

**Governing Body**

**Meeting to be held at 2pm on Thursday 28<sup>th</sup> July 2016 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE**

<b>No.</b>	<b>Item</b>	<b>Lead</b>	<b>Recommendation</b>
1	Apologies for Absence	Chair	
2	Declarations of Interest	Chair	
3	Minutes of the Meeting held on 26 <sup>th</sup> May 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	Locality Development Plan Updates	Helen Goodey	Information
11	Strategy for the Procurement of Health Care Services	Mark Walkingshaw	Approval
12	Assurance Framework	Cath Leech	Information
13	Sustainability and Transformation Plan update	Kelly Matthews	Information
14	General Practice Forward View Investment Plan	Helen Goodey	Approval
<b>Items to Note:</b>			
15	West of England Academic Health Science Network Board Report	Mary Hutton	Information
16	Integrated Governance and Quality Committee Minutes	Julie Clatworthy	Information

17	Audit Committee Minutes	Colin Greaves	Information
18	Auditor Panel Minutes	Colin Greaves	Information
19	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
20	Priorities Committee Minutes	Chair	Information
21	Joint Commissioning Partnership Board Minutes	Mary Hutton	Information
22	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 29 <sup>th</sup> September <b>2016</b> at 2pm in Board Room at Sanger House			

## Governing Body

### Minutes of the Meeting held at 2.00pm on Thursday 26<sup>th</sup> May 2016 in the Board Room, Sanger House, Gloucester GL3 4FE

<b>Present:</b>		
Dr Andy Seymour	AS	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
Julie Clatworthy	JC	Registered Nurse
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
Dr Hein Le Roux	HLR	GP Liaison Lead – Stroud and Berkeley Vale
Mary Hutton	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Tristan Lench	TL	GP Liaison Lead – Forest of Dean
Dr Raju Reddy	RR	Secondary Care Doctor
Ellen Rule	ER	Director of Transformation and Service Redesign
Sarah Scott	SS	Director of Public Health, GCC
Mark Walkingshaw	MW	Director of Commissioning Implementation and Deputy Accountable Officer
Valerie Webb	VW	Lay Member - Business
Dr Jeremy Welch	JW	GP Liaison Lead – Tewkesbury
Margaret Willcox	MWi	Director of Adult Social Care, GCC
<b>In attendance:</b>		
Becky Parish	BP	Associate Director Patient and Public Engagement
Anthony Dallimore	AD	Associate Director, Communications
Kathryn Hall	KH	Associate Director, Service Redesign
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Corporate Governance Support Officer
There were 8 members of the public present.		

### Introduction

AS welcomed members to the meeting, his first as Clinical a Clinical Chair. AS thanked Dr Helen Miller, the former Clinical Chair for her

contribution to the CCG.

AS informed the meeting that the CCG was participating in the Healthy Workplace Week and that Sanger House Marathon Relay challenge was being held that day.

## **1 Apologies for Absence**

- 1.1 Apologies were received from Joanna Davies, Helen Goodey and Dr Will Haynes.

## **2 Declarations of Interest**

- 2.1 There were no declarations of interest received.

## **3 Minutes of the Meeting held on Thursday 31<sup>st</sup> March 2016**

- 3.1 The minutes of the meeting held on Thursday 31<sup>st</sup> March 2016 were approved subject to the amendments below:

- JC to be included in the list of attendees.
- Section 12.5 to be amended to read '*It had been suggested that the Clinical Priorities Forum was the **group best placed to lead on the clinical programmes work.***'

## **4 Matters Arising**

- 4.1 28.05.15 AI 18.5 – Report from West of England Academic Health Science Network Board – MH advised that a meeting was held with the Industry Advisory Group and was pleased to report that relationships were being built with businesses in Gloucestershire. MH advised that she would circulate a briefing report. **Item Closed.** **MH**
- 4.2 30.07.15 AI 9.7 – Accountable Officer's Report – MAE advised that the primary care engagement activity plan was presented to the IGQC meeting. It was also noted that the overall engagement plan was being developed as part of the Sustainability and Transformation Plan (STP). **Item Closed**
- 4.3 28.01.16 AI 8.5 – Locality Development Plan Updates – MGe advised that a presentation on frailty was held the previous day at the South Cotswold Locality meeting and noted that this work was making good progress. **Item Closed.**

- 4.4 31.03.16 AI 10.8 – Operational Plan – AS advised that the action relating to a schedule of meetings which required secondary care presence was covered as part of the STP work. CBU highlighted that he attended a meeting with the secondary care consultants who had advised that these meetings were not scheduled within their job plan and articulated that this was still an issue.

## **5 Final Annual Accounts 2015/16**

- 5.1 CL presented the final annual accounts for 2015/16 for Gloucestershire CCG.
- 5.2 CL reported that the CCG had achieved its statutory duties and had achieved a surplus of £9.456m which was higher than the £7.3m surplus originally planned. CL also reported that the CCG had remained within its programme and running cost allocation.
- 5.3 CL advised that that the CCG also remained within the cash holding allocations which were within the maximum cash drawdown limit set by NHS England (NHSE).
- 5.4 CL reported that the CCG achieved the 95% performance target against the Better Payment Practice Code in both the value and volume of invoices.
- 5.5 CL advised that following the delegation of primary care responsibilities to the CCG, the accounts reflected the expenditure that had been reported noting an increase of approximately £80m.
- 5.6 CL explained that a disclosure was added to the operating leases section that covered the nature of the relationship with GP practices for premises.
- 5.7 CL advised that the related party transactions note included payments to practices under the delegated co-commissioning arrangements for the 2015/16 financial year.
- 5.8 CL informed members that the accounts had been audited and that that an unqualified opinion had been issued. It was noted that there was nothing to report in respect of regularity and that they had nothing to report by exception.

5.9 CL thanked the finance team, the auditors and other key staff for their work on producing and finalising the annual accounts.

5.10 **RESOLUTION: The Governing Body approved the CCG's 2015/16 Audited Annual Accounts**

## **6 External Audit - Assurances from Management and those charged with Governance**

6.1 CL advised that the attached documents had been provided to the external auditors by herself and the Chair of the Audit Committee in order to provide additional assurances to the auditors in relation to their assessment of the final accounts. The documents provided assurances regarding the governance and internal control processes operated by the CCG.

6.2 **RESOLUTION: The Governing Body noted the content of the report.**

## **7 Annual Report 2015/16**

7.1 AD presented the 2015/16 Annual Report and advised that the report celebrated many of the achievements delivered by the CCG and its partners during the year and also reflected the challenges and opportunities facing the CCG.

7.2 AD updated members on the distribution plan and advised that limited hard copy quantity of the full Report and a wider community stakeholder distribution of an abridged version would be produced. It was noted that a shorter public facing newspaper style highlights magazine would also be distributed in the summer to Gloucestershire households and that the CCG was discussing distribution arrangements with partner organisations.

7.3 The Governing Body expressed thanks to the Communication Team for their hard work in producing the Annual Report.

7.4 AP advised that an NHSE representative had informally indicated that this was an excellent Annual Report with particular praise to the public facing nature.

7.5 **RESOLUTION: The Governing Body received the Annual Report and summarised Accounts 2015/16 which was subject to any**

**final opinion from the auditors.**

## **8 Patient's Story**

8.1 BP and KH provided a presentation and a patient's story relating to the Cancer Patient Reference Group (CPRG).

8.2 BP welcomed Pat Eagle to the meeting and advised members that she was a member of the CPRG.

8.3 The presentation covered:

- background context;
- aims;
- engagement cycle; and
- key milestones.

8.4 KH informed members that the CPRG was currently recruiting for members and invited Governing Body members to forward any expressions of interests of those they considered to be suitable for the role.

8.5 MH felt that the ownership of the CPRG had not been apparent within the video and queried if it would be shared across the system. KH advised that the video had been shared with partnership organisations and that a good collaborative process was in place.

8.6 AS recognised the work of the CPRG and the support they provided and commended the presentation.

8.7 **RESOLUTION: The Governing Body noted the patient story.**

## **9 Public Questions**

9.1 There were no questions received from the public.

## **10 Gloucestershire Clinical Commissioning Group (CCG) Clinical Chair's Report**

10.1 AS presented this report that was taken as read, with a summary of key issues that arose during May 2016 being highlighted.

10.2 AS highlighted the work on the social prescribing pilot and advised

that good progress was being made. Members noted that social prescribing was fully operational across the county with referrals accepted from staff in all 81 GP Practices and that as at the end of March 2016, there had been approximately 1,700 referrals to the programme. AS advised that the University of the West of England was currently evaluating the social prescribing programme and that the findings from the review would be presented to a future Governing Body meeting.

10.3 AS advised that G.Doc had launched a new pilot on the 20<sup>th</sup> May 2016 designed to reduce admissions for patients with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD) at risk of emergency admission at weekends.

10.4 AS drew attention to the work being undertaken to address the primary care workforce issues particularly highlighting the work that had been undertaken for the British Medical Journal (BMJ) recruitment campaign. AS advised that the campaign had created considerable interest nationally. Members were advised that the BMJ video could be accessed on the link below:

<http://beagpingloucestershire.co.uk/>

10.5 The work of the Eye Health Clinical Programme Group was highlighted to members. AS advised that the new community eye care service was on track to commence on the 31<sup>st</sup> May 2016. Members noted that positive feedback had been received from the targeted project aimed at increasing awareness of the increased risk of Glaucoma within the Black and Minority Ethnic (BME) population.

10.6 JC queried who the provider was for the G.Doc pilot and was advised that the Rapid Response Team would be reviewing these cases. MGe considered that this service should be covered within the Out of Hours contract and was advised that this was a targeted area of work.

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

11 **Gloucestershire Clinical Commissioning Group Accountable Officer's Report**

11.1 The Accountable Officer introduced this report which was taken as

read, and provided a summary of key issues arising during April and May 2016.

- 11.2 MH drew attention to Section 2 of the report relating to the development of a large scale project to design and agree a service model to deliver integrated primary and community based urgent care services seven days per week across Gloucestershire. It was noted that an essential element of developing the proposal was through a series of workshops in April, May and June 2016 and that this would be completed by a commissioning led business case. It was anticipated that the new arrangements would be implemented from Spring 2017 onwards.
- 11.3 MH updated members on the primary care infrastructure development and advised that the CCG would be submitting bids for the NHS England Estates and Technology Fund. It was noted that a number of practices had also submitted requests for smaller proposals to improve their existing buildings. MH advised that the applications were due to be submitted to NHS England by the end of June 2016.
- 11.4 MH drew attention to Section 4 of the report relating to the place based model. It was noted that this was a key element of the Sustainability and Transformation Plan (STP) for Gloucestershire. MH advised of the long term ambition for the Gloucestershire population which was highlighted in Section 4.2 of the report. Members noted that this project had commenced within the Stroud and Berkeley Vale locality and that strong support had been received from all the partner organisations.
- 11.5 The work of the early intervention programme was highlighted and it was noted that the CCG and GCC jointly sponsored the use of Positive Behavioural Support workers as part of the Gloucestershire Challenging Behaviour Strategy and noted that this was closely linked with the Transforming Care Programme.
- 11.6 MH advised that the CCG and GCC were working together to improve the national statistics which state that only 6% of people with a Learning Disability were in paid employment. It was highlighted that the Gloucestershire level was at 18% and that this was triple the national average. AS queried how Gloucestershire benchmarked nationally in terms of the statistic for people with a Learning Disability that were in paid employment and it was noted that Gloucestershire

benchmarked well and were the highest in the country.

11.7 MH drew attention to Section 7 of the report relating to the England/Wales Cross Border Healthcare issues and highlighted that the financial transfer of funding had still not been agreed.

11.8 Members were advised that the national report on cultural commissioning had recently been published by the New Economics Foundation and could be accessed on the following link:

[http://b.3cdn.net/nefoundation/073b949f02e1842037\\_vqm6vugbd.pdf](http://b.3cdn.net/nefoundation/073b949f02e1842037_vqm6vugbd.pdf)

11.9 Members were also advised that the CCG had provided funding for 40 organisations across Gloucestershire to sign up to the National Workplace Wellbeing Charter which was endorsed by Public Health England.

11.10 MH informed members that the Healthy Individuals Programme Group had now formally been replaced with a new strategic group to lead on prevention and self-care and that this work was being led by SS.

11.11 It was also noted that the engagement process continued as part of the review of the community services in the Forest of Dean which would inform the development of options for the future of community services.

11.12 AS commented that he attended the Big Health Check and Social Care Day the previous day which was a well-run event and a positive move for the community.

11.13 CBu queried how the NHS 111 service assimilated with the integrated primary and community based urgent care service as concerns had been raised regarding how fully integrated the service was with the urgent care service. MW advised that there had been strong engagement from the NHS 111 service and highlighted that a key part of this proposal was evaluating how the service could align with the NHS 111 service and primary care. It was noted that a national policy had been published which indicated that there was scope for the NHS 111 service to access primary care directly in the future.

11.14 **RESOLUTION:** The Governing Body noted the contents of this

report.

## 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 April 2016.

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 advised that the 2015/16 year-end performance for the 4 hours emergency department target was 86.6% which was below the target of 95%. MW advised that a new recovery trajectory for 2016/17 had been agreed with GHFT and highlighted that this was on track to deliver against the agreed trajectory. MW recognised that the increases in demand were putting additional pressure to the service and that this was being evaluated on how best to address the system pressure.

12.4 MW informed members that there had been changes to the ambulance quality indicators from the 19<sup>th</sup> April which had changed the way all calls would be prioritised; these code set changes were now Red, Amber and Green. It was noted that SWASFT were a national pilot site and that the outcome from this would be reported to a future Governing Body meeting. MW

12.5 Members were informed that the CCG had been working with 2gether regarding Improving Access to Psychological Therapies (IAPT) target rate. MW advised that the CCG had increased its investments for this service to recruit additional therapists due to the level of concerns that had been raised.

12.6 JC enquired if any innovative methods of delivery of the urgent and emergency care had been developed from the System Resilience Group. MW advised that an in-depth analysis of the causal drivers for emergency department pressures were a key focus for the Group.

12.7 MGe drew attention to page 20 of the report which illustrated a chart outlining GHFT ED 4 hour performance and suggested that an

overlying chart was included which showed the actual number of attendees.

- 12.8 ER updated members on the 62 day cancer performance target and noted that delivery of the target had been challenging throughout 2015/16 in the face of significantly increased demand, particularly in the urology service and noted that there had been difficulties in recruitment for the additional capacity. It was indicated that the additional demand had partly been fuelled by the 'Be Clear on Cancer' and other awareness campaigns. ER reported that the year to date performance was 76.5% which was below the target of 85%.
- 12.9 ER reported that the performance against the two week cancer wait target had declined to 85.3% in March, bringing the year-end position to 90.9% which was below the target threshold. It was noted that the Cancer Clinical Programme Group (CPG) were participating in case reviews for patients who had long waits in order to inform any future service developments.
- 12.10 JC enquired if any early learning was highlighted as part of the cancer significant event audit process and was advised that the audit was still in progress and highlighted that this was a substantial piece of work.
- 12.11 CBU highlighted that the issue in relation to the increase in referrals for suspected cancer had been a national issue and that Gloucestershire were not an outlier. CBU provided assurance that a huge amount of work was being undertaken to address these issues.

### **Patient Experience**

- 12.12 MAE updated members on patient experience and advised that a programme of clinical case reviews had been developed to support the Clinical Programme Groups and other areas of work.
- 12.13 MAE advised that the patient experience team were supporting and developing the practice participation groups further.
- 12.14 Members were informed that the patient experience team were also undertaking a focused piece of work to review the impact of the 4 hour performance waits on patients and was working with GHFT to monitor this.
- 12.15 MAE reported that the 2015/16 year end performance for C.Difficile

was 157 cases against a threshold of 157. It was noted that the target for 2016/17 were to remain the same with 157.

- 12.16 MAE informed members regarding the mixed sex breaches within GHFT and highlighted that the majority of these breaches occurred in the Acute Care Units (ACU). MAE advised that the CCG was working with NHSE regarding the reporting requirements. It was also assured that the privacy and dignity had been protected for all these patients.
- 12.17 JC enquired of the impact associated with the junior doctors' strike in relation to any cancelled operations and was advised that there had been an impact in relation to cancelled operations and outpatient appointments although it was highlighted that GHFT had good contingency plans in place to mitigate this.
- 12.18 JC commended the work being undertaken to improve the dementia diagnosis rates.
- 12.19 JC also enquired if GCS were proceeding with the use of Medworxx and was advised that there had been some IT issues which had delayed the implementation.
- 12.20 CBu highlighted that to date, all GP practices that had been inspected by CQC were rated as 'good' or 'outstanding'.

### **Partnerships**

- 12.21 MW highlighted the strong partnership working between the CCG and local authorities particularly on the Better Care Fund plans. It was noted that this plan had been assessed as green and highly commended nationally.

### **Staff**

- 12.22 MW provided a brief update on the Staff Perspective and advised that this was rated as green. MW advised that staff survey results were currently being collated and would be circulated shortly.
- 12.23 MH advised that the results of the 360° stakeholder survey had recently been received and that a summary of the feedback would be reported at a future meeting. It was noted that the feedback show as mostly positive although noting that there were further work to undertake to build relationship at member practice level. MH

### **Finance and Efficiency**

- 12.24 CL provided a brief summary of the 2015/16 financial position and it was noted that the CCG had delivered a surplus of £9.5m against an initial planned surplus of £7.3m.
- 12.25 CL advised that there was significant over performance in emergency activity against contracted levels. CL explained that the majority of these related to the increase in emergency admissions and that other smaller overspends included elective and outpatient activity and that these were being analysed. The other significant area of over performance was in the use of excluded drugs, specifically Lucentis.
- 12.26 Members noted the increased expenditure on prescribing costs and that these were primarily to costs associated with NOACs and the volume of the diabetes drugs.
- 12.27 CL also updated members on the progress of the QIPP schemes and advised that there was mixed performance overall. It was considered that the full year impact should be realised in the 2016/17 position.
- 12.28 RESOLUTION: 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 one;**
  - **noted the risks identified in the Finance and Efficiency report; and**
  - **noted progress on the QIPP schemes.**

### **13 2016-17 CCG Annual Budget - Update**

- 13.1 CL presented the paper which provided an update to the budget which had been approved by the Governing Body in March 2016. The paper was taken as read.
- 13.2 CL informed members that a revised surplus of £9.456m was being planned against an initial planned surplus of £7.511m.
- 13.3 CL noted that contracts had been agreed with the CCG main providers and the impact been reflected in the budget position.
- 13.4 Members noted that the expenditure budget associated with allocation transfers for cross border and specialist commissioning

transfers were not included in the budget and work was underway to establish the expenditure budgets required for these areas.

13.5 JC drew attention to Appendix 3 of the report relating to the 2016/17 savings plans and requested that these were presented in risk order and she questioned how deliverable some of these schemes were i.e. rapid response. MH advised that further innovation was required for the urgent care schemes which had savings plans associated and to ensure that robust plans were in place for the development of whole system integrated care approach to patient flow, matching capacity and demand.

13.6 **RESOLUTION:** The Governing Body approved the revised budgets and noted the risks inherent within the plan.

#### 14 **Sustainability and Transformation Plan Update**

14.1 MH presented the paper which provided an update on the progress towards developing a system wide Sustainability and Transformation Plan (STP) for Gloucestershire towards the June 30th submission. The paper was taken as read.

14.2 MH explained that STPs were 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 had been agreed across England, each convened by a local leader, backed by national bodies.

14.3 MH advised that the Gloucestershire STP builds on the strategic commitments set out in the joint strategy: Joining Up Your Care and responds to the three gaps in the Five Year Forward View. These were:

- health and wellbeing;
- care and quality; and
- finance and efficiency.

14.4 It was noted that the STP sets out a system wide resources plan for Gloucestershire for the next five years.

14.5 MH advised that there were four key work programme priorities areas. These were:

- enabling active communities
- clinical programme approach (final name to be agreed)
- reducing clinical variation; and
- one place, one budget, one system.

- 14.6 It was noted that two key pilots had been prioritised to deliver in the first half of 2016/17 – our system wide Respiratory programme and our 30,000 population integrated model
- 14.7 MH also updated members on the governance structure and advised that the main partners for the Gloucestershire STP were outlined in Section 4.2 of the report and advised that wider stakeholders were included in the Oversight Board which included district councils, Healthwatch, Academic Health Science Network (AHSN), NHSE and other key stakeholders.
- 14.8 Members were advised that a communication and engagement strategy and plan was in development to support the STP approach.
- 14.9 MH informed members of the key dates and advised that the submission date for the full STP was the end of June 2016 and that the assessment and review was the end of July 2016.
- 14.10 AS queried how the submission date aligned with the Governing Body schedule and was advised that an Extraordinary Governing Body meeting would be held. ER advised that the plan should be available from the 20<sup>th</sup> June in order for all the partners to present to its respective board to agree formal sign off.
- 14.11 CG suggested that although NHSE guidance stated that formal sign off was not mandatory, it would be good practice for all respective boards to formally 'signup' to the Plan as this would show commitment from all the partners.
- 14.12 CG enquired on the assessment process for all the 44 STPs and if there would be any regional variation on the checking process.
- 14.13 CG also highlighted that the lay members had valuable expertise that could be added to the process.
- 14.14 CBU articulated that in order to drive real transformational change, all partners need to be committed and should use this opportunity to work with partners to deliver sustainability and accept that difficult

decisions would need to be made. MH concurred and invited members to present any ideas that could be brought to the table.

**14.15 RESOLUTION: The Governing Body:**

- noted the key requirements of the national planning guidance relevant to the STP; and
- noted the progress made towards the development of the STP.

**15 Assurance Framework**

15.1 CL presented the final update of 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 T13 regarding the specialised services for children and young people with mental health problems; and
- risk No C6 regarding the maximum four hour wait in Emergency Department.

**15.3 RESOLUTION: The Governing Body noted the paper and the attached Assurance Framework.**

**16 Audit Committee Annual Report 2015/16**

16.1 CG presented the Audit Committee Annual Report which outlined the activities of the Audit Committee during the financial year 2015/16. The report was taken as read.

16.2 CG informed members of the new requirement of the Audit Committee to incorporate the functions of the Auditor Panel as approved by the Governing Body on the 26<sup>th</sup> November 2015.

**16.3 RESOLUTION: The Governing Body accepted this report on the work of the Audit Committee as part of its overall governance and assurance programme for 2015/16.**

**17 Integrated Governance and Quality Committee Minutes**

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

Integrated Governance and Quality Committee held on the 3<sup>rd</sup> March 2016.

**17.2 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 28<sup>th</sup> January 2016.

**18.2 RESOLUTION: The Governing Body noted these minutes.**

**19 Priorities Committee minutes**

19.1 The Governing Body received the minutes of the meeting held on the 4<sup>th</sup> February and the 10<sup>th</sup> March 2016.

**19.2 RESOLUTION: The Governing Body noted these minutes.**

**20 Any Other Business**

20.1 The Governing Body thanked VW for her contribution to the CCG and recognised the support she had provided. It was noted that VW was leaving at the end of May 2016.

**21 The meeting closed at 15:35.**

**22 Date and Time of next meeting: Thursday 28<sup>th</sup> July 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 – May 2016

Item	Description	Response	Action with
31.03.2016 Agenda I10.8	Operational Plan	RR queried if there was a schedule of meetings which specified where secondary care presence was required that could be made available to the providers in order to ensure that these were prioritised in their job plan. The Governing Body supported this approach. <i>26.05.2016 CBU highlighted that this was still an ongoing issue.</i>	ER
26.05.2016 Agenda Item 4.1	Matters Arising	Report from West of England Academic Health Science Network Board – MH advised that a meeting was held with the Industry Advisory Group and was pleased to report that relationships were being built with businesses in Gloucestershire. MH advised that she would circulate a briefing report	MH
26.05.2016 Agenda Item 12.4	Performance Report	MW informed members that there had been changes to the ambulance quality indicators from the 19 <sup>th</sup> April which had changed the way all calls would be prioritised; these code set changes were now Red, Amber and Green. It was noted that SWASFT were a national pilot site and that the outcome from this would be reported to a future Governing Body meeting.	MW

26.05.2016 Agenda Item 12.23	Performance Report	MH advised that the results of the 360° stakeholder survey had recently being received and that a summary of the feedback would be reported at a future meeting. It was noted that the feedback show as mostly positive although noting that there were further work to undertake to build relationship at member practice level.	MH
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**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Gloucestershire Clinical Commissioning Group Chair's Report</b>
<b>Executive Summary</b>	This report provides a summary of key issues arising during June and July 2016.
<b>Key Issues</b>	<p>The key issues arising include:</p> <ul style="list-style-type: none"> <li>• Primary Care Update;</li> <li>• Planned Care;</li> <li>• Estates and Technology Transformation Fund submission;</li> <li>• Transforming Care;</li> <li>• The Integrated High Needs Team;</li> <li>• Social Care Impacts;</li> <li>• Reablement;</li> <li>• Developing Integrated Commissioning;</li> <li>• Mental Health;</li> <li>• Crisis Care Concordat</li> <li>• Strategy and Planning;</li> <li>• Workplace Wellbeing Charter;</li> <li>• Forest of Dean Community Services Review;</li> <li>• Clinical Programmes ;</li> <li>• Prevention and Self-Care plan; and</li> <li>• Meetings attended</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	None.
<b>Financial Impact</b>	None.
<b>Legal Issues (including NHS Constitution)</b>	None.
<b>Impact on Health Inequalities</b>	None.
<b>Impact on Equality and</b>	None.

