performance indicators		
Developing a plan for Gloucestershire, via Gloucestershire Strategic Forum, to identify the most appropriate service roadmap for Gloucestershire to take forward the five year forward view		Amber
GSF work plan – develop further and deliver with partners including GCC. GSF work plan to be attached as an appendix in January, update on one area of the programme each month.		Amber
Further develop and maintain system wide BCF forum encompassing all providers across health and social care, independent sector and voluntary sector and housing.		Green
Success criteria 2: *Work with the voluntary sector alliance to take forward the work with the voluntary and community sector in Gloucestershire.*		Green
Key performance indicators		
Roll out social prescribing and build on the existing evaluation to take forward learning		Green
Develop the "kitemark" for voluntary sector organisation		Green
Develop a cultural commissioning programme in conjunction with the New Economics Foundation, National Voluntary of Community Council's and Arts Council England		Green
Build capacity in the voluntary sector (re work with VCS)		Green
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.		Green

ii) Reducing inappropriate admissions of older people (65+) in to residential care	Green
iii) Rehabilitation / reablement, increase in effectiveness of these services whilst ensuring that those offered service does not decrease	Green
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.	Amber
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)**

A series of facilitated workshops for GSF (Gloucestershire Strategic Forum) members have been held, with more planned over the coming months to review the current service models and review against the objectives within the Five Year Forward View.

4.1.3 **Success criteria 2: Work with VCS to take forward the work of the voluntary & community sector organisations in Gloucestershire.**

Roll out social prescribing and build on the existing evaluation to take forward learning

As a part of the CCG's prevention and self-care agenda, we have worked with G.Doc and a range of voluntary and statutory partners to develop an innovative social prescribing model. Social prescribing is a structured way of linking patients with non-medical needs to sources of support within a community and of providing one to one support where this is needed. These opportunities may include: arts; creativity; physical activity; learning new skills; volunteering; mutual aid; befriending; and self-help, as well as support for a wide range of problems including: employment; benefits; housing; debt; legal advice; and parenting problems.

By the end of February 2016 the scheme had been extended with social prescribing available to all GP practices in the county. Roll out to staff in ICTs and community hospitals continues, and will be completed by the end of March 2016.

The external evaluation by the University of the West of England (UWE) to conduct an independent evaluation to inform the future of the service has commended with a final report due in August 2016.

The CCG will fund social prescribing for the year 2016/17 subject to evaluation.

Develop the "kitemark" for voluntary sector organisations engaged in social prescribing

The VCS Alliance has been instrumental in the development of a kitemark for social prescribing. To date 56 organisations have completed the questionnaire which seeks assurance in areas such as staff training and support, policies and procedures and insurance. A graphic for a kitemark for social prescribing is now in use.

Develop a cultural commissioning programme

To build on our work on social prescribing, Gloucestershire has also been working alongside the New Economics Foundation, National Voluntary of Community Council's and Arts Council England to understand how arts and culture can be used to improve the health and wellbeing of our local population.

During the summer, Arts and Cultural organisations from the VCSE were invited to apply for funding via the cultural commissioning grant programme. The aim of the grant programme is to test out opportunities for arts and culture interventions to support health and wellbeing outcomes for participants. The CCG received a total of 24 applications and awarded grants to six of the nine projects. Examples of successful applicants include singing for respiratory disease, mindfulness based art approach for chronic pain in men and a multi-art programme for young people exploring themes of social media; bullying; self-harm & violence in relationships.

Clinical Programme Groups will be working alongside clinicians, lay members and the VCSE to co-develop appropriate and effective service models. This will provide the opportunity for commissioners and the public to ensure that the pilots are designed in a way that provides meaningful and measurable outcomes.

The grant programme has been support by a number of partners including the VCS Alliance, Forest of Dean District Council, Gloucester City Council and Tewkesbury Borough Council. Create Gloucestershire (the county umbrella organisation for art and culture) have also supported the grant programme by developing capacity within the VCSE sector. This included supporting organisations with their applications and acting as a bridge between the sectors

Build capacity in the voluntary sector (re work with VCS)

The CCG approved a draft framework and action plan which suggested ways in which we might work with, support and learn from the VCSE in future. We are on target in terms of the delivery of the action plan and led a conversation with partners on the areas covered by the framework during November. As part of our work on Enabling Active Communities (EAC), the aim is to have a joint framework with Gloucestershire

County Council. The VCS Alliance will continue to support this piece of work.

The CCG issued a two year grant to the VCS Alliance to cover the period 2015/16 and 2016/17. The predominant aims, in addition to the above, were for the VCS Alliance to act as the main conduit for all links into NHS commissioners in Gloucestershire and for the Alliance to actively promote two way engagement with smaller VCSE organisations and community groups in the county and feed the outcome to the CCG.

In future utilising an Enabling Active Communities (EAC) Commissioning Group (involving CCG, GCC, Police and Crime Commissioner, districts and town and parish councils) we will aim to co-produce specifications to commission VCSE sector services which support health and wellbeing. The inaugural meeting of this group took place in December.

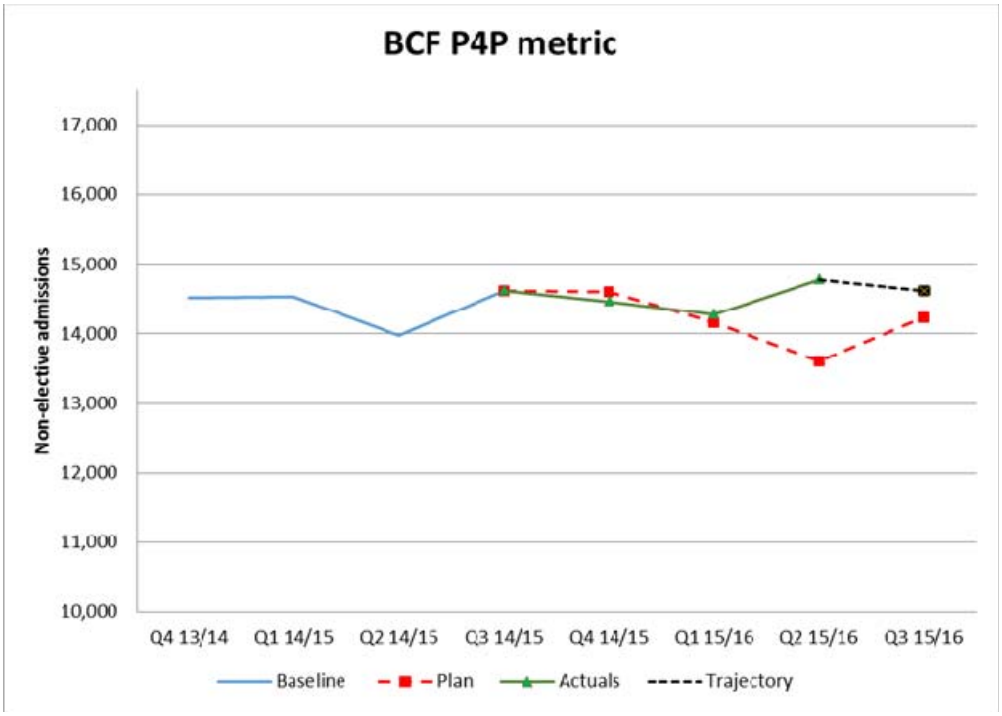
Success criteria 3: Partnership working group established to review dashboard and set targets.

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:

4.1.4 **Reduction in 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.

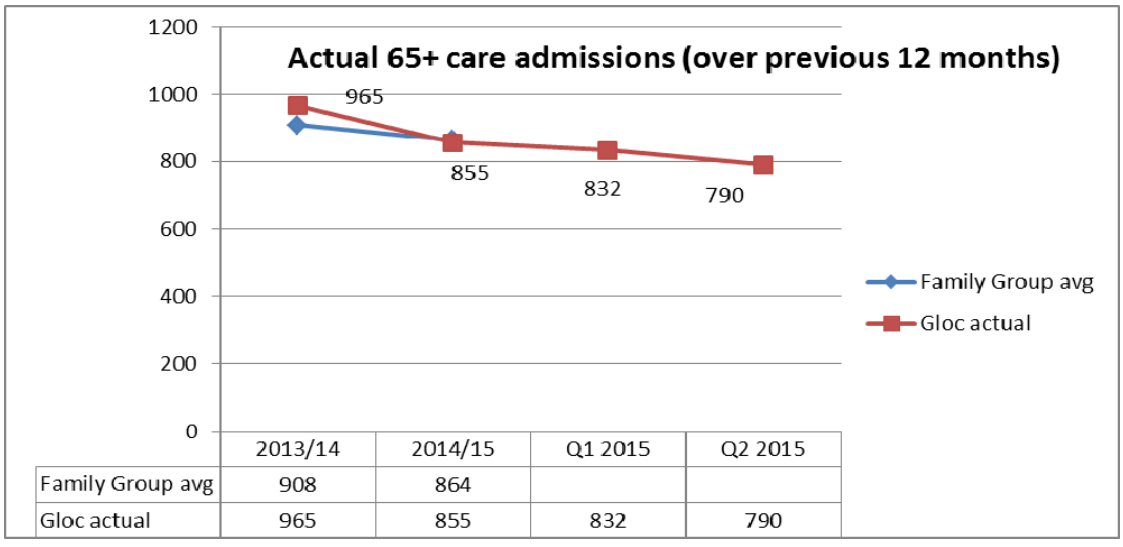
During quarter 2 non-elective admissions were 5.7% higher than in the baseline period (Q2 of 2014/15) which is 8.6% (1,168 admissions) above the planned reduction.
The overall aggregate position (January 2015 to September 2015) is an overall increase in admissions of 1,125 (2.7% above plan). The following graph provides a summary of progress to date:



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

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

Local data received from Gloucestershire county council supports this showing a decreasing trend in admissions continuing through 2015, indicating we are on track to hit our BCF target of 779.2 for 2015/16.



	2013/14	2014/15	Q1 2015	Q2 2015
Family Group avg	908	864		
Gloc actual	965	855	832	790

Increase in the number of people at home 91 days post discharge

This 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.

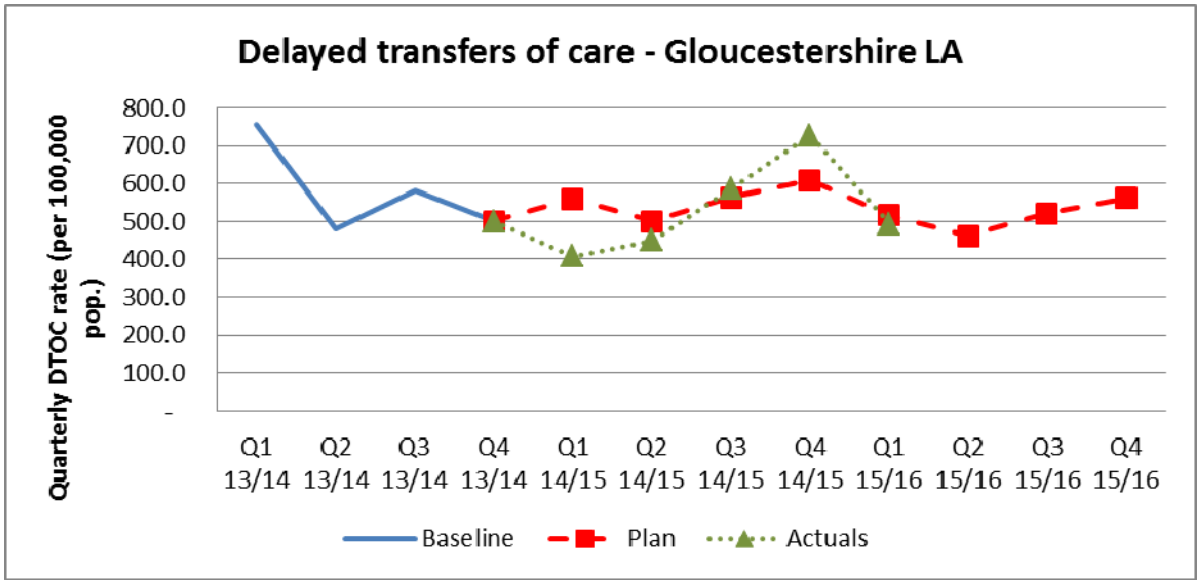
2014/15 provisional performance shows a 4.3% increase on 2013/14.

Reduction in Delayed Transfers of Care (DTOC)

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.



DTOCs during quarter 1 reduced by 4.4% when compared to the Health and well-being plan.

Improved Patient Experience

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.

During the latest reporting period, the following question was asked of ICT rapid response clients, 'How likely are you to recommend our service to friends and family if they needed similar care or treatment'. 131/133 clients (98.5%) provided a positive response (95 extremely likely and 36 likely)

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 29th February 2016

PERSPECTIVE 4	Staff	Green
Success criteria 1: *Attracting and retaining high quality staff aligned to the CCGs vision and values*		Green
Key performance indicators		
Turnover - % of employees leaving the organisation		0.64%
Number of current Vacancies in structure		11
Success criteria 2: *Personal development processes that are linked to the strategic plan*		**Due March 2016**
Key performance indicators		
All staff should have a PDP by the end of November (90% target) and should have had an appraisal in the last 12 months		**Figures available April 2016**
95% of staff who have completed their mandatory training by the end of March 2016 – update from		**Figures available April 2016**
Success criteria 3: *Staff are Happy and Motivated*		Green
Key performance indicators		
Staff sickness levels		2.76%
Staff Survey		**To take place before end of March 2016**
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 December was 0.64%. The number of leavers since the 1st April is 17, giving a monthly average of 1.54 leavers per month.
As at the end of February 2016, there were 11 jobs 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.

The CCG organisational development plan is currently being updated and is on track to be finalised by March 2016.

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 December have equated to 2.76% 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.

2.76% equates to 1,753.86 full time equivalent (FTE) working days, or 7.34 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 29th February 2016

Summary:

Perspective 5	Finance & Efficiency	Amber

Success criteria: To ensure a financially viable commissioning organisation with an underlying recurrent surplus			Amber
	Threshold	Lower threshold	RAG
Underlying recurrent surplus (%age)	2%	1%	Amber
Surplus - year to date variance to planned performance (%age)	0.10%	0.50%	Green
Surplus - full year variance to planned performance (%age)	0.10%	0.50%	Green
Running costs year to date (variance to running costs allocation)	Within RCA		Green
Running costs forecast outturn (variance to running costs allocation)	Within RCA		Green
BPPC performance on non-NHS invoices by value (year to date)	95%	80%	Green
Cash drawdown in line with planned profiles (%age variance)	2%	5%	Green
Success criteria: QIPP Full year Forecast			**Amber**
	Threshold	Lower threshold	RAG
QIPP - full year forecast delivery to planned performance (%)	95%	75%	Amber

- The CCG is forecasting to deliver a surplus of £9.6m against an initial planned surplus of £7.3m;
- Known risks and pressures have been fully assessed and included within the CCG's forecast position, with mitigating actions where appropriate
- There is significant over performance in emergency activity against contracted levels.
- There continues to be slippage on QIPP schemes for the financial year. This is both in terms of implementation and associated investments as well as in terms of benefit realisation.
- A number of planned investments have slipped due to difficulties in recruitment.
- 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 96.95% 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)

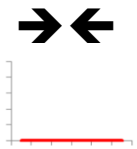
The overall assessment for the finance and efficiency perspective is amber for which more detail is provided in the following sections. However, this assessment should be read in conjunction with those risks outlined within paragraph 6.9.

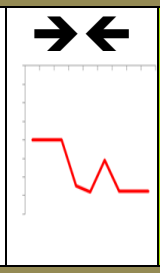
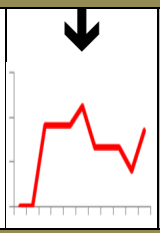
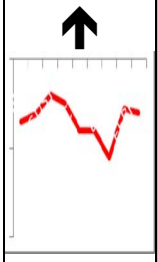
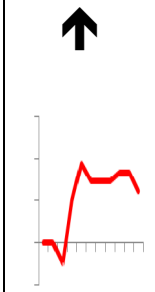
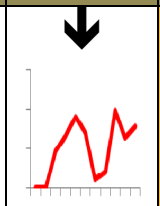
6.2 Resources

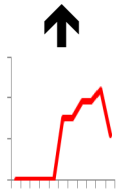
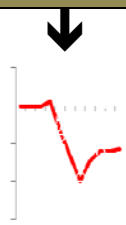
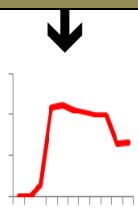
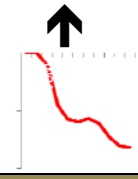
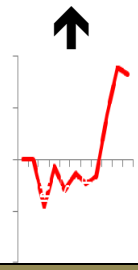
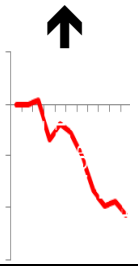
The CCG's current anticipated resource limit (see Appendix 2) is £811.4m. This includes all primary care co-commissioning delegated budgets which now total £75.4m. In the month, there was a non-recurrent reduction of £2.6m for an agreed adjustment with the South Central NHSE team.

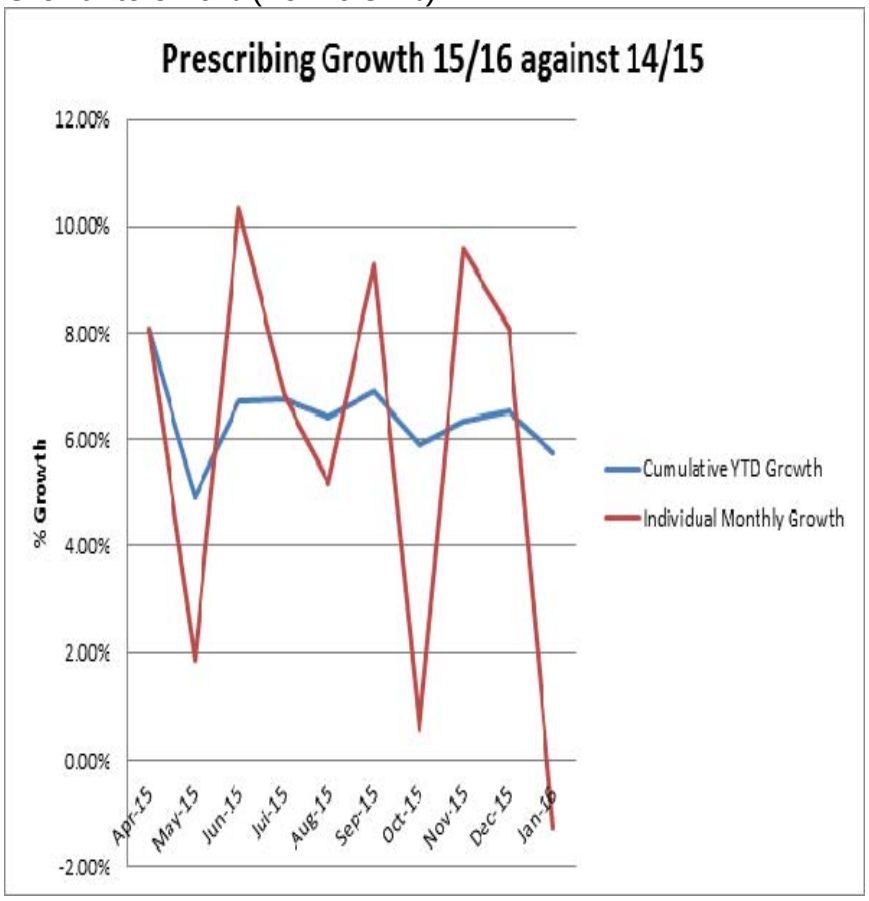
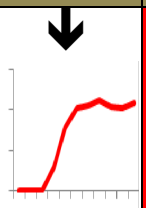
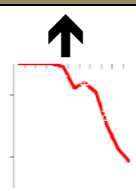
6.3 Expenditure

The financial summary as at 29th February 2016 shows a year to date surplus of £8.8m and a forecast surplus of £9.6m. Further detail is shown at Appendix 3. There has been slippage in investments, particularly relating to QIPP and service redesign. These primarily relate to difficulties in recruitment of clinical staff due to shortages in a number of areas, these are national shortages. The CCG has reviewed non-recurrent investments which fit with the CCG's strategic plans, particularly around workforce and pump priming developments which are already planned for 2016/17 to bring forward a number of investments. 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		
Activity trends are showing over performance in emergency spells, outpatient activity and excluded drug costs. ED performance is 3.3% above the activity seen last year to the end of February and emergency admissions after adjustments for coding and counting are 1.3% above last year Over-performance against emergency plans includes a combination of increased demand, slippage in the implementation of some QIPP plans. Specific pressures continue within medical specialities. Outpatient activity remains over plan in gynaecological oncology, ophthalmology, general surgery and T&O. Variable non PbR activity is above contracted levels primarily driven by drugs excluded from tariff such as Lucentis. Discussions continue with the aim of reaching a settlement regarding the outturn position		£0

Winfield Hospital		
Elective and Outpatient under-performance against the contract has remained consistent with the previous month. Elective activity is below plan by 546 spells (21.6%), mainly in trauma, orthopaedics, spinal and pain management. Outpatient attendances are below contracted levels by 1,250 (16.9%) again within trauma, orthopaedics, pain management and general surgery.		(£678k)
Oxford University Hospitals NHSFT		
There has been an increase in the over-performance against the contract compared to last month; primarily due to increased critical care activity. The contract as a whole continues to overspend within all areas covering T&O, gynaecology, and general medicine.		£340k
North Bristol NHS Trust		
The Trust continues to have issues with their new activity system (a contract performance notice has now been issued) and, therefore, forecasts are based on Month 7 data. The contract as a whole is underperforming within hip, shoulder, foot and knee procedures, T&O, geriatric medicine and pain management. Non PbR activity is in line with the plan, however a query has been raised with the Trust regarding a local price for adult mental health which had previously been removed. Penalties are due to be applied for quarter 1&2 mainly due to referral to treat incomplete waiters agreement has been reached to reinvest penalties.		(£300k)
Royal United Hospital Bath NHSFT		
There was a favourable movement this month with the previously reported overspend within high cost drugs and devices being resolved with no overspend anticipated. Elective activity continues to highlight some over-performance in T&O for reconstruction procedures. A previous query relating to activity during June for elective and non-elective procedures has now been resolved.		£120k
University Hospital Bristol NHSFT		
Day cases activity for paediatric urology and T&O reconstruction have increased in the last month. Overspends are also reported in emergency admissions for pancreatic necrosectomy, T&O and paediatrics ear, nose & throat. There has also been increased activity for diagnostic imaging.		£156k

University Hospital Birmingham NHSFT		
There has been a favourable movement this month due to costs for pancreatic surgery being identified as specialist and, therefore, not a CCG cost. The contract as a whole continues to over-perform, predominantly within day cases for endoscopic/radiology with complications and interventional radiology and non PbR in adult critical care. There is a slight offset with under-performance in non-elective activity in hepatobiliary surgery.		£108k
South Warwickshire NHSFT		
The position has remained stable overall with underspends in elective activity for orthopaedics and cardiology and underspends against the contract position for non-elective activity within orthopaedics and care of the elderly.		(£115k)
Planned Care		
Nutricia –There has been a minimal change to the position which now includes plastics/peripherals and feeds.		£131k
Oxford Fertility – Underspends continue to be seen with no signs of the revised IVF policy impacting on the position.		(£326k)
Learning Difficulties		
The improved position is due to a decrease of two private placements within the month.		£332k
Continuing Healthcare		
The last 2 months has seen a significant drop in the number of cases per month for funded nursing care and also average cost per case causing a further increase in the underspend.		(£4,305k)

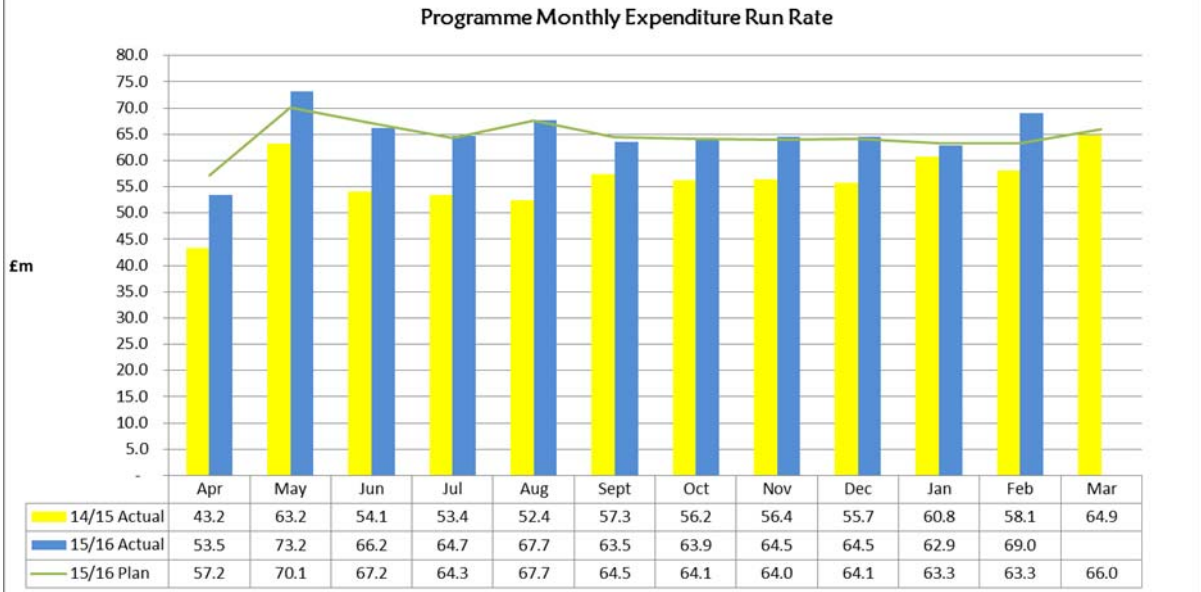
Prescribing When comparing January 2016 against January 2015, there has been a significant decrease in growth of 1.28% for the month itself. This had the effect of decreasing the YTD Growth to 5.76% (from 6.32%).  The graph highlights the growth, month by month, compared to the same time last year and the year to date impact of these fluctuations.		£4,400k
Running costs The further improvement in corporate budgets is due to slippage on vacancies being appointed to and instances where the incoming postholders notice period necessitates a start in the new financial year.		(£1,356k)

6.4 QIPP

The CCG has a £17m QIPP target. Delivery against the plan is currently forecast to under achieve by an estimated £2.8m. Additional programmes have been reviewed in year to mitigate any shortfall and have been brought into the plan.

Recognising that all forecasts have been based only on information available at the end of January, 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	53.5	73.2	66.2	64.7	67.7	63.5	63.9	64.5	64.5	62.9	69.0	
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. February is showing that programme is in excess of anticipated spend by £5.7m and cumulatively the CCG is now above estimated spend for Programme by £3.8m.

6.6 Cash (Appendix 6)

By the end of February, the CCG has drawn down 91.07% of the total cash limit which is consistent with a straight line profile. The cash balance at the end of February was £254k.

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 97.45% invoices paid by value and 96.95% 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 January which still highlights a potential significant overspend in this area. Although the CCG has now received a nationally developed forecast, the CCG continues to use 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). Current indications suggest that no release is due.

- QIPP slippage
  The current slippage in the QIPP programme is unlikely to be substituted by new schemes in the remainder of the financial year..

- Continuing Healthcare
  Both continuing healthcare and funded nursing care budgets are currently significantly underspent. The data supporting this position is being continually monitored in detail to ensure robustness.

- Specialised Commissioning
  The CCG is working through the allocation transfers from specialist commissioning for wheelchair services and outpatient neurology services to ensure that they are accurate, initial indications show that this transfer should not leave the CCG with a financial pressure. A further review of specialist services is currently underway with further national transfers potentially being undertaken in 2016/17 (adult morbid obesity procedures) and 2017/18.

- National position
  The overall NHS position in the current financial year has highlighted significant financial pressures within the overall service. As a result, all budgets and forecasts are being reviewed by NHS England, Monitor and the TDA. This exercise has increased our reported surplus has increased from £7.3m to £9.6m.

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 Walkingshaw	Maria Metherall
		GRH	88.1%	89.4%	92.2%	93.7%	92.3%	82.2%	85.4%	83.3%	85.8%	79.1%	76.1%	69.0%		85.9%	85.9%			
		CGH	93.3%	95.2%	95.8%	97.2%	96.2%	92.1%	94.9%	91.1%	92.3%	89.2%	87.3%	88.7%		93.2%	93.2%			
		GHNHSFT total	90.0%	91.5%	93.5%	95.0%	93.7%	85.8%	89.0%	86.1%	88.1%	82.7%	80.1%	76.3%		87.5%	87.5%			
		GCS - MIU	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.7%	99.5%	99.8%	99.7%	99.8%	99.9%		99.8%	99.8%			
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	0	0	0	1	2	0	1					
		CGH	0	0	0	0	0	0	0	0	0	0	0	0						
		GHNHSFT total	0	0	1	0	0	0	0	0	0	1	2	0	1					
		GCS - MIU	0	0	0	0	0	0	0	0	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 Walkingshaw	Maria Metherall
		SWASFT	75.2%	79.0%	75.4%	75.3%	75.3%	76.2%	75.0%	76.9%	73.1%	75.3%	72.0%	66.0%		74.4%	74.4%			
		Glos only	66.4%	72.7%	69.8%	64.9%	62.4%	60.0%	64.0%	76.2%	62.7%	68.8%	58.9%	55.1%		65.0%	65.0%			
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%	66.7%	69.0%	68.1%	69.4%	65.1%	63.9%	61.0%	54.5%		65.1%	65.1%			
		Glos only	66.4%	64.8%	62.3%	65.2%	61.9%	63.8%	63.4%	68.4%	67.8%	67.1%	64.4%	56.3%		64.1%	64.1%			
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%	90.7%	91.7%	91.5%	91.8%	90.9%	90.3%	89.0%	83.9%		90.4%	90.4%			
		Glos only	91.5%	90.2%	89.8%	89.7%	89.1%	90.3%	90.4%	90.1%	91.4%	90.8%	88.9%	85.4%		89.6%	89.6%			
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	88	70	66	66	82	92	74		761	761			
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	14	11	6	2	20	5	13		92	92			
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	188	181	188	176	152	187	182	147		1,881	1,881			
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	14	26	8	13	22	9	6		159	159			
Delayed Transfers of Care (DTOC)																				
Local	Number of Delayed Transfers of Care for acute patients	GHNHSFT target		14	14	14	14	14	14	14	14	14	14	14	14	14	14	C	Mark Walkingshaw	Maria Metherall
		GHNHSFT actual	10.9	8	9	11	11	16	13	8	26	19	16	16		13.9	13.9			
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	GHNHSFT	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
Local	Number of Delayed Transfers of Care for non-acute patients	GCS target		10	10	10	10	10	10	10	10	10	10	10	10	10	10	M		
		GCS actual	2.3	3	3	5	2	2	5	8	3	5	3	2		3.7	3.7			
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%	88.6%	91.6%	94.7%	94.4%	93.7%	89.4%						
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%	2.1%	1.0%	0.7%	4.3%	1.0%	1.7%						
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%	82.0%	85.3%	87.5%	86.2%	84.7%	89.6%						
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%	6.1%	6.8%	6.4%	6.2%	6.2%	6.4%		6.0%	6.0%			
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%	35.5%	41.5%	42.3%	48.1%	42.0%	34.0%						
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	08:42:00	06:27:00	00:11:39	00:12:34	00:08:29	00:12:31						
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	08:42:00	07:21:00	01:29:48	00:13:49	00:16:45	08:10:00						
Planned Care																				
Acute Care Referral to Treatment																				
E.B.1	Percentage of admitted pathways treated within 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%	89.2%	88.6%							89.7%	89.7%			
E.B.S.4	Number of completed admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0											
		Actual	-	6	2	6	8	3	3											
Local	Number of specialties where admitted standard was not delivered	Actual	-	8	7	7	8	8	7											
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%	C		
		Actual	95.4%	95.8%	95.6%	95.2%	95.8%	95.0%	94.2%	93.3%	92.9%	91.9%	91.3%			94.1%	94.1%			
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			
		Actual	-	0	3	3	2	0	1	1	4	2	1				0			
Local	Number of specialties where non-admitted standard was not delivered	Actual	-	6	4	4	6	7	8	10	11	14	14							

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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.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%	C		
		Actual	92.0%	92.1%	92.2%	92.2%	92.1%	92.3%	92.3%	92.5%	92.4%	92.3%	92.5%			92.3%	92.3%			
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			
		Actual	-	20	23	21	17	21	25	24	19	19	17			206	206			
Local	Number of specialties where incomplete standard was not delivered	Actual	-	8	8	9	8	8	6	7	5	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	8	7	8	4	3	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	1	0	1	0	1	0	2							
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	621	425	143	122	186	186	231		3,823	3,823			
		Actual Perf		5.0%	6.3%	3.9%	5.2%	6.6%	4.5%	1.5%	1.3%	2.0%	2.0%	2.4%		3.7%	3.7%			
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		
		Actual breaches	1,290	137	81	131	180	150	87	79	107	171	192			1,315	1,315			
		Actual Perf	92.0%	90.3%	94.1%	90.8%	89.0%	89.7%	94.1%	94.7%	93.3%	89.9%	87.8%			91.3%	91.3%			
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	17	17	19	10	11	13			140	140			
		Actual Perf	87.8%	93.9%	97.8%	95.3%	90.5%	92.3%	92.9%	91.0%	95.5%	94.6%	93.7%			93.6%	93.6%			
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	1	1	0	0	1	0			12	12			
		Actual Perf	99.2%	99.2%	98.6%	98.5%	100.0%	99.6%	99.6%	100.0%	100.0%	99.6%	100.0%			99.5%	99.5%			
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	0	1	1	0	0	2			12	12			
		Actual Perf	96.2%	94.5%	96.0%	93.5%	100.0%	100.0%	98.0%	98.7%	100.0%	100.0%	97.0%			97.9%	97.9%			
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	Ellen Rule	Annemarie Vicary
		Actual breaches	0	0	0	0	0	0	0	0	0	0	0			0	0			
		Actual Perf	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%			
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	0	0	0	0	0	0			1	1			
		Actual Perf	99.6%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			99.9%	99.9%			
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	18	38	29	24	25	27			308	308			
		Actual Perf	82.7%	73.6%	71.6%	71.7%	68.7%	85.9%	72.1%	79.3%	81.3%	79.5%	78.6%			76.1%	76.1%			
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	1	2	0	2	1	4			12	12			
		Actual Perf	93.2%	100.0%	93.8%	100.0%	96.7%	92.3%	93.1%	100.0%	92.3%	96.9%	84.0%			95.2%	95.2%			
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	1	0	0	0	0	1			4	4			
		Actual Perf	93.5%	50.0%		50.0%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	85.7%			91.7%	91.7%			
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%	70.5%	81.7%	88.0%	91.3%	95.6%	82.4%	81.8%							
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%	38.1%	35.4%	28.1%	25.6%	36.0%	25.0%	27.7%							
E.A.S.1	Dementia diagnosis rate	Target						66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	C		Helen Vaughan
		Glos						65.0%	64.5%	65.5%	66.4%	66.9%	68.2%	67.2%						
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%	94.0%	97.0%	97.0%	98.0%	98.0%	85.0%	93.0%		93.8%	93.8%			
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%	99.7%	99.8%	100.0%	99.8%	99.2%	98.0%	100.0%	100.0%	96.5%		99.4%	99.4%			
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%	98.3%	100.0%	100.0%	100.0%	97.3%	96.8%		99.3%	99.3%			
Adult																				
Local	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		Debbie Clark
		Actual	91.5%	93.0%	91.0%	99.0%	96.0%	98.0%	98.0%	95.0%	94.0%	93.6%	94.5%	96.0%		95.3%	95.3%			
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%	98.0%	98.0%	97.0%	98.0%	99.0%	98.3%	98.1%		98.2%	98.2%			

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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
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		Debbie Clark
		Actual	99.8%	99.0%	86.0%	85.0%	85.0%	85.0%	83.0%	87.0%	85.0%	90.0%	82.0%	87.0%		86.7%	86.7%			
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%	93.0%	92.0%	86.0%	92.0%	94.6%	93.7%	92.6%		91.5%	91.5%			
Specialist Nurses																				
Local	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		Debbie Clark
		Actual	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%			
Local	Percentage of patients referred to the Diabetic Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual	98.0%	100.0%	100.0%	100.0%	96.0%	100.0%	96.0%	95.0%	96.0%	97.0%	97.3%	97.6%		97.7%	97.7%			
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 Walkingshaw	Eddie O'Neill
		Glos	97.7%			98.0%			96.5%			96.4%				97.0%	97.0%			
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				3.75%			7.5%			11.25%			15.0%	15.0%	15.0%	C	Mark Walkingshaw	Eddie O'Neill
		Glos actual	16.9%			4.1%			8.3%			14.0%					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%			31.0%			25.0%				33.0%	33.0%			
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%			90.0%			81.0%				88.0%	88.0%			
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%			99.0%			99.0%				99.0%	99.0%			
Quality																				
Quality Indicators																				
E.B.S.1	Eliminate mixed-sexed accommodation breaches at all providers sites	GHT	0	0	0	0	0	0	0	37	0	30	50					C	Marion Andrews-Evans	Kay Haughton
		Care Services	0	0	0	0	0	0	0	0	0	0	0	0						
		2gether	0	0	0	0	0	0	0	0	0	0	0							
	Number of Never Events	GHT	3	0	0	0	1	0	0	0	0	1	0					C	Marion Andrews-Evans	Kay Haughton
		Care Services	0	0	0	0	0	0	0	0	0	0	1	0						
		2gether	0	0	0	0	0	0	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%	95.4%	94.6%	94.4%	93.1%	94.1%	93.6%	92.3%	92.8%							
		GCS		96.7%	97.8%	96.5%	90.2%	90.6%	84.4%	76.1%	65.9%	77.3%	84.7%	95.2%						
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	0	0	1	0	2	1	0	0			7	7			
	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	0	0	0	0	0	0	0	0	1	0			1	1			
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	126	157	C	Marion Andrews-Evans	Teresa Middleton
		Glos HC actual	153	15	14	16	10	11	15	11	13	7	17			129	129			
	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	30	37	C		
		GHNHSFT actual	37	4	4	0	4	4	2	3	4	2	6			33	33			

Appendix 2

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position as at 29th February (Month 11)

AS AT Month 11 2015/16	2015/16 R £000	2015/16 NR £000	2015/16 TOTAL £000	Cash Limit £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	76,802		76,802	76,802
GPIT		1,622	1,622	1,622
Risk Share Agreement		1,430	1,430	1,430
Planned Surplus				(7,300)
MCD Adjustment				(2,492)
Waiting List validation/improving operational processes		22	22	22
Eating Disorders and Planning in 15/16		319	319	319
Transfer To Specialist Commissioining		(35)	(35)	(35)
Transfer to Specialist Commissioining		505	505	505
BCF Support		30	30	30
Liaison Psychiatry - Mental health		140	140	140
UEC Network		60	60	60
CAMHS Transformational Funding		798	798	798
MoD - Out of hours		13	13	13
Liaison Psychiatry		140	140	140
14-15 Quality Premium award		533	533	533
Capital Grant: - shared care information		750	750	750
Capital Grant: - Equipment provided by LA to enable discharge from hospital		3000	3,000	3,000
2015-16 CEOV and non-rechargeable services allocation adjustment		(513)	(513)	(513)
Agreed change in 15/6 PC allocation to £75,440k		(1,362)	(1,362)	(1,362)
Last month total	**795,814**	**18,246**	**814,060**	**804,268**
Adjustments in month				
M11 allocation transfer with SC		(2,606)	(2,606)	(2,606)
Adjustments actioned in month		**(2,606)**	**(2,606)**	**(2,606)**
TOTAL NATIONALLY REPORTED LIMIT	**795,814**	**15,640**	**811,454**	**801,662**

Appendix 3

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Summary Financial Position

Overall financial position as at 31st January 2016 (Month 10)

	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)	325,546	319,044	(6,502)	355,597	355,814	217
Acute contracts - Other providers	8,728	13,431	4,703	9,586	7,485	(2,101)
Acute - NCAs	6,110	6,137	27	6,667	6,697	30
Pass-through payments						
Sub-total Acute services	**340,384**	**338,612**	**(1,772)**	**371,850**	**369,996**	**(1,854)**
Mental Health Services						
MH contracts - NHS	69,744	69,854	110	76,085	76,136	51
MH contracts - Other providers	3,485	3,841	356	3,852	4,350	498
Sub-total MH services	**73,229**	**73,695**	**466**	**79,937**	**80,486**	**549**
Community Health Services						
CH Contracts - NHS	83,748	83,250	(498)	90,979	90,548	(431)
CH Contracts - Other providers	(5,277)	(5,350)	(73)	(5,684)	(5,874)	(190)
CH - Other						
Sub-total Community services	**78,471**	**77,900**	**(571)**	**85,295**	**84,674**	**(621)**
Continuing Care Services						
Continuing Care Services (All Care Groups)	20,782	18,981	(1,801)	22,575	20,793	(1,782)
Local Authority / Joint Services	3,676	2,189	(1,487)	4,010	2,388	(1,622)
Free Nursing Care	8,722	7,896	(826)	9,515	8,614	(901)
Sub-total Continuing Care services	**33,180**	**29,066**	**(4,114)**	**36,100**	**31,795**	**(4,305)**
Primary Care services						
Prescribing	84,044	88,028	3,984	91,686	96,034	4,348
Co-Commissioning and Enhanced services	75,863	75,641	(222)	82,765	82,635	(130)
Other	8,916	8,887	(29)	9,727	9,572	(155)
Sub-total Primary Care services	**168,823**	**172,556**	**3,733**	**184,178**	**188,241**	**4,063**
Other Programme services						
Re-ablement funding						
Other	21,694	21,524	(170)	23,603	23,461	(142)
Sub-total Other Programme services	**21,694**	**21,524**	**(170)**	**23,603**	**23,461**	**(142)**
Total - Commissioned services	**715,781**	**713,353**	**(2,428)**	**780,963**	**778,653**	**(2,310)**
Specific Commissioning Reserves (Inc headroom and Contingency)	8,468	10,337	1,869	9,124	10,694	1,570
Total - Programme Costs (excl Surplus)	**724,249**	**723,690**	**(559)**	**790,087**	**789,347**	**(740)**
Running Costs (incl reserves)	12,403	11,343	(1,060)	13,534	12,507	(1,027)
Quality Premium	489		(489)	533		(533)
Total - Admin Costs (excl Surplus)	**12,892**	**11,343**	**(1,549)**	**14,067**	**12,507**	**(1,560)**
Surplus	6,692		(6,692)	7,300		(7,300)
Total Application of Funds	**743,833**	**735,033**	**(8,800)**	**811,454**	**801,854**	**(9,600)**

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	4,670	(2,762)	A	A	A
As at 31st December 2015 (Month 09)	2,910	3,264	354	A	A	A
Community	1,200	600	(600)	A	A	A
Prescribing	4,070	3,694	(376)	A	A	A
Transactional	1,430	1,930	500	G	G	G
Unidentified	0	0	0			
Grand Total	**17,043**	**14,158**	**(2,884)**			
Additional Schemes			0	**n/a**	**n/a**	**n/a**
Additional QIPP / Slippage / Contingent resources / Application of QIPP rule		2,884	2,884			
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)	

GCS has produced a detailed report of the current operational issues including level of performance of Rapid Response. This report was considered at the ICT Performance & Delivery Group (8th January 2016) resulting in a number of actions to be progressed by GCS.