<b>Diversity</b>	
<b>Impact on Sustainable Development</b>	None.
<b>Patient and Public Involvement</b>	Not applicable.
<b>Recommendation</b>	The Governing Body is requested to note this report which is provided for information.
<b>Author</b>	Andy Seymour
<b>Designation</b>	Gloucestershire CCG Clinical Chair
<b>Sponsoring Director (if not author)</b>	

## **Gloucestershire Clinical Commissioning (GCCG) Clinical Chair's Report**

### **1. Introduction**

1.1 This report provides a summary of key issues arising during June and July 2016.

### **2. Primary Care Update**

2.1 Since the previous Chair's report, which reported on the challenges facing general practice and the actions GCCG have taken, the release of the General Practice Forward View has given further impetus to the work already underway in Gloucestershire, although detail of additional funding for Primary Care is still unclear.

#### **2.2 Primary Care Strategy**

2.2.1 We are developing a Strategy based on the General Practice Forward View, our local vision and within the context of our STP. It introduces new models of care and includes our plans for Primary Care Premises and Workforce.

2.2.2 We have been undertaking a process of engagement and consultation on our draft Strategy and will be working with partners and our Primary Care Commissioning Committee to finalise for sign-off in September.

2.2.3 With regards to Premises, we have now made twelve submissions on behalf of our member practices to NHS England for the Estates and Technology Transformation Fund (ETTF), as prioritised within the framework agreed within our Plan.

2.2.4 For workforce, amongst other initiatives, we have recently launched a campaign with the British Medical Journal (BMJ) to promote Gloucestershire as a place for GPs to live and work ([www.beagpingloucestershire.co.uk](http://www.beagpingloucestershire.co.uk)), alongside advertisements for current vacancies. The print campaign is supported by online and social media activity, with seventeen practices already advertising and four having appointed.

## **2.3 Sustainability and Transformation of Primary Care**

2.3.1 In order to drive delivery of the ambitions of our Strategy and STP, we have committed to investing £1.2million in the sustainability and transformation of primary care. We are encouraging practices to form collaborations of at least a 30,000 combined list size to consider innovative, sustainable bids that improve patient care within a 'place based' approach. Practices have engaged with this process, with, so far, 79 of our 81 practices identified within a collaborative bid. We are now assessing bids and working to ensure consistency along with the sharing of knowledge and best practice across the county. The identified Locality GP Provider Leaders and their membership of the newly established 'New Models of Care Board' will be key to the delivery of this.

## **3. Planned Care**

3.1 The work to support the demand management programme for 2016/17 continues. Within this work the reduction in outpatient follow-up appointments is being progressed at pace. This will deliver the right resource at the right time and prevent unnecessary appointments.

3.2 One key highlight from the planned care team has been the work to support the improvements to urology services at GHFT. The CCG, GHFT and a company led GP Care have agreed to work together to manage capacity and demand more effectively. Under the new arrangement, referrals to GHFT (excluding 2WW and paediatrics) will initially be reviewed within a Clinical Assessment Service. This service will be managed by GP Care on behalf of GHFT. All referrals will be clinically reviewed by a urology specialist and will then be allocated to a clinic slot either within the GP Care Community Urology Service or within the GHFT Urology Service, depending on clinical need. This approach will help ensure that patients who need a specialist appointment are allocated to the next available, clinically appropriate clinic slot, reducing waiting times significantly. In any cases where, following triage, a specialist appointment is not considered necessary, the referral will be returned to primary care with a clear management plan.

## **3.2 G-Care**

3.2.1 In 2016/17 we plan to significantly increase the volume of full pathways on

G-Care, and have a programme in place to develop a significant number of pathways over the next year. Clear and consistent governance arrangements have been developed in order to ensure that the full impact of the pathways is understood within the organisation. We will look to continue to develop G-Care into the future and increase its usage.

#### **4. Estates & Technology Transformation Fund submission**

4.1 Members approved a Primary Care Infrastructure Plan (PCIP) for the period 2016/ 2021 setting out key priorities for investment in GP surgeries to deliver new models of care. This sets 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. Members will know that the PCIP included reference to a national fund, now called the Estates & Technology Transformation Fund (ETTF), which covers the period 2016/ 2019 and is managed by NHS England. Its main focus is to offer capital contributions to improvements or extensions to existing facilities used for primary medical care services, refurbishment of unused or under-utilised premises to increase clinical capacity and Construction of new premises.

4.2 The CCG sees the ETTF as a key mechanism for delivering the priorities of the PCIP and has been working with a number of prioritised practices, as well as receiving requests from other practices to improve their existing buildings, to set out ambitious proposals that will meet the specific objectives of the fund namely: -

- increased capacity for primary care services out of hospital;
- commitment to a wider range of services as set out in your commissioning intentions to reduce unplanned admissions to hospital;
- improving seven day access to effective care;
- increased training capacity; and
- we have also been keen to focus on what the future digital building will be for patients and staff.

4.3 It should be noted that a prioritisation framework was used to score applications with a key emphasis on transformation, the likelihood of delivery in three years, prioritisation in the PCIP and overall estimated financial value of the proposal. This was reviewed by the CCG Core Leadership Team and following earlier discussion of key PCIP priorities by the Primary Care Commissioning Committee (PCCC), a submission was

approved on behalf of its members by the Chair of the PCCC on 30<sup>th</sup> June 2016 to NHS England. There are twelve submissions with a total estimate value (including construction, land, fees and IM&T) of almost £47m. The order of priority for this specific fund is as follows: -

Beeches Green (Stroud)	New building for three practices
Cheltenham Town Centre	New building for up to six practices
Cinderford (Forest of Dean)	New building for two practices
Romney House Tetbury	New building for one practice
Brockworth & Hucclecote (Gloucester)	New building for two practices
Minchinhampton	New building
Gloucester City Health Centre	New building
Culverhay Surgery (Stroud & BV)	Improvement to existing premises
Springbank (Cheltenham)	Improvement to existing premises
Cirencester	New buildings and extension
Stonehouse	New building and extension
Lydney Practice (Forest of Dean)	Improvement to existing premises

4.4 It should be noted that initial reviews of applications will take place between now and the end of August. NHS England will then provide feedback to CCGs on which bids successful met the criteria and will progress to the next stage. The next stage is of course, the development of business cases and other due diligence requirements.

4.5 Detailed guidance was issued in May 2016 with a requirement to submit proposed schemes via an electronic portal by the 30<sup>th</sup> June 2016. It should be note that the transformation of service delivery and the deliverability of schemes over the next three years are the Funds key criteria and the CCG was also asked to prioritise and ensure proposals reflected the local Strategic Estates Plan.

## 5. Transforming Care

5.1 The Transforming Care programme is a national NHS England programme with the goal of returning long stay patients in in-patient units around the country being returned to their home county to live in community based settings. Gloucestershire has 16 such individuals placed in in patient units. This is a low figure given the national figure is 2700. It is likely these

patients will be high cost given their high levels of needs.

- 5.2 Whilst national funding was available so far Gloucestershire has only received capital funding money amounting to £0.7m. Gloucestershire applied for £0.9m of operational funding but received no funding. It does have access to part of the 0.5m which is available to the entire south region.
- 5.3 Work has continued for those impacted patients to return them home. There was a successful 'Homes not Hospitals' event in June and an MOU has been signed with the Director of Adult Social care to ensure that activities and costs are shared across health and social care.

## **6. The Integrated High Needs Team**

- 6.1 Following a decision of the Joint Commissioning Partnership Executive an Integrated High needs team is being planned in order to achieve better outcomes for those service users with high needs in the area of complex and challenging behaviour. Increasingly the population of service users with complex and challenging behaviour is becoming both a growing population and a more difficult and costly one to manage. The Integrated High needs Team will join CCG resources with GCC social workers, support planners and enablement workers to better plan, manage and deliver services to this group.
- 6.2 The 30 day consultation period for this initiative has now concluded and the direction of travel is confirmed. By August 1<sup>st</sup>. a new integrated team will be in place and the population being served will be joined up into a single approach and a single pathway.
- 6.3 It is planned that this will be a developing initiative and that further discussions will occur with other health partners to specifically bring in further health professionals to add to the repertoire of skills and knowledge being employed by the team. The Governing Body and the JCPE will continue to be kept abreast of developments.

## **7. Social Care Impacts**

- 7.1 As part of the overall reduction in social care expenditure the budget for people with a learning disability will be reduced in this financial year. Given knowledge and experience related to the social determinants of health it is likely that health impacts may occur to this vulnerable population. The LD

Programme Board has been requested to consider these implications.

7.2 The planned changes include a focus on trying to find employment opportunities for people with a learning disability and assisting them to be more independent. In order for reductions to be achieved care packages must ultimately be reduced and these impacts must be considered.

7.3 Ensuring that this vulnerable population are well served by Annual Health Checks and Health Action Plans may be one of our strategies to ensure we can mitigate some of the impacts of this significant and unprecedented circumstance.

## **8. Reablement**

8.1 Reablement is a community based service to enable vulnerable and older people to live independently in their own homes and communities as long as possible, and that their need for ongoing care and support are minimised.

8.2 Reablement is a time-limited intervention that is co-ordinated by ICTs. The service is free at the point of delivery to the service user for a period of up to six weeks. It is funded by the Gloucestershire Clinical Commissioning Group (c. £1.5 million) and Gloucestershire County Council (c. £5.5 million).

8.3 By intervening with a skilled programme of reablement in a timely way, we will maximise the potential for independent living. This will also allow us to use resources more effectively and reduce the unit cost of delivering the service.

8.4 There is currently variable level of provision and geographical coverage and we need to ensure that Gloucestershire can meet the expected rise in demand arising from the forecast increase in the older population.

8.5 As such during 2016/17 a further review of the service will look to provide strategic direction for the 'in-house' service as well as work with the new domiciliary care providers to enhance the Reablement offer via the independent sector to ensure all citizens of Gloucestershire have access to Reablement service regardless of who delivers it.

## **9. Developing Integrated Commissioning**

- 9.1 We have much to be proud of in Gloucestershire with regards to how we approach commissioning across our Health and Social Care system. Our shared approach and long history of joint commissioning directly contributes to improving the quality of life for our citizens. Collectively – seeing health, public health, social care, and other local authority functions such as housing, education and leisure, as a whole system rather than lots of individual services can only benefit our patients and residents generally.
- 9.2 The Commissioning process can be resource intensive and there are efficiencies in doing this jointly. In many instances, the needs of patients and service users are indivisible to agency boundaries but the responses to meet that need are often diverse and sometimes disjointed across organisations.
- 9.3 The CCG and the council both face a number of common challenges across the health and wellbeing system:
- rising demand/ need and expectations;
  - major changes in government policy and expectations e.g. the Care Act, 5 Year Forward View, Transforming Care etc;
  - reducing or limited central government funding;
  - inflexible systems and processes that do not support a focus on individuals – patients, service users or families;
  - workforce recruitment and retention issues across the health and care system;
  - professional workforce that is less integrated than it might be and needs to shift to an enabling approach;
  - inefficiencies, overlap and duplication as well as ‘repeat’ incidents; and
  - mutual interdependence so that savings in one area might increase pressure on another e.g. hospital admissions and discharge.
- 9.4 For these reasons both the CCG and Gloucester County Council already have a number of arrangements in place, principally through joint commissioning agreements, to manage and drive change across a number of complex systems. Key strategies such as Joining Up Your Care and the Children and Young People’s Plan are jointly owned and an overarching Section 75 agreement is in place covering a number of areas. The Better Care Fund is well embedded within our commissioning strategies and service redesign processes locally.

- 9.5 We currently have formal joint commissioning governance and funding arrangements with GCC of in excess of £165m in an aligned fund, and work within the NHS collaborative commissioning framework agreements in respect of the 2gether Trust and Gloucestershire Care Services. In addition there are a number of other areas where we recognise mutual interdependencies although funding is separately managed (e.g. Enabling Active Communities). Public health funding is another area where there are mutual interests.
- 9.6 On a day to day basis our shared capacity relies on five joint commissioning posts (covering mental health, learning disabilities, physical disabilities, children and older people) that are accountable to both organisations, reporting to the Associate Director, Partnerships, Joint Commissioning and Community Services for the GCCG and to the relevant Commissioning Directors in the council.
- 9.7 Via ongoing discussions within our Joint Commissioning Partnership Executive and supported by both the Joint Commissioning Partnership Board and the Health and Wellbeing Board it has been agreed to adopt a phased approach to further integration that involves:
- establishing clear leadership for integrated commissioning between the two organisations by appointing a Joint Director of Integration and a Head of Commissioning for Families (see 'Leadership Arrangements' below);
  - maintaining the five existing joint commissioning posts, with these individuals working in the hubs and some having line management responsibility for staff in the hubs. These individuals have 'dual nationality' in that they are effectively seconded to whichever organisation is not their employer for half of their time; and
  - extending 'dual nationality' to officers in the hubs who will report to joint commissioners. There are approximately 100 members of staff who work in the five joint commissioning areas, with a roughly 50:50 split between GCCG and GCC employees. As a first stage, an arrangement would be put in place between the GCCG and GCC to allow employees to work for whichever organisation is not their employer for part of the time in a similar way as the existing joint commissioners. Officers would remain employed by their current employer and on the same terms and

conditions of employment. A second stage could involve extending the scope of integrated commissioning thereby bringing more officers into the jointly owned commissioning function.

- 9.8 To conclude an integrated commissioning function will formalise the partnership between GCC and GCCG ensuring that across Gloucestershire our citizens are served by an experienced and knowledgeable team, maintaining a critical mass of expertise to advise all partners. An integrated commissioning function will also ensure that the resources of all partners can be effectively and efficiently used to deliver good quality integrated care whilst reducing the health inequalities.

## **10. Mental Health**

### **10.1 Gloucestershire's Future in Mind 5 Year Mental Health Transformation Plan**

- 10.1.1 Work continues regarding the implementation of the Gloucestershire Future in Mind 5 year transformation plan, including the successful ongoing work of the DFE/NHSE funded schools pilot in Stroud locality. 14 schools are taking part including Primary, Secondary, a Special school and an Alternative provision. The aim of the pilot is to better join up schools and mental health services so that children and young people are identified and supported earlier and that schools are better equipped to support young people facing issues. An action plan is in place which includes developing a streamlined training matrix for schools based on a 'low cost or no cost' model and providing more support for parents. The pilot is being evaluated to assess the benefits and need for county-wide roll-out, but early feedback is extremely positive.
- 10.1.2 Schools Centres of Excellence in Mental Health award is being developed to promote 'whole' school approaches to emotional wellbeing including promoting the emotional wellbeing of staff and students.
- 10.1.3 Development work on the local mental health website for children and young people is due to go live with a soft launch in July and full promotion from September for the new school year. Work has commenced on webpages for parents and professionals.
- 10.1.4 An online counselling pilot with Teens in Crisis has gone live and is available through self-referral countywide. The CCG have also supported

the expansion of countywide counselling services for young people via a grant fund to 'Teens in Crisis'.

- 10.1.5 Work also continues on implementing the changes to the mental health liaison and crisis services to include children and young people under 16. The work programme on self-harm for children and young people continues with evaluation of the new pathway of support linked to young people attending ED.

## **11. Crisis Care Concordat**

- 11.1 We are continuing to recommission our Crisis Resolution Home Treatment Teams (CRHTTs) as part of our Mental Health Crisis Concordat action plan. It is intended that the enhanced service will work with a broader range of problems as opposed to the narrow focus on Serious Mental Illness, will work with children and will provide advice/support to colleagues working in emergency services.

- 11.2 Co-location at Waterwells is currently in progress and early feedback from Police colleagues has demonstrated the value of joint working/information sharing. We have case examples where we have actively avoided s136 detentions/ED.

- 11.3 The Crisis Café for Gloucester has been commissioned as a 1 year pilot aiming to prevent individuals experiencing emotional crises having to utilise statutory services. The service went live in mid-July.

## **12. Strategy and Planning**

- 12.1 A national report on cultural commissioning has recently been published by the New Economics Foundation. The report brings together the learning and experiences from two national pilots sites (one being Gloucestershire) around integrating arts, culture and health. Local work is continuing across the county to pilot a range of programmes across our clinical programme groups. Some of the projects are summarised below:

- a mixed media arts project for men of working age living with chronic-pain, to learn arts based strategies of managing pain. Co-delivered with an expert pain patient;
- a drama based project with teenagers living with Type 1 diabetes to increase confidence and diabetes self- management. Co-delivered

- with a teenage creative arts intern who has Type 1 diabetes;
- bespoke choirs for people with COPD and asthma;
- shared art project (wall mural) and connection to nature, to reduce psychological barriers such as stigma and shame for people with significant weight issues; and
- comedy and animation project for BME community to raise awareness of early signs of dementia and increase uptake of early support.

### **13. Workplace Wellbeing Charter**

13.1 The CCG have provided funding for 40 organisations across Gloucestershire to sign up to the National Workplace Wellbeing Charter which is endorsed by Public Health England. A project group has been convened to oversee implementation and involves engagement with Active Gloucestershire, LEP, County Council and District Councils.

13.2 The CCG have submitted an application to NHS England for use of a free license for the Patient Activation Measure. The PAM is a valid, highly reliable tool that assesses an individual's knowledge, skill, and confidence. Research has also shown that it's highly predictive of most health behaviours, self-management and use of health services. The aim would be to implement the tool across a range of pathways to promote person-led care and promote self-management.

### **14. Forest of Dean Community Services Review**

14.1 Over 40 engagement meetings have taken place as part of the review of community services in the Forest of Dean. During the next month we will be drawing together a final engagement report which will then inform the development of options for the future of community services.

### **15. Clinical Programmes**

15.1 We are pleased to report encouraging progress with our Clinical Programmes. Some programmes are already launching new service models that offer patients streamlined, accessible and high quality care. Other programmes are now bringing together partners to collaborate on new work to improve the health of our population and ensure sustainable services.

#### **15.2 Respiratory**

15.2.1 The Respiratory CPG is undergoing a refresh, under the umbrella of the STP, to test a pathway approach to models of care. This programme provides an exciting opportunity to build on respiratory service development to date and test out multi-disciplinary integrated working across a patient pathway. Four priority pathways have been agreed by the clinical programme group, commencing with Chronic Obstructive Pulmonary Disease (COPD), for which a system wide planning workshop is scheduled in July 2016.

### **15.3 Circulatory**

15.3.1 Following the Circulatory Clinical Programme Group meeting in June, pathway improvement plans are now progressing including: non-elective activity for chest pain through the development of a pathway for those with suspected cardiac chest pain, this will deliver a consistent approach for low, moderate, and high risk conditions, and negates unnecessary admissions and improves outcomes. Other projects to be progressed include: managed shared care between community services and secondary care for individuals with Heart Failure which will further join up the services offer and prevent hospital admissions and at times the need for outpatient appointments; utilisation of remote monitoring (telehealth) for individuals with Heart Failure, to detect exacerbations for management by the community heart failure service; remote monitoring for individuals with a cardiac defibrillator or cardiac resynchronisation therapy to reduce follow up activity. An alternative ambulatory ECG service using an annual KPI approach has now commenced and will be reviewed for potential service provision across the county.

### **15.4 Stroke**

15.4.1 The Circulatory Clinical Programme Group Meeting in September is scheduled to focus on the Stroke pathway in order to assess the impact of recent pathway changes and plan for sustained improvements including: access to stroke wards, consultants and nurses; fewer outliers with more people spending time on the specialist stroke wards; faster access to CT scanning; reduced length of stay and improvements in access to therapies. A business case for the development of in-reach community beds is also currently being progressed.

### **15.5 Eye Health**

- 15.5.1 The first phase of the new community eye care service went live as planned on 31st May 2016. 63 practices signed up so far as sub-contractors with good geographical coverage across the county, with 67 practitioners are fully trained. The first contract and performance meeting will be on 14th July 16. The Primary Eye Care Company and GHFT are now working collaboratively working on next phase protocols for Minor Eye conditions (Flashes and Floaters) and meetings have been pre-arranged ahead of future phases to ensure smooth delivery.
- 15.5.2 There has been a delay in getting the new voluntary sector Eye Care Liaison Officer Service operational. This new service provides emotional and practical support for people affected by poor eye health; the team are working to get this resolved as quickly as possible. Forest Sensory Services have taken up the opportunity to be trained to support staff working in Care Homes and will be working to upskill care home staff.
- 15.5.3 Lesson learnt workshop is planned for 26<sup>th</sup> July 2016. This learning will be shared with other clinical programmes to continually improve the way we work.

## **15.6 Musculoskeletal (MSK)**

- 15.6.1 The phased implementation planning is now nearing completion and will see more efficient service delivery for patients, getting the right patients to the right services at the right time and more effective conservative management where appropriate. Since the last update the following has been completed:
- 1) A referral form which will simplify, standardise and streamline the referral process has been developed and tested. The form minimises the time required by GP's for completing data sets, but still ensures all relevant information arrives with the referral to facilitate effective triage.
  - 2) Implementation planning around the enhanced Advanced Practitioner Service (staffed by specialist Physiotherapists and Podiatrists). This will ensure there is consistency of access across the county to specialist skilled staff.
  - 3) Clinical Network Groups have been established and these will provide cross-organisational forum for operational discussion.

- 4) The clinical triage model (single point of access) will be replicated at locality level to avoid duplication and simplify the process for referrers and patients with spinal conditions. Each locality will have a single point of access for Orthopaedic spinal referrals and will have a cross organisational Multi-Disciplinary Team for triage and complex case management.
- 5) Discussions have begun to replicate this model through the foot & ankle pathway, which will have a Multi-Disciplinary Team including Orthopaedics, Physiotherapy & Podiatry Advanced Practitioners and Orthotists.
- 6) The falls education service has now recruited 3 additional staff to lead the coordination of falls management and prevention. The group is currently establishing plans to ensure that stratification of patients at risk occurs early, people are referred to community services which support exercise activation and balance work as soon as possible, and that Physiotherapists in core services carry out detailed falls assessment when required.
- 7) The falls project is also working with the fire service and SWAST (for whom there is a Commissioning for Quality and Innovation (CQUIN) this year) to maximise the effectiveness and efficiency of the falls “pick up” service.
- 8) Work packages for all services have been developed and are out for consultation with all services to ensure every service has the following:
  - a. Referral Criteria
  - b. A triage process
  - c. Stratified discharge summaries
  - d. Urgent vs Routine criteria
  - e. MSK-HQ Outcome measure embedded as part of the service
  - f. Standardised clinic names
  - g. Link champions/contact people to facilitate inter-service working and feed the CNG's & MDT's
- 9) Pathway guidance to continue to be developed and housed on G-Care.

## **15.7 Diabetes**

- 15.7.1 The planning for the refresh for the Diabetes CPG is well underway, with workshop planned for 1<sup>st</sup> September to review Type 2 Diabetes. We now have a good quality data pack with a good understanding about how we are performing against other areas. We have additional public feedback being gathered whilst raising public awareness of diabetes by going out on the information bus and offering testing, which was well received by the public. The service walkthrough is planned for 20<sup>th</sup> July and all information will then be pulled together with the evidence based and needs assessment as background information to inform the review.

## **15.8 Diabetes footcare**

- 15.8.1 This project is progressing to plan. Engagement with key stakeholders is almost complete which will inform the final pathway redesign ready for circulation and comment.
- 15.8.2 Next project team meeting is due to focus specifically on the complex Multi-Disciplinary Team clinic and foot protection team to work this into a coherent plan and begin a business case. GHFT are undertaking actions relating to CQUIN including root cause analysis of major amputations and implementation of foot care sticker (in advance of trakcare)

## **15.9 Cancer**

- 15.9.1 The programme's ambitious local development strategy is fully aligned to Achieving World-Class Cancer Outcomes: a cancer strategy for England 2015-16
- 15.9.2 *Early Diagnosis of Cancer:*

This area of work now completed its second year. The extensive Macmillan GP Master Class series has achieved over 900 GP attendances at interactive educational events, with the latest in April focussing on the Brain and Central Nervous System. The programme for 2016/17 is being confirmed and will be advertised shortly. In addition all GP practices are completing their returns into a large-scale quality improvement project that is taking learning from 500 Significant Event Audits, which we have developed in collaboration with the Royal College of General Practitioners. We are now completing joint development work on our pathways to

diagnosis in line with the latest NICE guidelines to streamline high quality referrals and ensure as many cancers as possible are detected at an early stage. Recently the CCG received an award from the All Party Parliamentary Group on Cancer for the work achieved to improve early diagnosis and one-year cancer survival rates.

### 15.9.3 *Gloucestershire Living With & Beyond Cancer Programme:*

This wide-reaching programme encompasses 7 lead projects transforming patient care with a range of partners across the care pathway, focussing in the current phase on Breast, Prostate and Colorectal Cancer. Within the hospital GHFT have started to implement the Cancer Recovery Package of Holistic Needs Assessments and Care Plans, and there has been a successful appointment to the clinical lead for HNAs. Following a successful bid to Macmillan and with the support of the CCG, 4 Support Worker posts have been agreed to assist in the success of implementing the Recovery Package within GHFT. Each Support Worker will be allocated to each tumour site (Breast, Colorectal and Prostate) and also one will be based in Oncology. The service design work is now well progressed for shifting to needs based follow-up approach and the production of Treatment Summaries to improve communications with patients and between health partners. We are especially pleased to announce the launch of our innovative community-based service Macmillan Next Steps that aims to improve the health outcomes for people following a cancer diagnosis. The service will be providing patient education programmes, 1:1 specialist recovery care including physiotherapy, occupational therapy, dietetics and emotional support. The ethos is to encourage health lifestyles and to enable patients to successfully self-manage. We will be holding tumour-site specific Patient Focus Groups over the summer to test from a patient perspective, whether the new design is ready to meet its objective of improving health outcomes and patient experience.