As part of the operational update GCS confirmed that there have been a number of approaches for strengthening the skills and competencies of Rapid Response practitioners which included:-

(a) There are eleven trained Non-Medical Prescribers in Rapid Response and five practitioners are scheduled for this course this year.
(b) Three staff are scheduled to commence 'Physical Assessment and Clinical Reasoning' training in January 2016

Also, GCS confirmed that sickness absence averages for Rapid Response staff is 2.5%.

Project	Older People's Assessment Liaison (OPAL)	

Scheme continues to record greater activity at GRH compared to CGH. CGH service availability reduced due consultant resignation. 7 day service implemented at GRH with support from on-call medicine consultants.

Project	Integrated Discharge Team (IDT)	

A revised escalation process has been agreed and implemented within IDT to ensure that where patients have remained on the medically stable list longer than the agreed time period that clear escalation processes are in place. This is to link with the complex patient panel. Case reviews are also being brought to the IDT Programme Board to help with escalation and learning.
It has been reported that there were fewer patients seen during Sept 15 compared to Sept 14. Despite fewer patients being seen, more patients were diverted by the 'Front Door' IDT team. The IDT team have noted that targeting staffing resources could further improve performance.

Project	Ambulatory Emergency Care (AEC)	

Activity against trajectory is below agreed (Jan 16 agreed plan is 21 new pts/ day). Cohort analysis suggests negative impact against admissions and savings. Completion of PDSA with Single Point of Clinical Access (SPCA). AEC staff have been present at the SPCA helpline every day over 1 week to improve communications and relations between services. 6 month report has been received and Locality presentations completed by service.

Project	Urgent Care Respiratory Pathways	

The respiratory pathways are completed. They are on G care and available to GPs. We have communicated via 'What's New This Week' and believe GPs are using them.

Project	Mental Health Liaison	

Contract requirements with GHT taken forward with appropriate CCG commissioners (GHT contract for Liaison service from 2g).
Issues with recruitment are ongoing. Posts have now been made substantive which may counter these issues

Project	Community Hospitals (Investment in relation to Medworxx)	

A contract variation for Medworxx has now been agreed but no efficiency savings will be achievable for this financial year.
It is not yet clear how the impact of Medworxx on efficiency savings should be measured.

Project	Signposting	

Currently Minor Injuries and Illness Unit (MIIU) attendances across Gloucestershire are up on this period last year by 3.5% YTD. Recent work with NHS111 to reduce 999 dispositions has seen an increase in ED dispositions as patients are being offered this option as an alternative to an emergency ambulance. It must however be recognised that these patients are likely to have resulted in ED conveyance. Nil financial outlay to date to support this QIPP.

Project	Single Point of Clinical Access (SPCA)	

Service Specification formally agreed via contract variation, including new agreed costing for the service. Work around development of SPCA is ongoing (including call targets, clinical challenge etc) - using activity data and collaborating with other urgent care and community projects to ensure the service is performing optimally. Fortnightly SPCA/Commissioner meetings have been set up for feedback from acute and other services, and vice versa. AEC will be spending some time in SPCA in January 2016 to help promote use of the AEC as an alternative to acute hospital admission.

Planned Care Schemes

Project	Direct Access Diagnostics	

Whilst later than planned, GHFT have partially completed their feedback on the i-refer guidance.

GHFT are no longer accepting via ICE GP Direct Access MRI (all body parts) and Head CT scans. We'd therefore expect that spend on non-contracted scans would decrease further due to this. This makes the remaining milestones hard to reach as they focus around coming up with a process by which non-contracted, but clinically appropriate and agreed scans could be undertaken and funded. Whilst NOUS continues to be offered as normal, there were considerably less scans being undertaken outside of contract and another piece of work (the lumps and bumps pathway clarification to GPs) will help ensure that any neck/thyroid lumps will not be scanned via direct access, but instead via a specific neck lump clinic already running at GHT.

Project	Diabetes Enhanced Service	

The CPG met on 14th December and agreed that a review of the enhanced service will need to take place, in particular monitoring of performance and payments to practices and a review of unplanned admissions. It is anticipated that there will be slow growth for Level 2 of the ES until practices are confident in initiating insulins. A sub group to be developed to interrogate data on referrals and follow ups, review the ES etc and report back to the next CPG meeting on 4th February 2016. Sanofi Aventis have now notified the CPG that funding is no longer available for training of Care Home staff and an alternative solution is being sought. A Diabetes Study Day for primary care healthcare professionals will take place on 27th Jan to include workshops/presentations on footcare.

Project	Respiratory Pathways	

Awaiting primary care guidelines/top-tips for the management of intractable/persistent cough and a service specification to support the management of Pulmonary Nodules (reduced follow-ups) has been drafted and forwarded to GHFT for agreement.

The self-management plan pilot for Bronchiectasis is well underway and positive feedback has been received from staff and patients alike. Business case from GCS for additional physiotherapy resource 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	Follow Ups	

A meeting has taken place with the GHFT scheme leads, who have confirmed that no further actions are planned in year for this scheme. GHFT believe that the actions taken to date – use of open follow ups and stratified approach to follow ups are working (particularly the open follow ups).

Data on the uptake of open follow ups does support that GHFT suggestion that this approach is having the desired effect, although it must be noted that there are some issues the quality of this data. Paediatrics have been using this approach for the longest, and issued 462 open follow ups in the first 6 months of the year. The reduction in paediatric follow ups shown in the monitoring data may be attributable to this change. This does not explain the growth in Neurology who have also adopted open follow ups, although this growth may in part be explained by pending list clearance work.

Project	Individual Funding Reviews (IFR)	

The monthly challenge process has continued with Month 7 reports being issued at the beginning of January 2016.

Agreement has now been reached on the process for a CBA audit at GHFT, which is now being undertaken. The results of this audit will be shared with the CCG at the end of February 2016. In order to secure agreement the audit has been scaled back in scope and only covers 4 procedures (Hip Replacement, Knee Replacement, Cataract Surgery and Hernia Surgery). GHFT will undertake the audit themselves but where they believe that a procedure was compliant with the policy they are required to share anonymised patient information to demonstrate this compliance.

Tetbury Hospital have been written to and asked to undertake a Cataract CBA audit on the same basis as GHFT, due to anecdotal feedback from the CPG suggesting there may be a particular issue with compliance at the hospital.

The IFR contract schedule has been re-drafted for 2016/17 contracts to include a CBA audit process based on the process that has now been agreed for 2015/16. The proposal is to undertake 3 audits during 2016/17 covering Q1-Q3, using the same process as in 2014/15 but covering all CBA procedures. The intention is to include this in all provider contracts not just GHFT.

The review of the final group of IFR policies has now been completed and these are due to be presented to IGQC in February, completing this element of

Project	Irritable Bowel Syndrome (IBS)	

Faecal Calprotectin test is now available on the ICE system for GPs to request. The full IBS pathway has now also been published on G-Care, and publicised through 'What's New This Week', providing clear guidance for GPs on the management of IBS. A new referral form has been published on G-care for the Refractory IBS clinic at GHFT, which will start accepting referrals from 25th January 2016.
There is a possibility that there will be decrease in colonoscopy however we need to be mindful that these might be backfilled with other colonoscopies. This could be seen as a risk to the delivery of the scheme.
This scheme starts from February 2016. Delayed implementation means that the scheme is not delivering against the QIPP target, which assumed benefit realisation from October 2015. We should be able to see a decrease in Consultant Gastroenterology appointments and increase into dietetic appointments once the service is live.

Project	Cancer (Living with and Beyond)	

Risk Stratified Pathways pathway maps submitted by GHNHSFT for Breast, Prostate and Colorectal. Further work now required to progress to full pathways proposals. Full business case is in development, modelling change in patient activity on routine follow-up.

Phase 2 to incorporate full integration into cancer pathway, to be supported by development of new Service Specifications. Final version of TS has now been sent to CCG, to be reviewed by primary care colleagues.

Project	Dermatology	

Answers to questions regarding intermediate tier received from Mark Gordon and adjustments to service Specification is being completed. Contract variation will be ready to be signed shortly.

Product testing for dermascopes are underway. Survey for interest in GP Champion role to be sent out next week.

Community Schemes

Project	Community Hospital Programmes	

A case has been made for alternative reporting arrangements for the seven work streams overseen by The Transforming Community Hospitals Group (TCHG). This paper will be put to the next Community Service Programme Board for a decision.

Project	Rehabilitation Pathways	

Financial activity modelling is now complete and has confirmed there will be no cost savings in the short term. However better outcomes for patients may lead to savings over a number of years. 2 related posts (Band 7 and Band 8b) have been approved and advertised. Interviews for the Band 7 took place on 19th January and closing date for the 8b is 27th January. A meeting was held with GCS on December 22nd where it was agreed the 8b Clinical Therapist role will be a shared role across the two organisations.
A series of Steering Group meetings have been arranged and the project lead will be attending the Cardio-Vascular Clinical Programme Group on February 16th to provide an overview of the project, gain views and set out next steps.

Project	Continuing Health Care (CHC)	

Date of 1 April 2016 has been set for the switch over to Care Track for GCC staff. This will be used for invoicing and setting up rate cards for all new packages of care.

Project	Learning Disabilities (LD) Joint Funding Reviews	

1 residential care placement is outstanding . Awaiting the implementation of a new Tool Price for LD residential care which is currently under negotiation with the Gloucestershire Care Providers Association (GCPA).
Cath Leech has agreed an action plan with Chris Haynes, Joint Commissioning Manager at GCC, to ensure the remaining cases are reviewed and savings released by 31 March 2016

Project	Leg Ulcers	

Now in implementation phase. Cheltenham and South Cotswold localities 'went-live' 30th November 2015
Stroud and Berkley Vale locality is on target to go-live in March 2016 dependent on remedial building work being completed on time. Contract variation sent to GCS on 15th January for review and comment.

Prescribing Schemes

Project	Centralised Continence Supplies	

Centralised procurement will not progress. NHSE have advised against this approach. This proposal is being taken forward as part of the CCG commissioning of GCS to become the main provider in the redesign and provision of the wider continence care pathway across the community in Gloucestershire. A GCS project development group has been set up to lead on this, which Mark Gregory is currently attending whilst it is in the care pathway development stage.

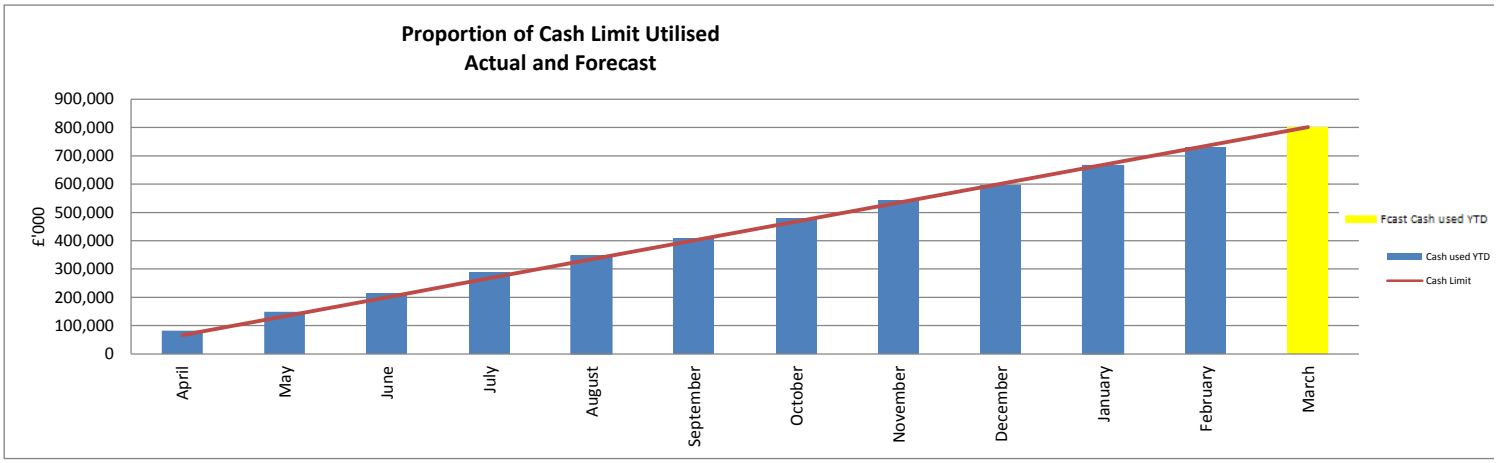
Appendix 6

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 29th February 2016 (Month 11)

		Actual/Forecast Charges in Month												
Month	Status	Drawn £000	Prescribing £000	Home Oxygen £000	Advance Drugs Payments £000	co Commissioning	CHC inc Risk pool contribution	Capital Allocation	TOTAL MONTH £000	TOTAL YTD £000	CASH LIMIT 1/12ths £000	CASH AT MONTH END £000	% CASH LIMIT DRAWDOWN %	Bal/Cash Limit %
April	Act	70,000	6,364	82	80	6,244			82,770	82,770	66,805	1,460	10.32%	0.18%
May	Act	50,000	7,149	89	(107)	9,169			66,300	149,070	133,610	2,429	18.60%	0.30%
June	Act	51,000	6,887	91	93	6,385	1,154		65,610	214,680	200,416	1,133	26.78%	0.14%
July	Act	60,000	6,756	87	(36)	6,232			73,039	287,719	267,221	3,735	35.89%	0.47%
August	Act	46,000	7,147	91	19	6,122			59,379	347,098	334,026	802	43.30%	0.10%
September	Act	49,000	7,392	90	(272)	6,075			62,285	409,383	400,831	6,747	51.07%	0.84%
October	Act	55,000	6,652	89	278	5,657			67,676	477,059	467,636	211	59.51%	0.03%
November	Act	53,000	7,317	92	(15)	5,606			66,000	543,059	534,441	5,561	67.74%	0.69%
December	Act	45,500	7,250	89	10	1,054			53,903	596,962	601,247	5,172	74.47%	0.65%
January	Act	56,000	7,022	93	(51)	5,714			68,778	665,740	668,052	914	83.04%	0.11%
February	F'cast	51,000	7,781	89	(79)	5,551			64,342	730,082	734,857	254	91.07%	0.03%
March	F'cast	58,159	7,781	89		5,551			71,580	801,662	801,662		100.00%	0.00%



Overview of current position

At the end of February £730m had been drawn down (91.1%) of the anticipated cash limit against 91.7% on a straight line basis for February.

Appendix 7

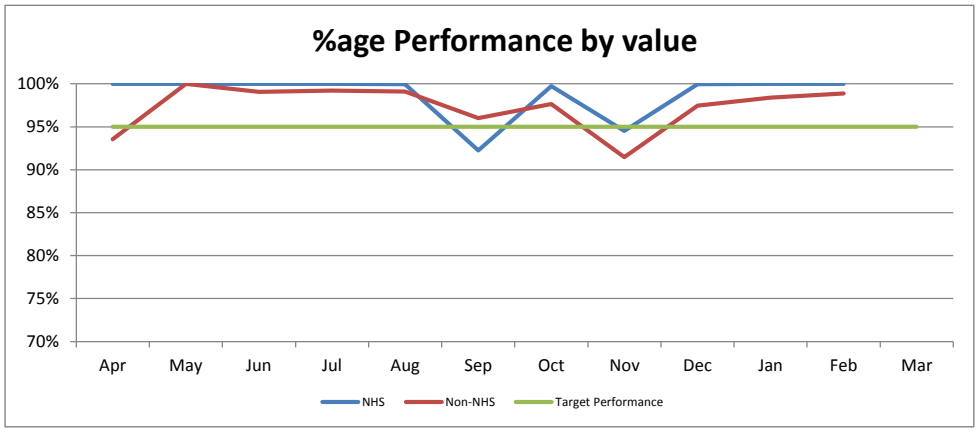
NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

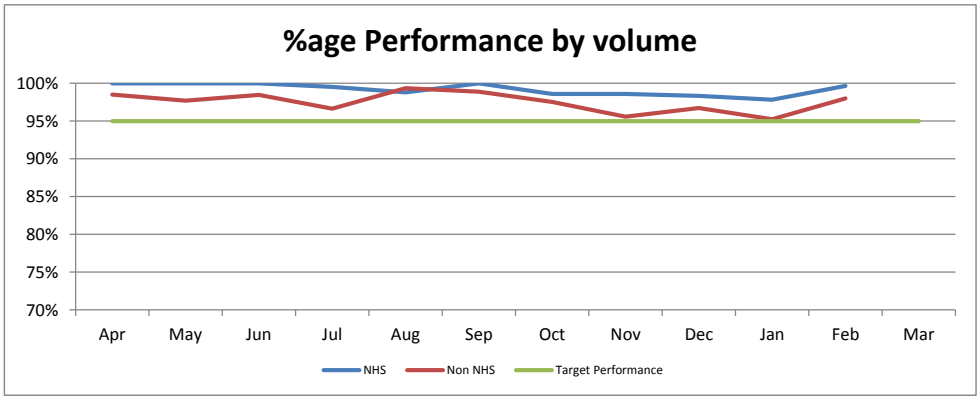
Performance against better payment practice code

As at 29th February 2016 (Month 11)

	In Month		Year to Date	
	NHS	Non NHS	NHS	Non NHS
By volume				
Total number of invoices	275	704	3,229	6,988
Number paid within target	274	690	3,182	6,775
Performance	**99.64%**	**98.01%**	**98.54%**	**96.95%**
By value				
Total value of invoices (£'M)	41.12	3.37	440.37	41.14
Value paid within target (£'M)	41.12	3.33	439.09	40.09
Performance	**100.00%**	**98.81%**	**99.71%**	**97.45%**

The target performance level is 95%





Appendix 8

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Statement of Financial Position

As at 29th February 2016 (Month 11)

	Opening 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	146	143
IM&T		0	0
Other		0	0
Long Term Receivables		0	0
Total non-current assets	**188**	**146**	**143**
Current assets:			
Inventories		0	0
Trade and other receivables	6,150	21,635	6,000
Cash and cash equivalents	104	254	1
Total current assets	**6,254**	**21,889**	**6,001**
Total assets	**6,442**	**22,035**	**6,144**
Current liabilities			
Payables	(40,361)	(50,925)	(40,000)
Provisions	(863)	(726)	(1,000)
Borrowings		0	0
Total current liabilities	**(41,224)**	**(51,651)**	**(41,000)**
Non-current assets plus/less net current assets/liabilities	**(34,782)**	**(29,616)**	**(34,856)**
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)**	**(29,616)**	**(34,856)**
Financed by taxpayers' equity:			
General fund	(34,782)	(39,772)	(34,856)
Revaluation reserve			
Other reserves			
Total taxpayers' equity:	**(34,782)**	**(39,772)**	**(34,856)**

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Agenda Item 10

Governing Body

Governing Body Meeting Date	**Thursday 31st March 2016**
Title	**Operational Plan 2016/17**
Executive Summary	The 2016/17 Operational Plan builds on the 2015/16 Operational Plan submitted to NHS England last year and marks the start of the third year since the formal instigation of our Clinical Commissioning Group. The plan takes stock of where we are, reflecting on the first two years of delivery of our five year strategy 'Joining Up Your Care' and the challenges that lie ahead. It sets out the ambitions that we seek to achieve across Gloucestershire and provides an overview of the steps GCCG will take to improve health and wellbeing, the quality of our services and ensure that financial targets are met.
Key Issues	Delivering the transformation of services that is required to meet GCCGs strategic and operational aims. Ensuring system resilience, particularly when there are high demands placed on the whole health system.
Risk Issues: **Original Risk** **Residual Risk**	Described in the Operational Plan (Annex 4)
Financial Impact	Successful delivery of the Operational Plan will ensure the achievement of financial targets.
Legal Issues (including NHS Constitution)	Successful delivery of the Operational Plan will maximise system performance including those cited in the NHS Constitution. Submission of the Operational Plan to NHS England is mandatory.
Impact on Health Inequalities	Operational Plan includes measures to reduce Health Inequalities.

Impact on Equality and Diversity	Operational Plan includes considerations to support policies on Equality and Diversity.
Impact on Sustainable Development	Operational Plan includes considerations to ensure sustainable development.
Patient and Public Involvement	Transformational activities requiring public and patient involvement are described in the Operational Plan (Annex 5).
Recommendation	The Governing Body is asked to note and approve the draft operational plan, and to provide any feedback as required to inform the final version.
Author	Ellen Rule
Designation	Director of Transformation and Service Redesign
Sponsoring Director (if not author)	

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GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

OUTLINE OPERATIONAL PLAN FOR 2016/17

DRAFT

Contents

1. Introduction from the Clinical Chair and Accountable Officer:

This plan marks the start of the third year since the formal instigation of our Clinical Commissioning Group and an opportunity to take stock of where we are, and the challenges that lie ahead. We have a great deal to be proud of as we reflect on the first two years of delivery against our strategy, Joining Up Your Care, which sets out the ambitions we seek to achieve across the Gloucestershire community on behalf of our population. (see Annex 1 for high level ambitions). We have been ambitious in delivering change and on focussing on improving health for people in Gloucestershire. Some of our highlights from the last two years include:

- Developing a shared vision for Gloucestershire underpinned by a real commitment to joint delivery from all health and care partners in our county
- Starting our journey to truly Transform Care through using the Clinical Programme Approach, which is starting to deliver tangible change in key Clinical Pathways such as Eye Health, Respiratory Care and Musculo-Skeletal Services
- Taking back local responsibility for Primary Care Commissioning and delivery of a coherent Primary Care Offer, with strong support for primary care commissioning from members
- Ensuring a comprehensive approach to quality through the instigation of quality summits, service 'walk throughs' and a Care Homes Quality Review
- Delivering the roll out of Integrated Community Teams across Gloucestershire
- Establishing a new social prescribing model that is now rolled out across our whole county, engaging the voluntary and community sector in a new way and improving wellbeing for people in Gloucestershire
- Development of a clear approach to Enabling Active Communities and Self Care and Prevention (including innovative cultural commissioning programme) supported by a Gloucestershire devolution proposal including Health and Social Care

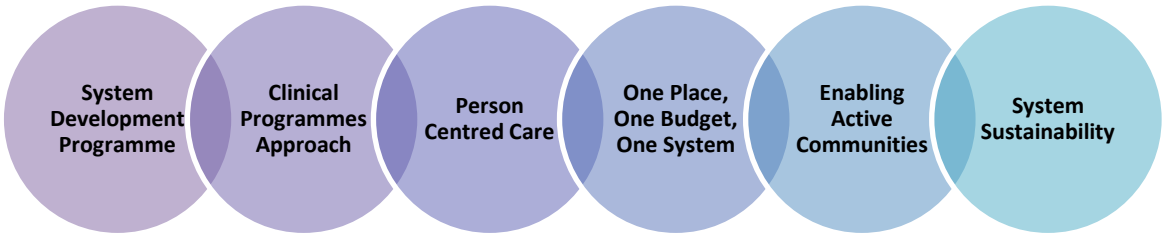
Alongside this comprehensive programme of delivery, the health system in Gloucestershire remains in good financial shape which puts us in a strong position for delivering real and sustainable system change and improvement going forwards. However, the health and care system remains under considerable pressure and there are still many significant challenges that we need to work through to deliver a sustainable future for health and social care services in Gloucestershire.

In October 2014 Simon Stevens published a compelling vision and strategy for the NHS, the Five Year Forward View. This vision describes the opportunities and challenges facing the NHS for the future and urges local health and care communities not to rely on "short term expedients to preserve services and standards" at a time which calls for true leadership and transformational change of our health and care systems. The strategy describes three critical gaps that risk being perpetuated if we fail to grip the scale of change required:

- The health and wellbeing gap
- The care and quality gap
- The funding and efficiency gap

In Gloucestershire we know none of these gaps are inevitable. As we enter our third year as a CCG we will continue to focus on the delivery of the core principles set out in JUYC and reinforced in the Five Year View. In order to ensure our system is joined up around these ambitions we are working together with our health and care partners to develop a shared Sustainability and Transformation Plan to 2020, focussed around the following objectives:

Figure 1 : High Level System Sustainability and Transformation Plan Objectives:



Taking account of our shared system objectives, our five year strategy Joining Up Your Care and the five year forward view priorities, our **organisational objectives for 2016/17** are as follows:

- Work with health and social care partners on our shared **System Development Programme,** to develop and deliver a system wide sustainability and transformation plan for Gloucestershire
- Work with system partners on **Transforming Care** for people in Gloucestershire using the Clinical Programmes Approach, particularly looking to create more joined up pathways moving from models of episodic based care to pro-active care and case management, particularly for those with long term conditions
- Further develop our approach to delivering **Person Centred Care**, rolling out personal budgets in partnership with social care and being an active member of the South West Integrated Personal commissioning pilot
- Work through the principle of **One Place, One Budget, One System** to develop a place based approach to service delivery, using this to develop our system response to the New Models of Care agenda and delivery of ongoing integration of our health and care system, facilitated by the work on Gloucestershire Devolution
- Work with system partners to deliver the **Enabling Active Communities** strategy, and improve **Health and Well-Being** for people in Gloucestershire, further building on the work we have developed through the prevention and self-care agenda. We will ensure there is a focus on prevention and self-care through all our key programmes of work
- Have a continuous focus on **System Sustainability,** ensuring constitution compliant, high quality and cost effective services, reducing avoidable variations in outcomes, aligning delivery incentives and use ways of working such as case reviews to bring a clinical and evidence based focus to service redesign and improvement
- Focus on **Primary Care and Locality Development** to ensure the future sustainability of this critical part of our system
- Ensure a continued focus on achieving **Parity for Mental Health and Learning Disabilities** for our population.

This document therefore sets out the high level plan for Gloucestershire CCG in support of our strategic aims, for the financial year 2016/17. Whilst the financial context creates a challenging environment our commitment is to ensure the money is used effectively across the health and care system to support joined up care, underpinned by ensuring the right care is provided in the right place, at the right time, by the right person at the right price.

Helen Miller
Clinical Chair

Mary Hutton
Accountable Officer

PART A: A WHOLE SYSTEMS APPROACH

2. System Challenges

As set out in The Five Year Forward View and described in the introduction, the NHS faces three critical gaps that risk being perpetuated if we fail to grip the scale of change required. Gloucestershire faces the same challenges, and we set out at the start of 2015/16 with a clear commitment to agree a system wide response to these. As a health community it is clear that we need to move our thinking beyond the old transactional models of commissioning and service delivery, and consider how we can work together to transform our health and care delivery system. The work programme of the Gloucestershire Strategic Forum (GSF) has stepped up a level through the last year, with a series of workshops having been held to allow dedicated strategic thinking time focussed around these challenges. More information on the output of the workshops is shared in section 3.7 of this document, our system development programme, and this joint working will form the basis of our system Sustainability and Transformation plan to 2020.

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

Our Response:

We are clear that we cannot just continue to commission more of the same within the same historic service patterns. In 2015/16 each of our active clinical programme groups has completed a health needs assessment, and is now actively prioritising a proportion of investment within each programme 'upstream' towards the public health and prevention agenda. In 2016/17 our Clinical Programme Groups will continue to have active conversations with stakeholders about where this should best be targeted, including with the public where this may be about significant variation or decommissioning other existing services to prioritise investment in the health and wellbeing agenda.

The CCG committed additional resources to the prevention agenda in 2015/16 in line with the activities and projects set out in the Healthy Individuals Programme, and has commissioned a number of pilot interventions through a grant making programme in partnership with the Gloucestershire Voluntary and Community Services Alliance (VCS) in 2015/16 to support the objectives set out in our Cultural Commissioning programme. Our intention in 2016/17 is to expand the level of investment to encompass a broader remit, to further commission a range of prevention and health and wellbeing interventions from the voluntary sector.

It is our intention to ensure that Gloucestershire has a strong public health offer, and we will continue to work with the Health and Wellbeing Board for Gloucestershire to ensure a strategic focus on the health and well-being agenda. We have worked in partnership with public health to develop health and wellbeing plans at locality level that respond to refreshed locality health needs assessments and these plans have been shared between key delivery partners, particularly district and county councils and are working to engage the voluntary sector in service delivery through our Enabling Active Communities approach. We will continue to develop our own 'Healthy Individuals Programme', delivering the programme of change we have committed to, examples of which include

further developing the role of telehealth in our health community, developing and embedding a consistent personal care plan template into the health and social care system across Gloucestershire.

***The care and quality gap*:** unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

Our Response:

Our intention for 2016/17 is to further challenge clinicians across our health and care systems to reduce unacceptable variations in clinical practice, and in doing so to improve quality, eliminate harm and reduce waste of valuable resources. We will do this through using appropriate clinically based evidence, such as through case reviews or primary care 'taxonomy' work. We have worked with partners to continue to develop our clinical programme approach in 2015/16 to ensure we are increasingly commissioning for outcomes, and are moving away from episodic, transactional models of care to more 'end to end' patient focussed pathways. In each clinical programme we identify targeted outcomes improvements in partnership with clinical colleagues across our system, then deliver these through pathway improvements and prioritising the spend within and across our programme budgets to ensure we are getting the maximum value in terms of health outcomes improvement for every pound we spend.

The work programme of the Gloucestershire Strategic Forum described in the last section has also taken up the challenge of working through our system response to the new care models described in the 5 year forward view, and considering how the experience of some of these 'vanguards' could support our intention to improve health services for people in Gloucestershire through ensuring Joined Up Care. This is currently 'work in progress' and our shared system Sustainability and Transformation plan due for publication in June will describe our next steps in more detail.

The CCG will continue to focus on delivery of core constitution standards and as described in our strategy for quality 'Our Journey for Quality' and we expect that all providers are working towards full implementation of the 2012 Nursing Vision and Strategy, Compassion in Practice - our culture of compassionate care (6Cs).The CCG expects providers to continue with the implementation of their action plans in line with the recommendations from the Francis Report, Keogh Reviews and Berwick Report. We will follow nationally mandated CQUIN requirements as set out in the National Operating Framework and intend to use the CQUIN framework innovatively to develop joint CQUIN priorities across our community providers to support collaborative working and delivery of our system priorities. We will continue to consider as a system areas where we wish to develop a culture of targeted improvement on issues of quality.

***The funding and efficiency gap*:** if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

Our Response:

The health community is facing increasing demands driven by financial constraint, demographic pressure, public expectation and technological change which all contribute to our collective financial challenge to fund and deliver health and care across our system. We believe that we still have work

to do to progress the culture across our system to a point where responsibility for resources is seen as everyone's business. The CCG will be looking increasingly to providers to prioritise senior clinical time to commit to our change programmes and we will need to think collectively around how we can build the right incentives into the system to support the changes we need to see. This may be through the use of innovative funding models such as capitated budgets; we intend to work together with our partners across the health and social care system, through the following principles:

- We will ensure commitment to a risk share approach aligned to our priorities. This should be underpinned by an open, transparent approach to the development of opportunities for change;
- We will commit to the principles of 'One Place, One Budget, One System' to improve services and outcomes for our population, whilst working to ensure financial stability across our system
- We will develop our clinical programme groups to the point where they are working with full visibility of programme budgets in 2016/17 to prioritise resources across programmes;
- We will work to the principle of moving care 'upstream', and will be aiming to prioritise resources within our care pathways towards primary care and prevention where possible;
- We will work to the principle of commissioning through a care pathways approach, and within commissioned pathways we will work together to identify opportunities for increased cost effectiveness, minimising the number of steps and driving greater efficiency;
- We will consider whether the pilot(s) of innovative organisational forms in line with the five year forward view new models for delivery of care will require us to develop any new and innovative approaches to contracting;
- We will not commission services that are deemed by evidence to not be cost or clinically effective

The national Right Care programme (including Commissioning for Value) has the primary objectives of maximising the value that patients derive from their care and treatment and maximise the value that the whole population derives from the investment in healthcare. The CCG has embraced the Right Care programme and has embedded the objectives and principles of Right Care and Commissioning for Value through its Clinical Programme Groups (CPGs) with system wide clinical leadership fully engaged in the approach.

In addressing the challenges in the Gloucestershire health economy, the CCG uses both the resources developed nationally e.g. the Atlas of Variation in Healthcare and the Commissioning for Value insight packs and local resources e.g. bespoke pathway benchmarking to identify and triangulate opportunities to deliver optimal healthcare for the residents of Gloucestershire. Right Care provides the platform for the CCG to identify variation in terms of healthcare spend and outcomes to outline the opportunities in the Gloucestershire healthcare system to meet current and future challenges.

3. Core Objectives

Our approach for 2016/17 continues to focus on delivery of the vision and strategy set out in our 5 year plan; Joining Up Your Care **(see Annex 1).** We have taken account of the progress we have made in 2015/16 as we have set out our planned next steps, and in each section of this document there are references to existing plans at programme level to ensure consistency with work already underway across our health and care system. Partners should note that this is a draft plan and that further amendments may be required to this plan once the national planning guidance is received, and that further details will be provided for programme level plans once the CCG prioritisation committees have been held in January and February of 2016.

Our 2015/16 CCG Operational plan set out the following objectives:

- Work with system partners to deliver the **Enabling Active Communities** strategy, and improve **Health and Well-Being** for people in Gloucestershire, further building on the work we have developed through the prevention and self-care agenda. We will ensure there is a focus on prevention and self-care through all our key programmes of work
- Focus on **Primary Care and Locality Development** to ensure the future sustainability of this critical part of our system
- Work with system partners on **Transforming Care** for people in Gloucestershire using the Clinical Programmes Approach, particularly looking to create more joined up pathways moving from models of episodic based care to pro-active care and case management, particularly for those with long term conditions
- Ensure a continued focus on achieving **Parity for Mental Health and Learning Disabilities** for our population.
- Work through the principle of **One Place, One Budget, One System** to develop a place based approach to service delivery, using this to develop our system response to the New Models of Care agenda and delivery of ongoing integration of our health and care system, facilitated by the work on Gloucestershire Devolution
- Further develop our approach to delivering **Person Centred Care**, rolling out personal budgets in partnership with social care and being an active member of the South West Integrated Personal commissioning pilot
- Work with health and social care partners on our shared **System Development Programme,** to develop and deliver a system wide sustainability and transformation plan for Gloucestershire
- Have a continuous focus on **System Sustainability,** ensuring constitution compliant, high quality and cost effective services, reducing avoidable variations in outcomes, aligning delivery incentives and use ways of working such as case reviews to bring a clinical and evidence based focus to service redesign and improvement

  During 2015/16 we have been working closely with our system partners through the Gloucestershire Strategic Forum to develop a system wide strategic transformation plan for Gloucestershire. This work has led to the development of a set of system level strategic objectives that will be further developed through the first half of 2016 to become the Gloucestershire System Sustainability and Transformation plan 2016 - 2020. The intention is that health and social care partners in Gloucestershire will demonstrate how their individual organisational objectives will align to the system wide Sustainability and Transformation plan.

The diagram below sets out the alignment exercise that has been completed to align the CCG operational objectives against the draft system sustainability and transformation plan objectives.

Figure 2 : System Development and Sustainability Programme

Summary of High Level Objectives for 2016/17

Enabling Active Communities and Health and Wellbeing	One Place, One Budget, One System
Primary Care and Locality Development	Person Centered Care
Transforming Care Programme	System Development Programme
Parity for Mental Health	System Sustainability

CCG Objectives for 2016/17:

- Work with system partners to deliver the **Enabling Active Communities** strategy, and improve **Health and Well-Being** for people in Gloucestershire, further building on the work we have developed through the prevention and self-care agenda. We will ensure there is a focus on prevention and self-care through all our key programmes of work
- The CCG will focus on **Primary Care and Locality Development** to ensure the future sustainability of this critical part of our system
- The CCG will work with system partners through the **Clinical Programmes Approach** for people in Gloucestershire, particularly looking to create more joined up pathways moving from models of episodic based care to pro-active care and case management, particularly for those with long term conditions
- The CCG will ensure a continued focus on achieving **Parity for Mental Health and Learning Disabilities** for our population.

- Work through the principle of **One Place, One Budget, One System** to develop a place based approach to service delivery, using this to develop our system response to the New Models of Care agenda and delivery of ongoing integration of our health and care system, facilitated by the work on Gloucestershire Devolution
- Further develop our approach to delivering **Person Centred Care**, rolling out personal budgets in partnership with social care and being an active member of the South West Integrated Personal commissioning pilot
- Work with health and social care partners on our shared **System Development Programme,** to develop and deliver a system wide sustainability and transformation plan for Gloucestershire
- Have a continuous focus on **System Sustainability,** ensuring constitution compliant, high quality and cost effective services, reducing avoidable variations in outcomes, aligning delivery incentives and use ways of working such as case reviews to bring a clinical and evidence based focus to service redesign and improvement

This document therefore sets out the high level intentions of Gloucestershire CCG in support of our strategic aims, for the financial year 2016/17. Whilst the financial context creates a challenging environment our commitment is to ensure the money is used effectively across the health and care system to support joined up care, underpinned by ensuring the right care is provided in the right place, at the right time, by the right person at the right price. As set out in the introduction, in 2016/17 we will continue to focus on the delivery of the core principles set out in JUYC and reinforced in the Five Year Forward View. Our specific intentions are set out below, with more details on each area provided in the following sections. Each section also includes a description of how we see our providers engaging with us around each of the core delivery principles.

3.1 Enabling Active Communities, and Health and Wellbeing

Work with system partners to deliver the Enabling Active Communities strategy, and improve Health and Well-Being for people in Gloucestershire, further building on the work we have developed through the prevention and self-care agenda. We will ensure there is a focus on prevention and self-care through all our key programmes of work

2016/17 Headlines:

- **Deliver our Enabling Active Communities strategy, further enabled by Devolution**
- **Diabetes Self Management Programme at scale / AHSN Test Bed**
- **Commit additional resources to invest in the Voluntary Sector in support of Self Care and Prevention, and through our Cultural Commissioning work**

Our work on prevention and self-care will continue to be delivered through the Healthy Individuals Programme Group that co-ordinates our work across primary, secondary and tertiary prevention. Supporting self-care is central to our approach as a CCG, and will be implemented as part of wider initiatives to improve care through educating practitioners, applying best evidence, and using technology, decision aids and community partnerships effectively. The list below highlights the priorities identified by the healthy individuals programme group and associated action plan:

1. **Prevention** - early identification and taking early steps with those at risk;
2. **Workforce expertise** – staff communicate effectively to enable individuals to assess their needs, and develop and gain confidence to self-care
3. **Information and advice** - supporting and enabling individuals and communities to access appropriate information to manage their self-care needs
4. **Patient led approach** - To support and enable individuals to develop skills in self-care
5. **Commissioning** - To ensure that individuals have access to appropriate services and support networks to self-care

Delivering on these priorities will require changes being made at the population level, the level of the patient, the professional and the health system. The CCG will continue to work with local government and partners to deliver actions that address the priorities outlined within the Joint Health and Wellbeing Strategy. This will include a renewed initiative to tackle obesity and health inequalities. New approaches to working with patients are required to address the challenges associated with increasing patient confidence, decision making, and lifestyle change to improve health outcomes and reduce health care costs. In 2016/17 the CCG will work with the AHSN to deliver a Diabetes Self-Management Programme at Scale as well as looking to improve our workforce skills through health coaching in order to promote self-care and patient activation, either alone or as part of a delivery system for long term conditions management, and improve patient satisfaction

The CCG will work with a wide range of partners from the statutory, voluntary and community services (VCS) sector to ensure an increased emphasis is placed on prevention, self-care and self-management approaches across our community, to ensure that patients are empowered to take control of their own health and well-being. We continue to recognise the contribution of our partners across health, social care, voluntary care, alongside patients, carers and their families, who will play a significant role in delivering our prevention and self-care action plan.

The CCG will actively seek to commit additional resources to the prevention agenda in line with the activities and projects set out in the Healthy Individuals Programme. We intend to continue our work on our cultural commissioning programme that will involve co-producing and piloting a small number of grant projects within the Arts and Culture Sector aligned with our clinical programme.

The CCG will further develop our approach to **Enabling Active Communities**, working with system partners and supported by Gloucestershire Devolution with an increased focus on the vital role carers play in our communities, on social prescribing and the use of the voluntary sector. For many people in Gloucestershire outcomes are good. However, there are some key challenges to consider in developing our approach including:

- 19,000 people in Gloucestershire classifying themselves as socially isolated;
- Comparatively high numbers of older people living in Gloucestershire mean there is greater pressure on health and care services;
- Challenges in supporting families and individuals who have benefited from intensive professional support and preventing re-referrals;
- The county covers a large geographical area, with some isolated rural areas and a widely distributed population with two main urban centers, posing a challenge for equality of access to health and care services, as well as leisure activities.

In line with the ABCD approach, we need to work **with** communities to identify what their needs are and how they might be better met. There are a number of examples across the health and care community where work is already underway, some include:

- The CCG and its locality teams continuing to deliver social prescribing at scale
- GCC's Active Together grant scheme encouraging more sport and physical activity;
- Phase two roll out of ICTs, which will ensure that a person shares the planning and review of their care and is supported by professionals who know each other and who operate within a culture where they connect people to the strengths and resources in their community;
- A "Healthy Marketplace" established at Cirencester Community Hospital, directing patients to appropriate community and voluntary services;

The high level objectives for 2016/17 are:

- Promote healthy lifestyles as part of our care pathways and whole system approach linking to public health commissioned and local council commissioned services e.g. exercise on referral and weight management programmes;
- Ensure appropriate coverage of key secondary prevention interventions that systematically detect the early stages of disease and intervening before full symptoms develop;
- Commission supportive technologies and innovative approaches to support self-care;
- Ensure a strategic approach to the commissioning of self-management support for those with long term conditions;
- Ensuring links to best practice person-centred initiatives to ensure the pathways link up for individuals and carers enabling them to remain at their healthiest for as long as possible;
- As outlined in JUYC we will continue to work towards ensuring parity of esteem with equality between mental health and physical health.

- Develop plans to better identify and support carers in our community, to provide better support to all carers but with a particular focus on vulnerable carers such as young carers and carers who are themselves over 85 years.

The CCG will:

- Further develop innovative ways to commission charitable and voluntary sector providers to support this agenda through our Cultural Commissioning Programme; (This will take account of work by NHS England to develop a standard short model grant agreement)
- Work with the Health and Wellbeing board for Gloucestershire to increasingly ensure a strategic focus on the health and well-being agenda for Gloucestershire;
- We will look to simplify online access to information and services for our patients and communities across the system to enable them to self-care
- Work with our partners across the county in delivering the Joint Policy on Enabling Active Communities that aims to stimulate and utilise existing assets within the community
- We intend to increase our investment in self-management education programmes
- We will work with our partners to enhance the knowledge and skills of our health workforce in order for them to become co-producers in health.
- Work with our partners and providers to ensure a co-ordinated approach to tackling obesity across the county and the development of seamless care pathways
- Across the community ensure effective utilisation of the well-being services available at a locality level through a co-ordinated approach (social prescribing);
- Develop the role of assistive technology within primary and community care settings
- Work with our health partners to standardise our approach to personalised care planning
- Increase utilisation of the smoking cessation service for patients prior to an elective operation.

We are looking to our providers to:

- Engage with, and demonstrate active support for the Health and Wellbeing agenda including signing up to the Healthy Individuals programme plan with an active statement of commitment;
- Develop and share organisational health and wellbeing plans, including a focus on improving staff health and wellbeing within their own organisations;
- Implementation of the commitments set out in the Health and wellbeing plan for Gloucestershire;
- Take an active part in developing a pathway approach that considers self-care and prevention within every pathway;
- Take an active part in the work to develop personalised care plans.
- Develop and maintain a food and drink strategy in line with the requirements set out in the NHS standard contract for 15/16.

Reference Documents:

- Joining Up Your Care.
- Healthy Individuals Programme Brief.
- Cultural Commissioning Programme Briefing Paper.
- Health and Wellbeing plan for Gloucestershire
- NHS England Five Year Forward View
- 2015/16 National Planning guidance - Five Year Forward View into action
- Gloucestershire Children & Young People's Partnership Plan

3.2 Primary Care and Locality Development

Focus on Primary Care and Locality Development to ensure the future sustainability of this critical part of our system:

2016/17 Headlines:

- **Agree the Primary Care Strategy, focus on new service models, primary care infrastructure and primary care workforce development for future sustainability**
- **Develop role of localities in leading delivery of place based plans**
- **Delivery of primary care aspect of new models of care, based around minimum of 30,000 populations**

The CCG will focus on **Primary Care and Locality Development** to ensure the future sustainability of this critical part of our system.

Primary Care

The CCG successfully applied for delegated commissioning arrangements for the commissioning of primary care services from NHS England with effect from 1 April 2015. In our first twelve months we have not only successfully and smoothly transitioned operations across from NHS England to the CCG to support our members within an environment of good governance that minimises any conflicts of interest, but also started developing our strategic priorities. In 2016/17, we will therefore use delegated authority to provide a much increased focus on the development of the role of primary care in support of our strategic direction, particularly focusing on:

- **Premises**
  In 2015/16, we undertook a six facet survey of our primary care estate. This revealed 90% of our practices are in buildings smaller than recommended sizes, with 25% significantly smaller. With a rising population and an ambition to see primary care at scale, offering more services to patients locally, this will be an important strategic priority.

- **Workforce**
  In late 2015, the CCG undertook a short workforce survey of our members that demonstrated the challenges being felt. 40% of all practices were carrying GP vacancies, 75% of which were partners. 56% also had impending GP retirements. We therefore urgently need to address this issue. We will develop a Workforce Plan that focuses on three distinct elements:
    1. GP workforce;
    2. Practice nurse education and training;
    3. New skill mixes within Primary Care (such as the implementation of our successful bid for the NHS England Prescribing Pharmacist national pilot).

- **Quality**
  Having established a Primary Care Clinical Quality and Review Group in 2015/16, we will be focusing on developing the metrics to measure the improvements we make to the quality of

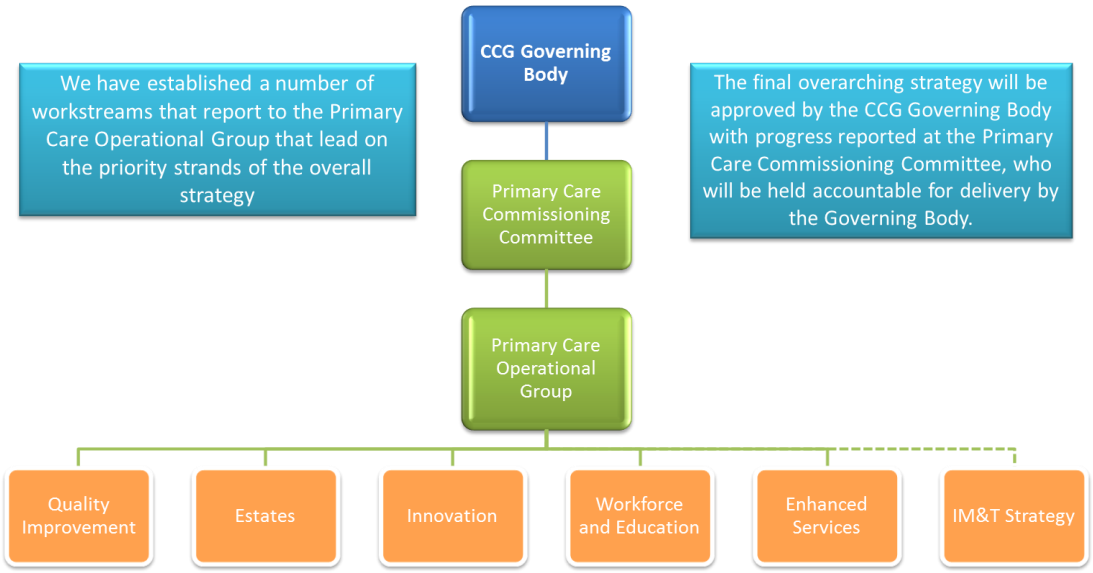
primary care in 2016/17. This will also include the reduction of unwarranted variation between, and within, practices.

- **IT**
  Our focus for 2016/17 will be on implementing the Primary Care elements from the IM&T Strategy developed in 2015, delivered through the Primary Care IM&T Strategy workstream, reporting to the Countywide IM&T Steering Group.

- **Transformational Change**
  Gloucestershire is already pioneering transformational change in Primary Care, such as with the successful Prime Minister's Challenge Fund bid, which is improving access at evening and weekends, providing more on-the-day urgent appointments, increasing technological innovations – such as e-consultations and video consultations – and providing primary care with specialist nurse support. We are also hosting, or supporting, 'Future of Primary Care in Gloucestershire' events, to develop our thinking with our members on the Primary Care Strategy we have prioritised for 2016/17.

In addition, we will ensure that we use our local flexibility to implement national priorities in a way that makes sense locally, with clinical leadership instrumental in delivering better integrated care for patients and better value for money. We believe that by working together as a community, in a more joined up way, we can transform the quality of people's care, with Primary Care at the centre of an out of hospital system.

Establishing a structure for strategy



The CCG will:

- Utilise our delegated commissioning responsibilities to continue to plan and work across pathways and leverage these powers to support our members continued resilience;

- Work with our members in the development of a Gloucestershire Primary Care Strategy that sets the future direction for 2016 – 2020, inclusive of:
    - Finalising our Primary Care Infrastructure Plan and commencing implementation of the prioritised list of developments in order to ensure we have a robust response to our rising population and have primary care premises fit for the future;
    - Development and implementation of a Primary Care Workforce Plan that sets out how we will respond to the national 'ten point plan', recognising the increasing challenges of recruiting and retaining the primary care workforce;
    - Developing and test new ways of working in primary care to help manage some of the increasing primary care pressures and improving sustainability;
    - Testing new models of care delivery with an emphasis on place-based planning that make sense locally for the diversity across our seven localities, which deliver integrated care and improved access at weekends and evenings;
    - Increased utilisation of technology to support new ways of working;
- Simplify access to urgent primary care to avoid unnecessary emergency hospital care;
- Support GP practices to make more use of voluntary services for their patients;
- Increase collaborative working between GP practices to provide the full range of services across a large geographical area;
- Develop ways of working to ensure the interface between in and out-of-hours primary care services works more effectively;
- Ensure GPs continue to develop a key role in ensuring co-ordination of integrated care; through the consideration of how primary care can better support the integration of care for patients with long term conditions (developed through the clinical programme approach);
- Support primary care to undertake pro-active case management and co-ordination of care of patients in context of Gloucestershire out of hospital care. At the same time supporting the CCG ambition to reduce increasing pressure on the hospital based urgent care system;
- Extend the range of services offered in primary care recognising diverse demography and health needs of the population across Gloucestershire;
- Reduce health inequalities through targeted commissioning across Gloucestershire.

We are looking to our providers to:

- Support dialogue between primary and secondary care clinicians and management to extend the range of services available in primary care, support the development of system wide care pathways and potential new models of care delivery.

Reference Documents:

- Primary Care Infrastructure Plan
- NHS England Five Year Forward View
- Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21

The CCG has been developing our locality commissioning approach and commits to continue to support them in their development. GCCG has seven localities, headed by Locality Executive Groups, where groups of GP member practices work collaboratively for the benefit of the local patient population and wider NHS. The role of the Locality Executive Groups is to support the improvement of local health services, through understanding the health service needs of their locality and on the basis of this to develop and deliver local priorities.

To achieve this each locality worked with local partners and stakeholders in the development of new two year Locality Development Plans in 2015. These plans set out the commissioning priorities for

each locality and how they will address health inequalities and evidence-based variation. 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. The priority themes identified from this process have been triangulated with the CCG operational plan and QIPP schemes. The table below maps the themes from the seven localities against their correlation with existing CCG Programmes:

Locality	Emerging themes mapped to CCG Programme Areas
Forest of Dean	**Children's** – Oral Health **Healthy Individuals** – Healthy Lifestyle Programme and Social Prescribing **Respiratory** – COPD **Urgent Care** – Addressing Variation
North Cotswolds	**Community Hospital** – Increasing appropriate utilisation **Healthy Individuals** – Social Prescribing and Physical Activity **Prescribing** – addressing variation **Urgent Care** – addressing variation
Tewkesbury, Newent & Staunton	**Children's** – Outreach Outpatients **Community Hospital** – Increasing appropriate utlisation **Healthy Individuals** – Social Prescribing and Adult Obesity **Mental Health** – Perinatal **MSK** – addressing variation in elective admissions **Urgent Care** – addressing variation
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 –** Establish 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 & 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 Cotswolds	**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

The CCG will:

- Focus on further developing partnership working at the locality level with district councils through implementation of the locality plans;

- Ensure localities work to their full potential as the interface between member practices and the GCCG Governing Body, ensuring a clinically-driven organisation working for local population need.

We are looking to our providers to:

- Proactively engage with localities and understand the different needs of the diverse communities across Gloucestershire;
- Provide commitment to and delivery of the objectives as agreed through the community services commissioning plan;
- Contribute to the implementation of the seven Locality Development Plans
- Work with us to respond to the national agenda to raise the profile, status and opportunities for volunteering to support identified needs in our community

Reference Documents:

- Joining Up Your Care.
- Enabling Active Communities.
- Cultural Commissioning Programme Board Briefing.
- Communities Strategy.
- NHS England Five Year Forward View

Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21

3.3 Clinical Programmes Approach

Work with system partners through the Clinical Programmes Approach, particularly looking to create more joined up pathways moving from models of episodic based care to pro-active care and case management, particularly for those with long term conditions

2016/17 Headlines:

- **Delivery of comprehensive transformation programme through Clinical Programme approach, reshape end to end pathways of care**
- **Ensure robust pathways compliance across the system, supported by G Care, for planned and urgent care**
- **Culture change across the system through 'choose well' philosophy to support pathways compliance approach for planned and urgent care (supported by clinical education strategy)**

Work with system partners through the Clinical Programmes Approach, particularly looking to create more joined up pathways moving from models of episodic based care to pro-active care and case management, particularly for those with long term conditions.

We will do this through the continued development of our Clinical Programme Approach to ensure the successful delivery of the key transformation programmes identified in our strategic plan. The Clinical Programme Approach is central to the way we work in Gloucestershire to improve the outcomes delivered by health and care services for our population, and brings together a clear pathway approach to delivery, alongside a focus on outcomes and structured programme disciplines.

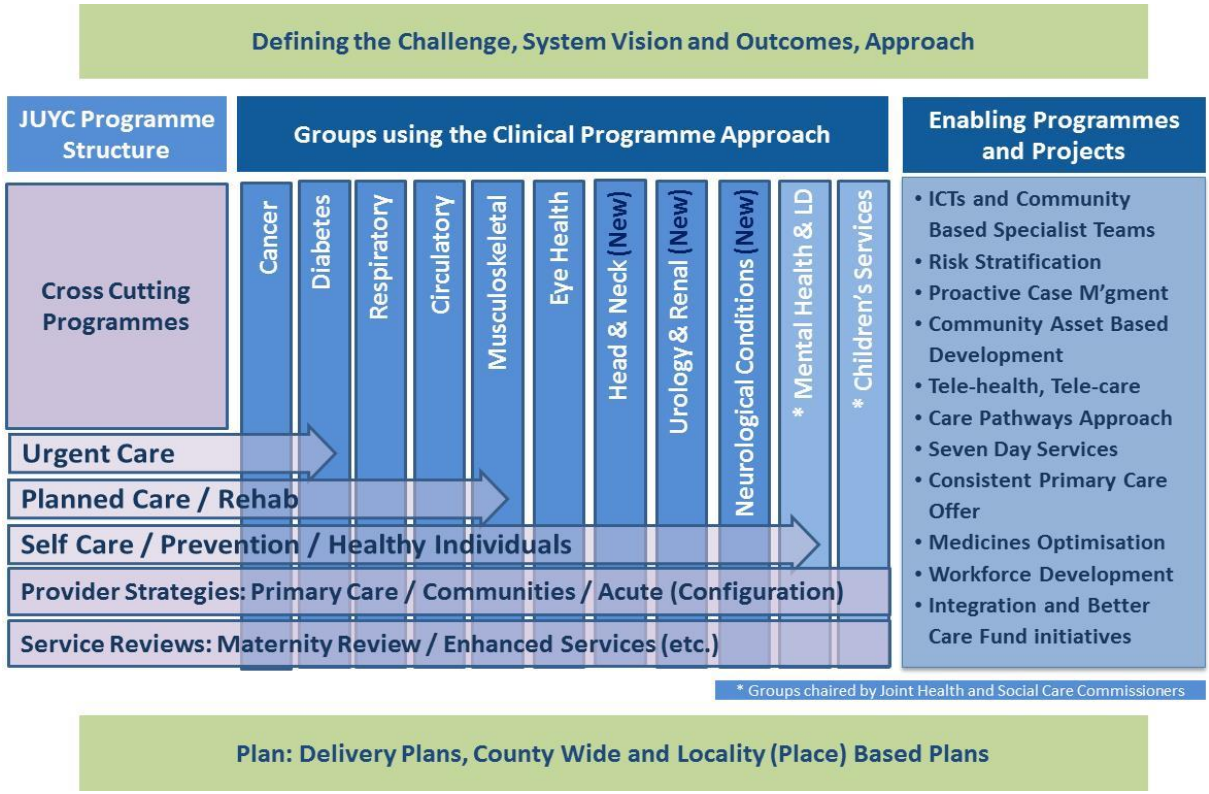
A clear set of health outcomes has been described for each of our programmes, linked to the NHS outcomes framework, the NHS right care programme and local outcomes that have been identified as important for service improvement within each particular programme. These are captured in a comprehensive set of benefits statements that have been described for each programme and are reported through the clinical programme group, with a summary position on our achievement against this framework included within our organisational performance report.

The principle of ensuring **Parity for Mental Health** runs throughout all of our programmes, however give the priority of this issue we have retained a specific separate objective for this (See section 3.4).

To **Transform Care** we will deliver three categories of programmes of work:

- Clinical Programmes – Programmes located around condition specific pathways to improve outcomes within available resources
- Cross Cutting Programmes – Programmes that ensure a joined up approach at different stages of the patient journey in support of the clinical programmes;
- Enabling Projects – that underpin our work and ensure consistent and robust improvement across all of our commissioned services to support our delivery of the clinical and cross cutting programmes. These will include key workstreams such as G Care and the Genomic Health Project

Figure 3: JUYC Programmes of Work



Each of our programmes identified within the matrix has an individual programme plan that identifies the specific delivery priorities within 2016/17 for that programme. In addition to the work in the identified programme areas the CCG may instigate specific service reviews if an identified need arises, which would lead to revised service specifications for providers. The CCG will work with providers to ensure that these are implemented in a timely way.

Clinical Programme Groups:

Given the resources involved in running a Clinical Programme Group (CPG), the CCG does not run active groups for all clinical programme areas all of the time. Programmes of focus are selected based on benchmarking of resources and 'materiality' of potential impact, supported by local knowledge identified clinical or financial pressures. Work is currently in hand to ensure CPGs have a greater depth of information available to enable groups to evidence improvement in health outcomes for our population, whilst also maintaining focus on the essential task of ensuring the CCG is commissioning services within available resources. The CCG is currently instigating a review of the 'non-active' programmes under the leadership of the planned care programme to consider whether the priority programme groups (as presented in figure 3 above) need adjustment for 2016/17. Our joint commissioning groups using the Clinical Programme Approach (for Children's Services, Mental Health and Learning Disabilities) will remain a key focus for us in 2016/17 (see following section for details of our specific intentions relating to Mental Health and Learning Disabilities).

The eight active Clinical Programme Groups have developed detailed Programme Plans that describe the work and outcomes expected to be delivered by the CPG in 2016/17. An on overview of which is provided in the table below:

Clinical Programme Group	2016/17 Programme
Cancer	- Early Diagnosis and Pathway Development - Acute Pathway Review - Living With & Beyond Cancer - Recovery Package - Macmillan Community Based Survivorship/Patient Education - Primary Care Cancer Survivorship Development - Community and Voluntary Sector Partnership
Eye Health	- Implementation of New Community Eye Care Service - Implementation of Health Inequalities Recommendation Report
MSK	- Implementation of New Service Model - Introduction of System Wide Outcome Measurement - Orthopaedics Follow-ups - Commissioning of Orthotics Service, FMS Pathway and GPwSI Service - Voluntary Sector Project - GP & Secretarial Education - Patient Facing Website & Self-Management - Implementation of Fall Strategy and Fracture Neck of Femur - Rheumatology Service Improvement
Circulatory	- Outcomes from acute pathway walkthrough & workshop developed to form 2016/17 plan - Chest Pain Pathway - Countywide roll out of Brain Naturietic Peptide Testing - Provider Plan to improve audit results and performance for acute stroke care
Respiratory	- CPG to be reconvened in 2016/17 with a renewed focus to deliver system transformational change.
Diabetes	- Provision of Generalist Diabetes Care in Primary & Community Care - Review of Diabetic Foot Care Pathway - Provision of Diabetes Education in Care Homes - Review of Hypoglycemia Pathway
Children & Young People	- Children's Mental Health Transformation Plan – including NHS England Schools Pilot, expanding earlier intervention approaches, looking at alternative models of delivery, integrating Mental Health and Social Care Services for vulnerable at risk groups. - Improving the Continence and Autism Pathway - Improving transition for young people with long term physical and mental health conditions - Implementing Personal Health Budgets
Mental Health & Learning Disabilities	**Mental Health** - Perinatal Mental Health - Personality Disorder Service - ADHD **LD** - Reconfiguration of assessment and treatment unit - Reconfiguration of Community Learning disability teams - National Mortality Review - Transforming Care - Implementing Personal Health Budgets

Based on benchmarking work undertaken the CCG will also consider forming 3 new Clinical Programme Groups in 2016/17. Further work is underway to develop the shape and content of the programmes:

Head & Neck	Programme under development – will include links across Three Counties Cancer Network to improve pathways for head and neck cancer, management of epistaxis pathway and our approach to audiology including consideration of potential for new AQP approach.
Urology & Renal	Programme under development, but will include: Urology pathway development and consideration of acute outpatient redesign. Renal programme will consider prevention and treatment of AKI in primary care and implementation of national guidelines.
Neurological Conditions	Programme under development, but will include: Demand management enhanced pathway.

Cross Cutting Programmes:

We run a series of broad 'cross cutting' programmes to draw together our approach across key stages of care delivery. These programmes are set up around urgent care, planned care and prevention/healthy individuals; alongside provider and service strategies, as shown in figure 3 above. Our agenda around health and wellbeing is set out in section 3.1 to this paper. Our high level approach for the urgent care and planned care programmes is set out below.

Urgent Care:

Urgent Care remains a critical priority for the GCCG both in terms of delivering national performance targets but more importantly in ensuring patient experience and outcomes are sustained and improved. Our priorities for 2016/17 are focussed on delivering the key components of our urgent care strategy**.** Both urgent and planned care strategies for 2016/17 will be based on the two main "pillars" of Demand Management across the system and Enhanced Pathway Compliance. The urgent care strategy is based on the existing 7 key system aims, which has been updated to reflect Safer, Faster, Better and the Urgent Care Commissioning Standards.

The main approach next year will be to keep our existing QIPP (Quality, Innovation, Productivity & Prevention) schemes for urgent care, with a commissioner focus on system leadership. Split by pre-hospital; in-hospital and out of hospital care. The focus for urgent care in the coming year is delivery against the existing QIPP schemes, particularly those being delivered by GHFT and GCS. There is a theme of greater co-ordination of these schemes so that clinical colleagues within the system can have a menu for admission avoidance and effective discharge which they can utilise (and is efficient). The focus in relation to primary care is greater utilisation of the Single Point of Clinical Access and peer review with secondary colleagues – locality involvement is key in this aspect.

The aim will be to reduce the demand for urgent care admissions through commissioning alternative services, working with partners to reduce acute and community length of stay, and ensure sustained delivery of the 4 hour wait target within both Emergency Departments;

- All providers continue to develop and implement plans for 7 day services (focussing on the national clinical standards);

- Focus will be maintained on delivery of current schemes we are all jointly signed up to, namely Ambulatory Emergency Care (AEC), Older People's Assessment and Liaison (OPAL), use of Single Point of Clinical Access (SPCA), Care Home Enhanced Service (CHES) and Integrated Community Teams (ICTs);
- 2016/17 will prioritise ensuring urgent care pathways work together in a joined up way and do not increase demand for services overall; standardising the approach and thresholds on matching the appropriateness of a patient's needs to that of the service
- We will maintain focus on the areas of our agreed strategy which will include: self-care and signposting
- Ongoing development of the psychiatric liaison services, including the night time cover provided by the enhanced Crisis resolution and Home Treatment Team (to be known as the Mental Health Acute response Service) and the piloting the reduced age range with CYPS
- Develop further the use of our community hospital provision to ensure a valuable contribution to communities across Gloucestershire.
- Work with the Urgent Emergency Care Network to progress work already started with an integrated clinical hub.
- Identify and develop pathways within GHNHSFT that allow patients that have been seen by their GP to enter the hospital system without entering through the Emergency Department
- Continue work that commenced in 2015/16 on reducing demand to the Emergency Ambulance Services (999)
- Work with providers and Health Education England to ensure workforce can be developed to respond to the evolving urgent care agenda
- Develop cross provider professional standards to ensure all services have a clear understanding of service requirements and expectations
- Work with Urgent Care providers to ensure the principles of "positive risk taking" are embedded across the system to ensure patients receive care that is suitably responsive to needs.
- Develop cross provider quality standards for urgent care which will ensure all parts of the urgent care pathway provide high quality care to our patients
- Information sharing arrangements between providers to encourage coordinated and continued patient care.

Planned Care:

The vision for the planned care programme is to: *Improve the patient journey through the planned care system and to continually improve outcomes, patient safety and cost-effectiveness of those services which we commission, ensuring we make the best use of the resources available to us.* The objectives of the Planned Care Programme are to:

- Ensure that appropriate care is available to all people for whom we commission services;
- Ensure timely access to care that meets are agreed access criteria;
- Ensure that care is provided as close to home as is possible and affordable;
- Ensure that care is provided to the patient by the right professional;
- Ensure that any professional caring for a patient has the right training and skills;
- Ensure that all care provided is evidence based and is compliant with NICE guidance unless excepted with good reason;
- Ensure that providers and commissioners work together to develop and implement system wide integrated Care Pathways and thresholds.

- Introduce a clear approach to pathway compliance to ensure new care pathways have maximum impact.

Our approach focuses on delivering improvement for patients throughout their healthcare journey, maximising quality and ensuring best value throughout. We believe that this focus should be wider than just the journey from the point of referral into planned care services, to the point of discharge. We believe that the journey must also include self-care and self-management, which can avoid unnecessary entry into the system, and support to exit care and return to normal life. The Planned Care Programme therefore encompasses the following five stages - Self-Care/Self-Management; Access to Services; Treatment; Follow Up; Exiting Care; and is underpinned by two core principles – Care Pathways; and Stronger Commissioning.

To Transform Care across our portfolio of programmes the CCG will:

- Lead and deliver the programmes of work as described in the comprehensive set of programme plans (available on request);
- Take an active role in ensuring ongoing system resilience for planned and urgent care;
- Focus on delivering the CCG outcomes framework.

We are looking to our providers to:

- Actively engage and commit with the clinical programme approach and the associated delivery programmes, including commitment of senior clinical and managerial time in support of this work and leadership and delivery of key component projects as agreed.
- To commit to work collaboratively with the CCG on specific service reviews and consequent identified service improvements, (whilst recognising that this will be subject to agreement of revised service specifications on a case by case basis)

Reference Documents:

- Joining Up Your Care.
- Developing the Clinical Programmes Approach.
- Programme Briefs for each of our Programme Areas.
- CCG Outcomes Framework
- NHS England Five Year Forward View
- 2015/16 National Planning guidance - Five Year Forward View into action

3.4 Parity for Mental Health and Learning Disabilities

Ensure a continued focus on achieving Parity for Mental Health and Learning Disabilities for our population.

2016/17 Headlines:

- **Deliver the Crisis Action Plan and, specifically, implement a new model of Crisis Care**
- **Continued focus on achieving parity of esteem for Mental Health and Learning Disabilities, through greater investment, meeting new waiting time targets and key performance measures (e.g. IAPT and dementia diagnosis rates)**
- **Deliver transforming care programme for people with Learning Disabilities**

In line with the commitments set out in the national planning frameworks and our local strategic plan the CCG will ensure a continued focus on achieving **Parity for Mental Health** for our population.

The key priorities the CPG wishes to pursue in 2016/17 to ensure **Parity for Mental Health** are:

- Continue to develop different methods of contracting and underlying information flows around patients and the services associated with mental health services.
- Review implementation of the Mental ICT in terms of allocation of resources based on agreed patterns of need/demand.
- Implementation of integrated care pathways across primary care and acute care pathways for mental health and physical health conditions identified as part of the work programme undertaken by the Mental Health CPG.
- Continue with, and review the learning, from the transition CQUIN
- Work with 2gNHSFT and NHSE to ensure delivery of IAPT national targets for access, recovery and wait times to treatment. Review pilot project in Stroud / Berkley Vale locality to enhance IAPT / GP psychological interventions for people with Long term Conditions (LTC) or Medically Unexplained Symptoms (MUS) with a view to determining future service developments.
- Implementation of recommendations from the independent review of crisis and emergency responses for urgent mental health assessments including interface and responses with Ambulance Trust and Police, including arrangements for children & young people.
- Review of Adult Eating Disorders pathway including the Child & Adolescent Home Treatment Eating Disorder service.
- Implement and support changes to assessment and planning processes for children and young people with special educational needs & disabilities (SEND).
- Work with NHS England Specialised Commissioning, local authority, and other commissioners, and with providers across all tiers (including all NHS providers, voluntary & community sector, schools, local authority) to improve pathways of care for children & young people including for crisis support, psychiatric liaison and alternatives to mental health inpatient care.

The CCG will:

- Review the adult ADHD specification and agree the process by which individuals can access a review.
- Review the Perinatal Mental Health Recovery service specification to ensure service expectations are clear to ensure delivery in line with expectations (NICE Guidance).
- Review the personality disorders CQUIN and agree next steps in enhancing delivery across generic mental health teams.
- Review the complex psychological interventions action plan and agree next steps in enhancing delivery (access / wait times) across both the specialist Complex Psychological Interventions team and generic mental health teams.
- Ensure delivery of the Crisis Care Action Plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat within Gloucestershire' specifically delivering a new model of Crisis Service in line with commissioning expectations and specifications.
- Implement fully the Mental Health Acute Response Service model across Gloucestershire, including the reduced age range by end of 2016/17
- Ensure delivery of Liaison Psychiatry Action Plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat within Gloucestershire.
- Review the outcomes and learning from the Community Health Services (Phase 2) integration of mental and physical health clinical care pathways.
- Remodelling of adult social care and care management services
- Review processes by which individuals have choice within mental health services (in terms of initial assessment/treatment and excluding urgent care) through the Personal Health Budgets programme.

Within the field of Children and Young People's Mental Health considerable progress has been made during 2015/16.

During 2016/17 the CCG will:

- Support implementation of changes to current self-harm pathways
- Work with GCC in the development of short-term overnight / shared care specialised fostering options for those young people who are not able or willing to return home following an incident of mental health crisis/self-harm.
- Improve the transition from children to adult services both within and between providers.
- Rollout a pilot of the multiagency pathway for preschool children with suspected Autistic Spectrum Conditions (ASC).

For Children and Young People's Mental Health each of the forces which drive the local and national agendas have been considered in the formulation of our approach to commissioning.

The CCG will:

- Pilot a locality model of support of earlier intervention and link children and young people into a system of mental health support from a range of practitioners with the right skills.
- Work with system partners to test out the development of online models of counselling support with the voluntary and community sector for children and young people that need some early help to expand capacity, making sure that services are provided in a way that is both attractive and accessible to children and young people.

- Work with partners to ensure timely access to a range of appropriate accommodation and safe places/places of safety including Foster Care, Voluntary Community Sector, Section 136, Gloucestershire Hospitals NHS Foundation Trust (when there are medical needs) for those young people who 'can't / won't go home' for whatever reason.
- Work with children and young people to expand support for emerging mental health needs in the community and more support for universal workforce. Including 'Drop Ins' and 'One Stop Shops' for young people and/or parents in localities in a variety of settings by a range of practitioners.
- Implement direct interventions to improve the mental health of young people with long term conditions.
- Work with partners to implement the recommendations in the Crisis Care Concordat and other work (NHS Essential Shared Capabilities) including development of a new service model of crisis resolution and home treatment that caters for young people under the age of 18 including transition from adolescent into adult services; and the development of the psychiatric liaison services for young people under the age of 16.
- Work with system partners to ensure there are evidence based parenting programmes as part of a more coherent offer and on a more targeted basis.
- Work with system partners to support the implementation of changes to current pathways and options for young people following an incident of self-harm. Identify and address the mental health needs of parents especially of vulnerable children and young people.
- Work with system partners to implement a model to support vulnerable adolescent's mental health supported by greater integration of working between social care, youth support and mental health services including those who have experienced trauma and/or violence.
- Pilot the 'Connecting Care for Children' model currently being run at Imperial College, London which has resulted in a reduction in inappropriate paediatric referrals. This will involve running regular multiagency locality network meetings for staff to discuss how they can support children and young people who have non-urgent physical or mental health needs who would otherwise have been seen in paediatrics or the local children and young people's mental health services.

The prevalence in Gloucestershire of dementia for those over 65 years is calculated to be 8326, and for those between 30 and 64 years 438. The Dementia Diagnosis Rate (DDR) is 68% of the prevalence above. However, the older population in Gloucestershire, currently 9042, is expected to rise to 10,524 by 2020 with an associated rise in the dementia prevalence (POPPI 2014). The Gloucestershire Dementia Strategy 2015 - 2018 sets out the key priorities and areas of work and is aligned to the Gloucestershire Health and Wellbeing Strategy 2012 – 2032; fit for the future, and are broadly defined as:

- Maintaining improvement to the local DDR
- Responding to NHSE DDR targets and challenge to widen the scope to include those conditions known to have a link with dementia; Learning Disabilities, Parkinson's disease. We would continue to improve access to dementia services for younger people and British, Asian and Minority Ethnic (BAME) communities
- Ensuring that the increasing numbers of people diagnosed with dementia are able to access quality and consistent post diagnostic support through to end of life
- Ensuring that the local workforce (in acute, primary care, community and care homes) have the right skills and knowledge to support a diagnosis of dementia and provide post diagnostic support
- Supporting carers
- Continuing to develop community networks and support for families living with dementia

The CCG will:

- Strengthen 2gether NHSFT post diagnostic support services
- Invest in the development of a BME Community Hub, based on the existing county wide Community Hubs
- Participate in county wide dementia awareness programme in partnership with local media
- Lead a partnership bid for Spirit of Achievement investment in a county wide reminiscence network alongside the Gloucestershire Archives For the Record project, linking communities with libraries, museums and offering befriending and volunteering opportunities
- Investment in locally developed tools and resources including :
- Living Well Handbook
- 5 Steps to Managing Challenging Behaviour
- Hydration Placemat for Care Homes
- Best Interest Tool
- Annual conference

Regarding learning disability services in Gloucestershire there are a number of driving forces which will propel the work of commissioning throughout the year. In particular, the main drivers for change are:

- **Joining Up Your Care**: In this strategy the broad nature of community based services for people with a learning disability is laid out. The need for services to be close to home, inclusive and to tackle health inequalities is paramount.
- **Transforming Care:** Following events at Winterbourne View we will ensure care for those with the most complex and challenging needs is being delivered in the local community. Placing people out of county must be minimised and opportunities developed to ensure that assessment and treatment beds are used for only the highest needs and for the shortest possible time.
- **Tackling Health Inequalities**: There is a national aspiration to ensure that the learning from the health indicators for people with a learning disability are appropriately tackled and the use of health care plans and health checks must be going up.
- **The Confidential Inquiry into the Deaths of people with a Learning Disability:** This Inquiry made a number of nationally agreed recommendations. These need to be rigorously planned and followed up on.
- **Employment:** The NHS has agreed to ensure it is a model of leadership in employing people with disabilities. Initiatives and opportunities must be sought to ensure people with a learning disability can find themselves as part of our workforce.

The CCG will:

- Work with the out of county board will continue in order to facilitate the return of those people placed from out of county. Best practice commissioning practices will be followed to ensure this is done within legal procurement standards and employs the established brokerage system including the Complex and Challenging Behaviour joint framework.
- Establish a Priority Placement Committee to keep track of all future potential out of county placements and to recommend alternate arrangements.
- The newly integrated Learning Disability Intensive Support Service will be given continuing support and guidance in order to ensure its successful embedding in current front line practice.

3.5 One Place, One Budget, One System

Work through the principle of One Place, One Budget, One System to develop a place based approach to service delivery, using this to develop our system response to the New Models of Care agenda and delivery of ongoing integration of our health and care system, facilitated by the work on Gloucestershire Devolution

2016/17 Headlines:

- **People and Place: Development of place based service plans for Gloucestershire with a particular focus on development of a community service model for circa 30,000 population base**
- **New Models of Care: Taking learning from NHS Vanguards to work with system partners to agree if we wish to develop a new model(s) of care in our county**
- **Integration: Ongoing and further integration of health and social care where this is in the best interest of achieving better outcomes, supported by our joint**

During 2016/17 the CCG will work with partners through the principle of **One Place, One Budget, One System** to develop a place based approach to service delivery, using this to develop our system response to the New Models of Care agenda and delivery of ongoing integration of our health and care system, facilitated by the work on Gloucestershire Devolution

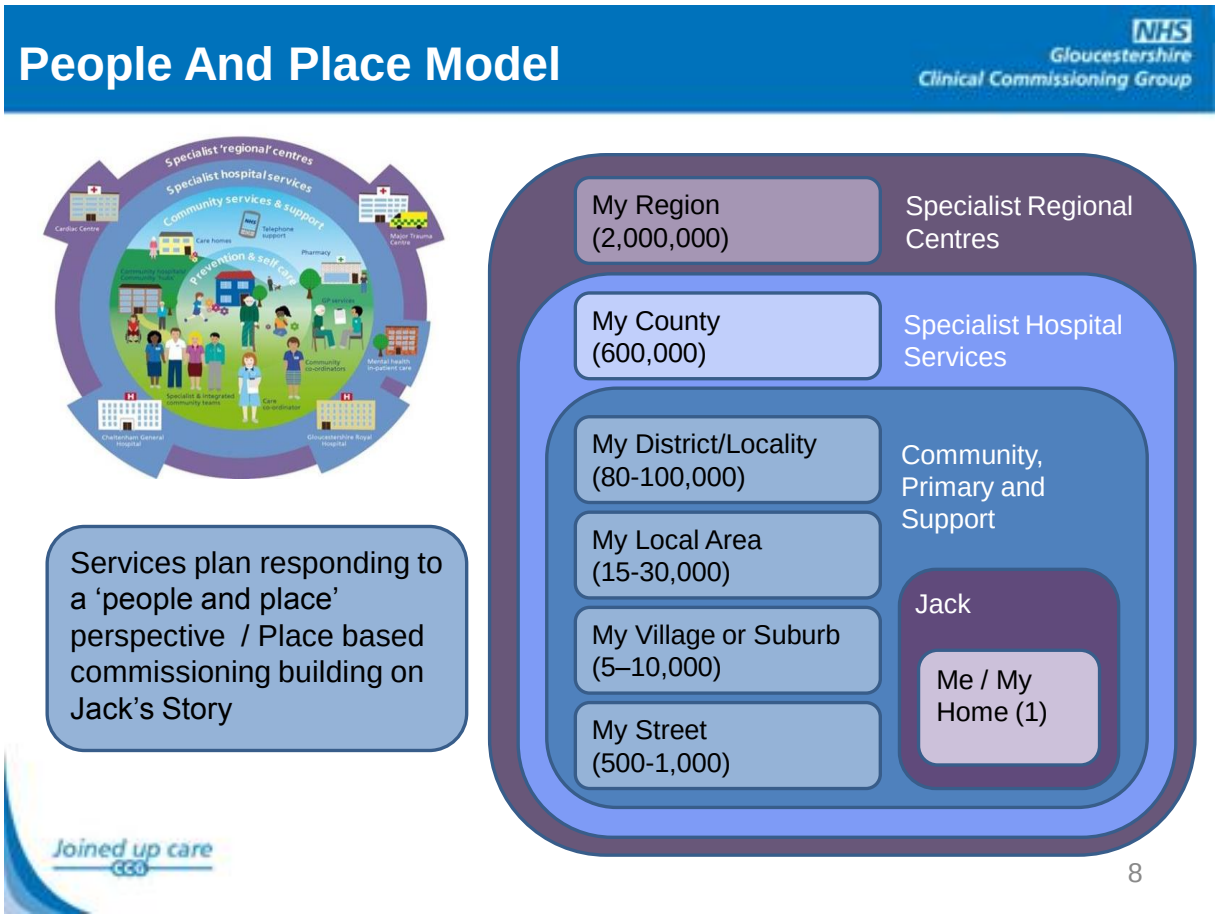
The key components of this strategic system level programme for the CCG are as follows

- **People and Place –place based services plan:**
  The CCG will develop a services strategy based on the principles of the **'people and place model'** that will be expressed through a new community services strategy, and will inform locality development plans, new models of care and the work on Enabling Active Communities

- **New Models of Care:**
  The CCG will work with system partners to agree an approach to New Models of Care for Gloucestershire, giving consideration to the potential benefits that could be delivered by adopting an Accountable Care Organisation approach in Gloucestershire

- **Integration :**
  The CCG will continue to work through integrated commissioning models between health and social care, and will take further steps to develop an integrated commissioning unit between health and social care in 2016/17

3.5.1: People and Place:



The Gloucestershire community has adopted a People and Place approach to developing our service plans. This combines both a population based approach to planning and developing health and care locally, with a place based focus building on natural geographies and communities. The November 2015 Kings Fund report, "Place-based systems of care, a way forward for the NHS in England" (Chris Ham and Hugh Alderwick) advocates a greater focus on population system planning. It recommends 10 key principles to guide the development of systems of care. Our shared Gloucestershire vision, the People and Place model and our principle of One Place, One Budget, One System follow the key principles set out in the report. The People and Place model has been developed with and supported by the Gloucestershire Strategic Forum and underpins the Gloucestershire devolution proposals which have at their heart developing vibrant communities and places to live. We have used this model to consult and engage with our partners and stakeholders on the shape of future health and care services for Gloucestershire. Our Clinical Programme groups have also used this model to test and to develop their service transformation plans. The outputs of this engagement and work from our clinical programmes are critical to developing the shape of our future provision and therefore our proposals for New Care Models. They are also key to how we build and strengthen our locality planning and our joint work with the council and the voluntary sector on Enabling Active Communities. Please see Annex 5 for a summary of the main themes emerging from our engagement events.