## 15.10 **Ear, Nose and Throat (ENT)**

- 15.10.1 An ENT CPG is currently being established. Dr Graham Mennie who has led the Eye Health Service redesign work will be the clinical lead and the project team is being established. Initial conversations have started and scoping of the initiation wider reaching programme has begun.
- 15.10.2 There will be two quick win projects undertaken to create momentum which will focus on Aural care and tinnitus pathways and will support the QIPP

follow up work; as a result these projects are starting immediately and will report into the CPG once it is set up. The learning from the Stroud and Berkley Vale ENT place base trial will be taken into account to inform any future service changes.

## **16 Prevention and Self-Care plan**

16.1 A new Prevention and Self-Care Plan has been developed as part of Gloucestershire's Sustainable and Transformation Plan. The plan focuses on four priorities which include supporting pathways; supporting our workforce; supporting places and supporting people.

## **17 Prevention and Self-Care plan**

17.1 Our work on the Diabetes Digital Coach Programme is progressing well. An online diabetes structured education programme called Map My Diabetes will be implemented across Gloucestershire in two phases. The first phase will involve testing out the tool within Gloucester City and the Forest of Dean. This has the potential to reach approximately 40% (12,000 patients) of the county's diabetic population. The second phase and subsequent roll out to the remaining 5 localities will be dependent on the outcomes of the evaluation and accompanying business case.

## **18. Meetings attended**

- 2<sup>nd</sup> June- South Central Leadership Forum, Swindon
- 2<sup>nd</sup> June- We are Gloucestershire Launch Event, Cirencester
- 9<sup>th</sup> June- Allied Rapid Reaction Corps Reception, Innsworth
- 13<sup>th</sup> June- UWE NHS Workforce and Health Education Event, Gloucester
- 15<sup>th</sup>-17<sup>th</sup> June- NHS Confederation Conference, Manchester
- 4<sup>th</sup> July- Mental Health and wellbeing Strategy Stakeholder Event, Gloucester
- 7<sup>th</sup> July- LMC, Gloucester
- 12<sup>th</sup> July- HCOSC, Gloucester
- 12<sup>th</sup> July- Chairs Meeting, Gloucester
- 14<sup>th</sup> July- Leadership Gloucester, Gloucester
- 15<sup>th</sup> July- SW STP Session, Reading
- 18<sup>th</sup> July- Cheltenham Quarterly Leads Meeting, Cheltenham
- 19<sup>th</sup> July- Health and Wellbeing, Gloucester

- 21<sup>st</sup> July- 2G AGM, Cheltenham

**19. Recommendation**

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

**Agenda Item 8**

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Gloucestershire Clinical Commissioning Group Accountable Officer's Report</b>
<b>Executive Summary</b>	This report provides a summary of key update and issues arising during June and July 2016.
<b>Key Issues</b>	The key issues arising include: <ul style="list-style-type: none"> <li>• Gloucestershire CCG Information Bus;</li> <li>• Urgent and Emergency Care;</li> <li>• Learning Disabilities Service;</li> <li>• Reablement;</li> <li>• Developing Integrated Commissioning;</li> <li>• Sustainability and Transformation Plan; and</li> <li>• Meetings attended.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	None.
<b>Financial Impact</b>	None.
<b>Legal Issues (including NHS Constitution)</b>	None.
<b>Impact on Health Inequalities</b>	None.
<b>Impact on Equality and Diversity</b>	None.
<b>Impact on Sustainable Development</b>	None.
<b>Patient and Public Involvement</b>	Not applicable.
<b>Recommendation</b>	The Governing Body is requested to note this report which is provided for information.
<b>Author</b>	Mary Hutton
<b>Designation</b>	Gloucestershire CCG Accountable Officer
<b>Sponsoring Director (if not author)</b>	

## **Gloucestershire Clinical Commissioning (GCCG) Accountable Officer's Report**

### **1. Introduction**

- 1.1 This report provides a summary of key updates and issues arising during June and July 2016.

### **2. Gloucestershire CCG Information Bus**

- 2.1 The Information Bus has had been fully booked promoting a variety of health and care messages across the county in the last two months. Highlights have included:

- End of Life planning - Dying Matters;
- Support to Stop Smoking;
- Insight – introducing the new Eye Care Liaison Officer (ECLOs) support service for newly diagnosed patients;
- Foster Care Fortnight;
- Mental Health Awareness Week;
- 8th Big Health and Social Care Open Day and launch of the Special Olympics;
- Forest of Dean Review Engagement - Lydney Community Fun and Information Day;
- Child Safety Week; and
- Diabetes Awareness Week.

### **3. Urgent and Emergency Care**

- 3.1 The Sustainability and Transformation Plan (STP) process has identified Urgent Care and Emergency Care as one of the key areas of work, the transformation projects include:

- redesign of urgent care pathways;
- development of an integrated Urgent Care Clinical hub;
- development of integrated Urgent Care Centres; and
- development of an urgent care digital access offer

- 3.2 The 4 hour improvement trajectory agreed with Gloucester Hospital FT (GHFT) and NHS England has been met for the first quarter of 16/17. Immediate work is focused on reducing emergency admissions to

hospital through utilisation of the Single Point of Clinical Access; Rapid Response working with the Integrated Discharge Team at GHFT front door and through a review of the patients within the hospital whose length of stay is over 14 days.

### **3.3 IDT Front-door update**

- 3.3.1 As part of the admission avoidance work stream Rapid Response is now fully operational within the ED departments at GHFT and CGH. The primary aim of the front door service is to prevent patients from being admitted from the emergency department into an acute bed where other community based care pathways are more appropriate. Following assessment the team will support patients to return to their own home where appropriate under the care of their GP, supported by the community based Rapid Response team.
- 3.3.2 The key objectives of the service is to reduce avoidable admissions for patients who:
- have an urgent health need; and
  - have a rapid deterioration in health which does not need secondary care as a result.

### **3.4 Development of integrated primary and community led/ based urgent care**

- 3.4.1 Members were previously provided with an outline of a large scale project to design and agree service models to develop plans for integrated primary and community based/ led urgent care services seven days per week across Gloucestershire.
- 3.4.2 A series of three workshops involving a range of Providers, locality GPs, patients, voluntary sector representation, Healthwatch and key subject matter commissioning leads from the CCG has now concluded. The key ideas emerging from these sessions are now being collated and will be available in early August.
- 3.4.3 This work will now be overseen by the New Models of Care Board. By the time of the next Governing Body meeting, that committee will have reviewed the Stakeholder feedback and confirmed the work plan going forward. Members should note that completed proposals will need to

be presented to the Governing Body. It is expected this will be completed by the Autumn of 2016. Subject to approval, new arrangements will be implemented from the Spring of 2017 onwards, although there might be some advanced testing from December 2016 in some localities.

## **4. Learning Disability Services**

### **4.1 Transforming Care**

4.1.1 The Transforming Care programme is a national NHS England programme with the goal of returning long stay patients in in-patient units around the country being returned to their home county to live in community based settings. Gloucestershire has 16 such individuals placed in in patient units. This is a low figure given the national figure is 2700. It is likely these patients will be high cost given their high levels of needs.

4.1.2 Whilst national funding was available so far Gloucestershire has only received capital funding money amounting to £0.7m. Gloucestershire applied for £0.9m of operational funding but received no funding. It does have access to part of the 0.5m which is available to the entire south region.

4.1.3 Work has continued for those impacted patients to return them home. There was a successful 'Homes not Hospitals' event in June and an Memorandum of Understanding (MOU) has been signed with the Director of Adult Social care to ensure that activities and costs are shared across health and social care.

### **4.2 The Integrated High Needs Team**

4.2.1 Following a decision of the Joint Commissioning Partnership Executive an Integrated High Needs Team is being planned in order to achieve better outcomes for those service users with high needs in the area of complex and challenging behaviour. Increasingly the population of service users with complex and challenging behaviour is becoming both a growing population and a more difficult and costly one to manage. The Integrated High Needs Team will join CCG resources with GCC social workers, support planners and enablement workers to better plan, manage and deliver services to this group.

- 4.2.2 The 30 day consultation period for this initiative has now concluded and the direction of travel is confirmed. By August 1<sup>st</sup>, a new integrated team will be in place and the population being served will be joined up into a single approach and a single pathway.
- 4.2.3 It is planned that this will be a developing initiative and that further discussions will occur with other health partners to specifically bring in further health professionals to add to the repertoire of skills and knowledge being employed by the team. The Governing Body and the Joint Commissioner Partnership Executive (JCPE) will continue to be kept abreast of developments.

### **4.3 Social Care Impacts**

- 4.3.1 As part of the overall reduction in social care expenditure the budget for people with a learning disability will be reduced in this financial year. Given knowledge and experience related to the social determinants of health, it is likely that health impacts may occur to this vulnerable population. The LD Programme Board has been requested to consider these implications.
- 4.3.2 The planned changes include a focus on trying to find employment opportunities for people with a learning disability and assisting them to be more independent. In order for reductions to be achieved care packages must ultimately be reduced and these impacts must be considered.
- 4.3.3 Ensuring that this vulnerable population are well served by Annual Health Checks and Health Action Plans may be one of our strategies to ensure we can mitigate some of the impacts of this significant and unprecedented circumstance.

### **5. Reablement**

- 5.1 Reablement is a community based service to enable vulnerable and older people to live independently in their own homes and communities as long as possible, and that their need for ongoing care and support are minimised.
- 5.2 Reablement is a time-limited intervention that is co-ordinated by ICTs.

The service is free at the point of delivery to the service user for a period of up to six weeks. It is funded by the Gloucestershire Clinical Commissioning Group (c. £1.5 million) and Gloucestershire County Council (c. £5.5 million).

- 5.3 By intervening with a skilled programme of reablement in a timely way, we will maximise the potential for independent living. This will also allow us to use resources more effectively and reduce the unit cost of delivering the service.
- 5.4 There is currently variable level of provision and geographical coverage and we need to ensure that Gloucestershire can meet the expected rise in demand arising from the forecast increase in the older population.
- 5.5 As such during 2016/17 a further review of the service will look to provide strategic direction for the 'in-house' service as well as work with the new domiciliary care providers to enhance the Reablement offer via the independent sector to ensure all citizens of Gloucestershire have access to Reablement service regardless of who delivers it.

## **6. Developing Integrated Commissioning**

- 6.1 We have much to be proud of in Gloucestershire with regards to how we approach commissioning across our Health and Social Care system. Our shared approach and long history of joint commissioning directly contributes to improving the quality of life for our citizens. Collectively – seeing health, public health, social care, and other local authority functions such as housing, education and leisure, as a whole system rather than lots of individual services can only benefit our patients and residents generally.
- 6.2 The Commissioning process can be resource intensive and there are efficiencies in doing this jointly. In many instances, the needs of patients and service users are indivisible to agency boundaries but the responses to meet that need are often diverse and sometimes disjointed across organisations.
- 6.3 The CCG and the council both face a number of common challenges across the health and wellbeing system:

- rising demand/ need and expectations;
- major changes in government policy and expectations e.g. the Care Act, 5 Year Forward View, Transforming Care etc;
- reducing or limited central government funding;
- inflexible systems and processes that do not support a focus on individuals – patients, service users or families;
- workforce recruitment and retention issues across the health and care system;
- professional workforce that is less integrated than it might be and needs to shift to an enabling approach;
- inefficiencies, overlap and duplication as well as ‘repeat’ incidents; and
- mutual interdependence so that savings in one area might increase pressure on another e.g. hospital admissions and discharge;

6.4 For these reasons both the CCG and Gloucester County Council already have a number of arrangements in place, principally through joint commissioning agreements, to manage and drive change across a number of complex systems. Key strategies such as Joining Up Your Care and the Children and Young People’s Plan are jointly owned and an overarching Section 75 agreement is in place covering a number of areas. The Better Care Fund is well embedded within our commissioning strategies and service redesign processes locally.

6.5 We currently have formal joint commissioning governance and funding arrangements with GCC of in excess of £165m in an aligned fund, and work within the NHS collaborative commissioning framework agreements in respect of the 2gether Trust and Gloucestershire Care Services. In addition there are a number of other areas where we recognise mutual interdependencies although funding is separately managed (e.g. Enabling Active Communities). Public health funding is another area where there are mutual interests.

6.6 On a day to day basis our shared capacity relies on five joint commissioning posts (covering mental health, learning disabilities, physical disabilities, children and older people) that are accountable to both organisations, reporting to the Associate Director, Partnerships, Joint Commissioning and Community Services for the GCCG and to the relevant Commissioning Directors in the council.

6.7 Via ongoing discussions within our Joint Commissioning Partnership Executive and supported by both the Joint Commissioning Partnership Board and the Health and Wellbeing Board it has been agreed to adopt a phased approach to further integration that involves:

- establishing clear leadership for integrated commissioning between the two organisations by appointing a Joint Director of Integration and a Head of Commissioning for Families (see 'Leadership Arrangements' below);
- maintaining the five existing joint commissioning posts, with these individuals working in the hubs and some having line management responsibility for staff in the hubs. These individuals have 'dual nationality' in that they are effectively seconded to whichever organisation is not their employer for half of their time; and
- extending 'dual nationality' to officers in the hubs who will report to joint commissioners. There are approximately 100 members of staff who work in the five joint commissioning areas, with a roughly 50:50 split between GCCG and GCC employees. As a first stage, an arrangement would be put in place between the GCCG and GCC to allow employees to work for whichever organisation is not their employer for part of the time in a similar way as the existing joint commissioners. Officers would remain employed by their current employer and on the same terms and conditions of employment. A second stage could involve extending the scope of integrated commissioning thereby bringing more officers into the jointly owned commissioning function.

6.8 To conclude an integrated commissioning function will formalise the partnership between GCC and GCCG ensuring that across Gloucestershire our citizens are served by an experienced and knowledgeable team, maintaining a critical mass of expertise to advise all partners. An integrated commissioning function will also ensure that the resources of all partners can be effectively and efficiently used to deliver good quality integrated care whilst reducing the health inequalities.

## **7. Sustainability and Transformation Plan**

7.1 In light of current discussions around the Sustainability and

Transformation Plan (STP), the Healthy Individuals Programme Group has now formally disbanded with a new strategic group being proposed to lead on prevention and self-care. The new group will be made up of senior representatives from across the system and will look to develop a substantial cross partner prevention plan for the next 5-years.

- 7.2 The first meetings of the Child and Adult Healthy Weight partnerships have taken place and these forums are launching the work to improve our pathways using the clinical programme approach.
- 7.3 A joint OD and workforce planning group has been established, led by Shaun Clee, Chief Executive of 2Gether NHS Foundation Trust. This group is taking forward the development of a shared OD and workforce action plan for the system to underpin the work of our Sustainability and Transformation Plan. The action plan is focusing on 3 key aims – developing the capability we need for our workforce, the capacity we need and the culture we need organisations and individuals to adopt in order to support the changes we need to make together.

## **8 Meetings**

02 June	South Central Quarterly Leadership Forum, Swindon
07 June	JCPB, Shire Hall
08 June	Enabling Active Communities Commissioning Group Meeting
08 June	JCPE
09 June	Gloucester Health & Well Being Board (GHWB), Shire Hall
13 June	Leadership Gloucestershire, Shire Hall
13 June	University of the West of England (UWE), Gloucester
14 June	Gloucestershire Strategic Forum (GSF)
15 June	NHS Confederation Conference, Manchester
23 June	Integrated Governance & Quality Committee (IGQC)
30 June	Test Bed VIP Visit, Bristol
04 July	Mental Health & Wellbeing Strategy Stakeholder Event
07 July	Health Watch Gloucestershire (HWG) - AGM
12 July	Health & Care Scrutiny Committee, Shire Hall
13 July	New Models of Care Board (NMOC)
18 July	Leadership Gloucestershire Officer Advisory Group, Shire Hall
19 July	Gloucester Health & Well Being Board (GHWB), Shire

20 July Hall  
Commissioners Learning Network, London  
26 July Gloucestershire Strategic Forum (GSF)

## **9 Recommendations**

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

**Governing Body**

**Agenda Item 9**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Performance Report</b>
<b>Executive Summary</b>	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 June 2016.
<b>Key Issues</b>	These are set out in the executive summary within the report.
<b>Risk Issues: Original Risk Residual Risk</b>	All risks are identified within the relevant sections of this report.
<b>Financial Impact</b>	This report gives detail on the financial position to the end of June
<b>Legal Issues (including NHS Constitution)</b>	These are set out in the main body of the report.
<b>Impact on Health Inequalities</b>	Not applicable.
<b>Impact on Equality and Diversity</b>	There are no direct health and equality implications contained within this report.
<b>Impact on Sustainable Development</b>	There are no direct sustainability implications contained within this report.
<b>Patient and Public Involvement</b>	These are set out in the main body of the report.
<b>Recommendation</b>	The Governing Body is asked to: <ul style="list-style-type: none"> <li>• note the performance against local and national targets and the actions taken to ensure that performance is at a high standard;</li> <li>• note the financial position as at month one;</li> <li>• note the risks identified in the Finance and</li> </ul>

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

**Gloucestershire CCG**

**Performance Report**

**1.0 Executive summary**

**1.1 Introduction**

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

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

A full summary of performance against all national and local standards is included within the relevant scorecard for that section of the report. An overarching GCCG performance dashboard is included as a supporting appendix; providing an overview of all key national and local targets. A further supporting appendix is provided in relation to the update on 2016/17 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 2016/17 – up to 30<sup>th</sup> June 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:**

- Progress is being reported across all active clinical programme groups with good clinical engagement across the system
- The Primary Care Clinical Quality Review Group have established a quality assurance framework for primary care. The group has met on several occasions and has considered the outcomes of practice Care Quality Commission (CQC) inspections. It has also monitored vaccination performance for last winter, medicines optimisation, Quality and Outcomes Framework (QOF) and primary care staffing including training and recruitment. Patient experience including the progress with patient participation groups and Friends and Family test (FFT) was also an agenda item.

**Good performance:**

- ED Performance in quarter one was 86.6%, which is 3.2% above the STP trajectory. June performance was 86.9% (STP trajectory was 85%)
- Improved Incomplete RTT performance, with the 92% incomplete standard
- 6 week Diagnostics - May performance improved to 1.3% against STP trajectory of 2.2%
- Continued achievement of Cancer 31 day targets

**Challenging performance:**

- Delivery of cancer targets was challenging throughout 2015/16 and this continues into 2016/17.
- 62 days below STP trajectory at 76.1%
- 2 week wait performance 86.6% (target 93%)
- Cancelled operations remain high
- IAPT – the impact of the recent NHSE Intensive Support Team has resulted in improved compliance with IAPT recovery standard; however access rates have dropped following the decision to not count the nursing arm of the service. IAPT access is currently 1.69% against a target of 2.5%

**Patient experience – Green.**

**Patient Experience - Perspective highlights:**

- Programme Engagement / Experience Form developed to support GCCG QIPP monitoring and delivery
- PROMs casemix-adjusted scores and outliers — 2015-16 Provisional Publication date: May 12, 2016: GHNHSFT 'not an outlier' for all procedures.
- The Practice Participation (PPG) Group network held a successful meeting in July 2016. The meeting introduced members to the GCCG Primary Care Strategy, featuring new ways of working in primary care, e.g. clinical pharmacists.
- Patient Engagement and Experience continues to develop across a wide range of GCCG projects. Key activities in the last period include:
  - A wide range of engagement activity to support GCCG projects. In particular three public drop-ins have been hosted in the Forest of Dean regarding new cross-border healthcare arrangements for English patients registered with Welsh GPs.

**Good performance**

- Comprehensive experience and engagement activity supporting CCG work programme.
- Most GP practices in Gloucestershire now have a Patient Participation Group (PPG).
- 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:**

- The evaluation of our social prescribing programme is underway. This is both a quantitative and a qualitative evaluation and will involve patient stories, focus groups and individual interviews. 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.
- A system resilience plan has been agreed for 2016/17 including a series of investments to improve system performance this winter.
- A multi-agency community group is meeting regularly. This now involves the CEOs of the Town and Parish Council Forum with all Districts/Borough, City Councils, PCC, Police and Voluntary and Community Sector represented. Predominately the CCG and our partners have a crucial role in working together to break down artificial barriers, championing community endeavour and signposting local people to networks of community support and action, joining up services and reducing duplication and bureaucracy.

**Staff – Green.**

**Staff - Perspective highlights:**

- Staff sickness level for June is 3.1% against a target of 3%.
- A working group is progressing the organisational development plan 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. The CCG is forecasting to deliver a surplus of £9.456m, however, there are significant risks to achieving this position

**Good performance**

- The CCG is forecasting to deliver a surplus of £9.456m
- The better payment practice code performance for the year to date (for non-NHS invoices by value) is 98.59% which is above the target figure of 95%.

**Challenging performance:**

- Emergency activity to the end of June is above planned levels
- QIPP schemes for 16/17 totals £18.042m. Currently there is slippage of £1m.
- Actual prescribing information received to the end of April indicates a pressure on this budget.

### 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 2016/17 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:

<b>Internal Perspective</b>	<b>Organisational Objective</b>
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 30<sup>th</sup> June 2016**

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

PERSPECTIVE 1	Clinical Excellence	Amber
<b>Success criteria: 1.</b> 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
<b>Success criteria: 2.</b> 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 2016/17 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
<b>Success criteria: 3.</b> 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
<b>Success criteria 4.</b> 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		In development

<i>to focus, in brief, on one CPG area per month</i>	
<b>Success criteria: 5. Key local and National standards relating to Patient Experience</b>	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, 2G NHSFT and Gloucestershire Care Services Trust. Further CQRG’s are held for Care Homes and Primary Care. These meetings report directly to the relevant NHS Gloucestershire CCG/Provider contract boards, and provide a focused opportunity for quality to be discussed between provider and commissioner.

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

**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.**

Since April 2015, GCCG have been responsible for commissioning primary medical care services through a delegation agreement with NHS England. The Primary Care and Localities Directorate, working with the Primary Care Operational Group (PCOG) and the Primary Care Commissioning Committee (PCCC), have managed a number of operational contractual issues in this time. This has included 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, along with PMS Reviews. These have been managed within a good governance process that minimised any real or perceived conflicts of interest.

Furthermore, we have now commenced the development of a Primary Care Strategy for Gloucestershire: Joining Up Your Primary Care. The Strategy sets

out a draft vision for Primary Care, with a plan to achieve it over the next five years:

So patients in Gloucestershire can stay well for longer and receive joined-up out of hospital care wherever possible, we need to have a sustainable, safe and high quality primary care service, provided in modern premises that are fit for the future.

To do this, we will:

- Attract and retain the best staff through promoting Gloucestershire as a great place to live and work, and offering excellent training opportunities;
- Ensure good access to primary care 7 days a week;
- Create a better work-life balance for our staff;
- Maximise the use of technology;
- Reduce bureaucracy;
- Support practices to explore how they can work closer together to provide a greater range of services for larger numbers of patients.

The strategy was out for consultation in June 2016, with comments now being collated to form the next version as we look to finalise and sign off the strategy. Once agreed, the key components and the commitments to deliver them will be shared within this report.

The Primary Care Offer for 2016/17 builds on the success of the previous two years. The key activity themes are:

<b>Cancer Management</b>	<ul style="list-style-type: none"> <li>• Improving health and wellbeing</li> <li>• Education programme (GPs and nurses)</li> <li>• Prostate cancer pathway</li> </ul>
<b>Practice based clinical audit</b>	<ul style="list-style-type: none"> <li>• Undertake clinical audit activity quarterly with GCCG PCCAG</li> </ul>
<b>Local Quality Improvement</b>	<ul style="list-style-type: none"> <li>• Antibiotics Prescribing</li> <li>• Acute Kidney Injury</li> <li>• Sepsis</li> </ul>
<b>Practice Variation</b>	<ul style="list-style-type: none"> <li>• Identifying variances from the new GP Portal</li> <li>• Analyse and act for continuous improvement</li> </ul>
<b>Caring for Carers</b>	<ul style="list-style-type: none"> <li>• Health checks for carers to include mental and physical health, prevention advice, social care needs</li> </ul>
<b>Frailty</b>	<ul style="list-style-type: none"> <li>• Undertaking frailty assessments for an identified cohort of patients</li> </ul>

Reporting on outcomes against these themes will follow later in 2016/17.

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

All seven CCG localities have developed two year Locality Development Plans running from 2015-2017. Each plan was developed in conjunction 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, with in-depth reporting on individual localities quarterly to the CCG Development Session.

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.

In addition, across the county, the GCCG Primary Care and Localities Directorate have been 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 events have now led to the development of a GP Provider Leadership Development programme, with identified leads from each locality. This GP membership will form the basis of the New Models of Care Board proposed within our Sustainability and Transformation Plan structure, with the inaugural meeting planned for 13<sup>th</sup> July 2016.

2.1.5 **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 Ambulance response times
- Cancelled operations
- Cancer 62 day GP referral

Areas of good performance include:

- Incomplete RTT performance
- Cancer 31 day targets

Areas of improving performance include:

- A&E 4 hour target
- 6 week diagnostic waiting times

2.2.1 As part of the 2016/17 planning cycle and in support of the sustainability and transformation plan for Gloucestershire, the CCG and GHNHSFT have been required to submit agreed performance trajectories for the following constitutional standards.

A&E – 4 hours: National standard 95%

A&E	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed trajectory	80.0%	85.0%	85.0%	87.0%	87.0%	91.9%	89.1%	91.2%	85.7%	85.1%	80.1%	89.6%

RTT incomplete pathways: National standard 92%

RTT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed trajectory	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Diagnostic 6 week: National standard 1%

Diagnostics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed trajectory	2.7%	2.2%	1.5%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

62 Day cancer: National standard 85%

Cancer 62 days	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed trajectory	77.2%	80.4%	82.6%	82.9%	84.4%	85.3%	85.0%	85.2%	85.0%	85.0%	85.1%	85.6%

The finalised trajectories were submitted on the 23<sup>rd</sup> May, for the purposes of this report the RAG rating applied to the above metric will be based on achievement of the trajectory as opposed to the national performance standard.

## 2.3 **Unscheduled care:**

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

Local and National standards relating to Clinical Excellence							
Unscheduled care	Threshold	Month	Latest Performance		YTD performance		6 month trend
SWAST Ambulance indicators							
Ambulance Red response	75%	May	69.0%	◆	68.4%	◆	
Ambulance Red response	75%	May	83.1%	◆	82.6%	◆	
Over 30 minute ambulance handover delays (GHNHSFT)			CCG / SWAST/ GHNHSFT are undertaking some additional validation of handover numbers for 2016/17				
Over 1 hour ambulance handover delays (GHNHSFT)							
A&E							
4-hour A&E target GHNHSFT	85%*	June	86.9%	●	86.6%	●	
4-hour A&E target GCS MIU	95%	May	99.7%	●	99.7%	●	
12 hour trolley waits	0	June	0	●	0	●	
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%	May	84.6%	●	86.8%	●	

\*STP Trajectory

### 2.3.1 SWAST Ambulance indicators

Key performance and activity indicators:

- SWAST Red response rate improved in May making the year to date position 68.4% (Ambulance Response Programme was initiated 18/04)
- Ambulance incidents with response indicate a decrease for months April and May 2016, with 207 fewer incidents than during the same period in 2015/16.
- Gloucestershire Conveyance to A&E has increased compared to 2015/16 (42.2%), with 49.8% of incidents resulting in conveyance to A&E.
- A demand management plan for Gloucestershire is in place with SWASFT and identified as part of the Improvement Plan and the Right Care 2 Programme.

SWASFT is participating in the Ambulance Response Programme Code Set Trial (ARP) which has seen a change to the way in which ambulance responses are measured. This change took place on the 19th April 2016.

Performance is measured against the Red 8 minute response in May was 69%, with a year to date of 68.4%. Red 19 minute response in Gloucestershire was 83.1% with a year to date of 82.6%

Ambulance incidents with response indicate a decrease for months April and May 2016, with a variance to contract of -3.9%.

During April and May 2016/17, hear and treat cases accounted for 11.6% of activity, conveyance to A&E continues increased compared to 2015/16 with 49.8% (7,421) of incidents resulting in an A&E attendance.

Ambulance activity and outcome variance April and May 2016 (compared to same period in 2015/16):

#### Ambulance outcome

	2015/16	2015/16	Change	%
Total incidents	15118	14912	-206	-1.4%
Hear and Treat	1799	1730	-69	-3.8%
See and Treat	5834	4867	-967	-16.6%
See and Convey (Total)	7485	8315	830	11.1%
See and Convey (A&E Department)	6343	7421	1078	17.0%
See and Convey (Other Destination)	1142	894	-248	-21.7%

#### **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 (STP trajectory for May – 85%).

- ED Performance in quarter one was 86.6%, which is 3.2% above the STP trajectory. June performance was 86.9% (STP trajectory was 85%).

At the end of June, year to date performance at GHNHSFT was 86.6% against a target of 95% (33,974 attendances and 4,550 breaches).

ED breaches have increased across all time bands during 2016/17; the biggest increase has occurred with patients breaching 4 hours between 10pm and 3am

(time patient discharged from ED).

Mondays and Tuesdays and Sundays show the biggest increase in breaches, Monday breaches have more than doubled compared to the first 12 weeks of 2015/16.

Bed availability continues to be the main reason for breaches in 2016/17, accounting for 33% of all breaches. The next highest reasons were due to patients waiting for assessments and ED capacity, these accounting for 26% and 12% respectively. Those waiting for assessment have significantly increased on 2015/16 – increasing from 15% to the current 26%.

The year to date performance for 4 hours improves to 90.5% when GHNHSFT performance is combined with MIU performance and the GP in ED.

#### **2.4 Planned care:**

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

Planned care	Threshold	Month	Latest Performance		YTD performance		6 month trend
<b>Referral to treatment (RTT)</b>							
% of incomplete Pathways that have waited less than 18 Weeks	92%	May	92.7%	●	92.7%	●	
Zero RTT pathways greater than 52 weeks	0	May	12	◆	22	◆	
<b>Cancer waiting times</b>							
% of patients seen within 2 weeks of GP referral for suspected cancer	93%	May	86.6%	◆	82.4%	◆	
% of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected	93%	May	94.7%	●	94.8%	●	
Cancer - first definitive treatment within 31 days of a cancer diagnosis	96%	May	99.6%	●	99.0%	●	
Cancer - subsequent treatment for cancer within 31 days - surgery	94%	May	100.0%	●	99.1%	●	
Cancer - subsequent treatment for cancer within 31 days - Drug Regime	98%	May	100.0%	●	99.1%	●	
Cancer - subsequent treatment for cancer within 31 days - Radiotherapy	94%	May	100.0%	●	100.0%	●	
Cancer - first definitive treatment within 62 days GP referral	80.4%*	May	76.1%	◆	78.1%	◆	
Cancer - first definitive treatment within 62 days screening service	90%	May	83.3%	◆	88.1%	■	
Cancer - first definitive treatment within 62 days upgrade	85%	May	100.0%	●	100.0%	●	
<b>Diagnostic waiting times</b>							
% of patients waiting more than 6 weeks diagnostic test	2.2%*	May	1.3%	●	2.9%	■	
<b>Local community waiting times</b>							
% referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	95%	May	92.1%	■	94.0%	■	
% referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	95%	May	97.4%	●	97.3%	●	
% referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	95%	May	98.3%	●	98.0%	●	
% referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	95%	May	88.6%	◆	86.7%	◆	
% referred to the Podiatry Service who are treated within 8 Weeks	95%	May	99.3%	●	99.3%	●	
% referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	95%	May	90.5%	■	90.7%	■	
% referred to the Adult Physiotherapy Service who are treated within 8 Weeks	95%	May	93.9%	■	93.8%	■	
% referred to the Parkinson Nursing Service who are treated within 8 Weeks	95%	May	90.0%	■	95.0%	●	
% referred to the Diabetic Nursing Service who are treated within 8 Weeks	95%	May	95.0%	●	95.4%	●	
<b>Elective cancellations</b>							
Cancelled operations - 28 day breaches	0	May	7	◆	27	◆	

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

In May there were 12 patients who were waiting longer than 52 weeks for treatment.

Ongoing capacity issues within the complex spinal service are the primary cause for the 10 breaches at North Bristol Trust (5 in T&O, 3 in Neurosurgery and 2 in Neurology)

There were 2 52 week breaches at GHNHSFT:

1 x Urology

1x Gastroenterology

There has been a slight increase in Gloucestershire patients waiting over 35 weeks at the end of May, with 322 compared with 317 in April.

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.

#### **G-care Website**

The G-care website has been designed for use by clinicians working in primary care, specifically to support Gloucestershire based GP's in their work. The website pulls together useful information from a range of sources and includes local care pathways, clinical guidance, referral forms, patient and care information, service information, as well as links to community resources such as social prescribing and voluntary sector groups. There have been 309 new users visit the site in June bringing the total number of unique visitors to the site to 1,436. The site was visited 3,490 times with 11,726 pages viewed.

 <a href="https://g-care.glos.nhs.uk">https://g-care.glos.nhs.uk</a>		
June 2016		
Total Users	1,436	
New Users	309	
Site Views	3,490	
Page Views	11,726	
<b>Top Pages Viewed</b>	<ol style="list-style-type: none"> <li><a href="#">Deep Vein Thrombosis</a></li> <li><a href="#">Irritable Bowel Syndrome</a></li> <li><a href="#">Non-visible Haematuria</a></li> <li><a href="#">Glaucoma</a></li> <li><a href="#">Safeguarding children – Primary Care</a></li> <li><a href="#">Injuries, accidents and wounds: general</a></li> <li><a href="#">Antibiotic use</a></li> <li><a href="#">Ambulatory Emergency Care (AEC)</a></li> <li><a href="#">Early Inflammatory Arthritis (EIA)</a></li> <li><a href="#">Dementia</a></li> </ol>	
<b>Top Referral Forms</b>	<ol style="list-style-type: none"> <li><a href="#">Specialist Diabetes Service</a></li> <li><a href="#">Community Diabetes Service (CDS)</a></li> <li><a href="#">Suspected Colorectal Cancer</a></li> <li><a href="#">Complex Leg Wound Service</a></li> <li><a href="#">Primary Care Transfer Form</a></li> </ol>	
<b>Content Updates</b>	<ul style="list-style-type: none"> <li><a href="#">New Community Glaucoma Service</a></li> <li><a href="#">New Community Cataract Service</a></li> <li><a href="#">Safeguarding Children - Dentists</a></li> <li><a href="#">Perinatal Mental Health Update</a></li> </ul>	

## **2.5.2 Cancer waiting times – first definitive treatment within 62 days GP referral – Threshold: 85% (STP trajectory for May 80.4%)**

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

Delivery of cancer targets was challenging throughout 2015/16 and this continues into 2016/17.

Performance against the 2-week wait target increased to 86.6% in May; despite this improvement there were still 226 breaches of which the main area of concern was still within the Urology service at GHFT (68 breaches). GHNHSFT have put in place actions to improve performance.

Performance against the 62-day wait target decreased from 80.1% in April to 76.1% in May, with 33 breaches of which 18 were in Urology.

There were 5 over 104 day breaches reported at the end of May.

Urology remains the speciality of most concern with ongoing discussions between GHNHSFT and GCCG regarding recovery actions. The key actions in July have focused upon creating capacity at GHNHSFT:

- GHNHSFT have plans to expand the current multidisciplinary and diagnostic clinics which will shorten patient pathways. Business case in development.
- GP Care are operating a clinical assessment service in conjunction with GHNHSFT and GCCG. In the first week 49 patients were reviewed by the service.

GCCG have agreed a recovery trajectory with GHNHSFT for Quarter One and Two of 2016/17, with a recovery date of September 2016. Additional CCG support has also been provided to GHNHSFT to support the recovery plan process to ensure that performance improves, with sustainable delivery during 2016/17.

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

There has been significant pressure on the 6-week diagnostic waiting time target, with performance challenged in particular in the MRI, echocardiography, neurophysiology and endoscopy services.

Performance in May improved to 1.3% (0.9% below the STP target) with the majority of breaches due to MRI, Cystoscopy, Urodynamics and Flexi Sigmoidoscopy.

This is a significant improvement on performance in the second part of 2015/16;

however, there are on-going concerns relates to sustainable delivery with Gastroenterology and Endoscopy capacity a primary focus.

**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 27 patients have been cancelled on the day of admission for non-medical reasons, and have not been provided with another date within 28 days; the threshold is zero.

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.

**2.5 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 2.5.1 This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Mental health indicators	Threshold	Month	Performance	YTD	6 month trend
Dementia diagnosis rate	67%	May	66.1% <span style="color: yellow;">■</span>	66.1% <span style="color: yellow;">■</span>	
Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	95%	Q4 15/16	97.6% <span style="color: green;">●</span>	97.1% <span style="color: green;">●</span>	
IAPT Access rate: Access to psychological therapies for adults should be improved	2.5%	May	1.69% <span style="color: red;">◆</span>	1.69% <span style="color: red;">◆</span>	
The proportion of people who complete therapy who are moving towards recovery	50%	Q4 15/16	48.0% <span style="color: red;">◆</span>	34.0% <span style="color: red;">◆</span>	
IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	75%	May	78.0% <span style="color: green;">●</span>	78.0% <span style="color: green;">●</span>	
IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	95%	May	98.0% <span style="color: green;">●</span>	98.0% <span style="color: green;">●</span>	

**2.5.1 Dementia diagnosis rate (DDR)**

Dementia diagnosis rate in May 2016 was 66.1%. The target is amber rated due to performance being below the 67% target; however, the CCG has a robust action plan in place and has completed regular case finding audits.

We have agreed with NHSE, a trajectory for 16/17 with a target to reach 67% Dementia Diagnosis Rate (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.

### **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 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.

During the recent NHSE Intensive Support Team (IST) visit, it was identified that some of the Improving Access to Psychological Therapies (IAPT) activity should not be counted towards the IAPT Access and Recovery rates as it was carried out by nurses who were not NICE compliant. By removing this activity 2G have shown improvement in their IAPT recovery results and April figures have achieved the target at 53%. This has however had impacted on the Access to IAPT services figure which is 0.92% against a monthly target of 1.25%

A member of the national IAPT Team is supporting 2G. They have also had an on-site visit from the NHSE Intensive Support team. 2G are creating an improvement plan for access and recovery which has been shared with the CCG, which includes an internal productive review and the providing of an E-provision via an external company to improve Access rates

### **Update on Gloucestershire's *Future in Mind* Transformation Plan for children & young people's mental health – June 2016**

#### **Introduction and background**

This paper provides an update on the progress made with the 'Gloucestershire's Future in Mind, 5 Year Transformation Plan for Children's Mental Health'.

The plan was signed off by the Health & Wellbeing Board (HWBB), Gloucestershire County Council (GCC) and the CCG, and submitted for approval to NHS England in October 2015 with excellent feedback received from them as follows:

"In particular, the Task & Finish Group complimented the high level of ambition, the governance arrangements, the excellent partnership working with schools, and the work done to date to improve CAMHS across Gloucestershire that will provide a springboard for the delivery of the service improvements proposed."

Our plan has a whole systems approach that is vital to transforming and making significant inroads into what is a growing problem of increasing numbers of children with mental health difficulties. The transformation plan included the development of

a system without tiers, **supporting children to cope in the wider system and getting swift access to the right support and evidenced based treatments and interventions when needed.** This would also support children and young people with more complex needs who have fluctuating ongoing severe needs who need to access support more than once.

**A coordinated system without Tiers:**



The **green** outer layer is where we will continue to build resilience across the system and build the skills of the workforce in understanding and promoting good emotional and mental health and wellbeing. All children and young people need support in universal services even when they need more help. This will be a joined up system with good access to information and advice.

The **yellow** layer is where we provide links between mental health support, schools, communities and GPs. Children and young people can access help when problems are emerging but also get support from communities during or after having evidenced based help.

The **orange** layer denotes access to evidence based interventions in response to needs that are more extensive with the **red** being access to support in a crisis.

The overwhelming priority identified by all of our stakeholders including children and young people, practitioners, parents and carers is to provide earlier intervention and a range of different ways of accessing advice, guidance and help

in a timely way. The other clear need is for much more joined up models of care across health, education, social care and other agencies for very vulnerable young people who have experienced trauma, abuse and neglect, including how we better address the needs of young people who may develop long term enduring mental health difficulties.

Research tells us that up to 75% of adult mental health difficulties begin during childhood and adolescence. The focus on earlier identification and more effective intervention are therefore designed to help tackle this phenomenon and impact positively on demand for support later in life.

### **Progress to date**

Good progress to date has been made in implementing the plan as follows:

**Website for children and young people.** In direct response to feedback from young people we have progressed developing a website with young people that can provide information, advice and guidance about self-help, access to trusted sources of support and available local services. This is due to be launched in September 2016.

**Support through a VCSE grant funding programme** to provide easily accessible counselling services for young people aged 9-21 across the county in addition to what the schools and colleges currently provide. This approach is being piloted and evaluated over the course of the year to inform future plans including feedback from children and young people. In the first 3 months, 192 referrals have been received with an average wait time of 3 weeks before being seen.

**Online access to counselling support** is being piloted through a VCSE organisation and is a response to young people wanting to access support in different ways. This approach is due to launch during July 2016 and will be piloted over the course of a year with an evaluation to inform the way forward.

**Schools and Mental Health Pilot funded through DfE/NHSE** to pilot more joined up approaches between schools and children's mental health services with the aim of providing better support to children, young people (CYP) and schools and improving outcomes. This pilot is based in the Stroud locality with a mixture of primary, secondary, special school and alternative provision. The project has the following core elements:

- Developing a **streamlined training** model for staff based on the principles upon which safeguarding training currently operates in Gloucestershire with a basic level that all staff undertake so that awareness about mental health is raised and is seen as everybody's business. Then increasingly more specialist levels of training for selected staff according to staff roles and levels of required knowledge. There are also resilience building courses recommended for students. This is based on the principle of 'no cost' or 'low cost'.

- Ensuring that everyone in the locality knows what **VCSE support** is available and joining this up with schools and mental health services.
- Looking at **whole school approaches** to mental health in school including what contributes to good mental health from the environment, including both the physical and cultural environment of a school.
- Improving access to **school nurse drop in sessions** for CYP to talk about any emotional concerns.
- Dedicated time every two weeks for the school wellbeing leads to meet with their **known mental health worker** to discuss any concerns about CYP mental wellbeing and providing advice, developing an appropriate support plan, involving the child or young person in group work to improve their self-esteem or direct one to one support. This could include more specialist support from mental health colleagues in the Children and Young Peoples service.
- Looking at ways to provide **better access to parents** for advice when they have concerns about their child's mental wellbeing or when their child is accessing therapy.

**Support for vulnerable children and young people** working closely across partners in researching and developing proposals to support our most vulnerable children and young people to provide the best support we can to families and children / young people, where they have experienced abuse, trauma and / or neglect. We are considering how we could best utilise and integrate the support of both social care and mental health services to both minimise the impact of these life events but also to provide effective support to young people that present in a crisis. This will include children & young people who require mental health inpatient care or foster care and who are currently often placed long distances from home; and also those young people who have in recent years sometimes been admitted to Wotton Lawn Hospital for a short period on a 'best interests' basis, on those occasions when no timely safe alternative is available.

**Support for Children and Young People in a crisis, including those who self-harm and present to Gloucestershire Hospitals Emergency Department.** Developing the hospital mental health liaison service and mental health crisis service to work with children & young people below age 16. This currently includes piloting an approach within Gloucestershire Royal Hospital for u16s; and the age range for the crisis service has been lowered from 18 to 16 (and 14 for those known to the early intervention in psychosis service) as a phased approach to lowering to age 12 in 2017.

**Waiting times for access to the specialist mental health Children & Young People's Service (CYPS – sometimes known as CAMHS)**

This service is known locally as CYPS rather than CAMHS in response to what

children & young people told us when we recommissioned the service in 2010 regarding their concerns at the stigma associated with the usual acronym.

Performance regarding waiting times has improved significantly since that time in reducing the waiting times for assessment and intervention.

This is particularly evident in the waiting time for initial assessment, with the target of 95% being seen within 4 weeks of referral consistently being met.

The targets for referral to treatment (80% within 8 weeks; 95% within 10 weeks) were initially met, but during 2015/16 these became more challenging to meet, partly due to an increase in demand for services overall (including in self-harm), coupled with an increase in expectations generally on CYPS fuelled by an increased awareness of mental health needs of children & young people, and reduced stigma in talking about it. This is a national trend as well as a local one. (It is worth noting that our local waiting time targets are more challenging than the national target which is set at 18 weeks).

These challenges are being addressed by some additional investment into the service capacity from the CCG, and also by the investments being made as part of the wider FiM plan described above which are expected to impact on the demand for the more specialist service, by improving the ability of schools to and others to identify and meet needs sooner, and by improving access to support for young people by providing a wider range of options (for example the access to counselling support provided by the VCSE provider mentioned above).

## **Conclusion**

Implementation of various aspects of the Gloucestershire *Future in Mind* Plan is now well underway, and the impact of these developments is being evaluated to inform future decisions.

This includes the impact they will have on demand for the specialist CYPS service and on the waiting times for that service

## **2.6 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 2.6.1. This section outlines year to date performance, identifies the issues leading to that performance and any mitigating actions being taken to improve performance.

Significant improvement is required in order to achieve all performance targets on a sustainable basis. A performance notice was issued in December 2015 and the CCG is closely monitoring the Arriva Transport Services Ltd (ATSL) remedial action plan and performance improvement trajectory. A further exception report

was issued in May 2016 as ATSL failed to achieve the worst case performance trajectory level expected for PTS04 for the month of March and saw a downturn in performance from February 2016.

Patient transfer services	Threshold	Month	Performance	YTD performance	6 month trend
Arrival within 45 minutes before, to 15 minutes after, booked arrival time	95%	May	84.8% <span style="color: red;">♦</span>	84.3% <span style="color: red;">♦</span>	
Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey	85%	May	81.2% <span style="color: yellow;">■</span>	78.7% <span style="color: red;">♦</span>	
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)	95%	May	94.4% <span style="color: yellow;">■</span>	92.7% <span style="color: yellow;">■</span>	

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

Inbound on-time arrival is an area where performance remains challenging. A significant performance improvement in January 2016, following implementation of actions identified in the ATSL Remedial Action Plan, has not been sustained in subsequent months. May’s report shows a slight increase of 84.8% of patients arriving with KPI timescales. An exception report has been issued against this KPI as the required trajectory, agreed in response to the contract performance notice, has failed to achieve the worst case performance trajectory expected for the month of March and this followed a downturn in performance from February 2016.

**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 May shows that 81.2% were achieved within the one hour compared to the target of 85%. This is a slight increase from April, although still well below that achieved in January. Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys.

Performance improvement in January 2016, following implementation of actions identified in the ATSL Remedial Action Plan, has not been sustained in subsequent months. An exception report will be issued against this KPI if there is further deterioration in performance below the agreed worst case performance trajectory in coming months.

**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%**

May 2016 saw an upturn in performance to 84.4% compared to a target of 85%. The high number of on the day bookings made by the Acute Trust for discharge and transfer, particularly those made at the end of the day, remain challenging for ATSL. In the 16/17 contract with GHFT a CQUIN around on the day transport bookings has been agreed. CQUIN payment is predicated on <50% of discharge/transfer bookings being made on the day. Actions to increase the number of bookings made in advance should support achievement of this target and improve patient experience. Actions outlined in the ATSL Remedial Action Plan will also support performance improvement.

**2.7 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	May	1	-	4	-	
Number of MRSA infections (GHNHSFT)	0	May	0	-	1	-	
Number of C.diff infections (Health Community)	157	May	17	■	31	■	
Number of C.diff infections (GHNHSFT)	37	May	3	●	8	■	
Mixed sex accommodation							
Mixed-sexed accommodation breaches	0	June	30	◆	30	◆	
Other quality indicators							
Number of Never Events	0	May	0	●	0	●	

**2.7.1 Number of MRSA infections (Health Community)**

There was 1 MRSA case reported in May, making the year to date total 4 cases. 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 2016/17 has remained the same with 157 for the CCG, and 37 for

GHFT.

Year to date performance is 8 cases of C. diff reported at GHNHSFT and 31 in the wider health community.

Breaches are reviewed by GCCG quality team.

Public Health England have been investigating a significant increase in E coli 0157 cases. An Outbreak Control Meeting on 22nd June with attendance from the Local Authority colleagues, national PHE and the Food Standards Agency amongst other relevant agencies has been convened. They are investigating 44 cases of which 21 share the same phage type (34). It is too early to determine whether this is a point source outbreak. 9 cases are currently in hospital and the majority are recovering well. Through epidemiological investigations there is an association between consumption of green leaf salad but it is too early to confirm whether this is the vehicle of exposure to the organism.

## **2.8 Mixed Sex Accommodation breaches**

During June, there were 7 breaches (affecting 30 patients). 6 out of 7 incidents occurred in the Acute Care Units. All breaches have been reviewed against the delivering same sex accommodation decision matrix agreed with GHNHSFT, NHSE and the CCG.

### **Other Key Performance Issue:**

#### **District Nursing**

To support the development of the Community Nursing Service the CCG has recently agreed to release £500K to fund more nursing posts. The recruitment situation for both band 5 and band 6 community nurses has significantly improved with minimal vacancies across the whole county.

#### **Community Hospital Nursing**

Current vacancy rates as of the 1<sup>st</sup> June within the Community hospitals continue to be unacceptably high, with 5.7 WTE vacant Senior nurses (Band 6) out of a funded establishment of 30 WTE, and 30.44 WTE vacant staff nurses (Band 5) out of a funded establishment of 122.43 WTE.

Particular “hotspots” include Cirencester (16.89 WTE), and Stroud (9.75 WTE) hospitals and as expected these wards continue to therefore require high use of bank and agency to cover the gaps in staffing. An ongoing recruitment campaign has been underway for some time; however continuing to close this gap remains a challenge.

### 3.1 Patient Experience

#### 3.1.1 Patient Experience – Period up to 30<sup>th</sup> June 2016

<b>PERSPECTIVE 2</b>	<b>Patient Experience</b>	<b>Green</b>
<b>Success criteria 1: Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.</b>		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
<b>Success criteria 2: Reporting: Improve reporting of patient experience including FFT (Marion Andrews-Evans)</b>		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
<b>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.</b>		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
<b>Success criteria 4: National targets-PROMs</b>		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
<b>Success criteria 5: All active Clinical Programme Groups are working with</b>		Green

<i>patients to ensure experience is incorporated into the programme and outcomes</i>	
<b>Key performance indicators</b>	
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	Green
<b>Success criteria 6: Develop patient experience work within primary care through working with PPGs to help inform and influence commissioning across the whole spectrum</b>	Green
<b>Key performance indicators</b>	
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' and was one of the first CCGs to commit to the 'Sign up to Safety' campaign. The campaign is now approaching its second birthday and is truly national, stretching across 360 organisations. 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.