The CCG is committed to strengthening our communities and community services. Through the shared vision contained in the Gloucestershire health and care community's Five Year Strategic Plan (Joining up Your Care) a clear vision was set out that sought to maximise the level of safe and appropriate care provided wrapped around people in or near to their homes. In response the Community Services Programme Board was established involving all providers across the health and care community, including social care and VCS partners. This Board has been a crucial forum where all planning issues around community services can be discussed and projects progressed. There has been good representation throughout from all parties, and the CCG expects this to continue through 2016/17.

There are seven linked work streams established to produce strategic service models covering:

- Diagnostics;
- Urgent care (including minor injury/minor illness);
- Long Term Conditions (especially those with two or more);
- Rehabilitation;
- Intensive and/or specialist support (incorporating the work of the Integrated Community Teams, and work around ambulatory care);
- Day Surgery;
- Enabling Active Communities (helping people to help themselves).

3.5.2: New Models of Care:

As set out in section 3.7 the CCG has been engaged in a system development programme with partners through the Gloucestershire Strategic Forum that has led to the development of our Gloucestershire system Sustainability and Transformation Plan (STP). A key workstream in our STP is the 'one System, One Budget' approach which sets out our approach to agree a new model of care for Gloucestershire. As a system we are working together to consider a new model(s) of care for Gloucestershire in line with the learning coming from the NHS Vanguard sites.

Vanguard Site Models:

- **Integrated Primary and Acute Care Systems** – joining up GP, hospital, community and mental health services (PACS)
- **Multispecialty Community Providers** – moving specialist care out of hospitals into the community (MCPs)
- **Enhanced health in care homes** – offering older people better, joined up health, care and rehabilitation services (EHCH)

The New Models of Care Board has been constituted to include provider representation across our system and will report to our STP Board, and will consider the relative benefits of the various Accountable Care Organisation (ACO) models, PACS and MCPs for Gloucestershire. A local framework which supports providers to work in a more integrated and seamless way for a defined population is a natural fit with our One Place, One Budget, One System ethos. This work is supported by connected work on regulatory frameworks, approaches to risk sharing and new approaches to commissioning. We are exploring the merits of levers such as capitated budgets and reviewing the evidence of their effectiveness. Our Clinical Programme Approach is a key enabler to redesigning pathways across organisations. A new care model for Gloucestershire will support the acceleration of greater integration and joined up care, key planks of our health and care devolution agenda. This will sit alongside our commitment to providing patient choice and to greater involvement of the VCSE sector which at a local level can make a significant difference in supporting people to stay well.

3.5.3: Integration:

The Gloucestershire Health and Social care community has made strong progress on integrated commissioning with over £200 million of resources in pooled budgets. Our work together to develop an innovative devolution proposal for Gloucestershire will further support our joint working. In the context of increasing financial pressures for public services and an ageing population there is an imperative to work together to focus on prevention and combat social isolation, to reduce unnecessary demand for services, and between us to make the most efficient and effective use of health and social care resources.

The Better Care Fund 2014 has been a key vehicle for integration, and articulated a vision for joint working by establishing a framework for health and social care services

(i) to work more effectively together
(ii) to provide Patients/Service users better support at home and earlier treatment in the community
(iii) to prevent Service User/Patients needing emergency care in Hospital or Care Homes (iv) to enable Service User/Patients to enjoy a healthy and active life within their communities.

The local implementation plan for the Better Care Fund (2014-16) was based on three core principles

- People will be empowered to direct their care and support, and to receive the care they need in their homes or local community;
- General Practitioners (GP) will be at the centre of organising and coordinating people's care;
- Health & Social Care systems will enable and not hinder the provision of integrated care. Adult Social Care and Health providers will assume joint accountability for achieving a Patients/Service user's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Based on the above GCCG and GCC have been working to embed a 'whole person' and 'strengths based holistic model of integration within the Integrated Community Teams. Our shared aim contributes towards the delivery of the following Better Care Fund key priorities as below;

- Reduce the number of over 65 years old being admitted to residential care and nursing care homes where this is not in their best interests
- Reduce emergency admissions to acute settings;
- People are still residing at home 91 days post discharge (reablement);
- Reduce delayed transfers of care
- Improving Patient experience;
- Supporting Carers and informal community networks.

As a Gloucestershire health and social care system we believe *"that by all working better together - in a more joined up way - and using the strengths of carers and local communities, we will transform the quality of care and support we provide to all local people"*

Working in a more joined-up way requires a focus on integrated ways of working, aligning systems that support integrated care and removing barriers through:

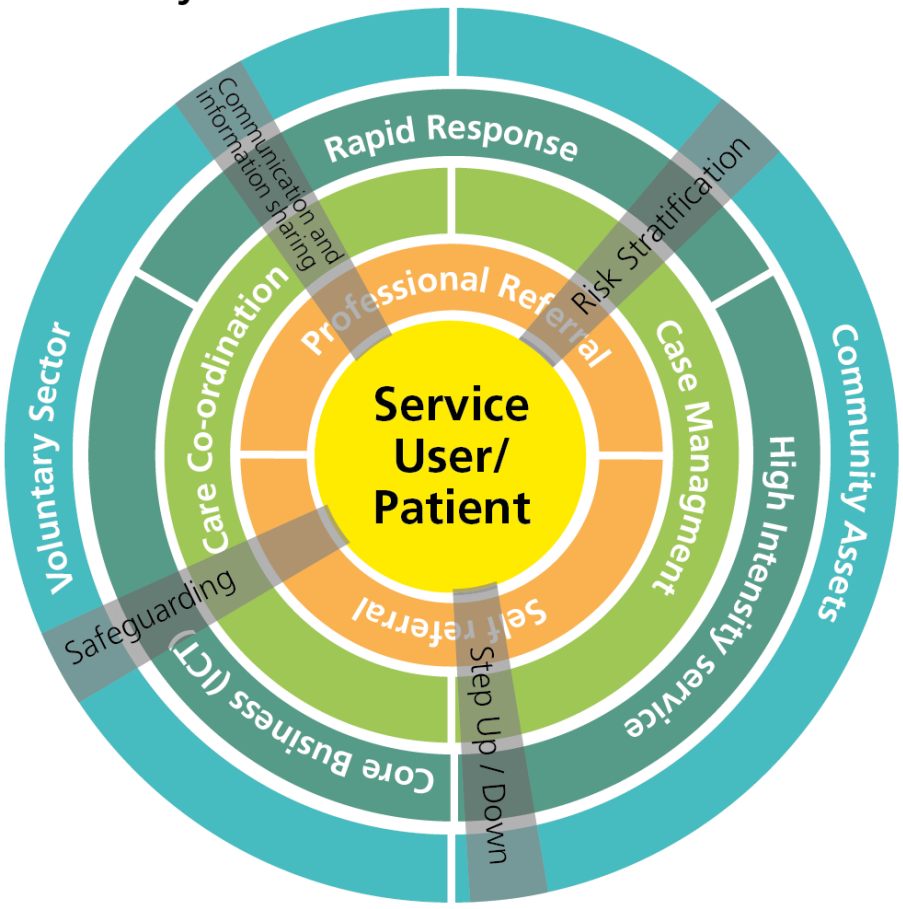
- Prevention and proactive support through care planning and co-ordination;
- Supporting independence through understanding individual capabilities and needs;
- Caring for people in the most appropriate setting, starting with their homes and community;

- Tackling social isolation adopting a “whole-person” approach to wellbeing;
- Using technology to develop networked, personalised health and care services;
- Eliminating gaps, duplication and disconnects between our health and care services and our local communities.

Gloucestershire Clinical Commissioning Group (GCCG) and Gloucestershire County Council (GCC) are commissioning ICTs together to deliver an operating model for adult Patients/Service Users (18 years of age & over) which shall promote, support or restore as appropriate a Service User/Patient’s independence, their ability to self-manage their individual needs whilst recognising their rights to exercise choice and control over any decisions which affect their lives. Integrated Community Teams (ICT) are one of the key services commissioned to provide a greater range of services that are built around the individual at home, supporting both their immediate and on-going health and wellbeing needs. The aim is to improve the quality of Service User/Patient’s experiences and outcomes. Throughout 2015 this was achieved by embedding multi-professional practices within an integrated operating model which strengthened the linkages for Service User/Patients across the local health and social care system including primary care, social care, community care, specialist care and care provided by third sector professionals/ providers across Gloucestershire. This integrated model is represented in Figure 4 below:

Figure 4:

Adult Health and Social Care Integrated Community Team Delivery Model



The model set out in the diagram is based on the principle that a range of health and social care agencies/professionals e.g. GP practices, Mental Health Services, District & County Council including ICT Staff will work collaboratively to provide 'Interventions' at the appropriate level necessary to address a Service User/Patient's health and wellbeing needs. The aim is to shift the focus from traditional models of 'caring for Service User/Patients' to preventative approaches which emphasise 'supporting' Service User/Patients' in their own home or community. This change in approach will actively contribute towards reducing a Service User/Patient's needs for 'Hands on Care' i.e. professional task-orientated Interventions delivered by ICT.

For reablement services, GCCG, GCC and Gloucestershire Care Services are working together to improve the existing service delivery in order to maximise the available capacity to meet demand. This includes a focus on increasing face to face contact by reducing down time, smarter scheduling, timely move on and reduced sickness absence of staff. Reablement is designed to support people to live at home safely, independently, meaningfully and in the way that they choose, enabling them to live their life their way. To help people to connect with and build sustainable family and local support networks that enables them to remain safe and supported by their local community, family, friends and neighbours.

To support this model we are also increasing our partnership working with the Gloucestershire Fire & Rescue Service (GFRS). There are common risk factors between health and fire services which increase demand such as multiple morbidity, cognitive impairment, smoking, drugs, alcohol, physical inactivity, obesity, loneliness and cold homes. The risk for someone over the age of 65 of dying in a fire is more than twice as high as the average risk for all age. NHS England is working closely with the Chief Fire Officers Association (CFOA) to provide national support and encouragement for local FRS to connect with NHS commissioners and services. The joint development of national policy and material based on current and emerging evidence and examples of best practice will support this way of working to be rolled out across the country. It will achieve better outcomes for people and better value for the money spent on public services.

Following a strategic review of telecare during 2015/16, several work streams are underway and will continue to be implemented within 2016/17 with a view to ensuring that processes and services are mainstreamed and improve service delivery, including:

- Responder service pilot with GFRS
- Simplify assessment / reduced assessment by offering telecare packages based on what risk is being mitigated
- Improved training / competency
- Increase self-assessment via web offer

The CCG will :

- Continue to deliver and refine the ICT model including the monitoring of agreed Key Performance Indicators (KPIs).
- Continue to play a leading role in the use of the Better Care Fund to support greater integration.
- Implement and evaluate a 'Discharge to Assess' service based on best practice models.
- Simplify the reablement pathway so that the service works closely with acute and community hospitals to facilitate safe discharges home.
- Develop stronger joint working with Gloucestershire Fire & Rescue Service including rollout of a Telecare Responder Service, providing Safe and Well visits and the development of Community Support Multidisciplinary Teams.
- Continue to progress the telecare and various community equipment work streams.

3.6 Person Centred Care

Further develop our approach to delivering Person Centred Care, rolling out personal budgets in partnership with social care and being an active member of the South West Integrated Personal commissioning pilot

2016/17 Headlines:

- **Pilot personal health budgets in partnership with social care**
- **Be an active participant in the South West Integrated Personal commissioning pilot**
- **Continue to ensure the patient voice is a strong influence across all of our change programmes to deliver person centred care for all**

The CCG will further develop our approach to delivering **Person Centered Care**, rolling out personal budgets in partnership with social care and being an active member of the South West Integrated Personal commissioning pilot.

Personal Health Budgets (PHB's)

PHBs have been implemented in Gloucestershire on a small scale since April 2014 and there are currently 18 adults, eligible for Continuing Health Care, with a personal health budget in place. Over the last few months Gloucestershire has been developing a PHB process and pathway for a larger scale roll-out of PHBs for people with long term conditions.

A Personal Health Budget (PHB) is an amount of money to allow more choices, flexibility and control over the care that an individual receives. The budget is intended to cover the individual's health needs within the context of a care plan to achieve agreed health outcomes. A PHB can be spent on anything that is set out in a Health and Support plan and agreed with the local NHS team. It can be held by the individual, a third party or a statutory body

Personal health budgets were initially available for people eligible for NHS Continuing Healthcare, who have had a 'right to ask' for a personal health budgets since April 2014 and a 'right to have' a budget from October 2014. The NHS Mandate commits to a further roll out of personal health budgets to people with a high level of health need who could benefit, including:

- People with learning disabilities or autism and high support needs
- People who need high cost, longer term rehabilitation: e.g. mental health recovery or people with an acquired brain injury
- People with high mental health needs and are ongoing users of mental health service
- People who have high levels of need but are not eligible for NHS Continuing Healthcare, but who have health needs which might be suitable
- Children with Education, Health and Care plans who might benefit from a joint budget

Gloucestershire Clinical Commissioning Group (GCCG) is working with key stakeholders to identify and offer personal health budgets to people who fall within these high health needs groups that may benefit from a personal health budget. During 2016, there will be a phased roll out of PHBs/integrated budgets for people who may benefit – support for local areas will include training, mentoring, use of quality improvement methodologies and evaluation of impact (outcomes and financial).

Integrated Personal Commissioning

One key part of our Joining up Your Care approach is our Integrated Community Teams, (part of our Joint Commissioning Programme) and as part of Phase 2 we are currently piloting a new 'Place Based' personalised model within one of our localities - Stroud and Berkeley Vale District. The CCG, Public Health and Stroud District Council have mapped the services they commission and provide within the District, Voluntary and Community groups and grouped them under our agreed system-wide health and wellbeing priorities. From this, the established multi-agency ICT Steering Group are working together to develop a model of care delivery which is truly person led with the person choosing their own goals and staff supporting people to achieve these.

All Partners have agreed a shared purpose and are committed to building a care model based on an individual person, the care worker and communities, building on each of their respective strengths and resources. We are creating better connections between ICT staff, our Mental Health integrated provider (2gether NHS Trust) and voluntary and community groups. In addition, this programme is connected to our work to implement a county wide 'social prescription' methodology which aims to link individuals with sources of support within a community. A recent evaluation of our social prescribing project found that across eight pre-defined categories of wellbeing, 83% of participants experienced a positive change in at least one category.

As part of the South West collaborative for Integrated Personal Commissioning we are closely collaborating with the regional resources for workforce development and time banks to create wider expertise of implementing personal budgets and delivery of choice. Included within this is the real wish to create truly person led care and support plans that have a currency across all the partners in each locality and across our system as a whole. The following key areas for development in 2016/17 have been identified whilst working within the Integrated Personalised Commissioning South West Consortium (IPC):

- Mental Health - for joint funded clients and how they could be managed.
- Young Peoples Disabilities (children with complex needs)
- ICT Case Management –case management approach and how we explore for the individuals
- End of Life – CCG engaged with the work undertaken by the EOL Expert Regional group
- Maternity (including peri-natal metal health)
- Equipment
- Wheelchairs
- Learning disability groups (joint funded, CHC and section 117 patients)"

Increasing the number of people offered PHBs in Gloucestershire (beyond the current CHC cohort) will be challenging. In 2016/17 we will produce a plan with specific milestones for improving patient choice including access to personal budgets by 2020.

3.7 System Development Programme

Work with health and social care partners on our shared System Development Programme, to develop and deliver a system wide sustainability and transformation plan for Gloucestershire

2016/17 Headlines:

- **Gloucestershire Strategic Forum work programme developed as system wide Sustainability and Transformation plan**
- **Working on innovative Devolution proposal for Health and Social care with county and district partners**
- **Deliver system wide quality academy and service redesign training programme**

Work with health and social care partners on our shared **System Development Programme** has been a key focus in 2015**,** which will continue to be developed and deliver a system wide sustainability and transformation plan for Gloucestershire in 2016.

We have held a series of strategic workshops with the Gloucestershire Strategic Forum to enhance our approach to local system leadership and to shape our response to the Five Year Forward View. The outputs of these workshops and our long history of joint working in Gloucestershire is forming the basis for our shared Sustainability and Transformation Plan. These workshops have had the commitment of Chief Executives and Chairs from across our health system, and Council Leaders and Directors of the County Council. Further workshops to develop our delivery plans are taking place during 2016. The workshops to date have focused on developing One Vision, Opportunities to Innovate and the Roadmap to Delivery. The outputs from these workshops have been:

- Reaffirming our shared vision for health and social care in Gloucestershire
- Agreement of the 'People and Place' model to support service transformation planning and development of place based budgets
- Agreed principles for joint working between GSF organisations
- Joint review of learning from FYFV Vanguard sites and implications for Gloucestershire (Focus on Manchester Devo and Mid Nottinghamshire 'Better Together')
- Development of refreshed GSF Programme Priorities, and establishing these as our shared STP priorities
- Shared assessment of scale of system wide challenge and any potential barriers to progress
- Agreement of clear plan for system wide transformation programme response to FYFV

These workshops have culminated in the development of 4 key building blocks to our system transformation which will underpin the GSF work programme and Sustainability and Transformation Plan going forward. These are set out below in Figure 5:


Clinical Programmes Approach
• Focussed around care pathways and communities of interest to improve health and care for our local population, focus on shifting towards prevention
• Programme budgeting approach ensuring the most benefit is delivered per pound, improving quality, reducing health inequality, improving patient experience and outcomes
Person Centred Commissioning
• Phased roll out of personal health budgets / integrated budgets jointly between health and care
• Working with South West Pilot for Integrated Personal Commissioning
One Place, One Budget
• People and Place - development of place based budgets at locality level (population 80 - 120,000
• New Models of Care - new service delivery models e.g. Integrated Community Health and Care Teams
• Integration - Integrated commissioning between health and care, including the Better Care Fund
Enabling Active Communities
• Health and Care working together on asset based community models, to develop approach to localised commissioning from the voluntary sector
• Joint focus on carers and carer support
• Delivery of Social Prescribing across Gloucershire
• Cultural Commissioning pilot with Arts Council

3.8 System Sustainability:

Have a continuous focus on System Sustainability, ensuring constitution compliant, high quality and cost effective services, reducing avoidable variations in outcomes, aligning delivery incentives and use ways of working such as case reviews to bring a clinical and evidence based focus to service redesign and improvement

2016/17 Headlines:

- **Delivery of IT Roadmap and JUYI Programme**
- **Continuous focus on delivery of constitution standards**
- **Deliver Workforce Strategy with plan to introduce new in county training offer**
- **Reduce variation through evidence based practice**
- **Assure quality services for all residents through the use of quality and equality impact assessments**
- **Reduce harm through the 'Sign up to Safety' initiative**
- **Encourage and promote research and innovation in community and primary**

The CCG will work to ensure that the system has a continuous focus on **System Sustainability,** ensuring constitution compliant, high quality and cost effective services, reducing avoidable variations in outcomes, aligning delivery incentives and use ways of working such as case reviews to bring a clinical and evidence based focus to service redesign and improvement. This section sets out our plan to ensure that the system maintains collective focus on the essentials.

1. Aligned Delivery Incentives

The CCG will ensure that where possible system incentives are aligned to support delivery of key objectives, using risk shares in contracts and opportunities for providers to gain share in QIPP benefits delivered. System wide CQUIN targets will be used to provide incentives for providers to work together across the system to drive up clinical quality in the best interests of patients.

2. Constitution Compliant Services

The CCG expects all providers to deliver to constitution standards and will commission improvements against key measures as set out in the national planning guidance produced by NHS England. In 2016/17 this will include a particular focus upon achieving parity for mental health. The national planning framework sets out the expectation that commissioners and providers will set out realistic and aligned assumptions about the expected activity levels for elective and emergency care, including diagnostics, that will be required to meet demand and deliver waiting times standards. Diagnostic capacity has been assessed with the Chief of Service and Divisional Manager with commissioning leads whilst endoscopy capacity has been assessed as within tolerance for the delivery of constitutional targets.

The activity plan and the contract will require providers to deliver the constitutional targets. Within the Gloucestershire community RTT has consistently delivered to the national targets. The planning model we have presented and agreed with our main provider accounts for population and referral growth, linear trends have been reviewed and activity assumptions agreed. Alternative provision through a mixed market model, support both choice and capacity for delivery of RTT standards. Furthermore, the CCG has commissioned additional capacity through an independent provider which will positively impact the delivery of Urology capacity for the Gloucestershire population which has been a challenge in 2015/16.

For A&E waits a system-wide 4 hour recovery plan is in place and is monitored by the System Resilienc Group. The focus is to achieve a sustainable 90% delivery and key areas of work include strengthening admission avoidance schemes, internal support for the management of flow (this is supported by the implementation of the Safer CQUIN) and addressing workforce issues.

The CCG recognises that risk remains around the delivery of Red 2 ambulance performance. The CCG has a shared 'Measures to Improve Plan' which focuses on actions that the commissioner and provider are jointly supporting to deliver Red 2 performance. The Computer Aided Dispatch for the North division has been implemented and this is anticipated to have benefits to the performance of Red performance targets. Commissioners would also recognise the trial and further extension of the Ambulance Performance Review which has impacted on Red 2 delivery during 2015/16.

We will expect all providers to:

Produce a detailed capacity plan in response to CCG demand planning that sets out the level of capacity the provider expects to need to deliver a constitution compliant performance in all areas, and to highlight where there are risks to delivery of core standards.

3. Delivering High Quality and Safe Services

As defined in our strategy for quality 'Our Journey for Quality' and two year operational plan there is an expectation that all providers are working towards full implementation of the 2012 nursing vision and strategy, Compassion in Practice – our culture of compassionate care (6Cs) and that services commissioned will contribute towards the improvement of outcomes, both from the perspective of demographic change and quality of commissioned service. This will routinely include completion of a Quality and Sustainability Impact Assessments (QSIA) in addition to Equality Impact Assessments (EIA) at initial submission stage for any service change or development.

In addition to our local priorities, there are a number of additional national requirements to deliver patient safety improvements. These are as follows:

- All providers and commissioners to take part in local patient safety collaborative and encouraged to join the 'Sign up to Safety' campaign (including developing our safety web page, sharing learning from SIs across the county, quality alerts, sign up to safety newsletters and focussed information for conditions such as sepsis and AKI)
- Work with GP's as delegated co commissioners to routinely deliver high quality clinically and cost effective healthcare to Gloucestershire residents. Quality assurance will be through the Primary Care Commissioning Committee and established quality assurance processes.

- All providers and commissioners to jointly develop plans, working towards the implementation of the NICE NG 15 (Antimicrobial Stewardship 2015 Guideline) and consider the national PHE antimicrobial resistance (AMR) work plan.
- All providers to agree Service Development and Improvement plans with commissioners setting out how they will make further progress to implement at least 5 of the 10 clinical standards for seven day services within available resources
- All providers and commissioners to work together to embed the practice of clear clinical accountability, with a named doctor responsible for a patients care within and across different care settings

The CCG will follow nationally mandated CQUIN requirements as set out in the National Operating Framework with some of our providers and will develop local measures, which are currently under consideration for inclusion in 2016/17. Proposals are invited from our key providers where the CCG is lead commissioner to inform CCG plans which are identified in more detail following national guidance. Similar to previous years the CCG intends to use the CQUIN framework to develop joint CQUIN priorities across our community providers to support collaborative working and delivery of priorities across our system.

Gloucestershire Hospitals NHS Foundation Trust
Urgent Care Safer Flow
Dementia/Frailty (National Adapted)
Transitions (Year 2)
Diabetes
National Emergency Laparotomy A (NELA)
Medicines Safety Thermometer
Cancer
Gloucestershire Care Services
Improving Staff Health and Wellbeing (National)
Anti-microbial (National)
Positive Risk Taking (Year 2)
Frailty (Year 2)
End of Life
Transitions (Year 2)
2gether NHS Foundation Trust
Transitions (Year 2)
Perinatal

NB: Above CQUIN 16/17 Schedule is currently under development with providers.

In addition to this:

- The CCG will lead a cross border transition project, in response to NHSE agreeing to cease from 1st April 2016 the current cross border healthcare arrangements protocol (2005) between England and Wales. Specifically in relation to patients registered with a Welsh GP and living in England or patients registered with an English GP and living in Wales.
- Using NICE standards and guidelines appropriately, the CCG will commission services that ensure provision of equity of access and continuity of care in the right place, at the right time by the most appropriate clinician and fully supporting agreed care pathways such as continence and leg ulcers, supporting cost and clinical effectiveness;

- The CCG will expect providers to continue with the implementation of their action plans in line with the recommendations from the Francis Report, Keogh Reviews and Berwick Report. The additional action plans from CQC visits will continue to be scrutinised by the CCG through the established quality review process. The service providers will be required to present their plans and on-going progress to key stakeholders, including the public and patient groups, to confirm compliance and provide assurance to the CCG;
- The CCG will continue to include a number of local quality indicators in addition to the national standard contract relating to patient safety, clinical effectiveness and patient experience. Providers will be required to strengthen methods for gathering feedback from patients, service users and staff to triangulate information, including patient involvement in decisions relating to their ongoing agreed care plan;
- Gloucestershire CCG will take every opportunity to monitor and strengthen commissioner assurance with regard to safeguarding for children, looked after children and adults, including implementation of CQC recommendations. The CCG will continue to focus on this aspect of contract reviews with our providers, and will ensure that safeguarding has a high profile within the assessment and review procedures carried out with individual service users;
- The CCG will work collaboratively with our service providers to support the implementation of the Chief Nursing Officer's Vision including the 6Cs. The CCG will drive initiatives across the healthcare community to ensure there is compassion in the care our patients receive;
- With regards to learning disability services, subsequent to the Winterbourne View report, the CCG will strengthen working relationships and links with Care Quality Commission, and will continue to monitor all safeguarding activity including adults and young people with Learning Disabilities. The CCG will ensure that adult safeguarding has a high profile in Gloucestershire with a focus on the protection of vulnerable groups:
- The Control of Health Care Acquired Infections (HCAIs) remains a high priority for the CCG and it will continue to work with local NHS Trusts and Primary Care to reduce the incidence of infections both in hospital and in the community;
- In addition the CCG will be requesting an improved standard of patient record-keeping by clinical staff, as well as better records management systems both paper and electronic, which supports the sharing of patient information to ensure continuity and safety of care.

The CCG has established a countywide patient safety forum and will continue to encourage all providers to actively participate. In addition the CCG expects all our main providers to be committed to the patient safety agenda and particularly 'sign -up to safety'. The CCG will have an increasing focus on the prevention of errors and increase in patient safety.

The CCG will specifically focus on**:**

- Acute Kidney Injury;
- Sepsis;
- Healthcare Acquired Infections;
- Falls;
- Pressure Ulcers.

4. Cost Effective Services

Over the next 3 years, GCCG has to meet a significant productivity challenge. The key drivers of this which may cause the challenge to change are:

- Provision of the Better Care Fund;

- Additional national requirements including changes to inflation and cost pressures compared to the assumptions within the 3 year funding allocations
- Increase in demand above those planned, particularly in urgent care
- Pace of implementation of urgent care and other QIPP initiatives;
- Development of new technologies and drugs;
- Changes in population demand

The aim of the CCG's financial plan is to ensure financial balance and stability through the effective management of available resources and financial risks to ensure statutory duties are met each year. Planning assumptions include: achieving a 1% surplus, holding a 1% contingency (0.5% mandated), and a 1% headroom budget funding to fund non recurrent items of expenditure, pump prime change and cover double running costs during periods of change and manage overall financial risk within the health community in line with NHSE guidance.

There is an obligation to patients to ensure that services are delivered with the greatest possible effectiveness and efficiency. Our expectation is that providers will co-operate to deliver service change for continuous improvement.

We will:

- Ensure a structured approach to commissioning is fully embedded within the CCG, including robust contracting and performance management to hold providers to account;
- The CCG will review the application of best practice tariffs to ensure quality outcomes
- National business rules will be rigorously applied in line with NHS contract terms
- CCG will be developing QIPP schemes in conjunction with providers with appropriate risk shares to support scheme delivery
- Ensure we deliver services within our means.
- Ensure that the CCG operates good financial management processes throughout

5. Reduce Avoidable Variations in Outcomes

Our intention for 2016/17 is to further challenge clinicians across our health and care systems to reduce unacceptable variations in clinical practice, and in doing so to improve quality, eliminate harm and reduce waste of valuable resources. We will do this through using appropriate clinically based evidence such as monthly Dr Foster reports which are reviewed and acted upon, ongoing review of SHMI/HSMR (including planned GP and acute trust joint review) and monitoring the outcome of the acute trust's mortality and morbidity group. The CCG intends to continue to develop our clinical programme approach to ensure we are increasingly commissioning for outcomes, and are moving away from episodic, transactional models of care to more 'end to end' patient focussed pathways. We will do this by identifying targeted outcomes improvements for our main clinical programmes, then by working with partners across the health and care system to deliver these through pathway improvements and prioritising the spend within our programme budgets to ensure we are getting the maximum value in terms of health gain for every pound we spend. Alongside this we will consider as a health community how the new care models described in the 5 year forward view could support our approach.

Our principles for developing an outcomes approach are summarised as:

- Outcomes should be meaningful and measurable;

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

An important specific area of outcomes improvement that cuts through all of our work is a focus on medicines optimisation. We will maintain the focus for medicines optimisation through five key areas, which are:

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

The CCG intends to maintain a consistent focus on these areas in 2016/17. Additional areas of focus will be centralised supply of ostomy products, rheumatology, pain management drugs reviews; and increased medicines optimisation in integrated care pathways. This will be developed integrally with the clinical programme approach as part of a pathway of care.

We will expect our providers to:

- Prioritise senior clinical time to work with the clinical programmes to minimise avoidable variation and to engage in the process of case reviews, taxonomy work and benchmarking on an ongoing basis
- Engage actively with our approach to medicines optimisation, utilising current national best practice principles to maximise clinical effectiveness and cost effectiveness, encouraging increased prescribing of generic medicines and locally recommended formulary drug choices.

6. Information and Technology

The CCG is working to ensure that it complies with the requirements of the National Information Board (NIB) framework with good progress already being made with respect to improving patients' access to their records, use of the NHS number by providers, uptake by GP practices of electronic prescriptions to pharmacies, the use of electronic discharge summaries and the number of referrals made electronically. It is important to align the CCG's existing IM & T Strategy with the requirements laid out by NIB and so a roadmap will be in place by June 2016 to ensure that this is the case. Workshops across the community have been and are continuing to be held to develop all aspects of the roadmap.

Providers will be expected to engage with the CCG agenda for the use of technology within our health community, including:

- Continued involvement in the procurement and subsequent implementation of the Gloucestershire clinical record sharing solution and including future development
- Full involvement in the development and implementation of the Gloucestershire Community IM&T roadmap
- We will expect providers to develop interoperable systems going forward in line with the national and local requirements.

7. Procurement Intentions

The table below outlines the intended procurements GCCG will undertake in 2016 /17. It should be noted that this list is indicative and is not intended to be exhaustive or binding.

Procurement Schemes (Authorised):

Scheme Title:	Completion Deadline:
Clinical Decision Support Tool	Circa October 2016
Provision of Commissioning Support Services	31 March 2017
AQP Computerised Tomography	30 June 2016
AQP MRI	30 June 2016
AQP Non-Obstetric Ultrasound	30 June 2016
AQP Direct Access Endoscopy Services	30 June 2016

Procurement Schemes (Pending Approval):

Scheme Title:

Provision of Orthotist Services and Associated Equipment Supply
Provision of Equitable Access in Primary Care (GHAC)
Provision of Tele-dermatology Services
Disposal of CHC, LD and Children's Commissioning Redundant / Surplus Equipment
Provision of Translation and Interpretation Services
Provision of Home from Hospital Service
Provision of Primary Care Enhanced Services (approximately 4 schemes
Supply of Risk Stratification Tool

In additional to the above, further procurement schemes may result from any introduction of Delegated co-commissioning of primary care medical services.

Contract re-procured:	**Current Service Provider(s)**
GP out of Hours	New provider to be in place from 1st April 2015
Stroke Befriending Service	Current provider – Connect. Procurement to be carried out from November 2014, provider to be in place from 1st April 2015.
Telehealth Services (and associated equipment supply)	Current provider – Tunstall (alongside other GCS providers). Procurement commenced from October 2014, provider to be in place from 1st April 2015.

8. Workforce

It will only be possible to deliver the scale and pace of change required if we have enough staff with the right skills, values and behaviors to deliver it. We have recently established a Gloucestershire system-wide workforce planning group to help us to collectively understand how we are developing the workforce we need in Gloucestershire. This group is developing a work programme to address key local workforce issues which would benefit from collective action. Our intentions are to develop a shared understanding and approach to workforce planning and to facilitate good practice across Gloucestershire. We are submitting a proposal to Health Education South West to develop a Community and Primary Care Development Network to give a local and coordinated focus to planning for the primary care and community nursing workforce for the future. We have delegated authority for commissioning primary care and developing a workforce strategy to support the sustainability and future for primary care is a key driver for us.

We are exploring opportunities for closer working with our Local Economic Partnership and the Council through work on apprenticeships and opportunities to train and employ people from vulnerable groups. Our local devolution proposals have a major focus on accelerating growth through skills and employment, and as a health community we will benefit from and can contribute to a greater system focus on supporting people to access employment. We wish to enhance the

opportunities for people to train and work in the health service in Gloucestershire and to develop greater local planning and powers to enable this. The NHS planning guidance identifies the following key actions with respect to workforce planning and the development of responsible employment practices:

- Each health economy should engage with the Local Education and Training Board (LETB) to work together to identify current and future workforce needs
- Commissioners and providers need to work together to prepare for the introduction of nursing and midwifery validation from the end of December 2015
- NHS employers to lead the way as progressive employers. From April 2015 first NHS workforce race equality standard will be introduced in the NHS contract, and all NHS employers and their boards will be required to examine themselves against this standard. Requirements in prevention agenda to promote workplace health
- All NHS workplaces to ensure that they provide NICE recommended workplace health programmes for employees
- All NHS Providers to develop a food and drink strategy, ensuring staff can access healthy food in staff canteens etc

PART B: PLANNING TIMETABLE and ENGAGEMENT APPROACH

Engagement Approach

As set out in the GCCG Engagement and Experience Strategy 'Our open Culture': "We want to hear the 'quiet voices' and be 'commissioners on the ground'. Through 2015/16 we have continued to develop our approach to patient engagement and experience; ensuring voices are heard by commissioners and are central to the strategic development of all of our programmes of work.. 'Our Open Culture' Framework promotes 'Equality' and working in 'Partnership' and the desire to enable 'Anyone and Everyone' to have a voice. To achieve this we will provide 'Information and good Communication', focus on 'Experience' feedback and undertake good 'Engagement and Consultation'. The Strategy's aim is to ensure that the CCG achieves the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual's experience of care is a driver for quality and service improvement.

The CCG collects views from patients, carers and staff all year round by facilitating the collection, analysis and reporting of feedback and views received from patients, carers, stakeholders, the wider public and staff. A number of specific engagement opportunities have been held through the development of our plan, as set out in our overview planning timetable set out below. The feedback we have heard has informed and influenced our commissioning priorities (See Annex 6). A dynamic and robust system is in place to ensure intelligence obtained from individuals' experiences of local NHS services, alongside other quality data on safety and clinical effectiveness, and engagement and consultation activities, is collected and reported. This intelligence will be used to monitor the quality and clinical effectiveness, from a patient or public perspective, of current commissioned services and thus inform future commissioning decisions, service redesign and reconfiguration proposals throughout the lifecycle of this operational plan.

The CCG has a strong track record of effective engagement and communication with the local population and stakeholders. For example, potentially contentious service transformations, such as changes to the Emergency Department (ED) at Cheltenham General Hospital, have successfully been delivered following extensive consultation, which was compliant with all relevant duties for CCGs under the Health and Social Care Act: S14Z2 (2012).

We are also particularly keen to hear the opinions of staff working in the health service and we use the staff survey results, as well as staff engagement exercises to gain feedback on the quality of our local health services and opportunities for improvement.

Our Planning Calendar towards development of this plan:

MONTH	EVENT CATEGORY	DATE	EVENT
Sept 2015	Engagement	3rd	AGM
	Planning and Contracting	30th	Contract intentions
Oct 2015	Finance	1st	Draft summary 5 year financial plan shared with NHSE
	Scheme Development	7th	Priorities Committee
	Engagement	22nd	Engagement Event with key stakeholders – Joining Up Your Care Five Year Forward View
	Scheme Development	29th	QIPP Development and Monitoring Group
	Scheme Development	30th	High level benchmarking for programme Groups
	Finance	30th	Budget meetings with Directors to assess baseline spend
Nov 2015	Engagement	2nd	Cheltenham Locality Executive Group
	Engagement	3rd	Tewkesbury, Newent & Staunton Locality Executive Group
	Engagement	10th	Gloucester Locality Executive Group
	Engagement	11th	Stroud & Berkeley Vale Locality Executive Group
	Scheme Development	12th 13th	Board Development : Overview of 15/16 Operational Plan progress
	Scheme Development		Directorates, clinical programmes and localities submit outline business cases
	Engagement	18th	Forest of Dean Locality Executive Group
	Engagement	18th	VCS Alliance Provider Forum
	Engagement	24th	South Cotswolds Locality Executive Group
	Scheme Development	26th 26th	QIPP Development and Monitoring Group Governing Body : Overview of 15/16 Operational Plan progress
	Scheme Development		
	Finance	30th	Second cut 5 year financial plan shares in CCG Development session
Dec 2015	Engagement	1st	HealthWatch Forum
	Planning and Contracting	21st	NHSE Publishes Planning Guidance (assumed)
	Planning and Contracting	31st	Finalise Commissioning Intentions and Governing Body sign-off
Jan 2016	Finance	11th	Allocations due
	Finance	29th	5 year Financial Plan (post allocations) presented to Development session as prelude to Priorities Committee
	Planning and Contracting	29th	Transformation Footprint return
Feb 2016	Planning and Contracting	1st	Updated contract intentions sent to providers
	Scheme Development	4th	Priorities Committee
	Planning and	8th	First draft of Operational Plan

	Contracting		
	Finance	8th	NHS England Financial Planning Returns
	Information	8th	CCG Monthly Activity and Other Requirements Submission
	Information	8th	SRG return
	Information	9th	Receive Provider Activity Returns
	Information	11th	CCG activity split by Provider submission
	Engagement	22nd	North Cotswolds Locality Executive Group
	Planning and Contracting	23rd	Contract Tracker submission
	Finance	29th	5 year financial plan including impact of Priorities Committee decisions
Mar 2016	Finance	2nd	NHS England Financial Planning Returns
	Information	2nd	CCG Level Activity submission
	Planning and Contracting	2nd	Second draft of Operational Plan
	Scheme Development	10th	Priorities Committee
	Planning and Contracting	8th	Contract Tracker submission
	Planning and Contracting	15th	Contract Tracker submission
	Planning and Contracting	22nd	Contract Tracker submission
	Planning and Contracting	**30th**	**All contracts signed**
	Finance	**31st**	**Budget setting paper presented to Governing Body**
Apr 2016	Information	5th	Contract Tracker submission
	Finance	11th	NHS England Financial Planning Returns - FINAL
	Information	11th	CCG Level Activity submission
	Information	11th	SRG Return
	Planning and Contracting	**11th**	**FINAL draft of Operational Plan**
	Planning and Contracting	12th	Contract Tracker submission
	Information	14th	CCG Activity Split by Provider Submission
	Planning and Contracting	19th	Contract Tracker submission
	Planning and Contracting	26th	Contract Tracker submission
May 2016	**Scheme Development**	**19th**	**Priorities Committee**
June 2016	**Planning and Contracting**	**30th**	**Submission of full STPs**

Annex 1: JUYC High Level Ambitions

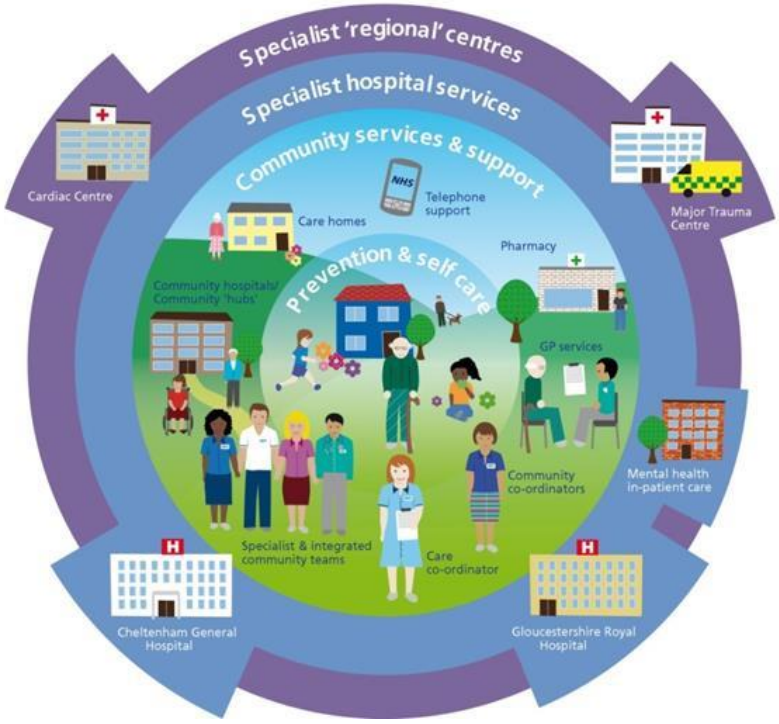
Joining up your care (2014-2019) sets out the ambitions we seek to achieve across the Gloucestershire community for the people of Gloucestershire. The starting point for achieving our ambition is a clear, widely supported, vision defined as:

> *"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".*

We believe that delivering this vision means that we need to ensure that:

- People are provided with support to enable them to take more control of their health and wellbeing, recognising that 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, moving away from the traditional focus on hospital-based care; and
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

These ambitions are articulated within the diagram below **JUYC Ambitions:**



Applying these principles will enable us to meet national outcomes targets and our local aspirations for the people of Gloucestershire.