To further highlight the Sign up to Safety (SU2S) campaign and engage CCG member practices, a new section of CCG Live is currently being developed to bring safety resources together. This new section will link Sign up to Safety to other initiatives such as 'Quality Alert' and act as a repository for briefings from the Central Alerting System. It is being developed with the intention of being a single destination for safety information and resources and aims to launch on SU2S's second birthday on 24<sup>th</sup> June.

Quality Alert continues to develop and the new CCG Live page will aim to publish themes and trends and increase its profile further. Currently the themes from reported Alerts focus on discharge and delays. However, this is likely to be as a result of a past request for these types of alerts.

As part of our ongoing work with the West of England Academic Health Science Network (AHSN), the CCG has identified an 'innovator' practice within

to county to work with them on improving safety reporting and associated learning in Primary Care. The AHSN project is being developed across the whole of the West of England and aims to focus GPs and practice teams on the idea of increasing openness and transparency around patient safety, which will in turn improve the patient experience.

### **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 latest data reported was in April 2016. This shows a slight increase in response rates for the GHNHSFT Inpatient FFT from 17.9% in March to 20.3% in April 2016 (national average 24.1%); % recommend is static at 95% (national average 96%). Response rates in A&E continue to be a concern at 2.3% against a national average of 12.9%. % recommend rates are at their highest point since July 2015, at 83% against a national average of 86%. GHNHSFT have awarded the FFT data collection contract to a new provider and anticipate that a new approach will lead to improved response rates during the next period.

GCSNHST % recommend rate increases by 1% in April 2016 to 95%. 2GNHSFT % recommend rate increased by 4% to 97%. No response rates are collected for community and mental health trusts.

### **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.

Case reviews are scheduled to review emergency respiratory admissions, emergency admissions of patients with cellulitis and emergency paediatric admissions.

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

In addition to these the CCG are working with GHNHSFT and community colleagues to review patients who have been in hospital for longer than 14 days. The learning from these deep dives will be shared across the system and inform the 'pull' model being designed in collaboration with the Integrated Care Teams.

A summary of these reviews will be shared with the Strategic Resilience Group (SRG).

As a result of the case reviews information is being collated to improve compliance with unscheduled care pathways to improve patient experience.

To augment the Case Review process, the CCG is currently investigating with GHNHSFT how patient experience feedback can be collected from patients whose case notes are included in Case Reviews.

#### **Success criteria 4: National targets-PROMs**

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are:

- hip replacements
- knee replacements
- groin hernia
- varicose veins

PROMs have been collected by all providers of NHS-funded care since April 2009.

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

PROMs casemix-adjusted scores and outliers — 2015-16 Provisional

Publication date: May 12, 2016:

Gloucestershire provider 'not an outlier' for all procedures.

[http://systems.hscic.gov.uk/maps/proms/20160512\\_1516/index.html](http://systems.hscic.gov.uk/maps/proms/20160512_1516/index.html)

**Success criteria 5: All active Clinical Programme Groups are working with patients to ensure experience is incorporated into the programme and outcomes**

All CCG Clinical Programme Group activity is supported by lay involvement.

The Eye Care CPG was recently shortlisted for a prestigious national award. The Lay Champion was invited to the award ceremony in London.

Two new CPGs are being established this quarter – ENT and Renal. Lay Champion and Healthwatch Gloucestershire representatives will be invited to participate in these new CPGs.

**Success criteria 6: Develop patient experience work within primary care through working with PPGs to help inform and influence commissioning across the whole spectrum**

The Practice Participation (PPG) Group network held a successful meeting in July 2016. The meeting introduced members to the GCCG Primary Care Strategy, featuring new ways of working in primary care, e.g. clinical pharmacists.

PPG representatives have attended three workshops hosted by the CCG to inform the development of new models for primary and community Urgent Care services in Gloucestershire.

## 4.1 Partnerships

### 4.1.1 Partnerships – Period up to 30<sup>th</sup> June 2016

<b>PERSPECTIVE 3</b>	<b>Partnerships</b>	<b>Green</b>
<b>Success criteria 1: Building effective partnership working by putting in place a joint planning and governance framework to improve outcomes for the Gloucestershire population</b>		<b>Green</b>
<i>Key performance indicators</i>		
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		<b>Green</b>
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.		<b>Green</b>
Further develop and maintain system wide BCF forum encompassing all providers across health and social care, independent sector and voluntary sector and housing.		<b>Green</b>
<b>Success criteria 2: Work with the voluntary sector alliance to take forward the work with the voluntary and community sector in Gloucestershire.</b>		<b>Green</b>
<i>Key performance indicators</i>		
Roll out social prescribing and build on the existing evaluation to take forward learning		<b>Green</b>
Develop the “kitemark” for voluntary sector organisation		<b>Green</b>
Develop a cultural commissioning programme in conjunction with the New Economics Foundation, National Voluntary of Community Council’s and Arts Council England		<b>Green</b>
Build capacity in the voluntary sector (re work with VCS)		<b>Green</b>
<b>Success criteria 3: Effective urgent care pathway to enable more patients to stay in their own home</b>		<b>Green</b>
<i>Key performance indicators</i>		
Effective relationships across adult social and health care to enable:		<b>Green</b>
i) Reduce non-elective admissions which can be influenced by effective collaboration across the health and care system.		<b>Green</b>
ii) Reducing inappropriate admissions of older people (65+) in to residential care		<b>Green</b>

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.	Green
v) To develop a system which measures patient experience of integration over time, allowing any improvements to be demonstrated.	<b>Year-end assessment</b>
vi) Enhancing quality of life for people with care and support needs.	<b>Year-end assessment</b>

**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 (Green)**

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.

This scheme is now fully operational across the county with social prescribing hub coordinators accepting referrals from all 81 GP Practices in the county and from staff in the county's 21 Integrated community Teams (ICTs) and staff from community hospitals. As at 31<sup>st</sup> May there had been 2058 referrals from across the county.

The external evaluation of social prescribing by the University of the West of England (UWE) is underway. This is both a quantitative and a qualitative evaluation and will involve patient stories, focus groups and individual interviews. A final report is planned for the end of September 2016 and a CCG led evaluation group is in place.

### **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 in excess of 60 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

The national cultural commissioning programme formally finishes in April 2016. The CCG and partners (CREATE Gloucestershire, Gloucester City Council, Tewkesbury Borough Council and the Forest of Dean District Council) have been working alongside the New Economics Foundation (NEF) and the National Council for Voluntary Organisations (NCVO) to help disseminate the work which has been undertaken in Gloucestershire. This includes contributing to national reports and presenting at a number of conferences (including the All Party Parliamentary Group for Arts, Health and Wellbeing)

The CCG recently re-advertised two grant projects focusing on how arts and culture opportunities may reduce barriers to engaging with weight loss programmes and how arts and culture could promote confidence and healthy lifestyles for people diagnosed with colorectal and prostate cancer. Bids received are currently being evaluated. Work is ongoing to co-develop and deliver the other 9 grant projects.

### **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.

Gloucestershire Health and Wellbeing Board and Leadership Gloucestershire have ratified a policy outlining how they will work to enable local communities to become more active, stronger and more sustainable, and in turn improve the health and wellbeing of local people. The Health and Well Being Board aims to ensure that this activity is joined up and learning is shared from community to community across the county. Its Enabling Active Communities objectives are designed to build community appetite and capacity for neighbourhood-level working, through three separate strands:

- Using existing assets e.g. workforce, buildings and community hubs;
- Building knowledge and resilience within individuals and communities and ensuring effective provision of advice and information;
- Developing local solutions – working with communities to identify local needs and how these might be better met using new or existing partnerships.

### **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.

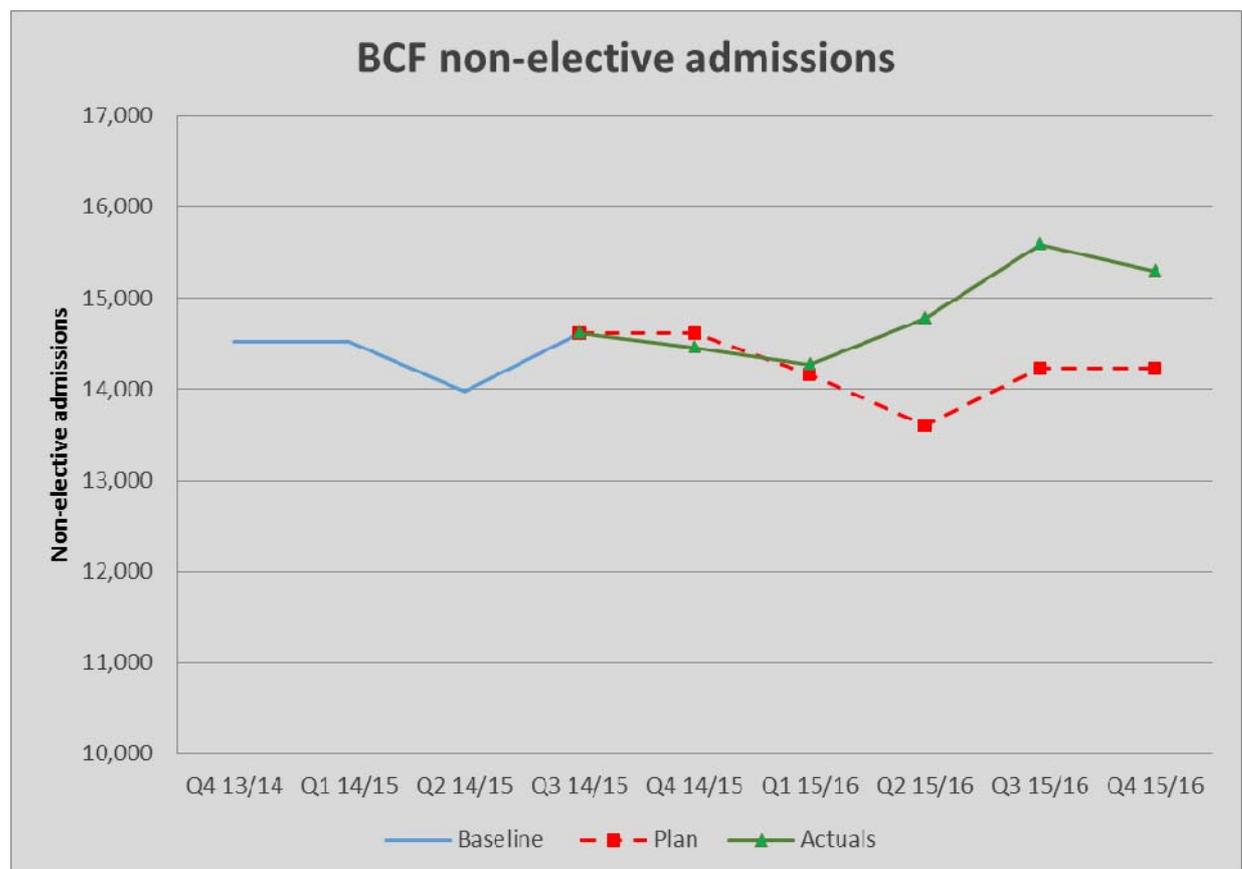
## 4.1.4 Reduction in non-elective admissions (general and acute)

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.

Within Gloucestershire we have seen 2.5% growth in non-elective admissions over the period January 2014 to December 2015. The 2.5% has been calculated using the defined BCF metrics (based on providers monthly activity returns MAR).

The Gloucestershire BCF plans for reducing non-elective admissions are aligned with the Gloucestershire CCG and Gloucestershire Hospitals NHSFT plans for 2016/17.

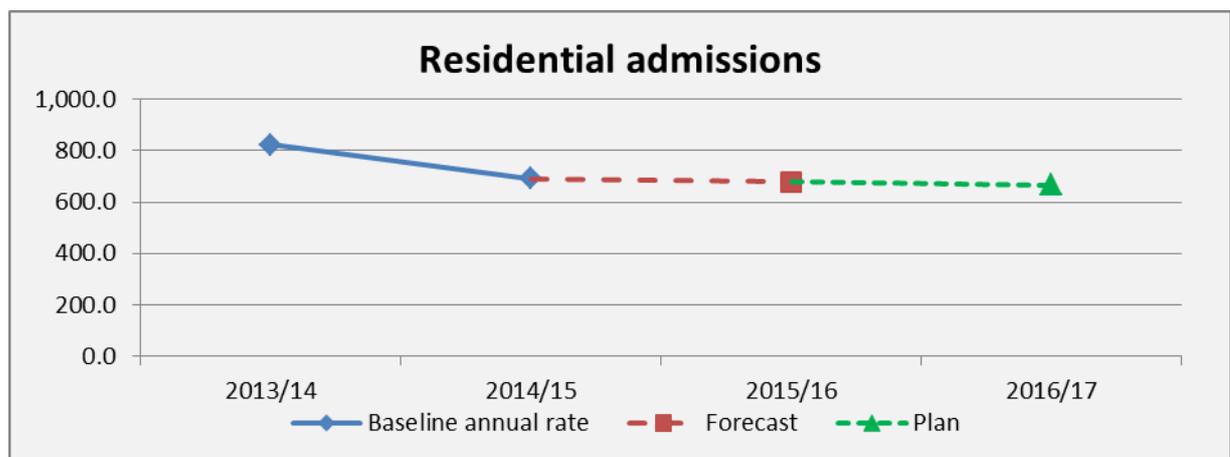
Gloucestershire CCG's plan is for a 1.6% reduction in non-elective admissions. Within this assumption growth is 2.5%, while revised contract baseline and admission avoidance schemes are estimated to make a 4% reduction.



**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.

Gloucestershire plans to continue the trend in the reduction of service users entering residential and nursing care. The CCG forecast for 2015/16 is a 2% reduction on the 2014/15 baseline, which equates to a 17% reduction on the BCF baseline period.

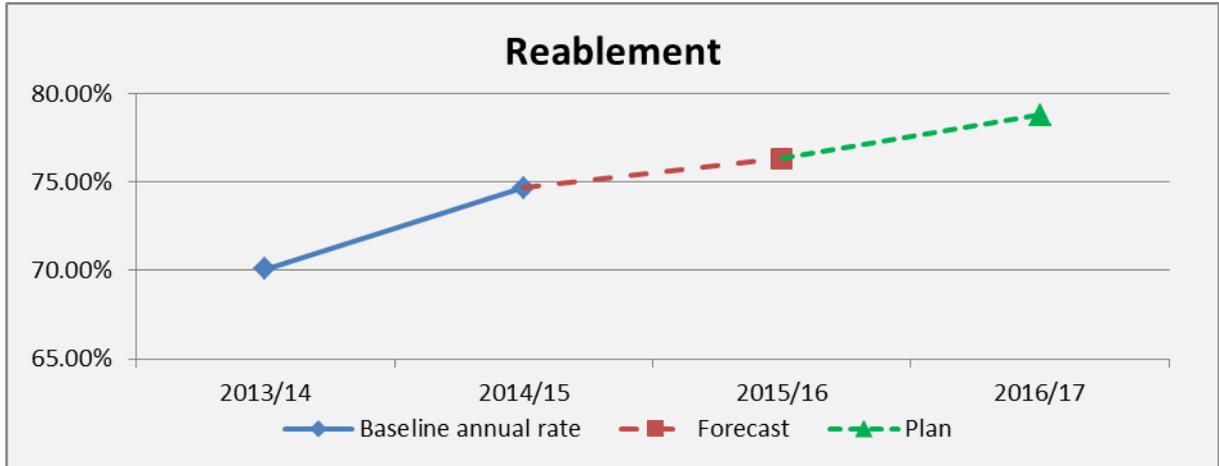


**Increase in the number of people at home 91 days post discharge**

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 proportion of people who were still at home 91 days after discharge increased by 4.6% during 2014/15, the plan is to improve to meet the south west average which represents a 4.1% increase by the end of 2016/17.

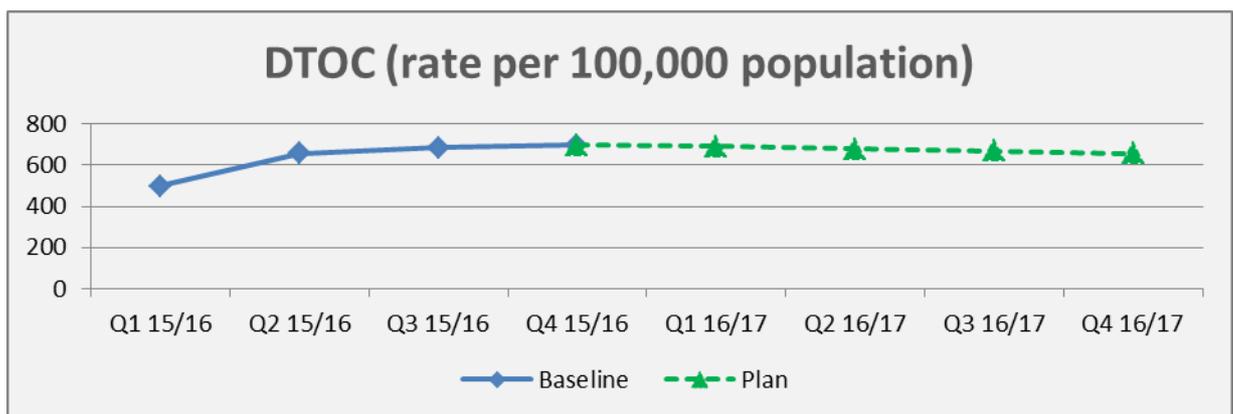
Focus and prioritisation continue in this area to ensure we have robust preventative and crisis management services in the community, in particular effective re-ablement services that support people post-discharge and help them to achieve their full potential recovery.



### 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.

Gloucestershire performance on delayed transfers compares favourably to the England average. The figures reported at the end of the BCF period (Q3 2015/16) show an increase in the number of delayed transfers, the forecast for quarter 4 has been factored through an additional increase due to the pressures within the healthcare system.



Across 2016/17 we have shown a 5% reduction from the Quarter 4 position across the year as this is an area of focus for our system.

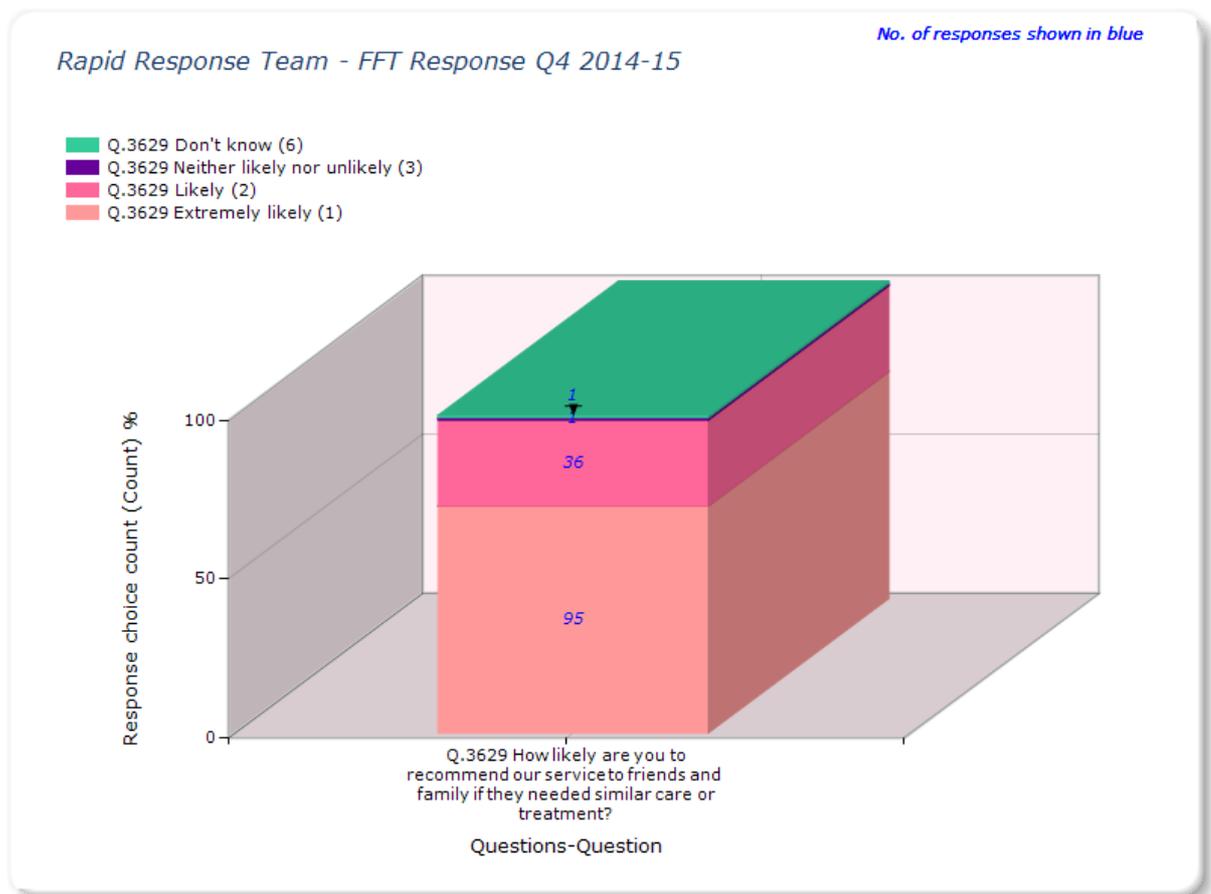
**Improved Patient Experience**

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.

A baseline was recorded during quarter 4 of 2014/15, with the following question 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':

2014/15 baseline results: 131/133 clients (98.5%) provided a positive response (95 extremely likely and 36 likely)



The latest results collated at the end of December 2015 indicate that from the 1<sup>st</sup> of April 98.93% of respondents have provided a positive response.

The main question is supported by 6 further questions based on NHS voices:

1. I always knew who the main person in charge of my care was
2. I didn't need to keep repeating how I was feeling and explain what I needed to different people
3. I was involved in discussions and decisions about my care as much as I wanted to be
4. Information was given to me when I wanted it
5. The information given to me was appropriate to my condition and circumstances
6. I feel the people I met were kind to me

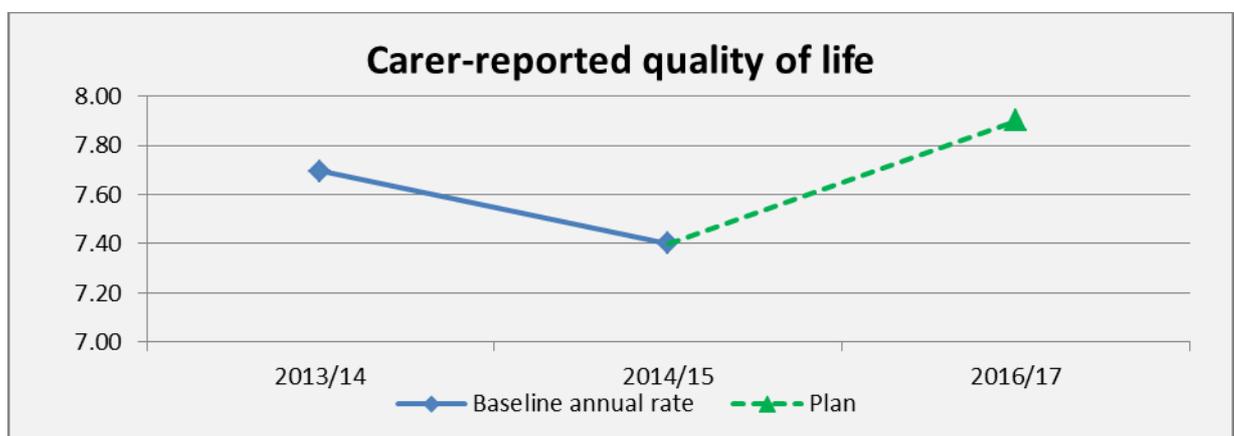
The plan for 2016/17 is to increase the response rate from 14.6% during 2015/16 to 15% in 2016/17; this is in line with the national guidance on the Friends and Family test.

### 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.

Results for the 2014/15 survey showed a 3.8% reduction in quality of life from the 2012/13 baseline. The plan for 2016/17 is to reach the England average by meeting the original BCF target of 7.9 (6.4% increase on 2014/15).



Carers Gloucestershire hosts the Gloucestershire Carers Alliance whose mission is to provide a strong, independent, diverse and inclusive carer-led and carer-centred group

influencing policy and services to improve outcomes for all carers. Plans are in place to further develop relationships with the Alliance/Carers Gloucestershire to provide a route through which providers and commissioners of services can engage and hear views and feedback from carers.

All of the 'carers' services' contracts include satisfaction surveys and are showing a strong positive response, with an increase in the number of carer's assessments undertaken and evidence of meeting the 6 week target from referral to assessment. In addition, each contract in turn will be subject to a carer peer group evaluation, which includes monitoring of contracts and interviews with carers.