Annex 2: Finance and Business Rules

High Level Assumptions:

- The CGG will model demography in line with the assumptions set out in the 5 year strategy and plans, adjusted for any new demographic information as required. The CCG will use this information combined with profiles of current demand, performance and benchmarking to set commissioning envelopes for main providers in line with the needs of the local population;
- The CCG intends to adopt any PbR mandatory tariff items including Best Practice and any new PbR terms which link the tariff to delivered outcomes; where providers claim for a best practice or outcome based tariff, they will need to clearly demonstrate that requirements are being delivered to receive payment;
- In conjunction with full Payment by Results, the CCG will negotiate marginal rates and capped resource contracts or service lines, which the CCG will seek to manage within a fixed commissioning budget recognising provider cost;
- Where review of non-tariff activity indicates a required change in the overall level of investment in the service under consideration the CCG will work with providers to agree a reasonable 'pace of change' arrangement that is commensurate to the scale of the change in investment / disinvestment required;
- The CCG will assume application of CRES to all services at a similar level to previous years across all healthcare providers;
- The PbR business rules will be applied to all contracts
- We will ensure commitment to a risk share approach aligned to our priorities (including a risk sharing approach to the delivery of QIPP). Risk sharing arrangements will be agreed in contracts that mitigate the risk of in year changes to the cost of activity; this will include shifts in case mix and coding and any outcomes of the unbundling of activity from tariffs. This should be underpinned by an open, transparent approach to the development of opportunities for change;
- The CCG will only contract with Providers that abide by our policies and protocols. These include, but are not limited to, local clinical policies and access criteria (including treatments of limited clinical effectiveness, prior approval thresholds and pathways as determined by the CCG). Providers should work to ensure that they have robust internal processes to ensure that they can avoid undertaking work that will not be reimbursed. The CCG will not pay for procedures that fall outside clinical policies unless there is evidence of prior approval or that criteria based access procedures have been followed;
- The CCG will continue to work with providers to develop tariffs and currencies that enable us to move, where appropriate, from block contracts to contracting methods that better incentivised the desired outcomes and that share risk appropriately across the system. This process will take time to develop and the CCG will work with providers to develop systems that support the direction of travel and also look at interim models that can be used to transition to new contracting models.
- We will consider if the pilot(s) of innovative organisational forms in line with five year forward view new models for delivery of care will require us to develop any new and innovative approaches to contracting.
- The CCG will develop our clinical programme groups to the point where they are working with full visibility of programme budgets in 2016/17 to prioritise resources across programmes, and use this work to further develop QIPP priorities for 2016/17 and beyond. We will work to the principle of moving care ‘upstream’, and will be aiming to prioritise resources within our care pathways towards primary care and prevention where possible;

- The CCG will work to the principle of commissioning through a care pathways approach, and within commissioned pathways we will look for cost effectiveness, minimising the number of steps and driving greater efficiency;

Detailed Assumptions:

- The CCG will undertake rigorous review, benchmarking and when appropriate, market testing to ensure that the CCG is paying the right price for each procedure, examples to include:
    - Payment at Outpatient procedure rate rather than daycase where care can be provided in outpatient setting;
    - The CCG will look to understand actual costs of delivery and reasonable overheads where new service models are developed, and will not agree to an automatic default to consultant responsible tariff when activity is delivered by different healthcare professionals in the multi-disciplinary team;
    - The CCG will not pay for an admission price when the provider chooses to 'admit to assess'. Examples include stays in Paediatric Assessment Unit of less than 4 hours, for which usual A&E tariff will apply, and patients being assessed on ACUA and subsequently discharged by the Older Peoples Assessment and Liaison Service (OPAL);
- CQUIN is not payable on certain areas such as excluded drug and devices spend in the 2015/16 financial year, and this is expected to continue next year. The CCG will work to the national CQUIN guidance when this is published;
- The PbR uplift and efficiency percentages will also be applied to non PbR services, as appropriate, where uplifts are not already determined within contracts;
- Where new services are being developed that do not fall within the scope of PbR, then the process to develop a local tariff will be through discussion and agreement with the provider and in line with the process described within the 2016/17 National Tariff Payment System guidance;
- The CCG will not accept any coding and counting proposals that have not had the appropriate contractual notice periods attached and will expect these to be overall cost neutral. A coding and counting proposal that leads to a need for additional investment by commissioners will need to be offset by an equal saving elsewhere in the contract;
- The CCG will not support investment business case proposals outside of the normal CCG prioritisation process, including where this relates to a proposed coding and counting change. Providers should not initiate in-year service developments unless formally agreed by the CCG. This includes any cost implications relating to new NICE guidance, which will be assessed for implementation on a case by case basis;
- Business cases for specialist services must go through the National NHS England process, the CCG will not pick up costs incurred by a provider as a result of a business case proposal for a specialist service that has been rejected by NHS England's specialist commissioning teams;
- A number of rules will relate to payment for Excluded Drugs & devices, including:
    - Validating clinical usage decisions at source to address unwarranted variation in prescribing practice;
    - Improving transparency in prices paid to better target shared areas on procurement opportunity; Working with other commissioners and providers, the CCG will secure the benefits of more widespread use of best value prices for drugs and devices, alongside increased transparency of billing;
    - Updated risk and reward sharing protocols to provide practical approaches to covering the resources needed where providers and commissioners aim, in addition to usual therapeutic switching, to dedicate additional resources to 'go the extra mile' together on more significant projects;
    - Budgets for excluded drugs and devices will be set annually based on the provider's assessment of need through horizon scanning, subject to a 'confirm and challenge' meeting

with the provider, with review of any outliers in rates of growth by the national specialised pharmacy lead. New excluded drugs and devices will not be funded in-year unless approved by NICE or previously identified and planned for within the planning round;

- Excluded drugs and device costs charged to the CCG will be reflective of actual product costs to hospitals and will be subject to audit to demonstrate this. Providers will charge the commissioner all drugs subject to discounts, rebates or other such Patient Access Schemes at net cost. These costs are also excluded from the tariff efficiency deflator arrangements;
- There will also be a move to ensure contracted drugs/devices are recorded at a patient level, where not available this should be by exception;

- CQUIN for 2015/16 is set at a level of 2.5 per cent value for all healthcare services commissioned through the NHS Standard Contract – it is anticipated that this will continue in 2016/17. A proportion of this value is to be linked to the national CQUIN goals, where these apply. The remaining proportion will be applied to schemes which support the local priorities;

The CCG will not pay for activity that is not commissioned and is subject to IFR policy. The CCG will not pay for activity where criteria based access or prior approval applies where this has not been sought. Providers will ensure activity can be audited for IFR and criteria based access. If information is not shared deductions will be made proportional to activity carried out where these policies apply.

Annex 3: Ambitions for GCCG Outcome Measures Framework

Outcome ambition	Outcome framework measure	Out Turn		Support measures	Examples of how we will deliver
1. Securing additional years of life for the people of England with treatable mental and physical health conditions.	Potential years of life lost to conditions amenable to healthcare in the respective calendar year per 100,000 population	1966.3 (2013)	1920.7 (2014)	None	• Outcomes focus in Clinical Programmes approach as set out in more detail through this document • Impact from our healthy individuals programme agenda.
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.	Health-related quality of life for people with long-term conditions	76 (13/14)	77.2 (14/15)	Increase Access to IAPT	• Outcome focus for Clinical programme groups • Development of pathways for specific cohorts of patients, prioritising diabetes, COPD, respiratory and stroke. • Continued development of integrated care teams • GCCG has improved dementia diagnosis rates from 56% to 67%. • Cancer, focus on patient experience • Continued focus on parity of esteem.
3. Reducing the amount of time people spend avoidably in hospital	Composite of all avoidable emergency	11550 (13/14)	11269 (14/15)	None	• Continued development of integrated community teams and creation of virtual wards and rapid response teams

Outcome ambition	Outcome framework measure	Out Turn		Support measures	Examples of how we will deliver
through better and more integrated care in the community, outside of hospital.	admissions				
4. Increasing the proportion of older people living independently at home following discharge from hospital.	Increase in the number of people at home 91 days post discharge	70.1% (13/14)	74.7% (14/15)	Adult social care outcomes framework indicator on re-ablement / rehabilitation	BCF ambition to improve performance • Re-ablement pathway review • Increased access to domiciliary care • Stroke high intensity service The Gloucestershire ambition is to increase access to relevant services, whilst improving the proportion of people who are able to live at home (see BCF ambition 4)
5. Increasing the number of people having a positive experience of hospital care.	Patient experience of inpatient care (average number of negative responses per 100 patients)	Previously only available at provider level	77 (13/14)	None	• Working with providers to increase the response rates and positive recommendations recorded by the Friends and Family Test • Embedding patient experience into all provider CQUINS 16/17 • ASAP campaign launched to provide information about alternatives to A&E, reducing unnecessary waiting for patients in A&E  • Clinical programme group pathway redesign, informed by experience feedback from patients, families, carers and staff

Outcome ambition	Outcome framework measure	Out Turn		Support measures	Examples of how we will deliver
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Patient experience of primary care (average number of negative responses per 100 patients)	Previously only available at provider level	67.4 (13/14)	None	• Delegated responsibility for Primary Medical Care commissioning enabling us to commission across whole pathways of care and develop a Primary Care Strategy to deliver new ways of working and a sustainable, resilient primary care for the future that provides more care in practice and the community, responding to the Five Year Forward View • Primary Care Offer – 100% sign-up to all building blocks of our locally commissioned service that increases quality in primary care and reduces variation • Estates strategy – Primary Care Infrastructure Plan – aligned with emerging Primary Care Strategy and addressing the rising population and those practices with unsuitable premises for current and future projected population
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	National indicator is in development.			Health care acquired infections	Gloucestershire will adopt the national set targets for clostridium difficile & MRSA in 2016/17 • RCA (Root Cause Analysis (localised)) of each case continues. • Local Task & Finish Group reviews C.diff outcome data and mitigating actions. Including:

Outcome ambition	Outcome framework measure	Out Turn		Support measures	Examples of how we will deliver
					• Practices to review all patients over 80 years on PPIs using Eclipse Live audits. Request prescribing of PPI as STAR PU by practice. • Ribotyping of all C diff cases • Continuous education and information to GPs via multi media

Measures of Success 2015/16 to 2016/17

Reference	Description	Target	2015/16 (RAG status)	2016/17 (RAG status)	Plan for Delivery
E.B.3	The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	92%	Green	Green	• Continued delivery of admitted and non-admitted performance • Achievement of Incomplete target with increased focus of data quality to ensure that weekly reporting is more reflective of fully validated position. • The CCG has identified increased pressures within Cardiology, General Surgery, Urology, Rheumatology and Neurology. • Plans are in place to redesign pathways in all of these areas to sustainably improve performance in the long term. • Short term actions include direct waiting list transfers, IFR compliance, working with alternative providers to put more capacity into the system in the short term.

E.B.4	Diagnostic test waiting times – under 6 week waits	99%	Red	Green	• The proportion of patients waiting over 6 weeks for a diagnostic procedure has increased in 2015/16. Performance throughout the year has been affected by short-term capacity related problems; the CCG is expecting sustainable delivery throughout 2016/17. • CCG are securing additional capacity for 2016/17 and will undertake retendering for AQP (Any Qualified Provider) diagnostic services.
E.B.6-14	All Cancer 2 week waits	93%	Amber	Green	• Delivery of cancer targets has been pressured with increased demand for services throughout 2014/15. • The CCG had identified pressure within Urology, General surgery and Respiratory medicine. • As with RTT plans are in place to redesign pathways in the long term with short term actions focused on creating capacity within acute providers.
	Two week wait for breast symptoms (where cancer was not initially suspected)	93%	Green	Green	
	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96%	Green	Green	
	31-day standard for subsequent cancer treatments - surgery	94%	Green	Green	
	31-day standard for subsequent cancer treatments	98%	Green	Green	

	– anti cancer drug regimens				• The CCG will continue to co-ordinated GP education and GP practice variation programmes during 2015/16. • The impact of 'be clear on cancer' campaigns have been quantified and reviewed with providers.
	31-day standard for subsequent cancer treatments - radiotherapy	94%	Green	Green	
	All cancer two month urgent referral to first treatment wait	85%	Red	Green	
	62-day wait for first treatment following referral from an NHS cancer screening service	90%	Green	Green	
	62-day wait for first treatment for cancer following a consultants decision to upgrade the patient's priority	90%	Green	Green	
E.B.5	A&E Department - % of A&E attendances under 4 hours	95%	Red	Red	• The CCG continues to implement a programme to increase urgent and emergency care system resilience to ensure that the system can cope with demand. • Priority areas are set out in our system resilience plans and focus on: 1. ED staffing and rotas 2. Acute beds and hospital flow 3. Community beds and flow 4. Weekend discharges • Shared understanding of key issues, informed by daily escalation calls.
E.B.15-16	Ambulance clinical quality – Category A (Red 1) 8 minute response time	75%	Green	Green	

	Ambulance clinical quality – Category A (Red 2) 8 minute response time	75%	Red	Green	
	Ambulance clinical quality – Category A 19 minute transportation time	95%	Red	Green	
E.A.S.1	Estimated diagnosis rate for people with dementia	66.7%	Green	Green	• Quarterly PCCAG and Medicines Management practice audits based on process tested above linked to locality visits • Strengthen support to practices by reviewing role of Community Dementia Nurse (2FT) and Dementia Advisor (Alzheimer's Society) Link to Care Home Enhanced Service for opportunities to recognise undiagnosed dementia in residents and for CHES audit to identify support data harmonisation
E.A.S.2-3	IAPT access (and recovery rate)	15% (50%)	Red	Green	• Continued maintenance of target during 15/16

Annex 4: Risk Assessment

The responsibility for monitoring risk on behalf of Gloucestershire CCG is delegated to the Integrated Governance & Quality Committee (IGQC). A corporate Risk Register is in place; collating organisational, programme and directorate risks. Managerial and clinical leadership to the management of risks (as appropriate) is in place; with routine updates in place. Specifically the following risks and mitigating actions should be noted as part of our 2016/17 Operational Plan:

Risk	Level of Risk (H,M,L)	Action
Level of transformational QIPP is not realised, impacting ability to deliver recurrent savings.	High	Established Programme Management Office processes are in place. QIPP plan aligned to the agreed work programmes, building on developments already progressing in 15/16. Accountability and risk share arrangements to be included in contracts. Allocation of specific workforce resource to enable comprehensive delivery.
Engagement of member practices in delivery.	Medium	Engagement with member practices and localities has commenced. Locality development plans are in place, and will be refreshed during 2016/17.
Individual organisation work plans divert resources from joint initiatives.	High	Joint working arrangements in place. Alignment of organisational plans, as far as possible, is fundamental.
Demographic growth is higher than anticipated, creating a demand pressure within services.	Medium	Demographic growth and incidence rate has informed the calculation, with local knowledge incorporated into planning assumptions.
Prescribing growth greater than expected levels	Medium	Robust Medicines Management QIPP plan and Joint Formulary in place. Engagement with clinicians is on-going and some contingency has been built into the plan. Clinical leadership by GP members on Governing Body and CPG leadership in place.
In year cost pressures impact on affordability	Medium	Robust planning and modelling assumptions utilised to develop Medium Term Financial Planning; including feedback from commissioner leads and integration with developed commissioning intentions. Systems and processes being established for in year management. Financial management framework refreshed and staff training planned.
Challenges to deliver required performance targets	High	Robust performance management in place. Action plans to be in place for areas requiring improvement. Change programmes in place to contribute towards delivery. Investment in

Risk	Level of Risk (H,M,L)	Action
		specific areas of key pressure in delivering performance.
Public, patients or stakeholders challenge plans.	Low	Engagement exercise completed regarding the priorities of JUYC. Regular representation within clinical programme developments.
Lack of staff engagement and staff development could limit the achievement of objectives	Low	Organisational Development plan is in place and will be refreshed to ensure it continues to meet the needs of the organisation. Appraisal process and staff PDP structure in place.

Annex 5: Engagement Feedback, and how it has informed our plan

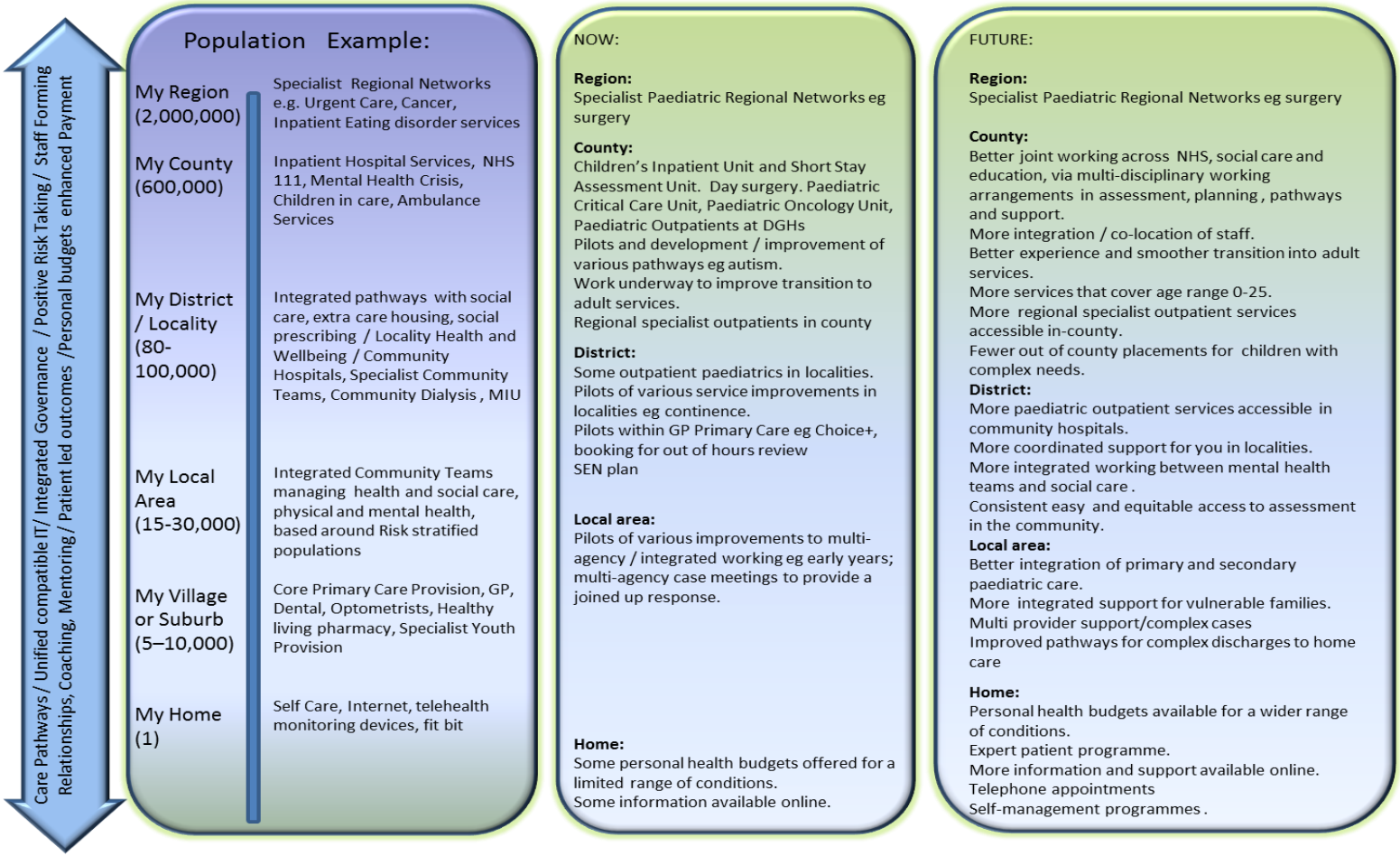
The CCG held a number of engagement events with the VCS Alliance, Healthwatch Gloucestershire, the localities, local authorities and providers. A summary of the main themes is shown below along with our response.

You said …	**CCG response …**
There should be a greater focus on prevention.	The CCG has established and is implementing a Healthy Individuals Programme. The CCG, in partnership with the County Council, has established and is implementing an Enabling Active Communities Programme.
Workforce issues are, or will be, a problem particularly in Primary Care.	The CCG has established a Gloucestershire system-wide workforce planning group to address workforce issues. The CCG has established a primary care workforce work stream which is developing a plan to attract GPs to and keep GPs working in Gloucestershire. This work stream is also looking at developing new roles in primary care.
Providers and commissioners need to work together more effectively.	The Gloucestershire Strategic Forum is overseeing the implementation of new models of care in line with the Five Year Forward View via the Gloucestershire System Sustainability and Transformation plan 2016 – 2020.
Providers and commissioners need to develop more effective ways of sharing information to support patient care.	Good progress is being made with respect to improving patients' access to their records, use of the NHS number by providers, uptake by GP practices of electronic prescriptions to pharmacies, the use of electronic discharge summaries and the number of referrals made electronically. Continued work towards the procurement and subsequent implementation of the Gloucestershire clinical record sharing solution.
More support should be given to patients, particularly those with long term conditions, to facilitate better self-care.	The CCG will commit additional resources to invest in the Voluntary Sector in support of Self Care and Prevention, and through our Cultural Commissioning work.
Social prescribing should continue to be developed and supported.	The CCG and its locality teams will continue to deliver social prescribing at scale and learning lessons from the service in 2015/16.
There should be continued investment in mental health services, particularly for children and young people.	The CCG will continue to focus on achieving parity of esteem through greater investment, meeting new waiting time targets and key performance measures (e.g. IAPT and dementia diagnosis rates).

	In addition, the CCG is planning a large number of schemes specifically aimed at children and young people with mental health *(see section 3.4)*.
Pharmacies should be given a bigger role in supporting primary care.	The CCG will continue to support the Pharmacy First initiative???
The VCS should be supported to have a bigger role in health and social care.	The CCG will develop innovative ways to commission charitable and voluntary sector providers to support healthy lifestyles through our Cultural Commissioning Programme. The CCG is developing a framework and principles for how we work with the VCSE sector building on the engagement event held with the VCS Alliance. Social Prescribing will be continued, thereby ensuring VCS have a greater role.
Technological solutions and social media should increasingly be used to improve health care.	Continued development and implementation of the CCG's IM & T Strategy. Investment in technology-reliant schemes such as telehealth, G-care and Florence.
Localities should be supported to play a bigger role in commissioning services.	A key CCG objective is to "Focus on Primary Care and Locality Development'. The CCG will continue to develop health and wellbeing plans at locality level that respond to annual locality health needs assessments.
There should be continued engagement in the development of CCG plans and strategies.	Continued implementation of the GCCG Engagement and Experience Strategy 'Our open Culture'. The CCG has implemented a Planning Cycle which includes an engagement cycle to ensure there is wide engagement prior to making major planning and strategic decisions.

Annex 6: Example of a People and Place Template

Children and Young People



NHS
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Agenda Item 12

Governing Body

Governing Body Meeting Date	**Thursday 31st March 2016**
Title	**Planning 2015/16 – Making it Happen - Update 5 Developing a Sustainability and Transformation Plan for Gloucestershire**
Executive Summary	This paper provides an update on the progress towards developing a system wide Sustainability and Transformation Plan (STP) for Gloucestershire. It is the fifth in an ongoing series of planning papers presented to the Governing Body to ensure visibility through the 2015/16 planning round.
Key Issues	The CCG Governing Body needs to note the key deadlines for the STP submission which is due to be returned to NHS England in early April, and the approach to STP governance.
Risk Issues: Original Risk Residual Risk	The risk of inherent complexity in managing the different planning issues across our system and networks.
Financial Impact	The Sustainability and Transformation Plan sets out how the Gloucestershire system will effectively use resources in the next 1-5 years.
Legal Issues (including NHS Constitution)	The Sustainability and Transformation Plan will include a commitment to ensure compliance with NHS Constitution Standards and meet the requirements set out in the national planning frameworks.
Impact on Health Inequalities	The Sustainability and Transformation Plan includes a clear commitment to reduce health inequalities.
Impact on Equality and Diversity	The Sustainability and Transformation Plan includes a commitment to ensure equality and value diversity and, therefore, there will be a net positive impact on equality and diversity as a result of implementing this paper.
Impact on Sustainable Development	The Sustainability and Transformation Plan will support sustainable development.

Patient and Public Involvement	The Sustainability and Transformation Plan will be informed through the developing process by patient and public involvement.
Recommendation	The Governing Body is asked to: i) note the progress so far towards developing the Sustainability and Transformation Plan; and ii) note the April deadline for the next Sustainability and Transformation Plan submission.
Author	Ellen Rule
Designation	Director of Transformation and Service Redesign
Sponsoring Director (if not author)	As above

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Governing Body

31st March 2016

Developing a Sustainability and Transformation Plan for Gloucestershire

1 Introduction

1.1 Sustainability and Transformation Plans (STPs) are described by NHS England as an opportunity to develop a local route map to an improved, more sustainable, health and care system. 44 STP footprints have been agreed across England, each convened by a local leader, backed by national bodies. It should be noted that footprints are not statutory boundaries, they are vehicles for collaboration and that planning will still need take place at different levels. Subsidiarity is a key principle.

1.2 The guidance states that a good STP will focus on the big questions and early action, and should be focussed on populations, not institutions or organisational forms. Systems are advised to 'spend time on identifying the practical opportunities and solutions, not endlessly debating the scale of the challenge'. It is recognised that developing an STP presents a considerable task in the current financial and operational climate, with the following issues needing careful consideration and approach to manage it effectively:

- Cross-footprint flows and boundaries
- Incentives that pull in different directions
- Building meaningful relationships
- Freeing people to focus on the long-term
- Moving quickly, whilst ensuring buy-in
- Managing short term delivery of key operational targets

1.3 In Gloucestershire, we see the STP as an opportunity to build on our strong joint working relationships already developed through the Gloucestershire Strategic Forum, across health, social care and local government, but also with patients, communities, staff and the voluntary sector. Trust and ownership will be crucial for implementation and we are clear that we will need to spend time investing in building relationships across our system.

2. National Requirements

2.1 The STP planning guidance sets out 'ten big questions' that every system needs to answer through their STP. These are as follows:

1. How are you going to prevent ill health and moderate demand? Including:

- A reduction in childhood obesity
- Enrolling people at risk in the Diabetes Prevention Programme
- Do more to tackle smoking, alcohol and physical inactivity
- A reduction in avoidable admissions

2. How are you engaging patients, communities and NHS staff? Including:

- A step-change in patient activation and self-care
- Expansion of integrated personal health budgets and choice – particularly in maternity, end-of-life and elective care
- Improve the health of NHS employees and reduce sickness rates.

3. How will you support, invest in and improve general practice? Including:

- Improve the resilience of general practice, retaining more GPs and recruiting additional primary care staff
- Invest in primary care in line with national allocations and the forthcoming GP 'Roadmap' package
- Support primary care redesign, workload management, improved access, more shared working across practices.

4. How will you implement new care models that address local challenges? Including:

- Integrated 111/out-of-hours services available everywhere with a single point of contact
- A simplified Urgent and Emergency Care (UEC) system with fewer, less confusing points of entry
- New whole population models of care
- Hospitals networks, groups or franchises to share expertise and reduce avoidable variations in cost and quality of care
- health and social care integration with a reduction in delayed transfers of care
- A reduction in emergency admission and inpatient bed-day rates.

5. How will you achieve and maintain performance against core standards? Including:

- A&E and ambulance waits; referral-to-treatment times

6. How will you achieve our 2020 ambitions on key clinical priorities? Including:

- Achieve at least 75% one-year survival rate (all cancers) and diagnose 95% of cancer patients within 4 weeks
- Implement two new mental health waiting time standards and close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and deliver your element of the national taskforces on mental health, cancer and maternity
- Improving maternity services and reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries
- Maintain a minimum of two-thirds diagnosis rate for people with dementia.

7. How will you improve quality and safety? Including:

- Full roll-out of the four priority seven day hospital services clinical standards for emergency patient admissions
- Achieving a significant reduction in avoidable deaths
- Ensuring most providers are rated outstanding or good– and none are in special measures
- Improved antimicrobial prescribing and resistance rates.

8. How will you deploy technology to accelerate change? Including:

- Full interoperability by 2020 and paper-free at the point of use
- Every patient has access to digital health records that they can share with their families, carers and clinical teams
- Offering all GP patients e-consultations and other digital services.

9. How will you develop the workforce you need to deliver? Including:

- Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values
- Integrated multidisciplinary teams to underpin new care models
- New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice.

10. How will you achieve and maintain financial balance? Including:

- A local financial sustainability plan
- Credible plans for moderating activity growth by c.1% pa
- Improved provider efficiency of at least 2% p.a. including through delivery of the carter review recommendations.

3. Developing the STP for Gloucestershire

3.1 The STP will not be a set of new priorities but will build on the strategy and shared vision set out in Joining Up Your Care and the joint programmes of work described in our Gloucestershire Strategic Forum (GSF) work programme. Our system has been ambitious in delivering change and focussing on improving health for people in Gloucestershire and we intend to build on the progress made and accelerate delivery to improve health outcomes for people in Gloucestershire. Some of the highlights from the last two years include:

- Developing a shared vision for Gloucestershire underpinned by a real commitment to joint delivery from all health and care partners in our county
- Starting our journey to truly Transform Care through using the Clinical Programme Approach, which is starting to deliver tangible change in key Clinical Pathways such as Eye Health, Respiratory Care and Musculo-Skeletal Services
- Taking back local responsibility for Primary Care Commissioning and delivery of a coherent Primary Care Offer, with strong support for primary care commissioning from members
- Ensuring a comprehensive approach to quality through the instigation of quality summits, service 'walk-throughs' and a Care Homes Quality Review
- Delivering the roll out of Integrated Community Teams across Gloucestershire
- Development of a clear approach to Enabling Active Communities and Self Care and Prevention (including innovative cultural commissioning programme) supported by a Gloucestershire devolution proposal for Health and Social Care.

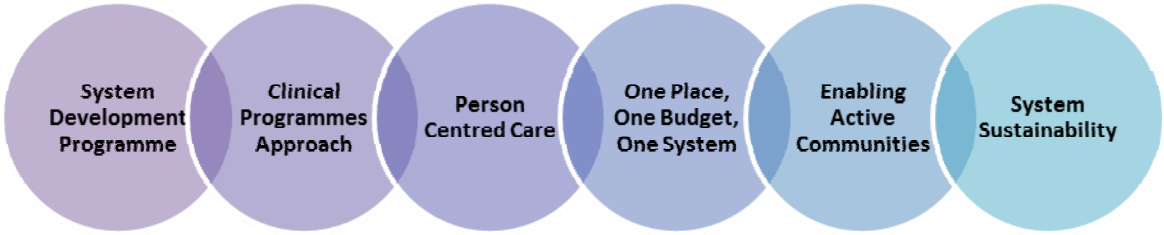
3.2 Alongside this comprehensive programme of delivery, the health system in Gloucestershire remains in good financial shape which puts us in a strong position for delivering real and sustainable system change and improvement going forwards. However, the health and care system remains under

considerable financial and operational pressure and there are still many significant challenges that we need to work through together to deliver a sustainable future for health and social care services in Gloucestershire.

4. STP Outline Planning Submission

4.1 The STP for Gloucestershire will build on the following objectives developed through the GSF workshops over the summer and building on the system vision described in Joining up Your Care.

High Level System Sustainability and Transformation Plan Objectives:



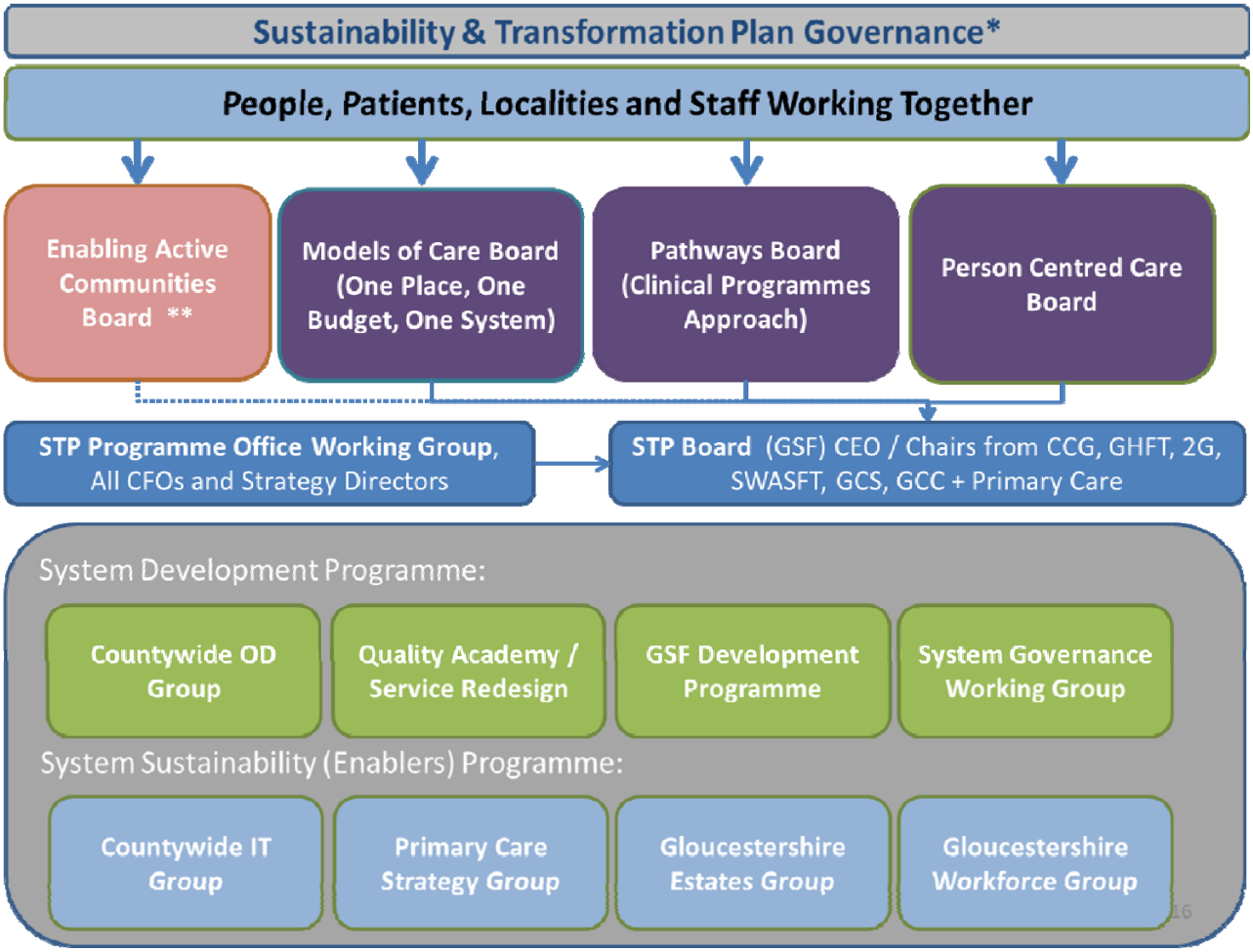
The outline contents of the plan will be as follows:

Sections	Notes
Foreword	**Introduction** from STP Board signed off by all Chairs / County Council HWB Chair
Chapter 1	**The Gloucestershire Context** • Our ambition for Gloucestershire (in context of FYFV) • Why we need change (Referencing Right Care, PHE Opportunities) • Population health outcomes
Chapter 2	**Our System Development Programme** • Developing Our System • Early implementation priorities
Chapter 3	**Our Plan Priorities** • Enabling Active Communities • Person Centred Care • One Place, One Budget, One System • Transforming Care Pathways (Clinical Programmes Approach) • Enabling Our System to Deliver
Chapter 4	**Building and Governing the Plan** • Principles of the Plan

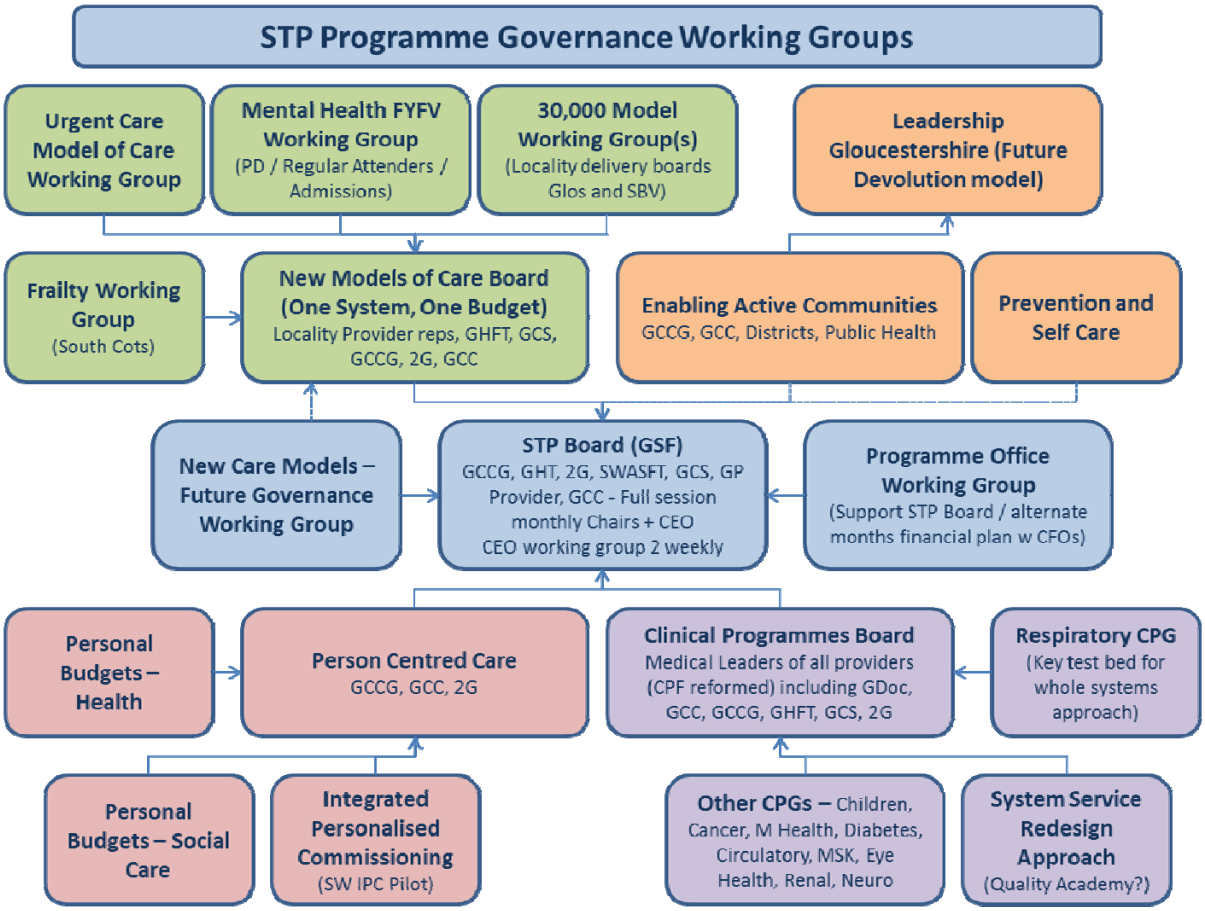
	• Working Together for Gloucestershire (Plan Governance)
Chapter 5	**Financial plan,** the financial challenge
Chapter 6	**Implementation** Plan and High Level Timeline

5. Governance Arrangements

5.1 An overarching governance structure for the STP has been agreed and supported across our system, as set out in the diagram below.



5.2 A set of working groups is being established below this to support the delivery of the key workstreams within the STP. These are set out on the following page:



6. Next Steps

6.1 The Governing body is asked to note the progress so far towards developing the STP for Gloucestershire. The next checkpoint in the national process is that each STP area is asked to make a submission by 15 April focusing on the following two questions:

a. What leadership, decision-making processes and supporting resources you have put in place to make progress?

b. What are the major areas of focus and big decisions you will need to make *as a system* to drive transformation?

7. Recommendation

The Governing Body is asked to:

- Note the progress so far towards developing the Sustainability and Transformation Plan;
- Note the April deadline for the next Sustainability and Transformation Plan submission.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda item 13

Governing Body

Meeting Date	**Thursday 31st March 2016**
Title	**Primary Care Infrastructure Plan 2016 to 2021**
Executive Summary	The CCG has developed a five year prioritised Primary Care Infrastructure Plan (PCIP) to set out where investment is anticipated to be made in either new or extended buildings, subject to business case approval and available funding for the period 2016 to 2021. A finalised version will have been presented at the Primary Care Commissioning Committee prior to the Governing Body meeting. Subject to that committee's approval, it needs to be ratified by the Governing Body for overall strategic and financial planning purposes.
Key Issues	The PCIP primarily needs to respond to an emerging direction of travel for primary care service provision and out of hospital services; population growth; a number of facilities significantly smaller than would be expected; a number of buildings where the current physical conditions and functional suitability of the main surgery building are no longer satisfactory. As the CCG is unlikely to be able to fund all the improvements it would like to make, a strategic prioritisation has been completed and this has identified eleven core schemes for taking forward for business case development.
Risk Issues: **Original Risk** **Residual Risk**	A strategic risk assessment is set out in section 6.7 of the plan and key risks are set out for programme coordination, the availability of finance and stakeholder / planning support.
Financial Impact	The additional net revenue costs for delivering the proposed schemes are set out in the strategy document amount to an estimated £2.89m per year.