## 5.1 Staff

### 5.1.1 Staff – Period to 30<sup>th</sup> June 2016

<b>PERSPECTIVE 4</b>	<b>Staff</b>	<b>Green</b>
<b>Success criteria 1: Attracting and retaining high quality staff aligned to the CCGs vision and values</b>		<b>Green</b>
<i>Key performance indicators</i>		
Turnover - % of employees leaving the organisation		1.1%
Number of current Vacancies in structure		7
<b>Success criteria 2: Personal development processes that are linked to the strategic plan</b>		<b>Green</b>
<i>Key performance indicators</i>		
All staff should have a PDP (90% target) and should have had an appraisal in the last 12 months		24%
95% of staff who have completed their mandatory training by the end of March 2017		
<b>Success criteria 3: Staff are Happy and Motivated</b>		<b>Green</b>
<i>Key performance indicators</i>		
Staff sickness levels		3.1%
Staff Survey		<b>Completed</b>
Completion of OD plan by 31 <sup>st</sup> May 2016		

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

Monthly turnover in June was 1.1%. The number of leavers since the 1<sup>st</sup> April is 9, giving a monthly average of 3 leavers per month.

As at the end of June 2016, there were 7 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. Current records show that 69 members of staff have a PDP in place (24%), with 11 having taken place in the past 6 months. Once records are updated, a review against strategic objectives will take place.

**5.1.4 Staff are Happy and Motivated**

Staff survey has taken place, and the results are being collated and will be reported on shortly.

Staff sickness levels year to date have equated to 3.1% which is above the GCCG target of less than 3%.

## 6.1 Perspective 5. Finance and Efficiency

### 6.1.1 Finance and efficiency – Period to 30<sup>th</sup> June 2016

Summary:

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

- The CCG is forecasting to deliver a surplus of £9.456m, which is in line with plan.
- Known risks and pressures have been fully assessed and included within the CCG's position with mitigating actions where appropriate. There are significant risks to the achievement of the financial plan.
- There is slippage on QIPP schemes within the financial year.
- Financial risks are managed through a continuous review of budgets and proposed investments and the use of the CCG's contingency reserve. All budgets and discretionary CCG expenditure is currently under review.
- A revised urgent care plan is now being developed by the community to try to address urgent care overperformance
- The better payment practice code performance (for non-NHS invoices by volume) is in line with the targeted figure.

Key risks:

- Provider contracts over perform in excess of those levels provided within the year end forecast although the extent of agreed challenges has yet to be agreed
- Slippage on QIPP schemes (noting that the current RAG ratings are embedded within current financial forecasts)

- Prescribing costs are volatile and current growth is significantly above that within the financial plan.
- Unexpected increases to the rate of funded nursing care (by 40%) which have been backdated to April 2016 (announced in July) has resulted in a unplanned commitment of over £3m.

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 resource limit (see Appendix 2) is £833.5m. This includes all primary care co-commissioning delegated budgets. There were additional allocations this month for eating disorders and Choice +.

### 6.3 Expenditure

The financial summary as at 30<sup>th</sup> June 2016 reports a year to date surplus of £2.36m; which is in line with the plan. Further detail is shown at Appendix 3. Key budget areas with either a significant financial risk or forecast outturn variance are highlighted below:

<u>Key</u>	Trend	Forecast Over/ (Under) Spend £'000
↑		
↓		
<b>Gloucestershire Hospitals NHSFT</b>		
Based on two months data there is early indications that suggest significant pressures primarily driven by emergency spells and, to a lesser degree elective activity. There is also pressure within Adult Critical Care. A number of challenges have been raised with the Trust and these are currently being worked through. The forecast includes assumptions on the outcome of these challenges. A revised urgent care plan is now being developed by the community to try to address urgent care overperformance. This plan includes actions pre, in and post hospital and includes all partners in the Gloucestershire community. At this point in the financial year a forecast breakeven position has been reported.	→ ←	£0
<b>University college London NHSFT</b>		
Elective activity in May has increased which has caused an adverse movement. Further information has been requested from the provider to support the current position.	↓	£40

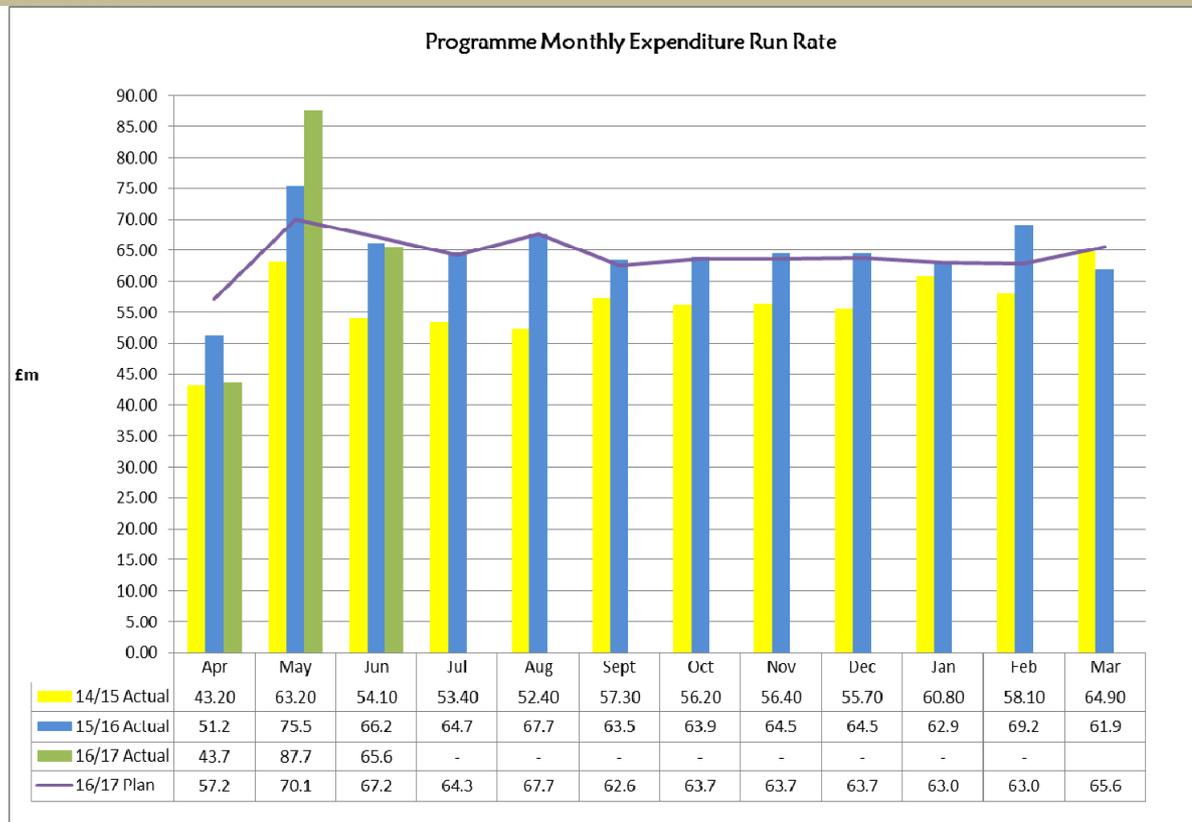
<b>Great Western Hospital NHST</b>		
Over-performance has been reported within elective activity (general surgery, T&O), day cases (podiatry) and non elective activity (geriatric medicine). A contract query has been raised regarding the unexpected variance at this early point in the year.	↓	£400
<b>Oxford University Hosp NHSFT</b>		
Overspends are highlighted within day cases for gynaecology and T&O and non elective activity in general medicine & trauma. A query has been raised regarding a shift in activity since the acute admissions unit opened; as no offset has been demonstrated.	↓	£200
<b>North Bristol NHST</b>		
Activity data has been received for April, however there are still data quality issues and the plan at PbR level has not been received. A letter has been sent dated 1st July from South, Central and West CSU requesting issues to be resolved expeditiously. At the end of May there were 10 fifty two week incomplete waiters; 5 T&O, 2 neurology, 3 neurosurgery.	↔	£0
<b>Mental Health Non Contract Activity</b>		
Non contract activity is showing signs of a pressure with Avon Wiltshire Partnership which was a contract last year. This is being investigated further as the current position is not in line with the modelling initially submitted by the Trust prior to the commencement of the current financial year.	↓	£310
<b>Learning Difficulties</b>		
Due to a review of current placements within joint funded this has seen a reduction.	↓	(£117)
<b>Prescribing</b>		
May data has been received with early indications that there will be a pressure again this financial year.	↓	£1,700
<b>Running costs</b>		
There is a pressure against this area of £92k, however this is offset by a non recurrent underspend within the pay areas due to vacancies.	↑	(£218)

**6.4 QIPP (Appendix 4)**

It is still very early in the year and information is limited; however indications from the information available indicate slippage of £1m against the plan. The CCG is

reviewing slippage on investments to mitigate this shortfall.

## 6.5 Run Rate



The graph above highlights the expenditure relating to programme budgets for this and the previous two financial years, compared to the resource available for programme excluding any reserves and the surplus. The in-month position in June shows that programme is below anticipated spend by £1.6m. However, cumulatively, the CCG is still above estimated spend for Programme by £2.5m

## 6.6 Cash (Appendix 5)

By the end of June, the CCG has drawn down 27.39% of the total cash limit which is slightly higher than a straight line trajectory. The cash balance at the end of June was £14.8m.

## 6.7 Better Payment Practice Code (Appendix 6)

It is a national target that requires the CCG to pay 95% of non-NHS trade creditors within 30 days of receipt of goods or a valid invoice. The current year to date performance stands at 98.59% invoices paid by value and 97.60% by volume; both being on target.

## 6.8 Statement of Financial Position (Appendix 7)

The position shown includes the audited opening balances from the 15/16 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 contracts are variable and there is a significant risk of over performance against the contracted value, particularly in urgent care. It is noted that there are a number of challenges that have been raised with providers that have yet to be resolved.
- Prescribing  
The prescribing budget is constantly under pressure with the introduction of new drugs. The net budget increase (after deducting QIPP) in the 2016/17 plan was 0.46% and indications are that the growth in the April actual figures is 4.93%. (Early indications suggest that the May growth has reduced but remains above the planned position).
- Funded Nursing Care  
On 13 July, a 40% increase to the FNC rate was announced by Department of Health (which will be backdated to 1 April 2016). This increase had not been included within the CCG's financial plan although it is suggested that an element was implicit within allocations announced in January 2016. The impact on the CCG is an unplanned pressure in excess of £3m. The rates will be reviewed further as at 1 January 2017.
- QIPP slippage  
Due to the nature and scale of system changes within the QIPP programme along with the number of live schemes for the organisation there is a high risk of further slippage to the programmes.
- Estates  
New national arrangements have been undertaken this year to charge on a market rent basis which could leave the CCG with a significant pressure that nationally NHS England has agreed to fund non recurrently this year however we are currently awaiting formal confirmation that quantifies the level of support.

**Appendices:**

Ref	Description
1	GCCG Dashboard 2016/17
2	Resource Limit Position
3	Summary Financial Position
4	QIPP Programme
5	Cash
6	Better payment practice code
7	Statement of Financial position

Gloucestershire CCG 2016/17 Integrated Performance Scorecard

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<b>Unscheduled Care</b>																	
<b>Accident &amp; Emergency</b>																	
E.B.5	<b>4-hour A&amp;E target</b> - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		GRH Attendances	6,926	7,621	7,355											21,902	21,902
		GRH Breaches	1,113	1,320	1,200											3,633	3,633
		GRH %	5	83.9%	82.7%	83.7%										83.4%	83.4%
		CGH Attendances	3,851	4,233	3,988											12,072	12,072
		CGH Breaches	463	172	282											917	917
		CGH %	0	88.0%	95.9%	92.9%										92.4%	92.4%
		GHNHSFT Attendances	10,777	11,854	11,343											33,974	33,974
		GHNHSFT Breaches	1,576	1,492	1,482											4,550	4,550
		GHNHSFT %	5	85.4%	87.4%	86.9%										86.6%	86.6%
		GCS - MIU Atts	5,771	6,774	6,473											19,018	19,018
		GCS - MIU Breaches	25	17	22											64	64
		GCS - MIU %	0	99.6%	99.7%	99.7%										99.7%	99.7%
		PC in ED Attendances	244	345	268											857	857
		PC in ED Breaches	0	0	0											0	0
		PC in ED %		100.0%	100.0%	100.0%										100.0%	100.0%
		Overall ED Attendances	16,792	18,973	18,084											53,849	53,849
Overall ED Breaches	1,601	1,509	1,504											4,614	4,614		
Overall ED %		90.5%	92.0%	91.7%										91.4%	91.4%		
E.B.S.5	<b>12 hour trolley waits</b> (no A&E attender should wait more than 12 hours from the decision to admit to admission)	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		GRH	0	0	0										1	1	
		CGH	0	0	0										0	0	
		<b>GHNHSFT total</b>	0	0	0										1	1	
		GCS - MIU	0	0	0										0	0	
<b>Ambulance</b>																	
E.B.15.i	<b>Cat A 8 min response</b> - 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%	
		SWASFT Responses	924													924	924
		SWASFT Resp < 8 mins	672													672	672
		SWASFT %	72.7%													72.7%	72.7%
		Glos Responses	106													106	106
		Glos %	63.2%													63.2%	63.2%
E.B.15.ii	<b>Cat A 8 min response</b> - 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 Responses	16,413													16,413	16,413
		SWASFT Resp < 8 mins	9,334													9,334	9,334
		SWASFT %	56.9%													56.9%	56.9%
		Glos Responses	1,724													1,724	1,724
		Glos %	54.9%													54.9%	54.9%
E.B.16	<b>Cat A 19 min response</b> - 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 Responses	17,286													17,286	17,286
		SWASFT Resp < 8 mins	14,878													14,878	14,878
		SWASFT %	86.1%													86.1%	86.1%
		Glos Responses	1,828													1,828	1,828
		Glos %	87.2%													87.2%	87.2%
	<b>SWASFT Ambulance Response Programme (Trial) - Red</b>	SWASFT Red Responses	1,636	3,937	3,687										9,260	9,260	
		SWASFT Red Resp < 8 mins	1,092	2,718	2,575										6,385	6,385	
		SWASFT Red %	66.7%	69.0%	69.8%											69.0%	69.0%
		Red 50th Percentile (mins)	6.6	6.3	6.3											6.4	6.4
		Red 75th Percentile (mins)	9.2	9.0	8.8											9.0	9.0
		Red 95th Percentile (mins)	18.0	16.7	15.8											16.8	16.8
	<b>SWASFT Ambulance Response Programme (Trial) - Amber</b>	Total Amber Responses	19,350	53,185	50,760										123,295	123,295	
		Amber Transport Responses	3,879	8,830	8,435											21,144	21,144
		Amber T - 50th percentile (mins)	22.2	23.8	23.2											23.1	23.1
		Amber T - 75th percentile (mins)	42.8	45.6	43.5											44.0	44.0
		Amber T - 95th percentile (mins)	109.5	111.4	103.9											108.3	108.3
		Amber Response Responses	12,178	35,954	33,794											81,926	81,926
		Amber R - 50th percentile (mins)	19.7	22.3	21.8											21.3	21.3
		Amber R - 75th percentile (mins)	36.5	41.5	40.6											39.5	39.5
		Amber R - 95th percentile (mins)	85.2	94.6	91.5											90.4	90.4
		Amber F2F Responses	3,293	8,401	8,531											20,225	20,225
		Amber F2F - 50th percentile (mins)	15.2	16.7	17.2											16.4	16.4
		Amber F2F - 75th percentile (mins)	29.1	31.7	32.3											31.0	31.0

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	Amber F2F - 95th percentile (mins)		74.6	78.9	77.5										77.0	77.0
	Total Green Responses		4,715	12,682	12,229										29,626	29,626
	Green Face to Face Responses		670	1,593	1,424										3,687	3,687
	Green F2F - 50th percentile (mins)		37.0	36.4	34.9										36.1	36.1
	Green F2F - 75th percentile (mins)		77.1	79.4	69.2										75.2	75.2
	Green F2F - 95th percentile (mins)		183.9	207.8	172.3										188.0	188.0
	Green Transport Responses		571	1,469	1,385										3,425	3,425
	Green T - 50th percentile (mins)		47.7	48.9	48.0										48.2	48.2
	Green T - 75th percentile (mins)		88.8	99.1	90.6										92.8	92.8
	Green T - 95th percentile (mins)		218.3	230.7	199.8										216.3	216.3
	Green Hear & Treat Responses		2,062	6,198	5,620										13,880	13,880
	Green H - 50th percentile (mins)		5.6	6.4	6.0										6.0	6.0
	Green H - 75th percentile (mins)		15.4	17.7	17.7										16.9	16.9
	Green H - 95th percentile (mins)		51.2	58.2	63.5										57.6	57.6
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
		Actual	172	198	154										524	524
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	1	4	10										15	15
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
		Actual	225	285	265										775	775
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	27	16	29										72	72

**Delayed Transfers of Care (DTOC)**

Local	Number of Delayed Transfers of Care for acute patients	Acute target	14	14	14	14	14	14	14	14	14	14	14	14	14	14
		Acute actual	23	12	16										17	17
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	Acute only	0	0	0										0	0
Local	Number of Delayed Transfers of Care for non-acute patients	Non-acute target	10	10	10	10	10	10	10	10	10	10	10	10	10	10
		Non-acute actual	2	3	4											0.0

**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%
		Actual	92.4%	85.6%	92.2%	93.5%										
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	1.7%	3.3%	1.5%	1.2%										
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	84%	81.7%	81.3%	80.7%										
Local	% calls referred to ED	Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
		Actual	6.0%	6.4%	6.1%	6.3%										
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	38.2%	26.9%	32.3%	34.1%										
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	-	00:10:46	00:11:19	00:09:29										
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	-	00:05:12	00:06:31	00:05:20										

**Planned Care**

**Acute Care Referral to Treatment**

E.B.1	Percentage of admitted non adjusted pathways treated within 18 Weeks	Target	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Actual	83.4%	82.9%											83.1%	83.1%
E.B.S.4	Number of completed admitted non adjusted pathways greater than 52 weeks	Target	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Actual	-	0	0											
E.B.2	Percentage of non - admitted pathways treated within 18 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
		Actual	91.4%	91.5%											91.5%	91.5%
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	-	2	3											0
Local	Number of specialties where non-admitted standard was not delivered	Actual	-	14	14											
E.B.3	Percentage of incomplete Pathways that have waited less than 18 Weeks	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
		Actual	92.7%	92.7%												0.0%
E.B.S.4	Number of incomplete pathways greater than 52 weeks	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		Actual	-	10	12											
Local	Number of specialties where incomplete standard was not delivered	Actual	-	9	7											

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<b>Cancelled Operations</b>																	
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	
		Actual	-	20	7												
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	-														
<b>Diagnostics</b>																	
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%	
		Actual breaches		414	119											533	533
		Actual Perf		4.5%	1.3%											2.9%	2.9%
<b>Cancer Waits</b>																	
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%	
		Actual breaches		353	226											579	579
		Actual Perf		78.0%	86.6%											82.4%	82.4%
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%	
		Actual breaches		11	11											22	22
		Actual Perf		95.0%	94.7%											94.8%	94.8%
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%	
		Actual breaches		4	1											5	5
		Actual Perf		98.4%	99.6%											99.0%	99.0%
E.B.9	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	
		Actual breaches		1	0											1	1
		Actual Perf		98.3%	100.0%											99.1%	99.1%
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%	
		Actual breaches		1	0											1	1
		Actual Perf		98.4%	100.0%											99.1%	99.1%
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%	
		Actual breaches		0	0											0	0
		Actual Perf		100.0%	100.0%											100.0%	100.0%
E.B.12	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	
		Actual breaches		27	33											60	60
		Actual Perf		80.1%	76.1%											78.1%	78.1%
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%	
		Actual breaches		2	3											5	5
		Actual Perf		91.7%	83.3%											88.1%	88.1%
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%	
		Actual breaches		0	0											0	0
		Actual Perf		100.0%	100.0%											100.0%	100.0%
<b>Long Term conditions</b>																	
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%	
		Glos		84.6%													
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%	66.7%	66.7%	66.7%	66.7%	
		Glos		66.0%	66.1%											66.06%	
<b>Community Care Referral to Treatment (GLOUCESTERSHIRE only)</b>																	
<b>Paediatric</b>																	
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%	
		Actual		95.9%	92.1%											94.0%	94.0%
Local	Percentage of patients referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
		Actual		97.2%	97.4%											97.3%	97.3%
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%	
		Actual		97.6%	98.3%											98.0%	98.0%
<b>Adult</b>																	
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%	
		Actual		84.8%	88.6%											86.7%	86.7%
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%	
		Actual		99.2%	99.3%											99.3%	99.3%
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%	
		Actual		90.8%	90.5%											90.7%	90.7%
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%	
		Actual		93.6%	93.9%											93.8%	93.8%
<b>Specialist Nurses</b>																	
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%	
		Actual		100.0%	90.0%											95.0%	95.0%

**Gloucestershire CCG 2016/17 Integrated Performance Scorecard**

Target	Principal Delivery Targets	2015-16 Outturn	Apr-16	May-16	Jun-16 / Q1	Jul-16	Aug-16	Sep-16 / Q2	Oct-16	Nov-16	Dec-16 / Q3	Jan-17	Feb-17	Mar-17 / Q4	Year / Quarter to date	Year End Forecast
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%
		Actual	95.8%	95.0%												95.4%
<b>Mental Health and Learning Disabilities</b>																
<b>Adults of Working Age</b>																
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			95.0%			95.0%			95.0%			95.0%	95.0%	95.0%
		Glos														
<b>Improving Access to Psychological Therapies (IAPT)</b>																
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%	2.5%	2.5%
		Glos actual													1.7%	1.7%
E.A.S.2	The proportion of people who complete therapy who are moving towards recovery	Glos target			25.8%			33.5%			41.2%			50.0%	50.0%	50.0%
		Glos actual													51.0%	51.0%
E.H.1_B1	The proportion of people that wait <b>6 weeks</b> or less from referral to their 1st IAPT treatment appointment against the no. of people who enter treatment in the reporting period.	Glos target			75.1%			75.1%			75.1%			75.1%	75.1%	75.1%
		Glos actual		-											78.0%	78.0%
E.H.1_B2	The proportion of people that wait <b>18 weeks</b> or less from referral to their 1st IAPT treatment appointment against the no. of people who enter treatment in the reporting period.	Glos target			95.1%			95.1%			95.1%			95.1%	95.1%	95.1%
		Glos actual		-											97.5%	97.5%
<b>Quality</b>																
<b>Quality Indicators</b>																
E.B.S.1	Eliminate mixed-sexed accommodation breaches at all providers sites (patients)	CCG			60	0										
		GHFT			69	0										
		Care Services			0	0										
		2gether			0	0										
	Number of Never Events	GHT			0	0										
		Care Services			0	0										
		2gether			0	0										
		SWAST			-	-	-	-	-	-	-	-	-	-	-	-
	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%
		GHNHSFT			94.0%	92.5%										
		GCS			95.4%	96.0%										
<b>Cleanliness and HCAIs</b>																
<b>Methicillin Resistant Staphylococcus Aureus (MRSA)</b>																
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
		Glos HC actual			3	1									4	4
	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target			0	0	0	0	0	0	0	0	0	0	0	0
		GHNHSFT actual			1	0									1	1
<b>Clostridium Difficile (C.Diff)</b>																
E.A.S.5	Number of total C Diff infections (Health Community)	Glos HC target			15	12	12	16	16	8	12	10	9	16	16	15
		Glos HC actual			14	17										31
	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target			3	3	3	4	4	2	3	2	2	4	3	4
		GHNHSFT actual			5	3										8
<b>Local Priorities</b>																
LP1	Reduction in COPD admission	Glos HC target														
		Glos HC actual		n/a												
LP2	Injuries due to falls per 100,000 population ages 65+	Glos HC target														
		GHNHSFT actual		2,236												
LP3		Glos HC target														
		GHNHSFT actual		n/a												

## NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position as at 30th June (Month 03)

AS AT Month 03 2016/17	2016/17			Cash
	<u>R</u>	<u>NR</u>	<u>TOTAL</u>	<u>Limit</u>
	£000	£000	£000	£000
<b>2016/17 baseline excl growth rolled forward</b>	<b>707,886</b>		<b>707,886</b>	<b>707,886</b>
BCF	11,596		11,596	11,596
ETO	2,300		2,300	2,300
Future in Mind	1,100		1,100	1,100
Capital Grant	3,000		3,000	3,000
Market Rent	321		321	321
GPIT	1,622		1,622	1,622
Neurology	43		43	43
Court Liaison	(35)		(35)	(35)
Wheelchairs	462		462	462
Cross Border	135		135	135
Co Commissioning	75,113		75,113	75,113
Growth - Prog	15,421		15,421	15,421
Growth - Admin	28		28	28
Growth Co - commissioning	3,410		3,410	3,410
15/16 Surplus Bfwd		9,456	9,456	
Maximum Cash Adj				(1,321)
<b>Last month total</b>	<b>822,402</b>	<b>9,456</b>	<b>831,858</b>	<b>821,081</b>
<b>Adjustments in month</b>				
Eating Disorders		311	311	311
Choice +		1,350	1,350	1,350
<b>Adjustments actioned in month</b>		<b>1,661</b>	<b>1,661</b>	<b>1,661</b>
<b>TOTAL NATIONALLY REPORTED LIMIT</b>	<b>822,402</b>	<b>11,117</b>	<b>833,519</b>	<b>822,742</b>

## NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

## Summary Financial Position

## Overall financial position as at 30th June 2016 (Month 03)

	Year to Date			Forecast Outturn		
	Budget	Actual	(Under)/Over spend	Annual Budget	Forecast Outturn	(Under)/Over spend
	£000	£000	£000	£000	£000	£000
<b>Acute services</b>						
Acute contracts - NHS (includes Ambulance services)	89,253	89,364	111	357,014	357,457	443
Acute contracts - Other providers	1,315	1,321	6	5,313	5,199	(114)
Acute - NCAs	1,691	1,691		6,767	6,767	
Pass-through payments						
<b>Sub-total Acute services</b>	<b>92,259</b>	<b>92,376</b>	<b>117</b>	<b>369,094</b>	<b>369,423</b>	<b>329</b>
<b>Mental Health Services</b>						
MH contracts - NHS	19,597	19,667	70	78,389	78,699	310
MH contracts - Other providers	1,082	944	(138)	4,330	4,310	(20)
<b>Sub-total MH services</b>	<b>20,679</b>	<b>20,611</b>	<b>(68)</b>	<b>82,719</b>	<b>83,009</b>	<b>290</b>
<b>Community Health Services</b>						
CH Contracts - NHS	23,583	23,564	(19)	94,331	94,331	
CH Contracts - Other providers	(2,864)	(2,782)	82	(11,458)	(11,611)	(153)
CH - Other						
<b>Sub-total Community services</b>	<b>20,719</b>	<b>20,782</b>	<b>63</b>	<b>82,873</b>	<b>82,720</b>	<b>(153)</b>
<b>Continuing Care Services</b>						
Continuing Care Services (All Care Groups)	5,429	5,393	(36)	20,330	20,330	
Local Authority / Joint Services	618	596	(22)	2,472	2,472	
Free Nursing Care	2,229	2,198	(31)	8,914	8,914	
<b>Sub-total Continuing Care services</b>	<b>8,276</b>	<b>8,187</b>	<b>(89)</b>	<b>31,716</b>	<b>31,716</b>	
<b>Primary Care services</b>						
Prescribing	24,144	24,519	375	96,576	98,276	1,700
Co-Commissioning and Enhanced services	21,048	21,013	(35)	84,150	84,150	
Other	3,121	3,055	(66)	14,056	14,036	(20)
<b>Sub-total Primary Care services</b>	<b>48,313</b>	<b>48,587</b>	<b>274</b>	<b>194,782</b>	<b>196,462</b>	<b>1,680</b>
<b>Other Programme services</b>						
Other	7,074	7,097	23	28,250	28,421	171
<b>Sub-total Other Programme services</b>	<b>7,074</b>	<b>7,097</b>	<b>23</b>	<b>28,250</b>	<b>28,421</b>	<b>171</b>
<b>Total - Commissioned services</b>	<b>197,320</b>	<b>197,640</b>	<b>320</b>	<b>789,434</b>	<b>791,751</b>	<b>2,317</b>
<b>Specific Commissioning Reserves</b> (Inc headroom and Contingency)	5,254	5,010	(244)	21,066	18,967	(2,099)
<b>Total - Programme Costs (excl Surplus)</b>	<b>202,574</b>	<b>202,650</b>	<b>76</b>	<b>810,500</b>	<b>810,718</b>	<b>218</b>
Running Costs (incl reserves)	3,442	3,365	(77)	13,563	13,345	(218)
<b>Total - Admin Costs (excl Surplus)</b>	<b>3,442</b>	<b>3,365</b>	<b>(77)</b>	<b>13,563</b>	<b>13,345</b>	<b>(218)</b>
<b>Surplus</b>	2,364		(2,364)	9,456		(9,456)
<b>Total Application of Funds</b>	<b>208,380</b>	<b>206,015</b>	<b>(2,365)</b>	<b>833,519</b>	<b>824,063</b>	<b>(9,456)</b>

Theme	Planned Gross Savings 2015/16 £'000	Forecast £'000	Variance £'000
Urgent Care	6,137	5,279	(858)
Planned Care	6,435	6,285	(150)
Community	1,050	1,050	0
Prescribing	4,420	4,420	0
Transactional	0	0	0
Unidentified	0	0	0
<b>Grand Total</b>	<b>18,042</b>	<b>17,034</b>	<b>(1,008)</b>
Additional Schemes			0
Additional QIPP / Slippage / Contingent resources / Application of QIPP rule		1,008	1,008
<b>Grand Total</b>	<b>18,042</b>	<b>18,042</b>	<b>0</b>

Theme RAG	Savings RAG	Recurrent / Trend RAG
A	A	A
A	A	A
A	G	G
A	A	A

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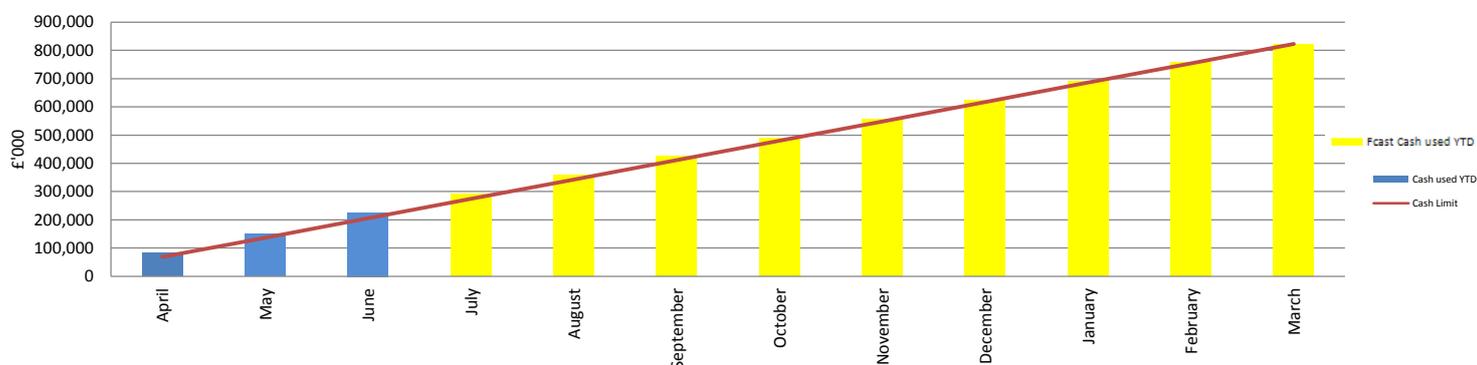
n/a	n/a	n/a
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## NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 30th June 2016 (Month 03)

		Actual/Forecast Charges in Month							TOTAL	TOTAL	CASH	CASH AT	% CASH LIMIT	Bal/Cash
		Drawn	Prescribing	Home Oxygen	Advance Drugs Payments	co Commissioning	CHC inc Risk pool contribution	Capital Allocation	MONTH	YTD	LIMIT 1/12ths	MONTH END	%	Limit
Month	Status	£000	£000	£000	£000			£000	£000	£000	£000	%	%	
April	Act	75,000	6,742	87	(175)		462	82,116	82,116	68,562		9.98%	0.00%	
May	Act	62,000	6,836	85	28			68,949	151,065	137,124	6,181	18.36%	0.75%	
June	Act	67,000	7,261	84	(35)			74,310	225,375	205,686	14,793	27.39%	1.80%	
July	F'cast	59,000	7,261	86	80			66,427	291,802	274,247		35.47%	0.00%	
August	F'cast	58,941	7,261	86	80			66,368	358,170	342,809		43.53%	0.00%	
September	F'cast	58,941	7,261	86	80			66,368	424,537	411,371		51.60%	0.00%	
October	F'cast	58,941	7,261	86	80			66,368	490,905	479,933		59.67%	0.00%	
November	F'cast	58,941	7,261	86	80			66,368	557,272	548,495		67.73%	0.00%	
December	F'cast	58,941	7,261	86	80			66,368	623,640	617,057		75.80%	0.00%	
January	F'cast	58,941	7,261	86	80			66,368	690,007	685,618		83.87%	0.00%	
February	F'cast	58,941	7,261	86	80			66,368	756,375	754,180		91.93%	0.00%	
March	F'cast	58,941	7,261	86	80			66,368	822,742	822,742		100.00%	0.00%	

Proportion of Cash Limit Utilised  
Actual and ForecastOverview of current position

At the end of June £225m had been drawn down (27.4%) of the anticipated cash limit against 25% on a straight line basis.

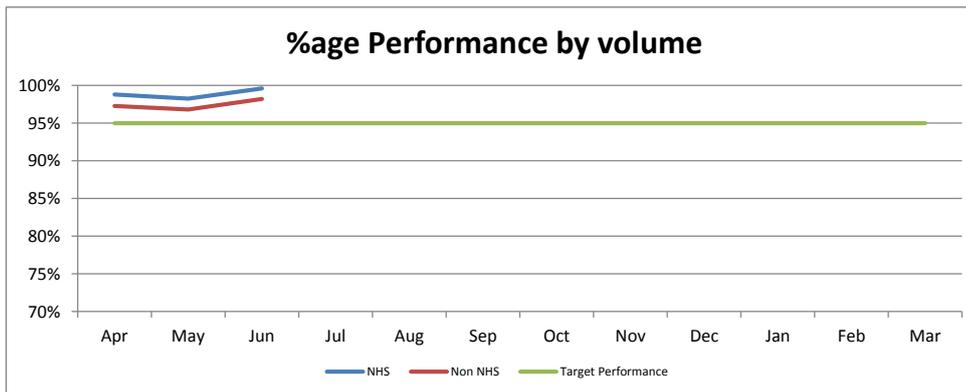
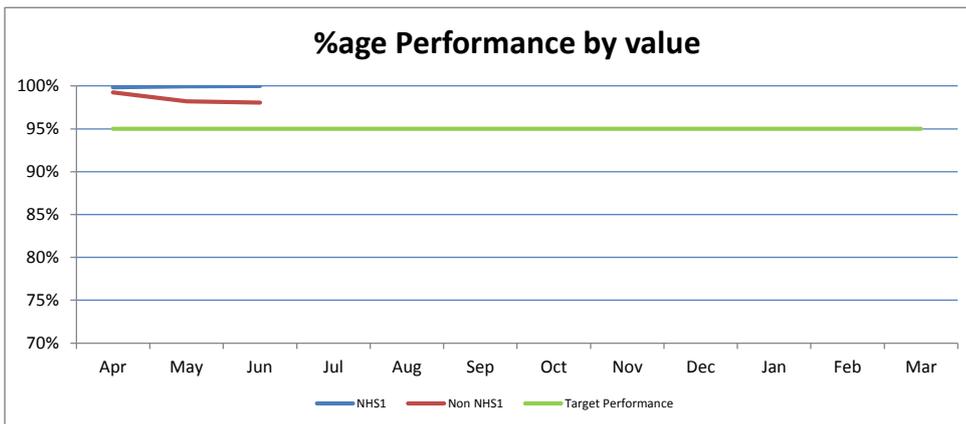
NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Performance against better payment practice code

As at 30th June 2016 (Month 03)

	In Month		Year to Date	
	NHS	Non NHS	NHS	Non NHS
<b>By volume</b>				
Total number of invoices	253	1,401	818	2,916
Number paid within target	252	1,376	809	2,846
<b>Performance</b>	<b>99.60%</b>	<b>98.22%</b>	<b>98.90%</b>	<b>97.60%</b>
<b>By value</b>				
Total value of invoices (£'M)	38.44	5.13	78.30	15.60
Value paid within target (£'M)	38.44	5.03	78.25	15.38
<b>Performance</b>	<b>100.00%</b>	<b>98.05%</b>	<b>99.94%</b>	<b>98.59%</b>

The target performance level is 95%



## NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Statement of Financial PositionAs at 30th June 2016 (Month 03)

	Opening Position as at 31 March 2016	Current Month end Position £000	Forecast Position as at 31 March 2017 £000
<b>Non-current assets:</b>			
Premises, Plant, Fixtures & Fittings	290	269	206
IM&T		0	0
Other		0	0
Long Term Receivables		0	0
<b>Total non-current assets</b>	<b>290</b>	<b>269</b>	<b>206</b>
<b>Current assets:</b>			
Inventories		0	0
Trade and other receivables	7,238	42,044	6,000
Cash and cash equivalents	23	14,793	1
<b>Total current assets</b>	<b>7,261</b>	<b>56,837</b>	<b>6,001</b>
<b>Total assets</b>	<b>7,551</b>	<b>57,106</b>	<b>6,207</b>
<b>Current liabilities</b>			
Payables	(43,221)	(73,585)	(40,000)
Provisions	(1,782)	(1,614)	(300)
Borrowings		0	0
<b>Total current liabilities</b>	<b>(45,003)</b>	<b>(75,199)</b>	<b>(40,300)</b>
<b>Non-current assets plus/less net current assets/liabilities</b>	<b>(37,453)</b>	<b>(18,093)</b>	<b>(34,093)</b>
<b>Non-current liabilities</b>			
Trade and other payables		0	0
Other Liabilities		0	0
Provisions		0	0
Borrowings		0	0
<b>Total non-current liabilities</b>		<b>0</b>	<b>0</b>
<b>Total Assets Employed:</b>	<b>(37,453)</b>	<b>(18,093)</b>	<b>(34,093)</b>
<b>Financed by taxpayers' equity:</b>			
General fund	(37,452)	(18,093)	(34,093)
Revaluation reserve			
Other reserves			
<b>Total taxpayers' equity:</b>	<b>(37,452)</b>	<b>(18,093)</b>	<b>(34,093)</b>

**Agenda item 10**

**Governing Body**

<b>Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Locality Development Plans 2015 – 2017</b>
<b>Executive Summary</b>	<p>This paper provides a succinct summary of progress made against some of the key priority areas identified by each of the seven localities within their Locality Development Plans (LDP).</p> <p>In addition the paper provides an overview of work underway countywide, within each locality, on new models of care within the context of our developing Primary Care Strategy and the Gloucestershire Sustainability and Transformation Plan (STP). This work has been undertaken at pace with significant progress made within a short period of time.</p>
<b>Key Issues</b>	<p>The key issue for localities within this period has been balancing the demands of developing new models of care while remaining focused on delivery of the LDP priorities. As can be seen by the progress updates within this document, despite this challenge, localities have done well in mitigating this.</p>
<b>Risk Issues: Original Risk Residual Risk</b>	<p>As identified in 'key issues' above, this will continue to remain a risk over the forthcoming period.</p>
<b>Financial Impact</b>	<p>The Locality Operating Framework for 2016/17 sets out a consistent approach to management money funds, how those can be spent, and how they should be recorded.</p> <p>Within locality plans, all localities have identified locality and / or practice variation as an area they are committed to work on.</p> <p>Clinical project workstreams are exploring and delivering approaches which aim to improve the</p>

	<p>quality and cost of services – aligning to QIPP where possible and supporting the delivery of countywide challenges.</p>
<p><b>Legal Issues (including NHS Constitution)</b></p>	<p>Localities are an important component of how the CCG responds to delivery of the NHS Constitution.</p> <p>Amongst others, localities particularly support the fifth of the seven key principles in the NHS constitution regarding working in partnership and across organisational boundaries in the interests of patients, local communities and the wider population. In addition, the right for patients to expect assessment of health requirements locally and to commission services accordingly is addressed directly by Locality Development Plans.</p>
<p><b>Impact on Health Inequalities</b></p>	<p>Localities are taking varying approaches to tackling health inequalities within their plans, including:</p> <ul style="list-style-type: none"> <li>• Child and Adult Obesity (Age);</li> <li>• Cultural Diversity (Ethnicity);</li> <li>• Men’s Health (Gender); and</li> <li>• Tackling variation – linked to locality demographics.</li> </ul> <p>Gloucestershire’s Public Health team has contributed to the development of all seven Locality Development Plans.</p>
<p><b>Impact on Equality and Diversity</b></p>	<p>Localities have assessed local demographics and deprivation with the aim to improve access to healthcare services as well as bringing care closer to home.</p>
<p><b>Impact on Sustainable Development</b></p>	<p>Services being provided closer to home for patients, avoiding the need to travel to secondary care settings.</p>
<p><b>Patient and Public Involvement</b></p>	<p>Locality Development Plans have taken into consideration ‘on the ground’ feedback from patients, either directly through patient representatives or indirectly from practice staff.</p> <p>Plans are hosted on the Gloucestershire CCG</p>

	<p>website and have been shared with PPGs and local stakeholders.</p> <p>Locality PPG sub-group events of the PPG network are now being planned.</p>
<b>Recommendation</b>	The Governing Body is asked to note some of the key highlights of progress and delivery by the seven localities
<b>Author</b>	<ul style="list-style-type: none"> <li>• Stephen Rudd</li> <li>• Penny Waters, Zaheera Nanabawa and Kirsty Young</li> </ul>
<b>Designation</b>	<ul style="list-style-type: none"> <li>• Head of Locality and Primary Care Development</li> <li>• Locality Development Managers</li> </ul>
<b>Sponsoring Director (if not author)</b>	Helen Goodey Director of Locality Development and Primary Care

**Governing Body  
Thursday 28<sup>th</sup> July 2016  
Locality Development Plans 2015 – 2017**

**1 Introduction and Background**

- 1.1 This paper provides a further update on progress of the seven localities against the priorities identified within their Locality Development Plans (LDPs).

**2. Key achievements to date**

**2.1 Countywide**

- 2.1.1 Localities have been hosting events, supported by the Localities Team, on 'New Models of Care' in the context of the developing Primary Care Strategy, the General Practice Forward View and the Gloucestershire Sustainability and Transformation Plan ('STP').

- 2.1.2 These events have been well attended within each locality and have represented a good level of engagement across practices. The meetings generated enthusiasm for change and requests for support to move this forward.

- 2.1.3 A significant component of the feedback from the events was that localities required clinical leadership and direction, an understanding of the models being tested nationally, the benefits and risks and the role of primary care in the wider integration agenda. In addition, a priority of the CCG, reflected within all seven LDPs, was for a redesign of urgent care, which was considered by many localities as an area where they could accelerate integrated working.

- 2.1.4 In response to our ambitions in delivering our Primary Care Strategy and the STP – particularly One Place, One Budget, One System – and building on the enthusiasm generated in localities, we set up a GP Forward View Workstream and an Integrated Urgent Care Working Group. Each locality was

asked to find a representative to attend each.

2.1.5 This was followed by an invitation in June 2016 to each practice to develop a collaborative bid, involving groups of practices with a total list size of approximately 30,000 or more, for an innovative, sustainable and transformative approach to improve patient outcomes. Localities have the natural infrastructure to support this development and have held further meetings and / or events to help the development of these groups or 'clusters' of practices.

2.1.6 In what is a relatively short period, we now have 15 clusters identified across the seven localities, representing 79 of the 81 practices. Conversations are ongoing with the remaining two practices by the GP Forward View Workstream local leader. The bids received from these clusters will be assessed by the end of July.

2.1.7 The GP local leaders attending the GP Forward View Workstream meetings represent Primary Care on the New Models of Care Board, which has just been established to deliver the One Place, One Budget, One System component of our STP.

2.1.8 With regards to integrated urgent care, localities have discussed concepts for local models that have been shared in to three workshops that have been held with provider, commissioner and patient involvement. This will now move to commencing detailed work so that a business case / case for change can be developed for Autumn 2016.

## **2.2 Forest of Dean Locality**

### **2.2.1 Healthy Lifestyles**

2.2.1.1 Following a successful Healthy Lifestyles workshop at the end of 2015, a Healthy Lifestyles working group has been formed led by 2 local GP's. Recent activity has included:

- the social prescribing team becoming part of multi-disciplinary team meetings;
- working with primary schools to discuss implementation of the 'midday mile'. This has also included attending the

Primary School Head Teachers forum with Active Gloucestershire and championing the daily mile to encourage uptake; and

- holding a 'Motivational Interviewing' protected learning time session in June. This was to help support difficult conversations with patients when presenting with certain conditions.

## **2.2.2 Community Services Review**

2.2.2.1 The Forest of Dean Community Services Review period of engagement concluded in June. A detailed engagement report is being produced. We are working to develop options for the future which we will consult on formally in the Autumn.

## **2.3 Cheltenham Locality**

### **2.3.1 Prescribing in Older People**

2.3.1.1 The locality have now completed an in-depth pilot in 4 practices to review medicines prescribed for patients over the age of 85 years, who live independently and are prescribed ten or more drugs. These patients are at increased risk of side effects and falls which can potentially lead to A&E attendances and unplanned admissions. This was undertaken by practice based pharmacists.

2.3.1.2 The pilot resulted in safer, more appropriate prescribing along with incidental savings. A project mandate is now being produced to roll the scheme out to all Cheltenham GP practices and look at existing prescribing pharmacist capacity to resource and deliver using locality management monies.

### **2.3.2 Support for Carers**

2.3.2.1 The provision of additional support for identified carers has been prioritised by the locality. A Carers audit has been completed with a new audit being run in October. Each practice will then write to their carers list inviting them to the practice who haven't had a recent health check and informing of the social prescribing scheme in Cheltenham and to contact their practice for further information.

## **2.4 Gloucester City Locality**

### **2.4.1 Frailty**

2.4.1.1 The locality has been working with a Consultant Geriatrician to scope out the needs of patients and GPs to support the provision of frailty care, through understanding more about national best practice and undertaking countywide case reviews of emergency admissions for frail patients.

2.4.1.2 An outline business case is being developed that will include as part of the implementation a consultant-led advice and guidance phone line for healthcare practitioners and GPs supporting frailty care for Gloucester City locality patients.

### **2.4.2 Respiratory**

2.4.2.1 Gloucester City locality are leading on the development of integrated care for respiratory conditions from which learning will be used on the implementation of future pathways across the county. This pilot brings together the respiratory clinical programmes approach combined with a place-based commissioning perspective at locality level.

2.4.2.2 GPs from across the city had the opportunity to contribute their views on respiratory services on 16 June. Alongside analysis of data relating to admissions and spend on respiratory care in Gloucester City, the lead GP is undertaking a number of practice-based case reviews of patients, bringing an enhanced understanding of the current care pathway and helping to identify areas for improvement at a local level.

## **2.5 South Cotswold Locality**

### **2.5.1 Cardiology**

2.5.1.1 Implementation of a 12 month pilot for practice based ambulatory ECG monitoring in the South Cotswold locality commenced at the end of May 2016. The implementation of the pilot was preceded by a well-attended session on Cardiology at the May protected learning time event to ensure referrals into the direct access service are appropriate and

safe.

- 2.5.1.2 The development of the project has included the business case going through QIPP assurance and working with the CVD clinical programme group to ensure the best outcomes for patients and the healthcare system. Patients in the locality will now be able to access ECG monitoring for palpitations with reduced appointment waiting times, and reduced report turnaround times for results.

## **2.5.2 Community Frailty Project**

- 2.5.2.1 The project team has successfully engaged on the proposed service model with patients, public and provider stakeholders on numerous occasions. There is a significant locality based appeal and commitment in supporting the development of additional resources based in locality GP practices for frail patients from all those involved.

- 2.5.2.2 The proposed service shared across all eight South Cotswold GP practices aims to include four Complex Case Management roles from 'Community Matrons', and four Wellbeing Coordinators who will specialise in supporting frail patients on their social and well-being needs. The project is working towards implementation in Autumn 2016.

## **2.6 Tewkesbury, Newent & Staunton Locality**

### **2.6.1 Utilisation of Community Based Services**

- 2.6.1.1 Building work commenced on the new Practice Health Centre earlier in the year, which is located on the same site as Tewkesbury Community Hospital. Building work is progressing well with expected completion late 2016. This will house Mythe Medical Practice and Church Street Surgery as well as a host of other services for patients. Discussions are underway to ensure full utilisation of this new multi-practice and community hospital site, and the potential range of services that will be available for patients locally.

- 2.6.1.2 The locality is also working closely with Tewkesbury Borough Council to fully utilise a new leisure centre facility for local patients, for example to tackle obesity through increasing

physical activity.

## **2.6.2 Paediatrics**

2.6.2.1 Tewkesbury has begun piloting paediatric multi-disciplinary team (MDT) meetings to review and assess all non-urgent paediatric referrals to reduce unnecessary outpatient appointments and acute attendances. These MDT meetings include representation from key providers such as GPs, Paediatricians, Occupational Therapists, Family's First, Community Nurses and School Nurses.

2.6.2.2 The MDT review all non-urgent paediatric referrals and direct them to the most appropriate service, ensuring patients are treated in the right place at the right time, often in the community instead of hospital, whilst also providing valuable education for clinicians.

## **2.6.3 Cultural Commissioning**

2.6.3.1 Tewkesbury Locality has been one of the pilot sites for Gloucestershire CCG Cultural Commissioning Programme. The Roses Theatre in Tewkesbury is delivering three grant cultural commissioning programmes offering wider services for local patients:

1. tier 3 obesity project working in partnership with GHNHSFT weight management service;
2. early intervention mental health programme for young people in Churchdown – based in the Tewkesbury Borough Council area; and
3. transition project for people with prostate and colorectal cancer back into everyday work and life.

2.6.3.2 These are delivered by local artists, developing their skills and workforce to contribute towards community based health and wellbeing.

## **2.7 Stroud & Berkeley Vale Locality**

### **2.7.1 Stroud & Berkeley Vale Test and Learn – ICT Phase 2**

2.7.1.1 An independent evaluation was undertaken by Health

Services Management Centre (HSMC) of the University of Birmingham to assess the impact of ICT Phase 2 in Stroud & Berkeley Vale which piloted a person-led model of working. ICT Phase 2 was fundamentally aimed at providing integrated care through development of relationships between staff in the 4 ICTs in Stroud & Berkeley Vale, 2gether NHS Foundation Trust and staff from the Voluntary and Community Sector (VCS) organisations, with a particular focus on mental health and wellbeing primarily in later life.