	It should be noted that some of these costs could be offset for 15 years, through capital contributions funded via the national Primary Care Transformation Fund
Legal Issues (including NHS Constitution)	In respect of individual premises schemes there are likely to be legal issues around land purchase, disposal of sites and lease arrangements (where a practice is to be a tenant in the building). The CCG will also need to apply NHS Directions. In terms of the NHS Constitution the author considers 'You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary' and 'You have the right to be cared for in a clean, safe, secure and suitable environment' as the most pertinent NHS Constitution rights applicable to the PCIP.
Impact on Health Inequalities	An impact assessment has not been completed and it is assumed this will be required for each specific premises proposal.
Impact on Equality and Diversity	An impact assessment has not been completed and it is assumed this will be required for each specific premises proposal.
Impact on Sustainable Development	An impact assessment has not been completed and it is assumed this will be required for each specific premises proposal.
Patient and Public Involvement	The plan sets out patient and public involvement and engagement requirements for each individual scheme. A draft version of the plan has been shared and discussed at a Gloucestershire wide Patient Participation Group event.
Recommendation	In light of any feedback from the PCCC and subject to that committee already approving the strategy, to ratify the Primary Care Infrastructure Plan 2016 to 2021.
Author	Andrew Hughes
Designation	Locality Implementation Manager
Sponsoring Director (if not author)	Helen Goodey Director of Locality Development and Primary Care

Agenda Item 13

Governing Body

31st March 2016
Primary Care Infrastructure Plan 2016 2021

1 Introduction

1.1 NHS Gloucestershire Clinical Commissioning Group (GCCG) has had delegated authority for primary care commissioning since April 2015. In respect of premises, the CCG responsibilities are mostly set out in The National Health Service (General Medical Services Premises Costs) (England) Directions and include the determination of new primary care premises priorities.

1.2 Consequently, GCCG has developed a five year prioritised Primary Care Infrastructure Plan (PCIP) to set out where investment is anticipated to be made in either new, or extended buildings, subject to business case approval and available funding for the period 2016 to 2021.

1.3 The draft plan and supporting appendices were discussed at the Primary Care Commissioning Committee (PCCC) in January 2016 and copies were also circulated to Governing Body member. Following feedback a finalised version will have been presented at the PCCC prior to the Governing Body meeting. Subject to that committee's approval, it needs to be ratified by the Governing Body for overall strategic and financial planning purposes.

2 Overview

2.1 The PCIP needs to respond to an emerging direction of travel for primary care service provision and out of hospital services where bigger, extended teams are providing a greater range of services across 7 days in larger facilities or networked facilities across a given area of typically around 30,000 to 50,000 people.

2.2 There will be significant population growth in Gloucestershire over the next 15 years and in a small number of geographical areas, this growth will be exceptional;

2.3 There are a number of practices presently who are providing services

in facilities significantly smaller than would be expected. This position worsens over the next ten to fifteen years if there is no investment in new, or extended, buildings;

2.4 For a number of practices in Gloucestershire, the current physical conditions and functional suitability of the main surgery building are no longer satisfactory;

2.5 There are likely to be a very small number of unique situations, which the CCG will need to take into account as part of the strategic prioritisation process;

2.6 In some instances, the PCIP will be informed by other service strategies.

2.7 As the CCG is unlikely to be able to fund all the improvements it would like to make, a strategic prioritisation has been completed and this has identified eleven core schemes for taking forward for business case development.

2.8 At this stage of planning and subject to individual business case approval, the additional net revenue costs for delivering proposed schemes are set out in the strategy document and would amount to an estimated £2.89m per year. It should be noted that some of these costs could be offset for 15 years, through capital contributions funded via the national Primary Care Transformation Fund and further detail is provided in the document.

3 Recommendation(s)

3.1 The Governing Body is asked to ratify the Primary Care Infrastructure Plan 2016/ 2021 subject to any feedback and approval from the PCCC.

4 Appendices

- Annexe 1 – Final draft Primary Care Infrastructure Plan 2016/ 2021
  - Appendix 1a – Practice spatial requirements 2015
  - Appendix 1b – Practice spatial requirements 2031
  - Appendix 2 – Estates survey summary
  - Appendix 3- Strategic prioritisation

Annexe 1

Joined up care CCG

NHS Gloucestershire Clinical Commissioning Group

Version : Final draft for approval
Issued 16/03/2016
Author: Andrew Hughes
Contact andrew.hughes8@nhs.net

Final draft Primary Care Infrastructure Plan 2016 to 2021

1. Table of contents

2. Introduction & background

NHS Gloucestershire Clinical Commissioning Group (GCCG) has had delegated authority for primary care commissioning since April 2015. In respect of premises, the CCG responsibilities are mostly set out in The National Health Service (general medical services premises costs) Directions 2013 and includes:-

- Managing the rents reimbursed to practices for the provision of general medical services in buildings owned by Practices or another body, where the Practice is a tenant and is charged a lease;
- Managing the reimbursement of business rates for the provision of general medical services in buildings owned by Practices or another body, where the Practice is a tenant and is charged a lease;
- Determining improvement grant priorities- the NHS is able to provide some funding to help surgeries improve, or extend their building;
- Determining new primary care premises priorities;
- Funding new premises annual revenue requirements as a result of additional/ new rent reimbursement requirements of new premises.

Currently, any capital funding requirements is not delegated to the CCG and NHS England approval is required.

As part of delegated authority, GCCG has developed this five year prioritised Primary Care Infrastructure Plan (PCIP) to set out where investment is anticipated to be made in either, new, or extended buildings, subject to business case approval and available funding for the period 2016 to 2021.

Part A -Where are we and where do we need to be?

Joined up care CCG

NHS Gloucestershire Clinical Commissioning Group

3. strategic context

3.1 The future direction of primary care service provision

A number of strategic plans recognise that day to day primary care services still need to be delivered but some care, currently provided in hospital settings, also needs to become a much larger part of what the NHS does in local facilities.

The wider range of services - extended primary care- is expected to include increased community services, Out of Hours services and other specialist based services such as diagnostics, more case management of vulnerable patients and more working with non-statutory bodies . These services will respond to local need and help keep people independent.

This broader range of services need to be available 24hrs per day and seven days per week and for some services will require practices to work together to improve urgent access at evenings and weekends. It is expected that Doctors will lead the provision of this extended primary care . The services will be better integrated, be at the heart of a stable care system and will remain connected with the local communities they serve.

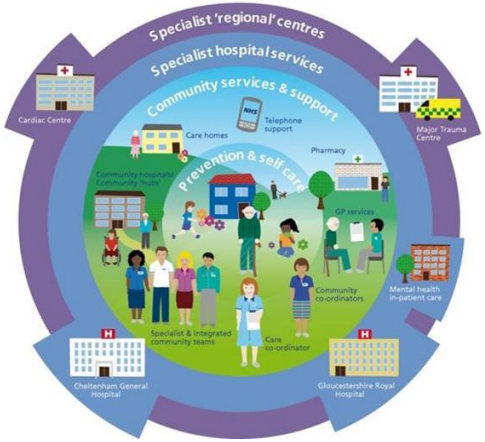
GPs will work even closer with nursing disciplines, other community health practitioners, hospital specialists mental health and social care – so there is a wider team including District Nursing , community matrons (case managers) health visitors, midwives and social workers.

Practices are increasingly expected to employ bigger teams , which in turn work together as well as with other health and social care providers through formal networks. Reference has also been made to emerging 'Super' practices – one practice operating from a number of sites – essentially general practice operating at a larger scale. Increasingly, local primary care services will be delivered for around 25,000 to 100,000 population.

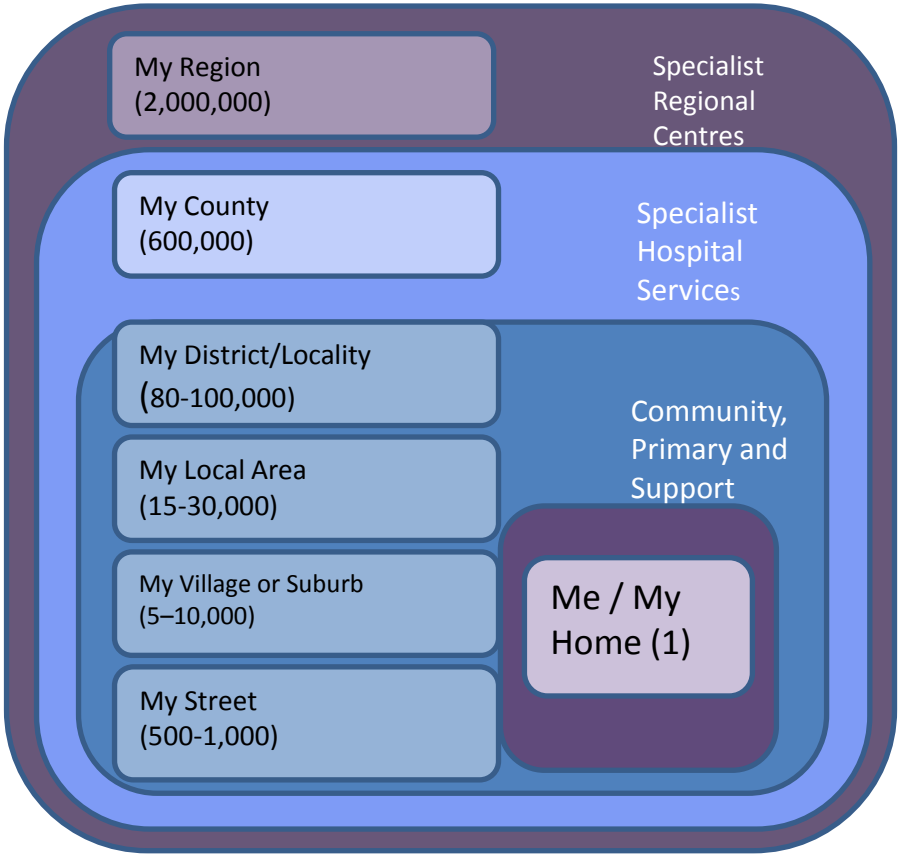
In order to deliver this emerging service strategy, literature refers to the development of local primary care hubs that practices are likely to be co-located within and/ or access for diagnostics, extended care and out of hospital services.

3.2 Gloucestershire CCG strategy – A people and Place approach to joined up care

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



Services plans responding to a 'people and place' perspective / Place based commissioning based on certain population sizes



Key focus for primary and community will be joined up care for the populations of around 30,000 to 40,000 people

Some geographical areas are already undertaking service reviews e.g. Forest of Dean to consider this emerging model. The development of primary care infrastructure could be required to deliver the agreed new models of care

3.3 Out of Hospital care

Support primary care to undertake pro-active case management and co-ordination of care of patients in context of Gloucestershire out of hospital care. At the same time supporting the CCG ambition to reduce increasing pressure on the hospital based urgent care system;

Support GP practices to make more use of voluntary services for their patients;

Enabling Active Communities (helping people to help themselves)

Develop ways of working to ensure the interface between in and out-of-hours primary care services works more effectively;

Ensure GPs continue to develop a key role in ensuring co-ordination of integrated care; through the consideration of how primary care can better support the integration of care for patients with long term conditions (developed through the clinical programme approach);

Extend the range of services offered in primary and community care recognising diverse demography and health needs of the population across Gloucestershire including diagnostics, rehabilitation, mental health, therapies and outpatients

Person led planning including what to do when Long Term Conditions or frailty exacerbate;

One summary care record – Joining Up Your Information (JUYI); Focus on prevention across all Clinical Programme Groups and health and wellbeing;

Working with well developed and active voluntary sector organisations and community groups;

Simplify access to and integrate urgent primary care to avoid unnecessary emergency hospital care;

Ensure greater utilisation of technology to support new ways of working within primary care;

3.4 The challenge of the existing estate

Across England, 40% of practices surveyed by the British Medical Association felt premises were not adequate to deliver existing services and 70% were too small to deliver extra services.

GCCG needs to ensure there is sufficient capacity for future need, whilst maximising use of facilities and delivering value for money as limited financial investment is available to fund requirements.

There needs to be a focus on enhancing patients' experience and improving the environment for staff to provide the best care. GCCG commissioned an estates survey in the Spring of 2015 that has highlighted spatial constraints in some buildings, that the condition of some buildings are no longer suitable for the long term and the functionality/ layout in some buildings is not satisfactory.

Whilst there are a number of committed developments and improvements, the survey suggests that Gloucestershire needs a programme to improve the quality and capacity of primary care buildings.

Whilst it is still essential to ensure core primary care services are available, there is a also a need to modernise premises to ensure more services can be delivered out of hospital and that some of this additional capacity will not be done at the single practice level. Further, improved and/ or enlarged infrastructure can be both catalyst for delivering change or an enabler to deliver agreed service models.

3.5 Rising population

This plan is using the period up to 2031. The registered population is set to rise from 622,000 in 2015 to 713,000 in 2031. An increase of over 90,000 people over a fifteen year period.

There will be significant housing developments in different parts of the County. The impact will fall more on some practices compared to others.

A number of existing committed schemes will deal with some of growth in population.

Significant pressure remains in the Brockworth and Coopers Edge areas; the far southern Gloucester City fringe/ west and north west of Stonehouse; West and North West of Cheltenham, Bishops Cleeve; parts of Cirencester and parts of the Forest of Dean.

Assumptions have been made on where patients are likely to register (patient flow)

There are opportunities to work with District Councils and housing developers to ensure contributions are made towards costs of new health centres required because of the construction of new homes

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NHS Gloucestershire Clinical Commissioning Group

4. The Current state

4.1 Current buildings

There are currently 82 practices providing general medical services to 630,000 registered patients.

Services are provided in 108 buildings. There are 73 main buildings, housing 82 practices and 35 branches. Although some practices operate more as split sites

58 of the buildings are owned by the Practices themselves. 32 of the buildings are leased, where the GP Practice is a tenant. 1 building is part leased and part owned. In one situation, the Practice is expecting to have to vacate their main leased site within the next 5 years

For 17 buildings , the ownership status is not available

On current registered list sizes, 90% of practices are in buildings smaller than current recommended sizes

Almost a quarter of practices are in buildings significantly smaller that current recommended sizes – that is 45% of more smaller. A breakdown by Practice is attached at appendix 1a

Taking into account future population growth, the proportion of practices in building significantly smaller than current recommended sizes increases to one third. A breakdown is attached at appendix 1b

4.2 Conditions and suitability of estate

A key part in determining future investment priorities relates to the current building condition, the building functionality and other key aspects relating to the estate. GCCG commissioned a six Facet survey. The survey is part of a suite of guidance referred to as NHS Estatecode. Originally aimed at hospital buildings, it can also used to for primary care buildings . The survey is aimed at helping to inform maintenance programmes and are also used to help inform future strategic investment. It is a set of standardised core information and comprises of a combination of six separate surveys: -

- Facet 1 – Physical Condition Survey (including mechanical and electrical aspects). A risk-based survey providing practical information for assessing building stock condition, which covers 23 elements;
- Facet 2 – Functional Suitability Review Assesses the appropriateness of the function/facility in relation to the activities taking place;
- Facet 3 – Space Utilisation Review Assesses the physical use of the building, identifying low use, empty and overcrowded rooms;
- Facet 4 – Quality Audit Based on factors which relate to the quality of the internal spaces when assessed. Enables premises to be judged and compared with one another. It determines those that are most and least pleasant for both staff and visitors;
- Facet 5 – Statutory Compliance Review -An assessment of statutory requirements , the elements of this audit help practices understand there position against their legal obligations. This audit identifies the extent to which the facilities comply with these statutory regulations;
- Facet 6 – Environmental Management Review - An assessment of the policies and procedures at the practice relating to the management of water consumption, energy usage, waste control and procurement (if applicable). It should be noted that facet 6 is not available for the Gloucestershire survey.

NHS England guidance recommends for primary care premises developments, attention should be placed on current buildings where the physical condition (facet 1) and/ or the functionality suitability review are deemed to be unsatisfactory. It should be noted that practices who are already progressing committed developments did not participate in the survey.

A summary of scores for Gloucestershire Practices without a committed development is provided at appendix 2. Scores of A and B are deemed as acceptable and scores of C & D are deemed not satisfactory. With regards to scores of C&D - this does not mean that the building is about to fall down or is dangerous, but is more likely to require improvement in the future. The scores for facet 1 and facet 2 have been taken forward as part of the prioritisation methodology and full reports have been shared with practices.

4.3 Current premises budget

The delegated premises budget agreed with NHS England for 2015/ 2016 is made up of the following items

Item	2015/ 2016 budget £m*
Rent	5.632
Rates	1.765
Clinical waste	0.134
Refuse	0.109
Water rates	0.076
Grand Total	7.716

The CCG medium term financial plan indicates that there will be significant financial challenges and the CCG premises will need to align with Quality & Productivity challenges. The CCG is producing wider Strategic Estates Plan, which the Primary Care Infrastructure Plan is a key element. One of the key aims of the plan, is maximum utilisation of the existing health and social care infrastructure and develop join approaches that maximise any future investment. It will also be important to utilise all funding sources such as the national Primary Care Modernisation Fund.

*Source: NHS Gloucestershire CCG

4.4 Committed developments

As at March 2016, there are a number of committed developments in different stages of delivery. These deliver some of the solutions to the challenges faced and, of course, are excluded from the strategic prioritisation

Locality	Practice	Scheme	Status
Cheltenham	Sevenposts surgery	New building in Bishops Cleeve, closure of existing main site on Prestbury Road and closure of existing branch in Bishops Cleeve	Approved subject to District Valuation Value for Money confirmation
Cheltenham	Stoke Road Surgery	Refurbishment and extension to existing building	Approved
Gloucester City	Churchdown	New building in new location and closure of existing facilities	Approved
Gloucester City	Hadwen Medical Practice	Refurbishment and extension of Glevum surgery site	Approved
Gloucester City	Longlevens surgery	Extension to existing building	Approved, subject to Primary Care Infrastructure Fund due diligence
Gloucester City	Rosebank health	GP led scheme- new building in the Kingsway area of Gloucester City to deliver services to new population	Approved
North Cotswolds	Stow Surgery	Third Party Development - Closure of existing building and new building	Previous approval remains with agreed size and financial envelope. Developing on a different site
Tewkesbury	Church Street & Mythe	GP Led development – new building on Community Hospital site and closure of all existing Tewkesbury town centre medical facilities	Approved and construction commenced

4.5 Summary – the gap and challenges

In summary, the PCIP needs to respond to the following challenge:

- An emerging direction of travel for primary care service provision where bigger, extended teams are providing a greater range of services across 7 days for a larger population being served in larger facilities or networked facilities across a given area of typically around 30,000 to 100,000 patients;
- There will be significant population growth in Gloucestershire over the next 15 years and in a small number of geographical areas, this growth will be exceptional;
- There are a number of practices presently who are providing services in facilities significantly smaller than would be expected. This position worsens over the next ten to fifteen years if there is no investment in new buildings, or extended buildings;
- For a number of practices in Gloucestershire, the current physical conditions and functional suitability of the main surgery building are no longer satisfactory;
- There are likely to be a very small number of unique situations, which the CCG will need to take into account as part of the strategic prioritisation process;
- In some instances, the PCIP will be informed by other service strategies such as the Forest of Dean community services review;
- Due to financial constraints, the CCG will not be able to invest in all the schemes it would like to. Therefore, it will need to first strategically prioritise against these challenges and subsequently will require business cases for each proposal to ensure they provide a compelling Case for Change and represent Value for Money.

Part B -How are we going to get there? Our strategic priorities and delivery

Joined up care CCG

NHS Gloucestershire Clinical Commissioning Group

5. Primary Care Infrastructure Plan

5.1 PCIP – methodology, approach and assumptions

- It is assumed that no new general medical service (GMS) contracts will be commissioned so that population growth and new service requirements will be delivered by existing contractors, or any merged contractors;
- Only main sites have been considered at this stage no branches. However engagement has indicated that the CCG might need to consider practices with split sites that have equal operating status;
- In considering future priorities, any practices with a committed development or significant extension are not included;
- Take into account current building condition – to what extent is the building not satisfactory?
- Take into account building functionality – to what extent is the building not satisfactory?
- Is the building 45% or more smaller than it should be to deal with current/ future predicted registered list size;
- Take into account housing and population growth and the assumptions of patient flow to practices and how this impacts on current facilities;
- Are there any specific unique factors to consider or wider tactical considerations;
- Following the early strategic determination of priorities, consideration then needs to be given to emerging service models and how priorities can be configured to best support this- i.e. more than one practice in a building – hubs;
- Identified priorities will also need to consider other concurrent service strategies such as the Forest of Dean community services review when identifying proposed solutions;
- It should be noted the PCIP will set out agreed priorities but any proposal will still need the development of a full business case before formal approval;
- The PCIP will support national Primary Care Transformation Fund bids and the CCG coordinate proposals with local practices in future years;
- It is assumed the national Primary Care Transformation Fund will be used to offset some of the capital costs – thus reducing revenue requirements (15 year rental abatement) and/ or to fund capital costs to support out of hospital service developments not part of GMS Premises Directions reimbursement;
- There needs to be patient engagement regarding specific proposals. This commenced with discussion of the this strategy at a Gloucestershire wide Patient Participation Group event in January 2016;
- Priorities will be grouped in assumed order of importance;
- An initial Financial framework has been produced to set out resource implications for identified priorities.

5.2 PCIP – Strategic prioritisation

Prioritisation explained

- High level assessment across five elements
- Assessment of how many of the five elements a practice appears in
- Essentially a point for each element – normally maximum of 5 points
- If the building condition was assessed as unsatisfactory in the recent estates survey, one point
- If the functionality of the building was assessed as unsatisfactory in the recent estates survey, one point;
- If the physical capacity of building (the gross internal area in square metres) is 45% or more smaller than current sizing regulations (as per NHS England guidance), 2 points, which recognises the added importance of prioritising practices that have a lack of space now in 2016;
- If physical capacity of building (the gross internal area in square metres is estimated to be 45% or more smaller than current sizing regulations (as per NHS England guidance) allow , 1 point;
- If there are specific, unique factors these have been taken taken into account with additional points ad rationale added. For example, the extreme population growth predicted over the next fifteen years in and around Brockworth
- Priorities have then been grouped

Priority Groups explained

Appendix 3 set out priorities in groups

- Strategic groupings 1 and 2 are schemes the CCG is expected to consider its top priorities
- Strategic groups 3 and 4 are schemes the CCG that are expecting to be important over the medium term
- Strategic groupings 5 & 6 are schemes that are less likely to considered for development during this period
- Strategic grouping 7 is not expected to be considered for the period 2016 to 2021

5.2 PCIP – Draft Key strategic priorities -

A full breakdown of scores and groupings is attached at appendix 3 . At the time of writing this version of the PCIP, the schemes below have been identified as the top priorities. As a result of additional information and data , the scoring might need to be changed through periodic review. It should be noted that some schemes will be made up of more than one practice. Hence they will spread more than one priority. This plan assumes the proposals below will be the minimum taken forward by the CCG

Locality	Premises proposal
Cheltenham	Replace up to5 practices with 1 or 2 new surgery sites (Berkeley Place, Crescent Bakery, Yorkleigh Surgery , Royal Crescent and Overton Park surgeries)
Cheltenham	Development of surgery provision for the West/ North West of Cheltenham due to new housing developments
Forest of Dean	Replace Cinderford Health Centre with a new health facility for the 2 surgeries currently residing within the new Building – Dockham Road and Forest Health care
Forest of Dean	Replacement of Coleford Health Centre with new surgery building
Gloucester City	Replace the existing Rikenel building with purpose built facility on a different site
Gloucester City	Either a new surgery or two surgeries, if one not achievable, to replace the Brockworth and Hucclecote surgeries and cover major population growth over the next 15 years
South Cotswolds	Whilst individually, the four Cirencester Town Centres do not appear as top priorities, collectively and with planned housing developments due to take place, there is a Case for Change for a new model of primary care , which will necessitate infrastructure development
South Cotswolds	Replace Romney House with a new surgery building in Tetbury
Stroud & Berkeley Vale	Replace the existing Beeches Green with new building to accommodate the Health Centre, Stroud Valley Family Practice and also include Locking Hill
Stroud & Berkeley Vale	Replace the existing Minchinhampton surgery
Stroud & Berkeley Vale	Review surgery provision in Stonehouse and north/ north west of Stonehouse , particularly for Regent street and Stonehouse health clinic

The next few pages set out more locality specific priorities and issues, including existing commitments set out earlier

5.3 (i) -Cheltenham locality priorities

Additional population growth over the next 15 years expected to be around 21,000 additional people

Sevenposts surgery – closure of two sites and new build on new site (Bishops Cleeve)- approved by NHS England

Stoke Road (Bishops Cleeve) –Extension to existing building around - approved

Winchombe – extension to existing building including space for physiotherapy

Leckhampton & Portland surgery second - further review on population growth in this area likely to be required

New surgery building for the North West/ West of Cheltenham and further work on patient flow assumptions for existing practices. Current assumption that the new building would register this population and be managed by an existing practice

Development of new surgery site(s) for up to 5 Town Centre surgeries

5.3 (ii) Gloucester city locality priorities

Overall local population set to rise by 27,000 in 2031 with significant growth in Churchdown, Innsworth, Brockworth, Coopers Edge and Southern fringes of the City

Hadwen medical practice- large extension to building and refurbishment around 840m2 additional space to existing building approved . At December 2015, planning permission granted but construction not yet started - expected Spring of 2017

Churchdown surgery –new building approved and at December 2015, planning application waiting to be submitted

New surgery to cover population expansion in and around the Kingsway area of Gloucester City approved

To deliver the existing committed to extend Longlevens surgery with 3 consultation rooms, health promotion room and other support space

To develop a new surgery site to replace the current Gloucester City Health surgery contained within the Rikenel building in the Centre of the City and consider the infrastructure requirements of other patients in the City Centre area

To develop and deliver ideally one surgery site , or two if not achievable to deal with increasing population in Brockworth, Coopers Edge and Hucclecote to replace the existing Brockworth and Hucclecote surgeries

To review the options to assess the requirement for a business case for the infrastructure requirements of the patients served by Cheltenham Road surgery

5.3(iii) North & South Cotswolds priorities

Population growth estimated to grow by over 4,000 people by 2031

Stow surgery- approval for new build on specific site. Practice currently working with developer on design and layout and will require Value for Money confirmation

No other high priorities identified but building constraints for Chipping Camden likely to become an issue over the medium/ longer time (currently 32% below recommended size but by 2031 this becomes 44%

Population expected to rise by 14,000 over the next 15 years. Growth focused in Chesterton part of Cirencester and in and around Tetbury. Further refinement of the assumed patient flow for new Chesterton development required to finally determine impact on local surgeries

Romney House in Tetbury key priority as Practice have advised that it will need to vacate the building as the owner wishes to sell the property. Business Cass to set out and test options

Four Cirencester practices are currently exploring a new model of primary care across the Town. Whilst the strategic prioritisation has currently indicated that currently these practices are relatively less of a priority, changes to existing infrastructure are expected to be necessary to deliver this new model. This is anticipated to be no more than two sites housing the four practices .

5.3 (iv) Stroud & Berkeley Vale priorities

Stroud & Berkeley Vale population expected to be over 9,000 higher in 2031

Locking Hill, The Health Centre Beeches Green and Stroud Valleys Family Practice very high priority for CCG and there is a commitment from practices to develop a single scheme on the existing Beeches Green Health Centre site to deal with current spatial constraints, the recent closure of another Town Centre surgery as well as other population growth

Development of new surgery for Minchinhampton

The Stonehouse area (including up to Huntsgrove area and fringe of Frampton) is likely to experience significant population growth over the next 10 to 15 years. Prioritise Stonehouse Town Centre practices to agree a long term solution

No other significant priorities identified relative to other practices across Gloucestershire.

5.3 (V) Forest of Dean, Tewkesbury, Staunton & Corse priorities

Population expected to increase by around 11,000 people over the next 15 years

Brunston Practice – extension to existing building for consultation rooms and practice manager rooms

Redevelopment of Cinderford Health Centre

Redevelopment of Coleford Health Centre and explore the potential for Brunston surgery to be part of any proposed new development

Need to ensure primary care premises developments align with proposals of the current review of community services across the Forest of Dean e.g. the potential for the development of Lydney Health Centre

Over 6,000 Increase in population by 2031

Completion of a new Tewkesbury Primary Care Centre and the closure of the current Tewkesbury Town Centre surgery buildings

Reviewing planned housing developments on former Ministry of Defence site at Ashchurch and further impact on primary care infrastructure

Joined up care CCG

NHS Gloucestershire Clinical Commissioning Group

6. Delivering the Plan

6.1 Delivering the priorities – business case processes

For the 2016 to 2016 PCIP there will be a two stage process: -

Stage 1 -A relatively short proposal will be completed. Due to the timing of this plan being at the same time as the submission of proposals to NHS England's Primary Care Transformation Fund at the end of February 2016, the CCG will adopt this documentation. It will be referred to as a Project Initiation Document (PID) for 'X' development. At the time of writing, the documentation is not available (December 2015) once issued , it will be incorporated into this plan as an appendix .

Stage 2 – the completion of a detailed business case. Following stage 1 approval, a detailed business case will be completed to demonstrate, viability and service benefits and is the key document for obtaining CCG support and the necessary funding. It will need to be compliant with the principles set out in the HM Treasury's (HMT) Five case model style of business case development and contain, at a minimum the following and be referred to as the Business Case for 'X' development : -

- Executive summary;
- Strategic context and the case for change;
- Options and options appraisal;
- The preferred option;
- Financial appraisal;
- Commercial case including benefits and outcomes, value for money and affordability assessment;
- Patient and stakeholder engagement/ consultation, including, where appropriate other health and wellbeing partners ;
- Travel plans;
- Risk analysis;
- Project development adviser team and project timetable.

The CCG welcomes discussion on whether it should issue a specific format to be used. Or whether practices and their developers should have the flexibility in producing their business case so long as it meets the criteria set out above. The specific practice/ practices will be responsible for the completion of documentation. However, CCG resource will be available to facilitate , help and advise and/ or fund additional support.

6.2 Delivering the priorities – use of primary care transformation fund

To send a clear signal that The NHS England £1bn four year Primary Care Infrastructure Fund is designed to improve services, from 2016/ 2017 onwards it will be known as the Primary Care Transformation Fund (PCTF). The bulk of the fund will be deployed to improve estates and accelerate digital and technological developments in general practice, and will be subject to an initial bidding process. At the end of October 2015, CCGs received a letter asking that they make recommendations to NHS England to support the funding of improvements or developments in practices in its area, initially by the end of February 2016 but currently is from the end of April 2016 onwards. The recommendations will need to demonstrate that they meet one or more of the criteria set out below:-

- Increased capacity for primary care services out of hospital (It is assumed this could include space that does not normally qualify for rent reimbursement);
- Commitment to a wider range of services as set out in your commissioning intentions to reduce unplanned admissions to hospital; (It is assumed therefore this could include spaces that do not qualify for rent reimbursement);
- Improving seven day access to effective care;
- Increased training capacity.

It is noted that CCG recommendations should also reflect the wider local Strategic Estates Plan currently being developed and due for completion in the Spring of 2016. The CCG should also produce phased funding plans (limited to 31 March 2019 for the PTCF) for recommended developments, which take into account their long-term affordability. The PCIP approach completely reflects this.

In respect of the PCTF, the CCG is working with identified prioritised practices on significant development proposals as well as offering other practices as offering other practices to opportunity to set out smaller improvement requirements so that an agreed submission can be made to NHS England within required timescales.

Subject to NHS England approval, the planning assumption is that pre project costs will be drawn down from the fund early to complete business cases during 2016/ 2017 and then subsequently a proportion of capital costs will be funded by the PCTF for the provision of general medical services (GMS) and/ or out of hospital services that might not normally qualify for GMS rent reimbursement. In line with Premises Directions, for GMS aspects, this will result in a revenue rental abatement for 15 will lower the revenue costs than would be the case without PCTF funding for this time period. However, it should be noted that full revenue costs are set out in this plan, which assumes no PTCF funding is received by the CCG.

6.3 Engagement and stakeholder involvement approach

NHS England (NHSE) has recently published the Patient and Public Participation Policy and Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning.
https://www.england.nhs.uk/ourwork/patients/ppp-policy/

These documents make it clear that responsibility for primary care commissioning engagement sits with 'delegated' CCGs under their duty to involve. Therefore , the NHSE policy and arrangements do not apply. This clarification from NHSE allows for the extension of the GCCG approach to engagement, which meets the CCG's duty in respect of the services we commission (section 14Z2 of the Health and Social Care Act, 2012), to primary care commissioning engagement. The GCCG Strategy for Engagement and Experience: *Our open culture* sets out GCCG's approach to engagement . It sets out our intention to promote 'Equality' and working in 'Partnership' and the desire to enable 'Anyone and Everyone' to have a voice. To achieve this we provide 'Information and good Communication', focus on 'Experience' feedback and undertake good 'Engagement and Consultation'.
http://www.gloucestershireccg.nhs.uk/feedback/gccg-engagement-and-experience-strategy/.

In respect of a proposed primary care premises development, the CCG sees two key stages and an engagement checklist is provided opposite: -

- Engagement during the completion of a business case where options are being considered
- Following approval, continued engagement through the detailed design and construction period

Engagement checklist

- ☐ A patient reference group in place *[which could be the patient participation group (PPG)]*
- ☐ Engagement Cycle: Agreed scope and level of engagement including collation, analysis and reporting of feedback [*It is expected that engagement will be on different options available and once the preferred option is agreed, further engagement on detailed design, layout and how the building will work day to day]*
- ☐ Identified a person(s) or project group to manage the engagement process
- ☐ A sound rationale for the change is described
- ☐ All stakeholders identified *[Our open culture identifies GCCG strategic partners. In respect to primary care infrastructure engagement and consultation GCCG will always involve relevant PPGs, Healthwatch Gloucestershire, relevant elected representatives and GCCG Lay Members.]*
- ☐ Identified engagement methods to be used
- ☐ Timetable for the engagement confirmed
- ☐ Engagement equality impact assessment completed
- ☐ Budget/resources to support the work identified

6.4 Financial assumptions

Locality	Premises proposal	Estimated List size	size m2 (gross internal area	capital cost 1,725 per m2 + fees at 12% plus VAT and average land costs	m2 rate inclusive of any VAT	Assumed annual current market rent	Less existing paid	Net revenue increase £
Cheltenham	Replace up to5 practices with 1 or 2 new surgery sites (Berkeley Place, Crescent Bakery, Yorkleigh Surgery , Royal Crescent and Overton Park surgeries)	47,031	3,083	£7.65m	£200	£587,800	£263,906/ £92,497	£323,894
Cheltenham	Development of surgery provision for North West of Cheltenham due to new housing developments	10,000	833	£2.43m	£200	£166,600	£0	£166,600
Forest of Dean	Replace Cinderford Health Centre with a new health facility for the 2 surgeries currently residing within the new Building – Dockham Road and Forest Health care	13,850	1,000	£2.82m	£200	£200,000	£40,000/0	£160,000
Forest of Dean	Replacement of Coleford Health Centre with new surgery building	7,773	667	£2.05m	£200	£133,400	£35,000/0	£98,400
Gloucester City	Replace the existing Rikenel building with purpose built facility on a different site	8,405	750	£2.24m	£200	£150,000	£18,500/ £ 0	£131,500
Gloucester City	New surgery to replace the Brockworth and Hucclecote surgeries and cover major population growth (section 106 assumed)	26,892	1,833	£4.75m	£200	£366,600	£120,950/ £54,827	£245,650
South Cotswolds	Replace Romney House with a new surgery building in Tetbury	10,952	874	£2.53m	£200	£174,800	£56, 200/ £25,064	£118,600
South Cotswold	Development of surgery provision for Cirencester Town primarily due to significant population growth in area known as Chesterton (section 106 assumed) with 1 or 2 surgery sites	17,326 18,908	1,136 1,208	£3.13m £3.30m	£200 £200	£227,200 £241,600	£115,274/ £42,536 £125,760/ £19,280	£111,926 £115,840
Stroud & Berkeley Vale	Replace the existing Beeches Green with new building to accommodate the Health Centre, Stroud Valley Family Practice and also to include Locking Hill	26,327	1,796	£4.66m	£200	£359,200	£55,000/ £0	£235,000
Stroud & Berkeley Vale	Replace the existing Minchinhampton surgery	7,271	667	£2.05m	£200	£133,400	£38,000/ £14,924	£95,400
Stroud & Berkeley Vale	Review surgery provision in Stonehouse and north/ north west of Stonehouse , either r joint development between Regent street and Stonehouse health clinic o	10,549	850	£2.47m	£200	£170,000	£36,600/ £25,865	£133,400
Sub total	Annual revenue					£2.91m	£0.91m	£1.94m
Sub total	Assumed annual rates (based on 40% of annual current market rent)					£1.16m	£0.275m	£0.87m
Grand total		**205,284**		**£40.08m**		**£4.07m**	**£1.18m**	**£2.89m**

6.5 Fees & other cost assumptions

The CCG will follow the National Health Service (General Medical Services – Premises Costs) Directions 2013. Key elements regarding fees that may be reimbursed are as follows: -

1. In the case where notional rent payments are to be paid in respect of newly built or refurbished practices, the reimbursable professional expenses are: -

- The reasonable costs of project manager to oversee the interest of and give advice to the contractor, up to a maximum reimbursable amount, which is 1% of the total reasonable contract sum relating to the construction or refurbishment;
- Reasonable surveyors, architects and engineers fees, which, taken together may be paid up to a maximum reimbursable amount, which is 12% of the total reasonable contract sum relating to the construction or refurbishment;
- Reasonable legal costs in connection with the purchase of a site (where applicable) and the construction or refurbishment work.

2. Where the practice premises are, or are to be, leasehold premises, the professional expenses are: -

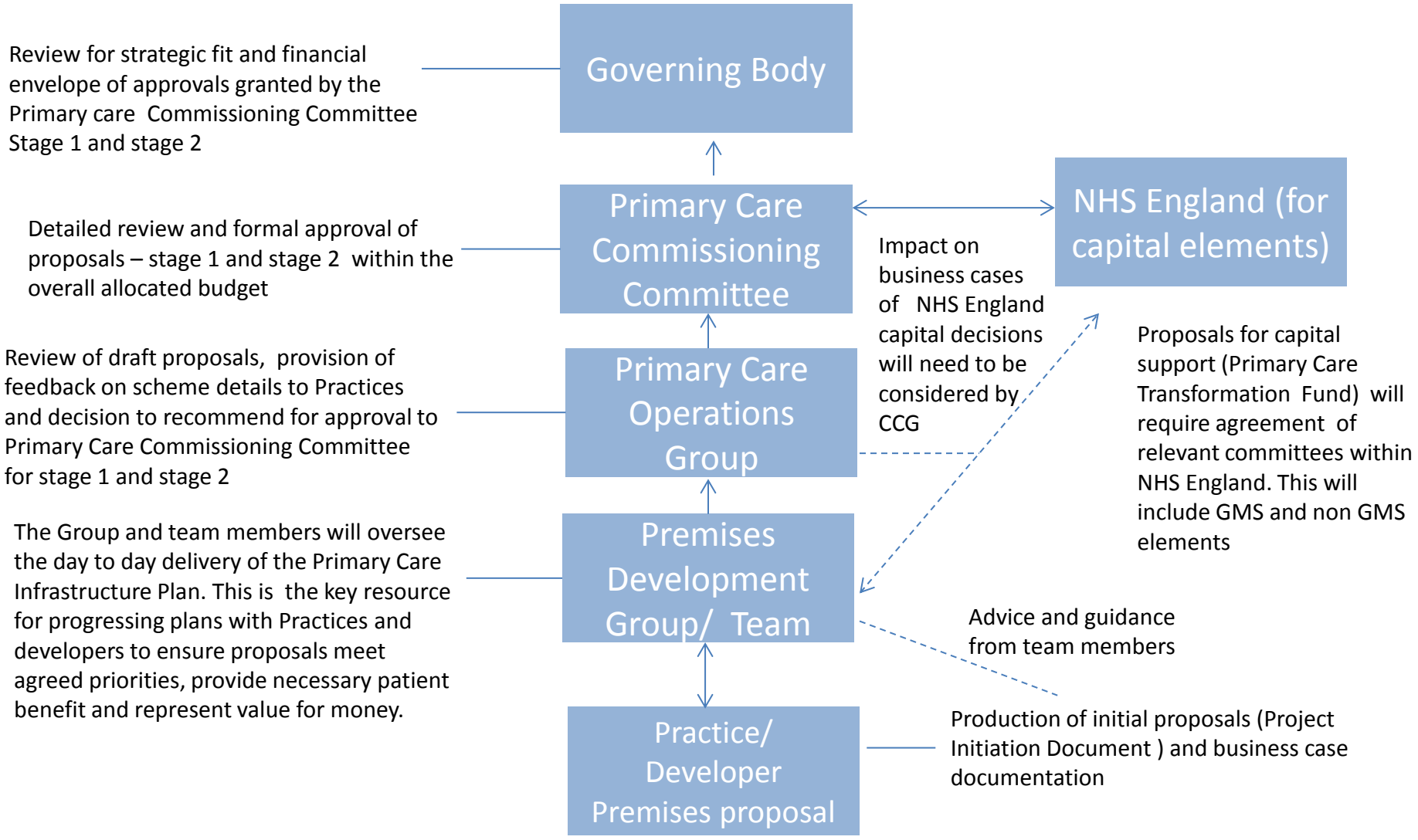
- The reasonable costs of engaging a project manager to over the interest of and give advice to the Contractor, up to a maximum reimbursable amount, which is 1% of the total reasonable contract sum relating to the construction or refurbishment work;

- The reasonable legal costs incurred by the contractor;

In the case where other fees may need to be paid by the Contractor, such as Stamp Duty Land Tax (SDLT), there is no obligation for the CCG to reimburse any of these costs to the Contractor.

It is assumed that the normal practice will be that fees will either be part of the overall financial appraisal considered for rent reimbursement, paid by the Practice or paid by the 3rd Party Developer . Only in exceptional circumstances, will the CCG consider reimbursement . In such circumstances, there will be no commitment to 100% reimbursement

6.6 Decision making and approval process



6.7 Risks & Risk management

Key initial strategic risks associated with this programme are set out in the table below. Risks will be managed through the Premise Development Group and reported through the CCG Risk Management process as part of the Directorate of localities and Primary Care Risk Register. Each development will also be required to produce, manage and if required, escalate key risks to the CCG.

Risk	Probability	Impact	Initial risk	Controls & assurance	Revised risk score
There is insufficient clarity on the aims and objectives of the programme, which means the benefits are not achieved , only partially achieved, delayed and/ or there is disagreement on proposed outputs and outcomes	3	5	15 high risk	• Programme owner in place; • Strategic Plan developed; • Business case process established • Governance arrangements agreed	1x5=5 Low risk
There is insufficient programme resource to deliver the requirements of the programme , which leads to delay in completing	3	4	12 Medium risk	• Programme team in place • Additional resource being commissioned to work with partners • Focus on key priorities • Implementation in waves	2x3 =6 Low risk
There is a risk that agreed developments are not supported by local people, patients and key stakeholders, which hinders implementation	3	4	12 Medium risk	• Engagement framework developed • Engagement with helping to agree key strategic priorities • Clear communication strategy • Enactment of engagement plan • Feedback mechanisms for key referrers to ICT	1x4 = 4 Low risk
There is insufficient financial resource to fund the development of necessary premises requirements, which means that practices are unable to provide the right level of service to patients leading to less effective care	3	5	15 High risk	• Financial framework developed • Use of PCTF to offset some costs • Development of larger Centres, wherever possible to maximise estate efficiency • Prioritising developments • Scheduling developments	2x4= 8 Low risk

6.8 Key programme timelines

Item	Planned date	status
Primary Care Infrastructure plan (PCIP)brief agreed	September 2015	Completed
Initial strategic prioritisation	October 2015	Completed
Initial engagement with CCG Member Localities and other CCG committees/ groups	October to December 2015	Completed
Primary Care Transformation Fund (PCTF)letter issued by NHS England outlining CCGS to act as coordinators of proposals	End of October 2015	Completed
Production of draft PCIP and issued.	December 2015	Completed
PCTF detailed guidance and application process issued	December 2015	Draft guidance issued February 2016
Review by Primary Care Operational Group	January 2016	Completed
Review by Primary Care Commissioning Committee	January 2016	Completed
Review by CCG Governing Body in development session	January 2016	Issued to Governing Body members
Engagement with patients and stakeholders	January to March 2016	PPG network event January 2016
Development and completion of PCTF proposals	January to April 2016	On track
Agreement and submission of PCTF proposals by CCG to NHS England, aligned with PCIP	End of April / May 2016	On track
PCIP refined and updated	March 2016	Completed
Considered and approved by Primary Care Commissioning Committee and CCG Governing Body	March 2016	On track
PCIP agreed and programme implemented with commencement of prioritised business cases with request for approval anticipated second half of 2016/ 2017 onwards . Each business case will have a detailed project plan for delivery PCTF decisions assumed to be made the summer of 2016	April 2016 onwards	On track

Practice	Locality	Actual Population at April 2015	Gross Internal Area (GIA)	Size allowance (m2)	Gap in current provision (m2)	% above/ below (minus)
Dockham Road Surgery	Forest of Dean	6115	164	511	-347	-68%
Crescent Bakery Surgery	Cheltenham	6069	193.78	584	-390	-67%
Churchdown surgery	Gloucester City	13585	345.00	1,000	-655	-66%
Rosebank health	Gloucester City	23463	550.00	1,580	-1,030	-65%
Gloucester City Health Centre	Gloucester City	7853	232.56	667	-434	-65%
Longlevens surgery	Gloucester City	7148	235.00	667	-432	-65%
Berkeley Place Surgery	Cheltenham	7495	240.00	667	-427	-64%
Springbank Community Resource Centre	Cheltenham	1596	76.66	199	-122	-61%
Stonehouse Health Clinic	Stroud & Berkeley Vale	2371	119.51	266	-146	-55%
Locking Hill Surgery	Stroud & Berkeley Vale	9248	385.56	833	-447	-54%
Regent Street Surgery	Stroud & Berkeley Vale	4115	195.26	417	-222	-53%
Overton Park Surgery	Cheltenham	11546	448.40	916	-468	-51%
Minchinhampton Surgery	Stroud & Berkeley Vale	7172	339.70	667	-327	-49%
Coleford Health Centre	Forest of Dean	7175	342.21	667	-325	-49%
Mann Cottage Surgery	North Cotswolds	3683	176.00	333	-157	-47%
Bartongate Surgery	Gloucester City	8885	403.50	740	-337	-45%
Hucclecote surgery	Gloucester City	8962	408.97	750	-341	-45%
Mythe	Tewkesbury	12441	525.15	942	-417	-44%
Yorkleigh Surgery	Cheltenham	8835	418.12	740	-322	-43%
Stoke Road	Cheltenham	9,718	475.7	833	-357.3	-43%
Cheltenham Road Surgery	Gloucester City	8270	399.80	690	-290	-42%
Royal Crescent Surgery	Cheltenham	6916	339	584	-245	-42%
Saintbridge Surgery	Gloucester City	8149	405.19	680	-275	-40%
The Portland Practice	Cheltenham	13750	596.34	1,000	-404	-40%
Culverhay Surgery	Stroud & Berkeley Vale	6256	351.54	584	-232	-40%
Church Street	Tewkesbury	13145	603.60	1,000	-396	-40%
Orchard Medical Centre	Stroud & Berkeley Vale	10116	520.00	875	-347	-40%
Rowcroft Medical Centre	Stroud & Berkeley Vale	11593	553.10	916	-363	-40%
The Medical Centre (Lechlade)	South Cotswolds	4627	255.05	417	-162	-39%
Holts Health Centre	Tewkesbury	10560	536.80	875	-338	-39%
St George's Surgery	Cheltenham	10127	538.82	875	-336	-38%
The Health Centre (Beeches Green)	Stroud & Berkeley Vale	7866	411.44	667	-256	-38%
Partners in Health (Pavilion)	Gloucester City	13804	629.14	1,000	-371	-37%
Sixways Clinic	Cheltenham	10864	550.59	875	-324	-37%
Yorkley Health Centre	Forest of Dean	7551	422.00	667	-245	-37%
Stow surgery	North Cotswolds	5522	322.00	500	-178	-36%
The Avenue Surgery	South Cotswolds	6682	378.94	584	-205	-35%
Phoenix Surgery	South Cotswolds	12689	627.00	958	-331	-35%
Leckhampton Surgery	Cheltenham	12738	634.66	958	-323	-34%
Frithwood surgery	Stroud & Berkeley Vale	6606	390.00	584	-194	-33%
The Surgery (Newnham)	Forest of Dean	3256	223.25	333	-110	-33%
The High Street Medical Centre	Stroud & Berkeley Vale	5628	336.00	500	-164	-33%
Chipping Campden Surgery	North Cotswolds	4810	281.76	417	-135	-32%
Brockworth surgery	Gloucester City	8750	518.41	750	-232	-31%
The Surgery (Frampton)	Stroud & Berkeley Vale	5017	347.16	500	-153	-31%
Quedgeley Medical Centre	Gloucester City	4515	291.40	417	-126	-30%
Forest Health Care	Forest of Dean	7735	467.00	667	-200	-30%
Stroud Valleys Family Practice	Stroud & Berkeley Vale	4093	295.18	417	-122	-29%
Corinthian Surgery	Cheltenham	8651	537.10	750	-213	-28%
The Park Surgery	South Cotswolds	7543	478.50	667	-189	-28%
St Catherine's Surgery	Cheltenham	9793	542.15	750	-208	-28%
The Chipping Surgery	Stroud & Berkeley Vale	8370	542.47	750	-208	-28%
Kingsholm Surgery	Gloucester City	4950	309.78	417	-107	-26%
Romney House	South Cotswolds	7955	500.68	667	-166	-25%
Hilary Cottage Surgery	South Cotswolds	7261	509.87	667	-157	-24%
St Peter's Road Surgery	South Cotswolds	6678	455.53	584	-128	-22%
Acorn Practice	Stroud & Berkeley Vale	4204	325.50	417	-92	-22%
Walnut Tree	Stroud & Berkeley Vale	4671	325.50	417	-92	-22%
The Surgery (Corse/Staunton)	Tewkesbury	6107	460.40	584	-124	-21%
Winchcombe Medical Practice	Cheltenham	6787	475.70	584	-108	-19%
Rendcomb Surgery	South Cotswolds	3808	278.18	333	-55	-16%
Royal Well Surgery	Cheltenham	6755	492.37	584	-92	-16%
Hadwen medical practice	Gloucester City	17561	984.00	1,167	-183	-16%
St Lukes Medical Centre	Stroud & Berkeley Vale	4058	352.15	417	-65	-16%
Brunston Practice	Forest of Dean	5730	428.03	500	-72	-14%
Underwood Surgery	Cheltenham	9866	662.90	750	-87	-12%
Mitcheldean Surgery	Forest of Dean	6025	524.10	584	-60	-10%
White House Surgery	North Cotswolds	4408	378.70	417	-38	-9%
The Surgery (Drybrook)	Forest of Dean	4436	380.00	417	-37	-9%
The Health Centre (Lydney)	Forest of Dean	6981	540.58	584	-43	-7%
The College Yard Surgery	Gloucester City	4542	395.44	417	-22	-5%
The Surgery (Blakeney)	Forest of Dean	3292	322.78	333	-10	-3%
Severnbank Surgery	Forest of Dean	4199	406.88	417	-10	-2%
Barnwood surgery	Gloucester City	6016	620.00	600	20	3%
Heathville Surgery	Gloucester City	10087	864.00	833	31	4%
Marybrook Medical Centre	Stroud & Berkeley Vale	4959	464.61	417	48	11%
London medical practice	Gloucester City	5106	568.00	500	68	14%
Hoyland House	Stroud & Berkeley Vale	4779	544.56	417	128	31%
Cotswolds Medical practice	North Cotswolds	10012	1182.00	833	349	42%
Matson Lane Surgery	Gloucester City	2181	341.00	219	122	56%
Gloucester Health Access Centre	Gloucester City	2208		199	-199	n/a

Practice	Locality	Est Forecast Population 2031	Size allowance (m2) with population growth	Gap to future need	% gap
Churchdown	Gloucester City	21,000	1300	-950	-73%
Dockham Road Surgery	Forest of Dean	7,101	593	-429	-72%
Springbank Community Resource Centre	Cheltenham	2,830	266	-189	-71%
Crescent Bakery Surgery	Cheltenham	7,303	667	-473	-71%
Gloucester City Health Centre	Gloucester City	8,405	750	-517	-69%
Berkeley Place Surgery	Cheltenham	8,729	750	-510	-68%
Longlevens surgery	Gloucester City	7,665	667	-432	-65%
Stonehouse Health Clinic	Stroud & Berkeley Vale	3,692	333	-213	-64%
Regent Street Surgery	Stroud & Berkeley Vale	5,436	500	-305	-61%
Mann Cottage Surgery	North Cotswolds	4,424	417	-241	-58%
The Medical Centre (Lechlade)	South Cotswolds	6,178	584	-329	-56%
Mythe	Tewkesbury	16,787	1200	-675	-56%
Brockworth surgery	Gloucester City	17,382	1167	-649	-56%
Stow surgery	North Cotswolds	7,426	675	-373	-55%
Royal Crescent Surgery	Cheltenham	8,150	750	-411	-55%
Locking Hill Surgery	Stroud & Berkeley Vale	11,313	833	-447	-54%
Overton Park Surgery	Cheltenham	12,780	958	-510	-53%
Yorkleigh Surgery	Cheltenham	10,069	875	-457	-52%
The Avenue Surgery	South Cotswolds	8,233	750	-371	-49%
Yorkley Health Centre	Forest of Dean	9,704	833	-411	-49%
Minchinhampton Surgery	Stroud & Berkeley Vale	7,271	667	-327	-49%
Bartongate Surgery	Gloucester City	9,437	790	-387	-49%
Hucclecote surgery	Gloucester City	9,514	800	-391	-49%
Coleford Health Centre	Forest of Dean	7,733	667	-325	-49%
Cheltenham Road Surgery	Gloucester City	8,822	750	-350	-47%
Stoke Road Surgery	Cheltenham	11,314	916	-426	-47%
The Health Centre (Beeches Green)	Stroud & Berkeley Vale	9,715	750	-339	-45%
Rendcomb Surgery	South Cotswolds	5,359	500	-222	-44%
Church Street	Tewkesbury	15,318	1083	-480	-44%
Saintbridge Surgery	Gloucester City	8,701	725	-320	-44%
Chipping Campden Surgery	North Cotswolds	5,659	500	-218	-44%
Rosebank Health	Gloucester City	23,664	1500	-650	-43%
Romney House	South Cotswolds	10,952	875	-374	-43%
The Portland Practice	Cheltenham	14,984	1042	-446	-43%
The Park Surgery	South Cotswolds	9,094	833	-355	-43%
Sixways Clinic	Cheltenham	12,098	958	-407	-43%
The High Street Medical Centre	Stroud & Berkeley Vale	6,949	584	-248	-42%
Quedgeley Medical Centre	Gloucester City	5,067	500	-209	-42%
Holts Health Centre	Tewkesbury	11,574	916	-379	-41%
St George's Surgery	Cheltenham	11,361	916	-377	-41%
St Catherine's Surgery	Cheltenham	11,027	916	-374	-41%
Orchard Medical Centre	Stroud & Berkeley Vale	10,968	875	-355	-41%
Phoenix Surgery	South Cotswolds	14,240	1042	-415	-40%
Culverhay Surgery	Stroud & Berkeley Vale	6,256	584	-232	-40%
Partners in Health (Pavilion)	Gloucester City	14,356	1042	-413	-40%
Rowcroft Medical Centre	Stroud & Berkeley Vale	11,847	916	-363	-40%
St Peter's Road Surgery	South Cotswolds	8,229	750	-294	-39%
Kingsholm Surgery	Gloucester City	5,502	500	-190	-38%
Forest Health Care	Forest of Dean	8,721	750	-283	-38%
Corinthian Surgery	Cheltenham	9,885	833	-296	-36%
The Health Centre (Lydney)	Forest of Dean	9,134	833	-292	-35%
Acorn Practice	Stroud & Berkeley Vale	5,056	500	-175	-35%
Walnut Tree	Stroud & Berkeley Vale	5,523	500	-175	-35%
Leckhampton Surgery	Cheltenham	13,972	958	-323	-34%
Frithwood surgery	Stroud & Berkeley Vale	6,705	584	-194	-33%
The Surgery (Newnham)	Forest of Dean	3,325	333	-110	-33%
Hilary Cottage Surgery	South Cotswolds	8,970	750	-240	-32%
The Surgery (Frampton)	Stroud & Berkeley Vale	5,017	500	-153	-31%
Severnbank Surgery	Forest of Dean	6,352	584	-177	-30%
Stroud Valleys Family Practice	Stroud & Berkeley Vale	5,299	417	-122	-29%
Winchcombe Medical Practice	Cheltenham	7,300	667	-191	-29%
The Chipping Surgery	Stroud & Berkeley Vale	8,370	750	-208	-28%
Underwood Surgery	Cheltenham	11,100	916	-253	-28%
Brunston Practice	Forest of Dean	6,288	584	-156	-27%
Royal Well Surgery	Cheltenham	7,989	667	-175	-26%
White House Surgery	North Cotswolds	5,149	500	-121	-24%
The Surgery (Corse/Staunton)	Tewkesbury	6,107	584	-124	-21%
The College Yard Surgery	Gloucester City	5,094	500	-105	-21%
Hadwen Medical Practice	Gloucester City	18,097	1209	-222	-18%
Hadwen Medical Practice	Gloucester City	18,097	1167	-183	-16%
Mitcheldean Surgery	Forest of Dean	6,230	584	-60	-10%
The Surgery (Drybrook)	Forest of Dean	4,551	417	-37	-9%
Marybrook Medical Centre	Stroud & Berkeley Vale	5,739	500	-35	-7%
Barnwood surgery	Gloucester City	6,568	647	-27	-4%
The Surgery (Blakeney)	Forest of Dean	3,361	333	-10	-3%
St Lukes Medical Centre	Stroud & Berkeley Vale	0	0	0	0%
London medical practice	Gloucester City	5,702	500	0	0%
Hoyland House	Stroud & Berkeley Vale	5,033	500	45	9%
Matson Lane Surgery	Gloucester City	2,733	266	75	28%
Cotswolds Medical practice	North Cotswolds	11,772	916	266	29%
Gloucester Health Access Centre	Gloucester City	2,760	240	-240	tbc

Practice Name	Locality	Condition Grade	Function Grade	Quality Grade	Space Grade	Statutory Gade
The Surgery (Corse/Staunton)	Tewkesbury	B	B	C	B	D
Holts Health Centre	Tewkesbury	B	B	B	B	D
Locking Hill Surgery	Stroud & BV	C	D	C	D	D
Orchard Medical Centre	Stroud & BV	C	B	C	D	D
Stonehouse Health Clinic	Stroud & BV	C	C	C	C	D
Culverhay Surgery	Stroud & BV	C	C	C	C	D
Marybrook Medical Centre	Stroud & BV	C	C	C	C	D
The Surgery (Frampton)	Stroud & BV	C	C	C	B	D
The Health Centre	Stroud & BV	C	C	C	B	D
Stroud Valleys Family Practice	Stroud & BV	C	C	C	B	D
The Surgery	Stroud & BV	C	C	C	B	D
Regent Street Surgery	Stroud & BV	B	C	C	B	D
Acorn Practice	Stroud & BV	B	B	B	C	D
Walnut Tree Practice	Stroud & BV	B	B	B	C	D
Rowcroft Medical Centre	Stroud & BV	B	B	B	C	D
The Chipping Surgery	Stroud & BV	C	B	B	B	D
The High Street Medical Centre	Stroud & BV	B	B	B	B	D
Rendcomb Surgery : Prices Mill Surgery	Stroud & BV	B	B	B	B	D
Frithwood surgery	Stroud & BV	B	B	B	B	C
Hoyland House	Stroud & BV	B	B	B	A	D
Romney House	South Cotswolds	C	D	C	C	D
St Peter's Road Surgery	South Cotswolds	C	C	C	C	D
The Avenue Surgery	South Cotswolds	B	C	C	B	D
The Park Surgery	South Cotswolds	C	B	C	B	D
Phoenix Surgery	South Cotswolds	B	C	C	B	D
The Medical Centre (Lechlade)	South Cotswolds	B	B	B	B	D
Hilary Cottage Surgery	South Cotswolds	B	B	B	B	D
Rendcomb Surgery	South Cotswolds	B	B	B	B	D
Chipping Campden Surgery	North Cotswolds	B	C	C	D	D
Cotswold Medical Practice	North Cotswolds	B	B	B	B	C
The Surgery (Hucclecote)	Gloucester	C	C	C	C	D
Gloucester City Health Centre	Gloucester	C	D	C	B	D
Bartongate Surgery	Gloucester	B	C	C	B	D
Saintbridge Surgery	Gloucester	B	C	B	C	D
Cheltenham Road Surgery	Gloucester	C	C	B	B	D
Partners in Health (Pavilion)	Gloucester	B	B	B	C	D
The College Yard Surgery	Gloucester	B	C	B	B	D
The Surgery (Brockworth)	Gloucester	B	B	C	B	C
Kingsholm Surgery	Gloucester	B	B	B	B	D
Matson Lane Surgery	Gloucester	B	B	B	B	D
Quedgeley Medical Centre	Gloucester	B	B	B	A	D
Gloucester Health Access Centre	Gloucester	A	A	A	A	D
Coleford Health Centre	Forest of Dean	C	C	C	D	D
Forest Health Care	Forest of Dean	C	C	C	C	D
Dockham Road Surgery	Forest of Dean	C	C	C	C	D
The Health Centre (Lydney)	Forest of Dean	C	C	C	C	D
Mitcheldean Surgery	Forest of Dean	B	B	C	C	D
Yorkley Health Centre	Forest of Dean	B	B	B	C	D
Brunston Practice	Forest of Dean	B	B	C	B	D
The Surgery (Newnham)	Forest of Dean	B	C	C	A	D
The Surgery (Blakeney)	Forest of Dean	B	B	B	B	D
Severnbank Surgery	Forest of Dean	B	B	B	B	D
The Surgery (Drybrook)	Forest of Dean	B	B	B	B	D
Crescent Bakery Surgery	Cheltenham	C	D	C	D	D
Royal Crescent Surgery	Cheltenham	C	D	C	C	D
Berkeley Place Surgery	Cheltenham	C	D	C	C	D
Leckhampton Surgery	Cheltenham	C	C	C	C	D
Yorkleigh Surgery	Cheltenham	C	C	C	B	D
Sixways Clinic	Cheltenham	C	C	B	C	D
St George's Surgery	Cheltenham	B	B	B	C	D
The Portland Practice	Cheltenham	B	B	B	C	D
Corinthian Surgery	Cheltenham	B	B	B	C	D
St Catherine's Surgery	Cheltenham	B	B	B	C	D
Royal Well Surgery	Cheltenham	B	B	B	C	C
Seven Posts Surgery	Cheltenham	B	B	B	C	C
Overton Park Surgery	Cheltenham	B	B	B	B	D
Underwood Surgery	Cheltenham	B	B	B	B	D
Springbank Community Resource Centre	Cheltenham	B	A	A	A	D

Practice Name	Locality	building condition unsatisfactory	Functionality unsatisfactory -	Signifcantly undersized for current registered population (double weighting)	Signifcantly undersized for future registered population	Additional unique situation to consider - assessment up to 4 points	Strategic priority group
Romney House	South Cotswolds	Yes	Yes	No	Yes	Yes- Owner selling building in next 5 years and informed Practice will need to vacate. Options to be tested through business case	1
Locking Hill Surgery	Stroud & BV	Yes	Yes	Yes	Yes		2
Crescent Bakery Surgery	Cheltenham	Yes	Yes	Yes	Yes		2
Coleford Health Centre	Forest of Dean	Yes	Yes	Yes	Yes		2
Stonehouse Health Clinic	Stroud & BV	Yes	Yes	Yes	Yes		2
Dockham Road Surgery	Forest of Dean	Yes	Yes	Yes	Yes		2
Gloucester City Health Centre	Gloucester	Yes	Yes	Yes	Yes		2
Yorkleigh Surgery	Cheltenham	Yes	Yes	Yes	Yes		2
The Surgery (Brockworth)	Gloucester	No	No	No	Yes	Yes - 100% popn growth - 4pts adjustment	2
Stroud Valleys Family Practice	Stroud & BV	Yes	Yes	No	No	yes- future viability of health centre and needs to partner Beeches Green	2
Berkeley Place Surgery	Cheltenham	Yes	Yes	Yes	Yes		2
The Surgery (Hucclecote)	Gloucester	Yes	Yes	Yes	Yes		2
The Surgery (minchinhampton)	Stroud & BV	Yes	Yes	Yes	Yes		2
Forest Health Care	Forest of Dean	Yes	Yes	No	No	yes- main site in Dockham Road H/C needs to partner	2
Regent Street Surgery	Stroud & BV	No	Yes	Yes	Yes		3
Springbank Community Resource Centre/ North &	Cheltenham	No	No	Yes	Yes	to act as proxy for extreme population growth in this area, score uplifted	3
The Health Centre (Beeches Green)	Stroud & BV	Yes	Yes	No	Yes	Would be part of wider beeches green development	3
Cheltenham Road Surgery	Gloucester	Yes	Yes	No	Yes		4
Bartongate Surgery	Gloucester	No	Yes	No	Yes		4
Royal Crescent Surgery	Cheltenham	Yes	Yes	No	Yes		4
Overton Park Surgery	Cheltenham	No	No	Yes	Yes		4
Saintbridge Surgery	Gloucester	No	Yes	No	Yes		5
St Peter's Road Surgery	South Cotswolds	Yes	Yes	No	No		5
Chipping Campden Surgery	North Cotswolds	No	Yes	No	Yes		5
Culverhay Surgery	Stroud & BV	Yes	Yes	No	No		5
Marybrook Medical Centre	Stroud & BV	Yes	Yes	No	No		5
The Health Centre (Lydney)	Forest of Dean	Yes	Yes	No	No		5
Leckhampton Surgery	Cheltenham	Yes	Yes	No	No		5
The Surgery (Frampton)	Stroud & BV	Yes	Yes	No	No		5
Sixways Clinic	Cheltenham	Yes	Yes	No	No		5
The Avenue Surgery	South Cotswolds	No	Yes	No	Yes		5
Phoenix Surgery	South Cotswolds	No	Yes	No	No		6
Orchard Medical Centre	Stroud & BV	Yes	No	No	No		6
Yorkley Health Centre	Forest of Dean	No	No	No	Yes		6
The Park Surgery	South Cotswolds	Yes	No	No	No		6
The Chipping Surgery	Stroud & BV	Yes	No	No	No		6
The Surgery (Newnham)	Forest of Dean	No	Yes	No	No		6
The College Yard Surgery	Gloucester	No	Yes	No	No		6
The High Street Medical Centre	Stroud & BV	No	No	No	Yes		6
Matson Lane Surgery	Gloucester	No	No	No	No		7
Gloucester Health Access Centre	Gloucester	No	No	No	No		7
Walnut Tree Practice	Stroud & BV	No	No	No	No		7
Holts Health Centre	Tewkesbury	No	No	No	No		7
Mitcheldean Surgery	Forest of Dean	No	No	No	No		7
Acorn Practice	Stroud & BV	No	No	No	No		7
Brunston Practice	Forest of Dean	No	No	No	No		7
The Surgery (Corse/Staunton)	Tewkesbury	No	No	No	No		7
Rowcroft Medical Centre	Stroud & BV	No	No	No	No		7
St George's Surgery	Cheltenham	No	No	No	No		7
The Portland Practice	Cheltenham	No	No	No	No		7
Corinthian Surgery	Cheltenham	No	No	No	No		7
St Catherine's Surgery	Cheltenham	No	No	No	No		7
Royal Well Surgery	Cheltenham	No	No	No	No		7
Seven Posts Surgery	Cheltenham	No	No	No	No		7
Partners in Health (Pavilion)	Gloucester	No	No	No	No		7
The Surgery (Blakeney)	Forest of Dean	No	No	No	No		7
Severnbank Surgery	Forest of Dean	No	No	No	No		7
The Surgery (Drybrook)	Forest of Dean	No	No	No	No		7
Kingsholm Surgery	Gloucester	No	No	No	No		7
Underwood Surgery	Cheltenham	No	No	No	No		7
Rendcomb Surgery : Prices Mill Surgery	Stroud & BV	No	No	No	No		7
The Medical Centre (Lechlade)	South Cotswolds	No	No	No	Yes		7
Hilary Cottage Surgery	South Cotswolds	No	No	No	No		7
Rendcomb Surgery	South Cotswolds	No	No	No	No		7
Cotswold Medical Practice	North Cotswolds	No	No	No	No		7
Frithwood surgery	Stroud & BV	No	No	No	No		7
Quedgeley Medical Centre	Gloucester	No	No	No	No		7
Hoyland House	Stroud & BV	No	No	No	No		7

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 14

Governing Body

Governing Body Meeting Date	**Thursday 31st March 2016**
Title	**West of England Academic Health Science Network Board Report**
Executive Summary	The attached document is the eleventh quarterly report produced by the West of England Academic Health Science Network.
Key Issues	The following key issues are referred to in the report: • business planning 2016/17; and • highlights and next steps from the work streams.
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	None
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note this report which is provided for information.
Author	Deborah Evans
Designation	WEAHSN Managing Director
Sponsoring Director (if not author)	Mary Hutton, Accountable Officer

Report from West of England Academic Health Science Network Board, 2 March 2016

1. Purpose

This is the eleventh quarterly report for the Boards of the member organisations of the West of England Academic Health Science Network.

Board papers are posted on our website www.weahsn.net for information.

2. Business Plan 2016/17

We won't know our financial allocation for 2016/17 before the end of March, but are working on the basis that most of the work will be a continuation of our current, well supported programmes.

At this stage it seems that new projects will include:

- A second phase of our popular crowd sourcing project "DesignTogether, Live Better" – this time with a distinctly digital flavour. The kick-off event "The Wisdom of the Crowd" on 19 April 2016 is filling up fast. Contact Nada for more information – nada.khalil@weahsn.net
- Avoidable mortality - our Acute Trusts are keen to work together on mortality reviews, sharing good practice. We will support this and bring patient contributors and primary care colleagues into the collaboration.
- Health Education South West are funding us to coordinate their new, grassroots approach to developing new models of care and addressing workforce issues in GP practice and wider primary, community and social care. This helps us to build on our primary care support to commissioners and our QI /patient safety work in this setting
- Improving wound care – bringing expertise and innovation from the Welsh Wound Improvement Centre we will be working across district nursing and community nursing in Swindon to support better wound care through quality improvement and skills development.

A couple of strategic developments in this year's Business Plan discussions are:

- We have had some good discussions with chairs, CEOs and clinical leaders about how we might support West of England organisations to develop a combined approach to rapid implementation of product innovation and service improvement. Two angles on the same process we think.
- How the AHSN can best support effective Sustainability and Transformation Plans – we've had lots of feedback that people value what we do now, would like more signposting towards best practice and would like further conversation about how far to change our approach towards community wide working. It was good to hear that senior leaders are happy with how we're doing things now.

3. Highlights and next steps from our work streams

We continue to report very high levels of momentum in our work and this is because we have huge levels of engagement from commissioners, providers, our Universities and wider partners:

- Diabetes Digital Coach Test Bed: after the celebrations at winning this high profile national competition we are now getting to grips with governance and making clear arrangements for this 27 month experiment with our member organisations and the companies. We will report progress quarterly and have learning events so everyone can join in.
- Health Innovators programme – the second programme is running in the first and second weeks of March with 16 participants who want to learn how to turn their entrepreneurial ideas into viable business cases.
- 'Don't Wait to Anti Coagulate,' our stroke prevention programme was scored by the other 14 AHSNs as the top adoption and spread project and one that they would be willing to adopt. We now have baseline results from 18 GP practices in Gloucestershire and are on track to save 90 people from having a stroke. People in Bristol will be the next to benefit as Bristol CCG takes this on in 2016/17.
- The Health Foundation have accredited us as the third Flow Academy in England joining Sheffield and South Warwickshire in being able to train flow coaches. RUH are working on 3 pathways and will share their learning.
- All 7 CCGs are inviting GP practices to volunteer for a primary care patient safety collaborative which will work initially on incident reporting.
- The Emergency Department safety checklist is in great demand and has impressive results. We are supporting all the EDs in the West of England to implement it through a collaborative approach. Colleagues from all over the country have asked to use it and we are running a masterclass on 25 April 2016 for all comers.
- March is the first birthday for our project to spot and treat deteriorating patients quickly. Every commissioner and provider in the West of England is active in this work to use the National/Early Warning Score across every single interface of care and SWAST are at the heart of this work.
- We held a very successful informatics event on 23 February 2016 which included a meeting of the Chief Clinical Information Officers network. The AHSN is supporting health community Digital Road Map events.
- Our Evidence and Evaluation Toolkits will be published on their own websites on 22 March 2016 and we warmly encourage you to use them and give us feedback. We will also offer a free two hour workshop on each of "Finding the Evidence" and "Getting started with Service Evaluation" to complement the toolkits in every CCG over the next 3 months.
- We continue to support the implementation of the West of England Genomics Medical Centre by leading the Public and Patient Involvement Steering Group and contributing to other work streams such as the education and training Steering Group. We supported the UWE bid to run the Genomics MSc which has now been awarded to Exeter University.

4. Find out more

Our e-newsletter is out click on:
http://us8.campaignarchive1.com/?u=f0307060daac60c96aab19b07&id=457348f4c7&e=57daf01a1b

Deborah Evans, March 2016

Agenda Item 15

Governing Body

Governing Body Meeting Date	**Thursday 31st March 2016**
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 15

Governing Body

Thursday 31st March 2016

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.

2.4 This version of the Assurance Framework was considered at the March 2016 meeting of the Integrated Governance and Quality Committee (IGQC). Further updates of the document will be provided to future meetings of both the IGQC and the Governing Body.

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					Controls		Assurances		Actions / Status	
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**	**Movement since last IGQC review**
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. Increasing examples in 2015/16 of practices becoming unsustainable.	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. Close working with member practices, delegated commissioning - maximising delegated functions.		Primary Care Commissioning Committee, Primary Care Operational Group, Risk and Issues log.		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. Event held 5th November 2015 to commence discussions with member practices, now events happening across localities on future of primary care.	⇔
T12	Risk around the specialised services for children and young people with mental health problems due to specialised commissioning transferring to NHS England leading to fragmentation of pathways.	Simon Bilous/Adele Jones	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		1. NHS England National Review completed and report published July 2014. Actions underway nationally, including commissioning of extra capacity. This is having a positive impact with fewer overstays in acute hospital and admissions to adult MH facility in 2014. But some cases are still not being found appropriate provision in a timely way which can have an impact on local systems with inappropriate admissions. 2. SW SCN commissioning guidance published October 2014. 3. Opportunities for co-commissioning with NHS England being explored. 4. Local work ongoing includes reviewing service arrangements for crisis support and psychiatric liaison including extending the age range to include u18s and u16s respectively as part of overall Children's Mental Health Transformation Plan; and developing additional options for care and support of young people in need of accommodating in a crisis (Safe Places / Place of Safety).	⇔
Objective 2: Work with patients, carers and the public to inform decision making.										
Q4	Risk of 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		Commissioning for Quality Report, Outcome of Engagement/Consultation Reports, CPGs and other programme groups	⇔
Q11	Failure to implement Deprivation of Liberty Safeguards (DoLS) as per recent judicial review.	Helen Crystal/Mary Morgan	12 (4x3)	6 (2x3)	Discussed at ASGB, Safeguarding Team CCG Lead identified, Multi-agency policy signed off, Expansion of the CCG Safeguarding function including appointment of lead roles.		Adult Safeguarding Board (ASGB) and provider Clinical Quality Review Groups (CQRGs) in place to monitor.		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.	⇔
Objective 3: Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation.										

Risk					Controls		Assurances		Actions / Status	
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**	**Movement since last IGQC review**
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 to Governing Body, 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. Streamling urgent care.	⇑
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 to Governing Body	Number of targets not being met, capacity in planned care.	Insufficient planned care capacity to meet demand could result in increasing waiting lists and inability to meet waiting time targets, impacting on the quality of local health services. A number of targets regularly not being met, including 62 day cancer target, 6 week wait for diagnostics, and a small number of 52 week wait breaches have been reported. Change fortnightly calls to weekly from October to monitor plans and trajectories. Monthly access and performance meeting arranged to discuss progress. Recovery action plans in place in a number of areas. Monthly communications being sent to GPs regarding waiting times across providers to encourage informed choice. Some patient transfers underway for long waiters, although this is primarily in Urology currently.	⇔
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 including growth estimates.	⇔
					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 have been reviewed.	⇔

Risk					Controls		Assurances		Actions / Status	
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**	**Movement since last IGQC review**
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).	Phil Jones	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.	The action plans for improving the operational performance and patient referral rate for Rapid Response are being actively reviewed e.g. the average number of weekly discharges from Rapid Response is 52 -53 cases per week (the revised target is 60 weekly discharges). The Rapid Response referral activity continues to be closely monitored and scrutinised by (i) ICT Performance & Delivery Group (monthly meetings) & (ii) A new Rapid Response Performance Monitoring Review Group (weekly meetings) (iii) ICT Briefing sessions with ICT Programme Sponsor (fortnightly meetings). At these meetings Rapid Response data generated via the clinical data codes agreed is evaluated in detail together with (i) performance data relating to the 'System Wide' KPI's aligned to ICTs teams and (ii) the outcome of planned patient case reviews - IT access issues relating to the new ICT Patient Case Review webpage have been escalated and a meeting has been arranged at the beginning of February to review and hopefully resolve. The draft ICT Service Specification has been agreed with GCS in principle. The associated schedules for this specification are now being drafted e.g. the first draft of an Occupational Therapy schedule has been drafted and is being considered by GCS.	⇔
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 in 2017/18 at the earliest	⇔
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 initially formed to oversee risk. Now managed by Finance and overseen by the Primary Care Operational Group.		Regular progress reports to Governing Body. Monitoring of budgets.		Due diligence undertaken through November, December and January prior to submission and continuing through 2015/16 as now entering business as usual activity.	⇔
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.	⇔

Risk					Controls		Assurances		Actions / Status	
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**	**Movement since last IGQC review**
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 now approved. BCF being produced for 16/17. JCPE and JCPB continue to provide oversight. Health and Wellbeing Boards plans established.	⇔
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. Regular meetings with editors. 'No Surprises' briefing on key announcements.		Sponsorship/partnership agreements, briefing arrangements within individual communication plans.		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 interventional procedures guidance (IPG) (March 2015).	⇔
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). Direct engagement of provider services in managing the new system and supporting compliance.		Reports to Governing Body		NHS engaging fully with GCC implementation plan. Interim champion arrangements now replaced with formal commissioning and funding by the CCG of SEND Designated Officer capacity in the 3 NHS Trusts and the CCG. Continued engagement of these officers in the implementation programme.	⇔
Objective 6: Develop strong leadership as commissioners at all levels of the organisation, including localities.										

Risk					Controls		Assurances		Actions / Status	
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**	**Movement since last IGQC review**
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 16

Governing Body

Governing Body Meeting Date	**Thursday 31st March 2016**
Title	**Integrated Governance and Quality Committee (IGQC) minutes**
Executive Summary	The attached minutes provide a record of the IGQC meeting held on the 17th December 2015.
Key Issues	The following principal issues were discussed: • Experience and Engagement Report • Quality Report; • Child Death Overview Panel Annual Report; • Healthwatch Gloucestershire Discharge Report; • Risk Register; • Assurance Framework; • Workforce Report; • Information Governance update; • Protecting Children from Harm; • District Nursing in Gloucestershire; • Equality and Diversity update; and • Geonomics Medicines Centre bid;
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 17th December 2015, Board Room, Sanger House

Present:		
Julie Clatworthy	JC	Chair
Dr Charles Buckley	CBu	GP – Stroud Locality
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Colin Greaves	CG	Lay Member – Governance
Cath Leech	CL	Chief Finance Officer
Mark Walkingshaw	MW	Deputy Accountable Officer
Valerie Webb	VW	Lay Member - Business

In Attendance:		
Raju Reddy	RR	Secondary Care Doctor
Teresa Middleton	TM	Deputy Director of Quality
Becky Parish (Item 6)	BP	Associate Director Patient and Public Engagement
Felicity Taylor-Drewe (Item 9)	FTD	Associate Director of Commissioning
Cate White	CW	Project and Business Manager Quality Team
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator

1. Welcome and Introductions

1.1 The Chair welcomed RR to the meeting.

2. Apologies for Absence

2.1 Apologies were received from Dr Helen Miller, Mary Hutton, Dr Tristan Lench, Dr Caroline Bennett and Sarah Scott.

3. Declarations of Interest

3.1 There were no declarations of interest received.

4. Minutes of the meeting held on 22nd October 2015

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

- Section 4.1 to be amended to read *'AP advised that the Information Governance training had been organised for Governing Body members on the 3rd December 2015.'*
- Section 10.6.1 to be amended to read *'JC enquired about the reasons for not including all providers within the Policy….'*

5. Matters Arising

5.1 **IGQC97 Information Governance Update**
AP advised that the Information Governance training was organised for members on the 3rd December 2015. **Item Closed.**

5.2 **IGQC108 Quality Report**
The presentation regarding the mental health improvement seminar was circulated on the 27th November 2015. **Item Closed.**

5.3 **IGQC115 Safeguarding Children Policy**
MAE advised that the national guidance was still awaited. MAE advised that NHS England have also issued guidance where it had been stated that a named GP for safeguarding was required.

5.4 **IGQC134 Experience and Engagement Report**
The hospital discharges report was covered under Agenda Item 9. **Item Closed.**

5.5 **IGQC135 Experience and Engagement Report**
BP advised that the dates for actions in the engagement activity table would be included in future reports. **Item Closed.**

5.6 **IGQC136 Quality Report**

MW advised of the national target for stroke regarding 80% of patients to spend 90% of their stay on a designated stroke unit. This target was achieved in full during August to November 2015. The October performance position was at 91.3% and that this was due to the further work undertaken with GHFT to introduce a third designated unit. **Item Closed.**

5.7 **IGQC137 Quality Report**

The dates of safeguarding incidents had been recorded in the Quality Report. **Item Closed.**

5.8 **IGQC138 Quality Report**

The response to the Lampard Action Plan was covered under Agenda Item 14. **Item Closed.**

5.9 **IGQC141 Risk Register**

AP advised that the risk relating to prescribing had now been received and a revised entry would be included in the next update.

5.10 **IGQC142 Gloucestershire Research and Development Terms of Reference**

MAE provided an update on the Research arrangements and noted that the research activity programme for next year was currently under review. **Item Closed.**

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 Quarters 2 and 3 of 2015/16. The report was taken as read.

6.2 BP updated members on the latest data from the Friends and Family Test (FFT) and highlighted that this was still a challenging area. BP drew attention to Section 3.5 of the report which stated that where response rates were very low, the validity of the statistical data was reduced.

6.3 BP highlighted the engagement activity supporting the CCG's annual refresh of Joining Up Your Care in response to the national Five Year Forward View.

6.4 The review of the health and care services in the Forest of Dean was highlighted and it was advised that Ellen Rule was leading on the project and was gathering information.

6.5 BP drew attention to Appendix 1 of the report which provided details of Healthwatch Gloucestershire involvement with CCG programmes and projects. BP advised that Healthwatch had recently published a Patient Transport Report and that a further update regarding this would follow. It was noted that the report was being discussed at the Health and Care Overview and Scrutiny Committee in January 2016.

6.6 JC drew attention to the findings of the review from the Podiatry Task Group and queried if any new learning was highlighted as part of the review process and if an action plan had been developed with social care. CBu responded that this was being addressed through the diabetes and footcare pathway group. MW highlighted that the CCG benchmark well across other systems and felt that the gap in social care required addressing. CBu suggested that the work of the Forest of Dean 'looking after your feet' project was revisited.

6.7 AE queried how the CCG benchmarked nationally in terms of the discharge process. MW advised that Gloucestershire benchmarked well across other systems and noted that there were issues with the method being used to collect information by Healthwatch. JC queried if this was logged onto the risk register. AP to confirm. AP

6.8 VW drew attention to the FFT results and felt that there should be other opportunities which can be utilised. VW also highlighted that there was a typographical error on the FFT results table on page 3 of the report; "20" should read as "20**%**".

6.9 JC queried how much belief and effort there was to manage the FFT process by GHFT. RR debated the motivation for a patient to complete this. JC stated that from her knowledge of other areas where results were better, it was the staff that motivated this process. RR suggested that the CCG could incentivise the staff to encourage the use of this and felt that this would impact the response rate dramatically. AE queried if there was a mechanism for provider feedback and was advised that this was reported through the Clinical Quality Review Groups.

6.10 AE queried the plans for primary care engagement and was advised that further national guidance was awaited. BP advised that learning from case studies were being used to inform a local engagement strategy. It was noted that the secondary care guidance could also be used to inform the strategy. BP also advised that a Patient Participation Group (PPG) Network was being established and that a meeting was being held in January 2016. BP

6.11 CBu understood that PPGs were now a contractual requirement and enquired if the CCG were proposing to support the Groups in order to develop its process further. BP advised that further work to address this was being identified and developed.

6.12 BP advised that patient engagement was embedded as part of the Joining Up Your Information project which included representation from patients and Healthwatch. CL advised that the Patient Access and Communication Group had discussions around the communication approach and that an easy read patient communication letter had been drafted which should be circulated in January 2016. CL also advised that the communications manager was liaising with Village Agents and PPGs in order to disseminate this information further.

6.13 MAE queried the communication materials that were available for patients with a learning difficulty. CBu suggested that it would be useful for a waiting room CL

leaflet which included animations was produced for patients. CL agreed that she would circulate the animations and newspaper article that had been produced.

6.14 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 advised that this was a developing framework.

7.3 TM provided an update on the arrangements to monitor compliance with NICE Technology Appraisals (TAs), Guidelines and Quality Standards. It was noted that the Clinical Effectiveness Group monitored the arrangements for NICE Guidelines and Quality Standards.

7.4 TM advised that the Clinical Effectiveness Group had reviewed its Terms of Reference and membership and noted that the review was now complete. It was advised that the next meeting would be used to establish a work programme. It was agreed that the revised Terms of Reference would be presented for approval at the February 2016 meeting of the IGQC. TM

7.5 MAE advised that the next Patient Safety Forum was being held on the 15th January 2016. It was noted that this forum had been previously well received across in-county providers which allowed for joining-up of initiatives and sharing of good practice across different settings. JC requested details on the location of the meeting and was advised that this would be circulated.

7.6 MAE updated members on the Public Health spending review. JC highlighted that a quantifiable figure had not been identified regarding the 3.9% reduction. CL advised that this should equate to £4m over five years.

7.7 CBu highlighted that the Drugs and Alcohol and Healthy Lifestyle service was out for consultation and urged members to contribute. MW advised that this was being addressed through the Joint Commissioning Partnership Executive Group and understood that the Children and the Drugs and Alcohol services was currently out for consultation and articulated the importance of ensuring that there was a good understanding of the impact on healthcare. CL advised that SS would be liaising with Matt Pearce to explore joint working opportunities and that further details would be provided to the development session.

7.8 MAE highlighted that concerns had been raised regarding the quality of assessments being undertaken by the Community Urology Service. JC queried if the Quality Team had visited the service and if not, recommended that this was done and to seek evidence of assurance of the clinical standards and clinical audit result. JC also queried if the clinical environment complied with relevant standards. MW advised that CQC had inspected premises within the community settings.

7.9 Members were updated on safeguarding who were advised that activity level was high. MAE advised that a member of her team attended the Adults Safeguarding Board who were interested in the CCG process for managing Serious Incidents and noted that they were satisfied with the response.

7.10 CW advised that a Dental Safeguarding Forum was being established in conjunction with NHS England and that a meeting was being held in January 2016.

7.11 AE highlighted that there were inconsistencies in the reporting arrangement of serious incidents and

highlighted that GHFT did not report on falls and queried the position regarding this. MAE advised that an extraordinary Clinical Quality Review Group meeting was held which focused on serious incidents and falls within GHFT. It was noted that GHFT had adopted a reporting criteria for falls which was not aligned with other providers in the county. MAE advised that GHFT would be reviewing its reporting process. MAE assured members that GHFT had an action plan on falls prevention in place.

7.12 MAE highlighted that a Never Event was reported the previous day by GHFT and was being investigated.

7.13 JC drew attention to Section 9.3 regarding the serious incidents reported by 2gether and sought assurance that there were mechanisms in place to protect staff from violence, assault and aggression. MAE assured members that there were robust plans in place.

7.14 JC enquired on the details of the pressure ulcer that was reported at GCS and requested that incidents were mapped against sites. MAE

7.15 JC requested that the Suicide Prevention Annual Report was circulated. It was noted that suicide rates were high in Gloucestershire although consistent with the regional trend in the South West. MAE

7.16 MAE advised that 2gether were inspected by CQC and that the report was awaited. MAE advised that she had difficulties contacting the inspector prior to the inspection and that the senior inspector had spoken to her following the inspection. Initial feedback to date indicated that the inspection was satisfactory overall although this had not been formally confirmed. It was noted that there were concerns identified around the seclusion arrangements.

7.17 JC raised concerns around the mortality rates and highlighted that the public health response was not sufficient to address the issue. CBu suggested that a briefing was prepared to detail the approach SS

underpinning the Dr Foster review and suggested that a representative from GHFT was invited to the meeting.

7.18 JC enquired when the Royal College of Surgeons report on the fractured neck of femur review would be available. It was agreed that this report would be circulated when published. JC also requested that Dr Will Haynes was invited to the February IGQC meeting. *Post Meeting Note: This action had now been moved to April 2016.* MAE

7.19 MAE advised that she was attending a meeting with Trust Development Authority (TDA) and GCS the following week to discuss the progress of the action plan in response to the findings from the CQC inspection.

7.20 AE raised concerns regarding the forecast made by the Royal College of Nursing (RCN) that around 4% of nurses would leave the profession due to the new requirements for Nursing Revalidation and particularly considering the current staff shortages. MAE advised that several workshops have been held and that there were no indications of nurses leaving the profession. CW advised that there was anxiety around the technological aspect of completing the training online and highlighted that there were supportive measures in place. JC felt that the risk required reassessing as it was currently rated as low risk. MAE felt that this could be related to nurses working within the private sector (60% of nurses worked in the private sector) and considered that this was not a high risk within the NHS. MAE

7.21 AE drew attention to the Quality Premium incentive requiring a 1% reduction in antibiotic prescribing and understood that there was a strong link between antibiotic prescribing and patient satisfaction and enquired how this would be managed. CBu advised that Gloucestershire had a good prescribing record and had a good benchmark position regionally. CBu articulated that there was an increasing importance in meeting targets and emphasised that it should focus on

appropriate antibiotic use and with a common sense approach.

7.22 MAE updated members on the C.Difficile and MRSA targets. It was noted that all the MRSA cases were community acquired infections.

7.23 JC requested that the CQRG minutes included the job titles of those present at the meeting. CW

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

8. Child Death Overview Panel Annual Report

8.1 MAE presented the Annual Report which was taken as read. The report outlined the work of the Panel and relevant learning from the cases reviewed to inform the priorities of the Local Safeguarding Children Board.

8.2 CBu felt that the table on page 14 of the report was unsatisfactory and required further specifics to indicate the cause of death. MAE agreed that she would feed this back although she considered that this could be that the report was a public document and could contain identifiable information. MAE

8.3 JC was concerned regarding the number of deaths which were recorded as inconclusive and was worried about the impact this could have on families and the length of time taken to effectively review cases.

8.4 The Committee expressed concerns regarding the ambiguity of the report and felt that additional specific data and information were required in order to learn and drive further improvements. MAE agreed that she would explore further. MAE

8.5 RECOMMENDATION: The Committee noted the content and discussed the recommendations.

9. Healthwatch Gloucestershire Discharge Report

9.1 FTD provided a presentation regarding the Hospital Discharge Task Group Report prepared by Healthwatch Gloucestershire and the next steps being outlined by the CCG.

9.2 The presentation covered:

- context;
- overview; and
- the recommendations made by Healthwatch and the response provided by CCG;

9.3 FTD considered that the response to the report would have benefited with a whole system response. It was noted that GHFT, GCS and 2gether had responded individually to the report.

9.4 MAE raised concerns regarding the national requirement for discharge summaries to be electronic and that it should be recognised that not all patients returned to the same 'normal' settings. MAE advised that mechanisms should be in place to ensure that GPs had access to this information and that staff should be aware of this when discharging patients particularly if patients were being transferred out of county. MW advised that the CCG had invested heavily into this programme of work and that benefits realisation had yet to be seen. JC queried if the role of discharge coordinator was fully established as a clinical role and that compliance with clinical standards should be robust and suggested there should further support to these roles.

9.5 JC queried if there were any plans for the Integrated Discharge Teams to be responsible for the Single Point of Clinical Access (SPCA) Teams. MW advised that a short term pilot had been agreed to provide clinical leadership which would also link with SPCA.

9.6 CG felt that the IDT teams had a high level of investment and sought assurance for a tangible return on investment. MW provided assurance that there was a series of actions being undertaken to monitor

performance although recognising that there was further work to do.

RECOMMENDATION: The Committee noted the presentation.

10. Risk Register

10.1 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.

10.2 The Risk Register comprised a total of 46 risks, four of which were graded as 'red' as outlined in Appendix 1.

10.3 CBu expressed concerns regarding the rating of Risk No C16 relating to AQP contracts. AP agreed to feedback to MW. AP/MW

10.4 RECOMMENDATION: The Committee reviewed the paper and the attached Risk Register and noted that there were no risks considered for closure.

11. Assurance Framework

11.1 AP presented the Assurance Framework for 2015/16 which provided details of the assurances that will be received by the Governing Body regarding the achievement of the CCG's Objectives. The paper also outlined the proposed refinements to the format of the Assurance Framework. The paper was taken as read.

11.2 JC highlighted Risk No Q3 relating to the risk round the specialised services for children and young people with mental health problems due to specialised commissioning and queried when the report would be available. MAE advised that the crisis service would pick up elements of this service.

11.3 Members noted that the format of the Assurance Framework was being reviewed by the Core Team in January 2016.

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

12. Workforce Report

12.1 MW presented the report for Quarter 2 for 2015/16 which provides an update on current workforce activities within the CCG. The report was taken as read.

12.2 MW highlighted that there had been an increase in headcount reaching a total of 240 and noted that this was primarily due to the transfer of staff from the CSU. The new staff that were recruited during this period were highlighted on page 2 of the report.

12.3 The levels of compliance with mandatory training were highlighted on page 5 of the report and it was recognised that there was further work to do to ensure compliance.

12.4 MW advised that the sickness absence rates were around 2% and that Gloucestershire benchmarked reasonably well nationally.

12.5 MW advised that the CCG was working to ensure that it fully discharges its obligations following the new mandatory requirement to comply with the Workforce Race Equality Standard.

12.6 RECOMMENDATION: The Committee noted the contents of the report.

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 CL advised that good progress was being made against the IG toolkit with the aim of achieving a strong level 2 in all areas. CL advised that an internal audit

review of the IG toolkit was to be undertaken in January 2016.

13.3 CL updated members on records management and advised that the new directory structure was now in place. An audit of the use of the new directory, file naming conventions and use of hyperlinks in e-mails was being planned in order to identify any further training needs.

13.4 Members were notified that the CCG web site was hacked in mid-October and that the web developer and IM&T team were reviewing to identify and implement additional measures to strengthen the controls for the main CCG web site and all other web sites managed by the CCG.

13.5 RECOMMENDATION: The Committee:

- **noted the notes from the Information Governance Group meeting; and**
- **noted the contents of this report.**

14. Briefing report on Protecting Children from harm

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

14.2 The report outlined the findings of the first phase of the Children's Commissioner for England's Inquiry into Child Sexual Abuse in the Family Environment published in November 2015.

14.3 The Committee questioned the next steps and queried who was responsible for responding to the report. MAE advised that there was a focus on the police and social services to respond although there was an element that could be picked up from Public Health as part of the commissioning of health visits in schools.

14.4 RECOMMENDATION: The Committee noted the contents of the report.

15. District Nursing in Gloucestershire

15.1 MAE presented the briefing report which provided an update on the district nursing action plan.

15.2 It was noted that there were resourcing issues within the Cheltenham Locality. It was also noted that there were issues with retention in South Cotswold.

15.3 MAE advised that the CCG were financially supporting nurses to undertake their Specialist Practitioner qualification and noted that the CCG had provided £150K funding for this.

15.4 It was also noted that the Core Group had agreed £0.5m funding for Nursing within the Integrated Community Team (ICT) service.

15.5 MAE highlighted that the issue remained with Band 6 posts as there was a lack of career progression. It was noted that the Band 5 position had improved.

15.6 JC queried if nurses can be recruited abroad and it was advised that there was very limited availability of community nurses abroad.

15.7 CBu stated that there was a significant investment in nurses and queried if there was a contract to prevent them from leaving for a set period of time. MAE advised that there was an employment contract for two years.

15.8 CG felt that the banding system for nurses was career limiting by design. RR considered that this could be individual choice and to progress to the next step meant that they would have to focus on the management aspects of the job compared to the clinical. JC advised that there was a new national framework established for community nurses which had career opportunities.

15.9 JC queried if the GP Executive Leads had seen the proposals for new community continence provision and

it was noted that the communication approach would be discussed at its next meeting. It was also noted that it was proposed that the supply of continence products was to go out to tender.

15.10 RECOMMENDATION: The Committee noted the contents of the report.

16. Equality and Diversity Update

16.1 VW provided a verbal update on Equality and Diversity. VW advised that the report was still in draft and it was proposed that the final version would be circulated electronically around 7th January 2016 with a view to present to the Governing Body on the 28th January 2016 and published on the website by the 31st January 2016.

16.2 RECOMMENDATION: The Committee noted the verbal update.

17. Genomic Medicines Centre Bid

17.1 JC provided a verbal update on the Genomic Medicines Centre bid. JC informed members that the bid was successful and congratulated the clinicians involved. JC advised that the contract should be placed in January and that the recruiting of patients would start in February and GHFT would go live in September if ready. It was noted that the internal governance needed to be worked through formally.

17.2 RECOMMENDATION: The Committee noted the verbal update.

18. Any Other Business

18.1 There were no items of any other business.

19. The meeting closed at 12.30pm.

Date and time of next meeting: Thursday 18th February 2015 in the Board Room at 9am.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 17

Governing Body

Governing Body Meeting Date	**Thursday 31st March 2016**
Title	**Audit Committee minutes**
Executive Summary	The attached minutes provide a record of the Audit Committee meeting held on the 8th December 2015.
Key Issues	The following principal issues were discussed: • Internal Audit; • External Audit; • Counter Fraud; • Registers; • QIPP; • Procurement decisions; • Waivers of Standing Orders; • Aged Debt Report; and • Auditor Panel arrangements.
Risk Issues: Original Risk Residual Risk	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note these minutes which are provided for information.

Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Colin Greaves Audit Committee Chair and Lay Member

NHS
Gloucestershire
Clinical Commissioning Group

NHS Gloucestershire CCG
Audit Committee

Minutes of the meeting held on Tuesday 8 December 2015
Wheatstone Room, Sanger House

Present:		
Colin Greaves (Chair)	CG	Lay Member, Governance
Valerie Webb	VW	Lay Member, Business
Alan Elkin	AE	Lay Member, Patient and Public Experience
Dr Andy Seymour	AS	Deputy Clinical Chair
Dr Hein Le Roux	HLR	GP Liaison Lead, Stroud and Berkeley Vale

In Attendance:		
Cath Leech	CL	Chief Finance Officer
Liz Cave	LC	Director, Audit, Grant Thornton
Natalie Tarr	NT	Internal Audit, PWC
Lynn Pamment	LP	Audit Manager, PWC
Andrew Beard	AB	Deputy Chief Finance Officer
Sallie Cheung	SC	Local Counter Fraud Specialist
Zoe Barnes	ZB	Corporate Governance Support Officer
Alan Potter	AP	Associate Director of Corporate Governance
Ian Goodall	IG	Associate Director of Operational Planning and PMO (items 5 and 9)

1. Apologies

1.1 No apologies were received.

2. Declarations of Interests

2.1 There were no relevant interests declared.

3. Minutes of the Meeting held 29 September 2015

3.1 The minutes were approved subject to the following four amendments:

- 5.3.5 - reference to EPRR on to be written in full;
- 5.3.8 – sentence “following the demise of the NHSE Local

Area Team" to be removed;

- 11.2 – sentence to read "The AV system for the AGM was queried (169/07/2015) as the wording in the table differed to the request form attached."
- 18.8 – the word 'and' to be removed from the end of the sentence on page 12.

3.2 **<u>Recommendation:</u> The Committee approved the minutes from the 29 September 2015 subject to the above four amendments.**

4. Matters Arising

4.1 Please read in conjunction with the attached matters arising log.

4.2 **16.09.14 Item 7.5 –** SC advised that a short questionnaire was now distributed at all Counter Fraud training sessions and the lunchtime sessions were going well. CL informed members that a staff survey was under development. It was agreed this item would remain open. **Item to remain open.**

4.3 **09.12.14 Item 5.20 –** It was noted that the ICT project update at a Development Session had been delayed and needed to be rescheduled. CL advised she would check with Mary Hutton and Andrew Hughes when this would be incorporated into the planner. **Item to remain open.**

4.4 **10.03.15 Item 8.4 –** It was noted that the Committee terms of reference had been revised and approved by the Governing Body following the requirement to have an Auditor Panel. AP advised that the Accountable Officer would be reviewing representation across all Committees in due course. **Item closed.**

4.5 **29.09.15 Item 5.3.12 –** CL advised that Marion Andrews-Evans was working through the actions and full information in terms of the BCP plan and report would be presented to the Governing Body in due course. **Item to remain open.**

4.6 **29.09.15 Item 19.4 -** CG requested that a tracker of the Financial Controls Environment Assessment actions was in place and was included within the matters arising log. CL advised that a further assessment would be completed in June 2016. **Item to remain open.**

4.7 **29.09.15 Item 18.7 –** CL gave an update and informed members that she had contacted the CFO at Wiltshire CCG. CL advised that they would be forwarding an example of their Finance Committee so the CCG could examine to ensure areas are covered appropriately.

4.7.1 CG queried if the monthly finance overviews at Development Sessions were satisfactory in terms of a method of providing financial assurance to the Governing Body. CL advised that this formed part of the pre-Governing Body discussions on a bi-monthly basis with briefings also held each month where there was not a Governing Body. It was agreed that feedback would be gained from the Governing Body and a review given to the Audit Committee in June/September 2016 on progress. **Item to remain open.**

5. Internal Audit

5. Progress Report

5.0.1 LP presented the Internal Audit update report.

5.0.2 LP highlighted the following key items from the report:

- Timing had been reviewed however no further delays were expected;
- Proposed amendments to the plan including review in relation to the 360 degree stakeholder questionnaire and a reschedule of the Information Governance review to Quarter 4.

5.0.3 LP assured members that the plan was on track to be completed within the year.

5.0.4 Recommendation: The Committee noted the contents of the report.

5.1 QIPP Follow Up

5.1.1 IG attended the meeting to discuss the Internal Audit QIPP review and the actions being taken from the recommendations.

5.1.2 LP noted that this was a follow-up review and that some

recommendations remain open however progress was being made.

5.1.3 LP highlighted the first finding from the report which related to the updating of the Health Perform system and was a medium risk finding. IG advised that project leads are given fortnightly reminders to update the system and felt assured that this was a manageable process. CG queried if fortnightly reminders were realistic and IG confirmed that longer reminders would result in delayed completions. VW queried if Health Perform did the prompting in an automated fashion and IG advised it does, but the PMO team also meet with project leads. This matter was discussed further and it was noted that an increase in self-ownership would be helpful.

5.1.4 LP discussed the second finding of the reporting of Key Performance Indicators (KPIs) and it was advised that these were now recorded on Health Perform.

5.1.5 No 3 finding was discussed and it was noted that this was in respect of the completion of business cases. LP advised there was an improvement however the action would remain open. IG assured members that he was confident that large projects have full business cases. CL noted that this issue may relate to Community Hospitals in particular and discussions were being held with the project lead. VW raised concerns that Community Hospitals would not be unique and advised that reference should be made to other projects. It was agreed this would be followed up in Quarter 4.

5.1.6 The Committee discussed the fifth finding regarding the reporting of savings which would be followed up in Quarter 4. It was advised that this was about the Governing Body receiving the appropriate amount of detail in financial reporting. CL informed the Committee that QIPP schemes were taken to a Governing Body Development Session at the beginning of the year and the CCG Core team. AE recommended that the Governing Body would need to be assured at the planning stage that there is a cost and benefit to each scheme. CG advised that the planning process had improved however it would be useful to review what had happened retrospectively. It was agreed that this would be looked at in January at a Governing Body development session as part of the 2016/17 planning round.

5.1.7 IG assured the Committee that actions were underway as appropriate and that the comments from the audit were fair. It was noted that the PMO team was under staffed and recruiting externally was a challenge. It was agreed that any significant issues which may impinge upon the CCG's performance would be flagged to Core team.

5.1.8 <u>Recommendation:</u> The Committee noted the contents of the follow up report.

5.2 <u>Internal Audit Recommendation Tracker</u>

5.2.1 LP presented the tracker which included a total of 32 recommendations. LP informed the Committee that 7 of the outstanding recommendations related to QIPP and 4 had been completed therefore only 3 remained. LP advised that where there were outstanding recommendations this was due to no updates being received however these were low risk areas.

5.2.2 The members agreed that the tracker was a useful tool. It was agreed that an executive summary would be included for the next report due to the viewing issues of the documents via IPads.

5.2.3 <u>Recommendation:</u> The Committee noted the tracker.

6. External Audit update report

6.1 LC discussed the External Audit report and highlighted the progress as at November 2015.

6.1.1 LC advised that the plan would be brought to the next Audit Committee and discussions were ongoing regarding how to audit Primary Care Commissioning.

6.1.2 LC highlighted the new criteria for the Value For Money (VFM) conclusion on page 6 of the report and noted that there would be less emphasis on performance and more emphasis on arrangements in place. LC advised that a risk assessment would be completed with work completed based around any risks found.

6.2 In addition, LC highlighted the following issues from the report:

- Information and Guidance including workshops;
- Emerging issues including the Grant Thornton Devolution report and 'Growing Healthy Communities' report.

6.2.1 LC highlighted page 10 within the Growing Healthy Communities report and advised that a date would be confirmed for a demonstration of how the tool works.

6.3 HLR noted the Kings Fund report into NHS performance and LC confirmed she would be happy to hear thoughts from members on this report.

6.4 <u>Recommendation:</u> The Committee noted the contents of the report.

7. Counter Fraud update

7.1 SC presented the Counter Fraud (CF) update report.

7.2 SC advised that the action plan was progressing however the CF team may need more days to complete actions and this is being monitored with the Chief Finance Officer.

7.3 SC highlighted point 2, Issues from Providers and noted that working when sick continues to be one of the highest numbers of referrals to CF, however, this type of fraud relates primarily to provider trusts and not CCGs due to the nature of the work.

7.4 CG queried the ongoing investigation relating to the CCG at point 2.2 of the report. SC confirmed that this was a joint investigation with the Council, a matter of which the CCG was aware.

7.5 AE questioned if the charging of overseas patients for healthcare issues had been progressed since the last Audit Committee. SC advised that this had been stalled at a high level. CL informed the Committee that each organisation was working on individual resolutions and the matter was about process methodology. It was agreed that the Committee should monitor this issue; however, it was noted that this was a national matter.

7.6 SC advised that the guidance with regards to the NHS Standard Contract 2016/17 changes had not yet been received. It was

noted that this would be monitored as part of the CF plan.

7.7 **<u>Recommendation:</u> The Committee accepted the contents of the report.**

8. Registers

8.0.1 AP presented the registers and advised there had been no change to the registers since the last report in September.

8.0.2 ZB informed the Committee that the new Standards of Business Conduct policy had been implemented which included information regarding the declarations of Gifts and Hospitality however this needed to be communicated well to staff to ensure they were aware of their responsibilities. It was noted that this policy would be updated in the new financial year.

8.0.3 AE questioned why the CCG would be reliant on Pharmaceutical companies to provide funding for staff to attend conferences. It was agreed that further information would be gathered on the two declarations made within the table at point 8.2.

8.0.4 ZB noted that Member Practices should also be aware of standards of business conduct and their responsibilities for declarations and the Committee discussed how this would be managed. It was agreed CL, AP and ZB would meet to work through how to proceed.

8.1 **<u>Recommendation:</u> The Committee noted the two registers which were provided for their information.**

9. QIPP Report

9.1 IG attended the meeting and presented the QIPP report and highlighted the following issues:

- There was a 2.32m shortfall in delivery which had not changed significantly since month four;
- Unscheduled Care View – high number of Emergency Admissions and Emergency Department (ED) attendances;
- Urgent care and planned care schemes would be reviewed as part of the planning process for next year;

- The Individual Funding Request (IFR) scheme was an area of positive good practice;

9.2 It was noted that the CCG had an amber rating with NHSE for QIPP performance overall.

9.3 CL added that a case review process was one of the tools being looked into to inform the progress of the schemes and that this was subjective to a degree. IG advised that the way that schemes are evaluated was currently being reviewed and that this was not a straight forward task.

9.4 HLR noted that there was an important learning aspect to be considered and that feedback from GPs would be useful to inform lessons learned.

9.5 The Committee discussed Integrated Community Teams (ICT). CL advised that progress had been made although this was gradual.

9.6 CG queried Community Care and requested further information. IG advised that the Community Hospitals project was still being defined. CL noted that Continuing Healthcare is delivering financial savings and a number of programmes were in place to manage i.e. better controls over the assessment of individual cases in detail for eligibility.

9.7 CG commended the good work of the team.

9.8 IG advised that new approaches and ideas would be presented to the Priorities Committee next year which was a reflection of positive work and developments.

9.9 <u>Recommendation:</u> The Committee noted the report on QIPP delivery at month seven including the savings delivery forecast position.

10. Summaries of Procurement Decisions

10.1 CL welcomed any questions with regards to the procurement decisions paper and none were received.

10.2 <u>Recommendation:</u> The Committee accepted the report.

11. Waivers

11. 1 Procurement Waiver of Standing Orders

11.1.1 CL presented the paper and requested comments from the Committee on specific waivers. None were received.

11.1.2 <u>Recommendation:</u> The Committee noted the paper and the attachments.

11.2 Register of Waiver of Standing Financial Instructions

11.2.1 The paper requested the Committee to approve a blanket waiver for ad hoc press advertisements in order to reduce administration time and the risk of missed deadlines.

11.2.2 CG raised concerns about blanket waivers however understood the rationale for the request from managers on the issue. CL explained that there are only a very limited number of local news publications and therefore it is not possible to obtain separate quotes as the CCG.

11.2.3 LP queried if this could be included within the CCG's standing orders instead. CL advised that the waiver applied specifically to local media and that other campaigns may need national media involvement.

11.2.4 CG requested that check and challenge takes place. CL confirmed that the waiver would be applicable for twelve months only and that a report would be given after this period to look at delivery.

11.2.5 VW queried if any waivers had been rejected to date. CL confirmed that none had been rejected as discussions were held prior to application in which the requestor would be advised if the waiver was not possible.

11.2.6 <u>Recommendation:</u> The Committee approved the single blanket waiver, for the specific suppliers identified in the table for a period of twelve months.

12. Aged Debtor Reports

12.1 AB discussed the aged debtor report and highlighted the following key issues:

- NHS Debt had increased since the previous report;
- Non NHS Debt had decreased since the previous report;
- No further issues anticipated with regards to the NHSE invoices;
- Discussions were ongoing regarding the processing of invoices at GCC.

12.2 CG queried if the payment process between the CCG and the Council was improving. CL advised she had been meeting with Jo Walker and AB was working with the team to develop the process.

12.3 LC wondered if the Council debt would be an in year problem and CL confirmed that it was anticipated the debt would be cleared by the end of the financial year.

12.4 <u>Recommendation:</u> The Committee noted the paper on the current level of invoices on the Sales Ledger of NHS Gloucestershire and the actions being taken to recover the outstanding debts.

13. Debts Proposed for Write-Off

13.1 There were none to report.

14. Losses and Special Payments Register

14.1 There were none to report.

15. Controls Environment Assessment Action Plan Progress

15.1 AB gave a verbal update on the financial controls environment assessment in terms of progress against the plan.

15.2 AB advised that the self-assessment was split into several areas and the five year plan was constantly reviewed.

15.3 It was noted that there was more emphasis on QIPP work and Urgent Care and Planned Care sessions were in place.

15.4 AB discussed financial reporting and advised that contact was increasing with managers to assist them in managing their budgets and run rates were included within Governing Body reports. Drop in sessions had also been set up for budget holders however attendance had been very low.

15.5 Financial control was discussed and AB informed the Committee that delegation limits were being reviewed and the CCG would like to review them in their own right. Other actions had been completed or were underway including:

- Full recruitment to the Finance team structure, vacancies have been covered with agency staff;
- Internal finance training plan for staff under development;
- Review of contract planning process;
- A programme of work was planned for the next 3 months to complete actions.

15.6 CG advised he had welcomed the process as a method of informing possible areas for improvement. CG informed the Committee that the assessments had been discussed at the Audit Chairs Forum he had attended and he noted that there was concern over long-term planning across all CCGs. CL noted that new 3 year allocations would help to improve the planning process.

15.7 It was agreed that AB would develop a tracker to monitor progress and this item would remain on the agenda.

15.8 <u>Recommendation:</u> The Committee noted the progress of the actions completed following the financial controls environment assessment.

16. Auditor Panel Arrangements

16.1 CL presented the paper which had been forwarded to the Governing Body meeting on the 26th November 2015.

16.2 CL informed members that the Audit Committee would

incorporate the functions of the Auditor Panel as approved by the Governing Body and the terms of reference had been updated appropriately. The revised terms of reference were attached.

16.3 **<u>Recommendation:</u> The Committee noted the extended role and responsibility of the Audit Committee as defined within the attached terms of reference.**

17. Any Other Business

17.1 SC informed members that this meeting would be her last as she would be leaving her post in Counter Fraud. CG thanked SC on behalf of the Committee for her work on Counter Fraud for the CCG.

17.2 HLR informed members that the West of England Academic Health Science Network (WEAHSN) had produced a website 'Open Prescribing Platform' which provides information on prescribing data across GP surgeries and CCGs and also includes national statistics. CL advised that the business intelligence team were looking at new tools like these as they come though. VW queried where the data comes from and it was noted that the Health and Social Care Information Centre provides a lot of the information. CL noted that some variation was positive.

The meeting closed at 10:30am.

Date and time of next meeting: Tuesday 8 March at 9:00am in the Board Room, Sanger House

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 18

Governing Body

Governing Body Meeting Date	**Thursday 31st March2016**
Title	**Primary Care Commissioning Committee (PCCC) minutes**
Executive Summary	The attached minutes provide a record of the PCCC meeting held on the 26th November 2015.
Key Issues	The following principal issues were discussed: • Review of Personal Medical Services contracts; • Springbank Alternative Provider Medical Services Contract Key Performance Indicators; • Standard Operating Procedure – Practice boundary changes; and • Standard Operating Procedure – Application to close a branch surgery.
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

Primary Care Commissioning Committee

Minutes of the Meeting held on Thursday 26th November 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
Helen Goodey	HG	Director of Locality Development and Primary Care
Cath Leech	CL	Chief Finance Officer
Mark Walkingshaw	MW	Deputy Accountable Officer
In attendance:		
Debra Elliott	DE	Director of Commissioning, NHS England Area Team
Rosi Shepherd	RS	Assistant Director of Nursing (Quality and Safety), NHS England Area Team
Cllr Dorcas Binns	DB	Chair of the Health and Wellbeing Board
Stephen Rudd	SR	Head of Locality and Primary Care Development
Barbara Piranty	BPi	Chief Executive of Healthwatch Gloucestershire
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were no members of public present.		

1 Apologies for Absence

1.1 Apologies were received from Mary Hutton and Dr Andy Seymour.

2 Declarations of Interest

2.1 There were no declarations of interests.

3 Minutes of the Meeting held on Thursday 24th September 2015

3.1 The minutes were approved subject to the amendments below:

- The resolution at section 5.12 to be amended to reflect the recommendation regarding Springbank Surgery.
- Section 7.1 to read *'AS presented a presentation to the Committee….'*

4 Matters Arising

4.1 24.09.2015 AI 5.8 – Springbank Procurement Update – DE advised that this would be forwarded to HG.

4.2 24.09.2015 AI 9.1.5 PMS Review – The PMS review was covered under Agenda Item 5. **Item Closed.**

5 Review of Personal Medical Services (PMS) Contracts

5.1 DE introduced this item and provided a local context to the rationale underpinning the review.

5.2 DE advised that the review was part of a national directive to align the principles of equitable funding to PMS practices. It was noted that the key aims of the PMS contracts were to provide greater flexibility to address the primary care needs of patients and that many practices received incentive or growth funding as part of the PMS pilot which was now perceived to be inequitable in relation to the amount paid to General Medical Services (GMS) contractors for an equivalent contract.

5.3 DE advised that reviews of PMS contracts were initiated within the life of the former PCT and that this had been standard practice and that the aim was to establish equitable funding to PMS practices in the light of the services they currently provided.

5.4 AE understood that the decision making was informed by the use of the Carr-Hill Formula and it was noted that the formula considered a huge range of weightings. DE advised that the

formula was currently being reviewed by NHS England as it was felt that that it did not weight certain demographics appropriately e.g. university practices.

5.5 HG introduced the report and advised that it outlined the review process which was undertaken following NHS England guidance.

5.6 HG advised that a PMS review panel was established which included NHS England and the Local Medical Committee representatives. The first panel met in September 2015 to review the five PMS practices in Gloucestershire.

5.7 HG highlighted that Nikki Holmes from NHS England had been communicating with the practices on a regular basis and that communication had been comprehensive during the process.

5.8 It was noted that although all five practices had the opportunity to submit proposals, only three had chosen to do so. HG provided a summary of the three proposals submitted as outlined below.

5.9 Bartongate Surgery provided PMS within a deprived area of inner-city Gloucester. The practice population consisted of 40% ethnic minority groups, with patients from 85 different countries. The panel concluded that this was atypical and recommended that the practice funding should be maintained. It was noted that other practices in this area would also be reviewed.

5.10 St Peter's Road Surgery provided a comprehensive proposal where it was highlighted that the practice served an elderly population. The panel felt that there were other practices with similar age demographics across Gloucestershire who provided equally innovative services within GMS contract funding and that the services provided were not above core and existing commissioned service and concluded that St Peter's Road should not receive reinvestment of PMS premium funding.

5.11 Underwood Surgery provided medical services to university students and this resulted in higher administrative costs. An analysis of the practice population profile demonstrated that the practice had almost 35% of patients in the age range of 15-24. A benchmark with other practices serving university patients in the

South of England was undertaken where it was highlighted that a practice in Bath drew 90% of its patients from the university population. It was also noted that the practice were commissioned through a Locally Commissioned Service (LCS) (formally an enhanced service) to provide additional services to their university population, including sexual health and counselling. The panel therefore concluded that this practice was proportionally an atypical practice and recommended that the practice retained 5.3% of the PMS premium funding in addition to the current LCS.

5.12 HG informed members that the Locking Hill and Hilary Cottage Surgeries did not submit practice reinvestment proposals and in the absence of any practice proposal, the PMS Review Panel concluded that the premium should be withdrawn over a five year period.

5.13 HG reported that discussions with the LMC had highlighted, there was an inequitable approach to PMS payments relating to rates, immunisation and vaccinations payments, which reflected activity at the time the PMS contract commenced and had not subsequently been updated to reflect current values. This therefore meant that PMS practices had been disadvantaged over time compared with GMS practices.

5.14 HG provided a summary of Appendix 2 of the report which detailed the PMS premium changes. HG also highlighted the overall projected cost/gain to the CCG Budget.

5.15 DB queried if Bartongate Surgery was profiled as an area of deprivation and was advised that this would be confirmed with Public Health. HG

5.16 DB also queried if the funding should be increased for Bartongate Surgery as there had been an increase in monthly registrations from new migrants. HG advised that the practice would receive capitation payments for each patient registered with the practice. It was noted that an equality and diversity review would also be undertaken going forward.

5.17 AE drew attention to section 4.3 and felt that the recommendation should be proposed by the CCG. It was agreed that this would be

amended.

5.18 DB enquired if Locking Hill and Hilary Cottage Surgeries responses were followed up and was advised that the CCG were in active dialogue with the practices. It was noted that both of the practices had confirmed that they would not to be submitting proposals.

5.19 It was noted that there was a residual risk from the appeals process although it was indicated that this was minimal. DE updated members on the appeals process arrangements and it was noted that a formal letter outlining the decisions would be forwarded to the practices during late December 2015.

5.10 **RESOLUTION: The Committee:**

- **reviewed, considered and approved the recommendations of the PMS Review Panel;**
- **approved implementation of the next steps of the PMS review process; and**
- **agreed to update the payments for rates, vaccinations and immunisations to reflect current activity for all five practices**

6 Springbank APMS Contract – Key Performance Indicators (KPIs)

6.1 HG presented the report and provided a background context to the report. It was noted that a procurement exercise was undertaken in September 2015 and that the new APMS contract would commence in December 2015.

6.2 HG introduced the proposed KPIs for Springbank, which had been agreed in principle with the practice. HG advised that the KPIs had been developed with input from Public Health and JC. JC stated that the KPIs were realistic and measurable and were focussed to achieve better outcomes in the light of the characteristics of the patient population of the practice.

6.3 CG felt that a few of the indicators were stretched and sought assurance that if the practice was placed under pressure, then the

targets would be reviewed and adjusted accordingly.

6.4 RS suggested that this linked with the work on patient safety, in particular, the work that the Academic Health Science Network was undertaking and linking in with the evidence from the National Reporting and Learning System (NRLS). RS also suggested that her team could assist if this were deemed necessary. MAE advised that Dr Hein Le Roux was leading on this initiative.

6.5 DB highlighted the KPI relating to Health Promotion and queried if this would be jointly worked with the Gloucestershire Healthy Living and Learning programme. It was agreed that this would be checked and confirmed. HG

6.6 <u>RESOLUTION:</u> The Committee reviewed, considered and approved the proposed Key Performance Indicators subject to a further review in six months.

7 Standard Operating Procedure: Practice Boundary Changes

7.1 HG presented the report and provided a brief introduction to the report. HG informed members that as an organisation with responsibility for commissioning primary care, under the Delegation Agreement with NHS England, the CCG was required to consider applications for practice boundary changes. A Standard Operating Procedure (SOP) had therefore been developed to standardise the process for consideration of such requests. It was noted that the SOP had been designed to ensure equality and diversity impacts were considered within each application, through the completion of an Equality Impact Assessment.

7.2 The Committee noted that there were three applications that had been received for practice boundary changes and that further details would be provided to the January 2016 Committee meeting.

7.3 HG advised that the practice would be required to complete an impact assessment if the boundary changes affected patients i.e. if this resulted in existing patients being removed from the newly

defined practice boundary and that the CCG would complete an assessment if the patients were not so affected.

7.4 JC felt that the neighbouring patients and practices should be included within the consultation. JC also suggested that the cost of the financial impact should be included within section 2.5. HG agreed that this would be clearly defined within the procedure.

7.5 JC felt that a further appendix detailing the appeals procedure was required. HG agreed that this would be available by the January 2016 Committee meeting. DE recommended that the involvement with the NHS Litigation Authority should be confirmed. HG

7.6 <u>RESOLUTION:</u> The Committee considered and approved the draft SOP for practice boundary change requests.

8 <u>Standard Operating Procedure: Application to close a branch surgery</u>

8.1 HG presented the report and members noted that this was an adoption of the procedure established by NHS England and had been subsequently updated with the inclusion of the Impact Assessment.

8.2 CG drew attention to section 2.14 of the procedure regarding the decision not to approve branch closure by the PCCC. CG expressed concerns that this could not be legally exercised as he felt that the practice was not obligated to the CCG. CG suggested that a further stage of negotiation should be added to the process. DE explained that the practice was legally obliged to fulfil its requirement through the contractual agreement and that requests were subjected to a rigorous process which included numerous factors e.g. the impact on patients and neighbouring practices.

8.3 BPi queried if set guidelines were established around the consultation process and was advised that the consultation process for the practice to undertake was fully outlined.

8.4 JC drew attention to section 2.14 and highlighted that it should read as 14 **working** days.

8.5 DB requested that section 2.10 should read as 'GCCG must then ensure they **notify'.** HG felt that this should read as **'consulted'** as those stakeholders should have the opportunity to comment. HG agreed to review the wording and sequencing of the process. HG

8.6 <u>RESOLUTION:</u> The Committee considered and approved the draft SOP for branch surgery closure applications subject to the above comments.

9 <u>Any Other Business</u>

9.1 There were no items of any other business.

10 The meeting closed at 12:20.

11 Date and Time of next meeting: Thursday 28th January 2015 in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Primary Care Commissioning Committee:

Signed (Chair):_____ Date:_____