2.7.1.2 The outcome of the evaluation indicated that:

- staff had a better understanding of other organisations and their roles, along with stronger links with Stroud District Council and VCS organisations;
- staff awareness of their own skills and those of colleagues in other organisations had increased;
- closer collaborative working had emerged;
- staff appreciated support with positive risk taking;
- an initial shift in culture to an asset based approach had commenced; and
- further improvements could be made by using the learning from the pilot, especially greater involvement of GP colleagues. , This is being taken forward through the new place based models of care within Stroud & Berkeley Vale.

2.7.1.3 Integrated ways of working, taken from the test and learn, are being rolled-out across the county and led by Gloucestershire Care Services.

## **2.7.2 Social Prescribing Evaluation**

2.7.2.1 Social Prescribing in Stroud & Berkeley Vale which is provided by Gloucestershire Care Services local area coordinators based within their Integrated Care Teams is progressing well. Positive feedback has been received from all stakeholders and patients with growing referral numbers within the locality and countywide.

2.7.2.2 The effectiveness of the pilot will be determined by an evaluation being carried out by the University of the West of

England for the countywide Social Prescribing Pilot, which is due for completion in September 2016. This will consider the qualitative element – through the use of patients wellbeing scores recorded both pre and post intervention – as well as assessing the impact on A&E attendance and admission six months before and after the social prescribing contact.

## **2.8 North Cotswold Locality**

### **2.8.1 Prescribing**

2.8.1.1 North Cotswolds Locality are piloting the use of Clinical Pharmacists for one year to address their prescribing overspend across the locality. The Clinical Pharmacists, working with all five practices, will work to deliver an agreed prescribing savings plan of £400k during the pilot.

2.8.1.2 Successful recruitment has recently taken place, with two full-time Clinical Pharmacists due to commence by the start of September.

### **2.8.2 Carers Afternoons**

2.8.2.1 After a successful first round of carers afternoons held by North Cotswolds practices last year, the locality are rolling out a second round of these planned for later this year.

2.8.2.2 Each practice invites carers to attend an afternoon at their surgery where they undertake a carer's health check and provide an opportunity for the carer to make contact with a range of voluntary and community sector organisations such as Cotswold Friends, Alzheimer's Society and Carers Gloucestershire, to gather advice, guidance and support. After each afternoon has taken place, the practices gather feedback to develop and improve the carer's health check and experience of the event for future enhancements.

## **3 Recommendations**

3.1 The Governing Body is asked to note some of the key highlights of progress and delivery by the seven localities.

**Agenda item 11**

**Governing Body**

<b>Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Strategy for the Procurement of Health Care Services</b>
<b>Executive Summary</b>	<p>This Procurement Strategy incorporating a Contestability Framework, Market Management and Dispute Resolution Policy has been prepared by the Head of Procurement and endorsed by the Director of Commissioning Implementation for consideration by the NHS Gloucestershire Clinical Commissioning Governing Body.</p> <p>This document incorporates reference to legislative changes resulting from the introduction of the European Union Public Contracts Regulations 2015. These came into force on 1<sup>st</sup> April 2015 for the provision of goods and generic services. Further changes which apply to certain reserved categories of service (including the provision of healthcare and social services and referred to as the Light Touch Regime) are effective from 18<sup>th</sup> April 2016 are also referenced in this revised document.</p> <p>The strategy takes account of the Conflicts of Interest (COI) guidance, issued by NHS England, and provides advice on the requirement to ensure that organisations bidding for GCCG contract opportunities (including the commissioning of services from GP practices in which GPs have a financial interest) declare COI's as part of the market testing processes.</p> <p>The document may require updates to take account of case law arising from the</p>

	introduction of the 2015 Public Contracts Regulations and any changes which may result from the UK's decision to leave the European Union.
<b>Key Issues</b>	Revised procurement strategy for the period 1st August 2016 to 31 <sup>st</sup> July 2018 which reflects changes to European Union public contracts regulations and new NHS England conflicts of interest guidance
<b>Risk Issues: Original Risk Residual Risk</b>	None identified
<b>Financial Impact</b>	No financial impact identified
<b>Legal Issues (including NHS Constitution)</b>	No specific issues identified. Legislative changes are referenced within document
<b>Impact on Health Inequalities</b>	Equality Impact Assessment is not required.
<b>Impact on Equality and Diversity</b>	No
<b>Impact on Sustainable Development</b>	Not Applicable
<b>Patient and Public Involvement</b>	Not required
<b>Recommendation</b>	The Governing Body is asked to approve the Strategy.
<b>Author</b>	David Porter
<b>Designation</b>	Head of Procurement
<b>Sponsoring Director (if not author)</b>	Mark Walkingshaw Deputy Accountable Officer



## **Strategy for the Procurement of Health Care Services**

**Incorporating:**

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

**1 August 2016 to 31 July 2018**

### **Document Control:**

<b>Date of Issue:</b>	1 August 2016
<b>Version:</b>	V2
<b>Author:</b>	David Porter, Head of Procurement
<b>Next Review Date:</b>	June 2018
<b>Approved by:</b>	NHS Gloucestershire Clinical Commissioning Group

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## **Executive Summary:**

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

This document incorporates reference to legislative changes resulting from the introduction of the European Union Public Contracts Regulations 2015. These came into force on 1 April 2015 for the provision of goods and generic services. Further changes which apply to certain reserved categories of service (including the provision of healthcare and social services and referred to as the Light Touch Regime) are effective from 18 April 2016 are also referenced in this revised document.

The strategy takes account of the Conflicts of Interest (COI) guidance, issued by NHS England, and provides advice on the requirement to ensure that organisations bidding for GCCG contract opportunities (including the commissioning of services from GP practices in which GPs have a financial interest) declare COI's as part of the market testing processes.

The document may require updates to take account of case law arising from the introduction of the 2015 Public Contracts Regulations and any changes which may result from the UK's decision to leave the European Union.

## Part A Procurement Strategy

### 1. Purpose / Introduction:

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

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

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

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

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

To achieve these aims, the GCCG will:

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

### 2. Procurement Policy:

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

Body:	Publication:
DoH / NHS Improvement / NHS England	Any Qualified Provider Operational Guidance (2011)
	Health and Social Care Act 2012
	Managing Conflicts of Interest – Guidance for CCG's (28 March 2013)
	Patient Choice (Nov 2011)
	Securing Best Value for NHS Patients (Aug 2012)
	Substantive guidance on the Procurement, Patient Choice and Competition Regulations (December 2013)
	The Operating Framework (Annual)
	The Public Services (Social Value) Act 2012
European Union	The Public Contracts Regulations 2015 (and any subsequent amendments to this legislation as enacted from time to time)
NHS Gloucestershire Clinical Commissioning Group	Equality Strategy
	Gloucestershire Joint Health and Wellbeing Strategy
	Integrated Annual Operating Plan
	NHS Gloucestershire Clinical Commissioning Group Constitution
	Public and Patient Engagement Strategy
	Quality Strategy
	Prime Financial Policies
	Strategic Commissioning Intentions

The National Health Service (Procurement, Patient Choice and Competition Regulations) (No.2) 2013 came into force on 1 April 2013 and apply to all Clinical Commissioning Groups (CCG's) and also to NHS England where it is responsible for procuring health care services.

The principles GCCG will follow include:

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

3. Overarching Principles of Procurement:

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

Principle:	GCCG Undertaking:
<b>Transparency:</b>	State Commissioning Strategies and Intentions:
	Publish short / medium procurement intentions on the GCCG web site
	State outcomes of service reviews and whether a competitive tender / AQP process is to be used.
	Pricing tariffs and other payment regimes will be fair and transparent.
	Advertise suitable procurement opportunities and contract awards via Contracts Finder, the Official Journal of the European Union and the GCCG website as applicable.
	Maintain an auditable tender documentation trail (and for decisions not to tender), providing clear accountability.
	Publish details of all contracts awarded on its website, including contractor names, addresses, contract type, value, duration and procurement process utilised.
<b>Proportionality:</b>	Commissioner resources must be proportionate to the value, complexity and risk of the service being procured.
	Contract duration to be proportionate to service type being commissioned.
	Whilst maintaining quality standards / patient safety, Additional award criteria (including financials) must be proportionate to the value, complexity and risk of the service being procured and will not discriminate against smaller organisations such as voluntary sector / social enterprises etc.
	The GCCG will seek to minimise bidder tender costs by avoiding timetable delays and significant changes to scope
<b>Non-Discrimination:</b>	The GCCG will ensure that the entire procurement process and associated documentation will not contain bias towards any particular bidder
	All evaluations criteria and associated weightings will be fully disclosed
	All relevant information will be disclosed equally and in good time to all prospective bidders
<b>Equality of Treatment:</b>	The GCCG will not favour a particular market sector i.e. public over private. Award decisions will always be taken based on a bidders ability to deliver the service rather than on the organisational type.
	Finance and quality assurance checks will be applied equally to all bidders

4. Commissioning Strategy / GCCG Procurement Intentions:

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

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

The GCCG as a Public Sector Contracting Authority is governed under the EU Procurement Directive and the following thresholds apply from 1 January 2016\* (changes biennially):

	Supplies	Services	Light Touch Regime Services*	Works
<b>Thresholds (Excluding VAT)</b>	<b>£106,047</b> Total aggregated contract value	<b>£106,047</b> Total aggregated contract value	<b>£589,148</b> Total aggregated contract value	<b>£4,104,394</b> Total aggregated contract value

\*Light Touch Regime threshold of £589.148 used for the provision of Health and Social Care Services

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

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

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

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

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

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

Procedure/ Process:	Description:
<b>Any Qualified Provider:</b>	Allows Commissioners to increase choice to patients by qualifying / registering organisations to provide services via an assurance process that test providers fitness to offer the particular NHS-funded service. The Commissioner sets local pathways and referral protocols which providers must accept. Referring clinicians offer patients a choice of qualified provider for the service being referred to. Competition is based on quality not price; providers are paid a fixed price determined by a national or local tariff (in the absence of a national tariff).
<b>Contract Management</b>	Can be used where an existing contract is in place in order to secure incremental improvements / changes to existing services, or to address underperformance as an alternative to procurement

<p><b>Competitive Dialogue:</b></p>	<p>Allows input into the tender process by participating bidders. There will be a 'Dialogue' phase where bidders are able to discuss all aspects of the contract with the commissioner. Dialogue generates solutions to the agreed requirements, and tenders are invited based on the bidder's solution.</p> <p>The Competitive Dialogue route should only be used where the GCCG is unable, due to the complexity of its requirements to define the technical means capable of satisfying the GCCG's needs or objectives, specify either the legal or financial makeup of the project, and where neither the open or restricted procedure would be appropriate for the award of the contract.</p>
<p><b>Framework Agreements:</b></p>	<p>Although currently limited in scope for clinical services applications, the GCCG is permitted to access nationally negotiated framework agreements, where appropriate, for direct award or mini competition processes.</p>
<p><b>Grants:</b></p>	<p>Public bodies must follow public procurement policy at all times. In certain circumstances grants are payable to third sector organisations. However, there should be no preferential treatment for third sector organisations. Use of grants can be considered where:</p> <ul style="list-style-type: none"> <li>• Funding is provided for development or strategic purposes.</li> <li>• The provider market is not well developed.</li> <li>• Innovative or experimental services.</li> <li>• Where funding is non-contestable (i.e. only one provider).</li> </ul> <p>Grants will not be used to avoid competition where it is appropriate for a formal procurement to be undertaken.</p>
<p><b>Negotiated Procedure:</b></p>	<p>This procedure allows the Commissioner to select one or more potential bidders with whom to negotiate the terms of the contract. There are two types of Negotiated procedure either with or without prior advert. Bidders need to be invited to negotiate the terms of the advertised contract.</p> <p>Under the procedure without prior advert, the GCCG could negotiate directly with its supplier of choice – this is usually due to the protection of exclusive rights where the contract can only be carried out by a particular bidder. The procedure should only be used in limited circumstances as detailed in the Regulations.</p>
<p><b>Open:</b></p>	<p>No pre-qualification stage. All prospective bidders may respond to the advertisement by tendering for the contract, although only those meeting the selection criteria (if stated) will be entitled to have their tender assessed.</p>
<p><b>Restricted:</b></p>	<p>All interested parties may express an interest in tendering for the contract but only those meeting selection criteria, assessed by a pre-qualifying stage, will be invited to do so. An Accelerated Restricted Procedure can also be undertaken.</p>
<p><b>Single Tender Action:</b></p>	<p>Single tender actions should usually be avoided as this is contrary to achieving value for money through open and fair competition. Exceptionally, single tender actions may be justified where:</p> <ul style="list-style-type: none"> <li>▪ The work constitutes follow up work, which is directly related to a recently completed contract, and the added value gained from the additional work being given to the same contractor outweighs any potential reduction in</li> </ul>

	<p>price that may be derived through competitive tendering. However the follow up work should not be of significant cost (i.e. not more than 50% of the original contract value);</p> <ul style="list-style-type: none"> <li>▪ The expertise required is only available from one source. This may be due to ownership of exclusive design rights or patents but, nonetheless, the specification should be reviewed to ensure that no other product / service would meet user requirements.</li> </ul>
<p><b>Spot Purchasing:</b></p>	<p>There will remain a need to spot-purchase for particular individual needs i.e. urgent medical requirement to place a patient in specialist care facilities. Whilst this requirement is infrequent, a waiver of standing orders will be sought to comply with the GCCG's requirements for financial transparency and probity.</p>

7. Market Analysis:

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

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

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

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

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

8. Provider Engagement:

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

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

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

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

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

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

#### 9. Public and Patient Engagement:

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

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

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

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

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

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

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

10. Procurement of Goods and Generic Services:

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

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

11. e-Tendering:

A semi-automated / electronic approach to competitive tendering is presently used by GCCG procurement staffs when conducting competitive tendering processes. In-line with European Union guidance (December 2011), the GCCG is required to conduct all procurement processes electronically no later than 2017. The GCCG will implement a compliant e-tendering system prior to this date.

12. Collaborative Procurement:

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

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

13. Contract Duration:

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

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

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

14. Contract Management:

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

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

15. Procurement Participation Guides:

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

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

16. Social Value Legislation:

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

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

17. Conflicts of Interest:

GCCG manages potential conflicts of interest in accordance with NHS England statutory guidance and the Procurement, Patient Choice and Competition Regulations (No.2) 2013. The latter places a requirement on the GCCG to ensure that it adheres to good practice in relation to procurement, does not engage in anticompetitive behaviour that is against the interests of patients and protects the rights of patients to make choices about their healthcare.

GCCG will take the following steps to manage potential conflicts of interest:

- Doing business appropriately;
- Being proactive, not reactive;
- Being balanced and proportionate;
- Conduct its business openly and transparently;

- Secure expert advice;
- Engaging appropriately with providers;
- Creating clear and transparent commissioning specifications;
- Follow proper procurement process and legal arrangement;
- Ensure sound record keeping, including up-to-date registers of interests; and
- Adopt a clear , recognised and easily enacted system for dispute resolution

Specifically, GCCG procurement staff will:

- Issue a conflicts of interest template when commissioning from GP practices, including provider consortia or organisations in which GP's have a financial interest.
- Issue a conflicts of Interest template for bidder / contractor completion and return in all Invitation to Tender processes
- Maintain a record of all declarations of interest associated with procurement processes undertaken and develop a process for assessing identified COI's and determining whether bidders should be excluded from bidding opportunities.
- Maintain a record of all procurement decisions which will be subject to routine Audit Committee scrutiny. This record will be published on NHS Gloucestershire CCGs external website.

18. Quality and Sustainability Impact Assessments:

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

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

## Part B Contestability Framework:

### 1. Introduction:

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

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

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

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

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

### 2. Obligations on Commissioners:

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

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

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

### 3. Triggers for Contesting a Service:

The GCCG will consider contesting services in the following circumstances:

- New Service Requirement - where there is a plan to place a new service contract (a service not previously provided)
- Contract Expiration - where an existing contract is coming to the end of its agreed term, or can reasonably be considered to be likely to come to an end for other reasons (for example a provider notifying commissioners that it is considering withdrawing provision)
- Failure to Achieve Quality Standards - where an existing provider is failing to achieve (or make sufficient progress on achieving) local or national quality standards or targets, or is not meeting the reasonable expectations of service users

- Value for Money - where an existing service offers poor value for money when compared to other relevant local or national benchmarking information
- Service Redesign - where a new type of service differs significantly from that currently in place (in terms of service model, volumes or types of activity, or financial value) such that a new range of service providers or partnerships might offer advantages in terms of patient care or cost compared to that currently in place

4. NHS Gloucestershire CCG Contestability Decision:

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

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

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

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

Procurement staff will follow one of a range of EU mandated procurement processes. This approach may be mandated for high value contracts or where there are significant non-clinical components of the service. The results of any tender process

will be published on the Contracts Finder web portal, in the Official Journal of the European Union and the GCCG external web site.

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

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

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

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

5. Decision Not to Tender:

- a. If, after a risk assessment and consideration of the principles contained within this framework, the GCCG determines that a competitive tender process is not required or is inappropriate, the reasons shall be recorded on the Decision Not to Tender Form (see Appendix 4).
- b. The GCCG Core Executive Team or Governing Body must approve any decision not to tender for new or significantly re-designed services

## **Part C Market Management Strategy**

### **1 Introduction:**

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

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

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

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

### **2 Current Provider Landscape:**

#### **2.1 Monopoly Providers:**

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

#### **2.2 Developing the Third Sector:**

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

#### **2.3 Information Technology:**

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

#### **2.4 Transport:**

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

3 Market Management in the NHS:

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

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

Table 1: The Responsibilities of the GCCG Market Manager

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

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

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

4 NHS Gloucestershire CCG's Approach to Market Management:

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

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

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

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

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

#### 4.1 Contract Management:

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

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

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

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

#### 4.2 Market Analysis:

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



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

The outputs for each step are defined below:

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

#### 4.3 Market Development:

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

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

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

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

## 5 Developing Provider Competence and Capability:

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

## 6 Market Management Support to the Commissioning Cycle:

### 6.1 Assess Needs/Review of Provision:

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

6.2 Decide Priorities and Investment:

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

6.3 Define the Service:

- Ensure clear service specifications are developed
- Identify the implications on the provider market of the proposed service
- Support providers in bidding for services

6.4 Shape Structure of Supply:

- Provide assurance on the selection process of providers
- Ensure provider requirement documents are robust
- Oversee the commissioner selection process

6.5 Formalise and Communicate :

- Clear awards process with feedback to unsuccessful providers which may help them develop for the future
- Clear implementation plan for delivery of new services

7 Contract and Performance Management Frameworks:

Market management is underpinned by effective contract, performance management (including quality) and procurement frameworks.

7.1 Contract Management:

- Regular discussions with all key providers. Formal Contract Boards and appropriate subgroups in place for all major contracts
- Clear issue resolution/escalation processes
- Consistent and rigorous negotiation processes
- Use of the standardised NHS Contract

7.2 Performance Management:

- Predictive modelling, analysis and performance management
- Clear Key Performance Indicators (KPIs) and defined performance improvement targets
- Regular and timely performance data analysed by efficiency, quality, outcomes, comparative benchmarks and patient experience
- Achievement of national targets and local KPIs.

7.3 Service Quality:

- Understanding the quality of services provided is a key element of market management. The following indicators will all be considered as part of a provider review.
  - Mortality rates
  - Readmission rates

- Length of stay
- First to follow up ratio's - outpatients
- Conversion rates
- DNA rates

8 NHS Gloucestershire CCG's Progress in Market Management:

Since NHS Gloucestershire CCG's inception, while we have been developing the skills needed to deliver the competencies for market management, we have taken a number of services and applied a variety of market intervention strategies.

Category:	Market Intervention Strategy:	Procurement Route:
Direct Access Diagnostics for: <ul style="list-style-type: none"> <li>▪ CT</li> <li>▪ Endoscopy</li> <li>▪ MRI</li> <li>▪ Non-Obstetric Ultrasound</li> </ul>	Diversify provision Clear signalling to the market and market stimulation Choice and information	Any Qualified Provider
Community Vasectomy Services	Diversify provision Clear signalling to the market and market stimulation Choice and information	Any Qualified Provider
Elective Care Services	Diversify Provision Choice and Information Clear signalling to the market and market stimulation	Any Qualified Provider

Table 2: Categories already addressed:

9 Measurement of Success:

- Clear articulation of current and future provider market
- Robust contracts negotiated with clear outcome measures
- Robust contract/performance management processes in place
- Capability is improved within the organisation

10 Conclusion:

This strategy sets out the GCCG's approach to market management and, together with the GCCG procurement strategy, forms an integral part of the GCCG's approach to system management. It explains the way in which the dual functions of market analysis and market development will support delivery of the GCCG's commissioning intentions.

Market management is an evolving concept for the NHS and this strategy will require regular review to ensure that it is consistent with patient experience, national policy and local requirements.

## **Part D      Dispute Resolution Policy:**

### **1.    Introduction:**

NHS Gloucestershire first developed its Dispute Resolution Policy in September 2009 and was again updated to reflect the introduction of the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations which came into effect on 1 April 2013 and the advent of the NHS Gloucestershire Clinical Commissioning Group (GCCG), 1 April 2013.

The GCCG will work to reach resolution of any dispute arising from contracting and commissioning decisions. Disputes, not resolved by access to any contractual terms that may exist between them, may arise over decisions about contractual sanctions and termination, remuneration, practice area and 'opt-outs.'

Contractors have the right of appeal in some circumstances against contracting / commissioning decisions. The Procurement, Patient Choice and Competition Regulations apply alongside the EU Public Contracts Regulations 2015. The former regulations, however, are a bespoke set of rules for the health care sector and provide a mechanism for NHS Improvement, as sector regulator, to investigate complaints and take enforcement action. The regulations are designed as an accessible and effective alternative to challenging decisions in the courts.

For the avoidance of doubt this Dispute Resolution Process is a non-contractual process and is intended for use in situations where the prospective parties have decided not to follow other resolution solutions that may be available to them including formal contract dispute resolution or action under statutory or legal provision available in UK law.

In the event that a provider or potential provider of services wishes to dispute the procurement / contracting / commissioning or related decision-making decisions by use of this Dispute Resolution Process, the following process will be followed:

- The GCCG will seek to resolve any disputes by local resolution. A conciliation process will be proposed in all cases.
- If the dispute is not successfully resolved at local level, the complainant or the GCCG can refer the dispute to NHS England.
- If the dispute is not successfully resolved by NHS England, it may be referred to the NHS Improvement for investigation / review.

The appellant may withdraw the appeal at any time during the process. If for any reason an appeal is withdrawn, the GCCG will not accept a future appeal on the same grounds.

### **2.    Objectives of the Dispute Resolution Process:**

The GCCG's objectives of this process are as follows:

- To resolve competition disputes transparently, fairly and consistently and to mitigate risks and protect the reputation of the NHS.
- To be compliant with NHS Improvement's (formerly Monitor) acceptance criteria
- To prevent where possible legal challenge and external referral processes.

- To provide confidence to parties that the process is fair and transparent, enhancing willingness to participate in the market.

3. Acceptance Criteria:

The CGG will only accept appeals that meet the following criteria:

- The content of the dispute is covered by NHS Improvement's (formerly Monitor) complaints procedure and no legal proceedings have commenced.
- There is complete disclosure of all relevant and applicable information. Any individuals connected to the complaint are available to provide further evidence or testimony and the GCCG is not precluded from requesting more detailed information to make an informed decision.
- To provide confidence to parties that the process is fair and transparent, enhancing willingness to participate in the market.
- That the GCCG is the commissioner or lead commissioner for the service in question.
- The dispute is not trivial or vexatious
- The dispute is raised within 3 months of the disputed event occurring.

4. NHS Gloucestershire CCG Process:

Stage 1 - The Complaint:

The GCCG will acknowledge the appeal within two working (business) days of receipt.

The first stage is to gather information (see attached form – Appendix 5) and complete an initial assessment. A nominated officer will be appointed to carry out the assessment.

Following the initial assessment, the GCCG may instigate an informal investigation to add further detail. This stage is to be completed within 14 days. Following this assessment there will be an opportunity for conciliation between the parties. A timescale will be set and notified to each party.

If the criteria for dispute are met and conciliation has not resolved the issue, the nominated officer will complete a report for the GCCG Panel.

Stage 2 - GCCG Panel:

Membership – the Panel has three core members:

- Non-Executive Member (Chair)
- Executive Director
- Head of Procurement

The nominated officer will attend to present their investigation.

The Panel will formally meet and review the case. This stage is to be completed within 20 working days. Both parties will have had the opportunity to submit written material in advance of the hearing. Both parties may be offered the opportunity to attend the Panel.

Stage 3: The Decision:

The GCCG Panel has 4 potential outcomes:

- Complaint upheld
- Further investigation needed – to be completed within a maximum 20 working days
- Complaint rejected
- Complaint judged to be beyond the scope of the Panel so will be referred to NHSCB Regional Panel or to the National Co-Operation and Competition Panel.

The GCCG will write to the complainant(s) notifying them of its decision, explaining the rationale and any course of action required.

If the complainant does not believe the case has been satisfactorily resolved an appeal can be lodged with NHS England.

All results of the process will be presented to the GCCG Governing Body on an annual basis for information. Reports will include summaries of complaints and outcomes, as well as performance against target timescales.

**Appendix 1**

**Procurement Template**

*(Template to be used when commissioning services from GP Practices, including provider consortia or organisations in which GPs have a financial interest)*

<b>Service:</b>	
<b>Question:</b>	<b>Comment / Evidence:</b>
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities? How does it comply with the CCG's commissioning obligations	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board? How does the proposal support the priorities in the relevant joint health and wellbeing strategy?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available? Have you recorded how you have managed any conflict or potential conflict?	
*Why have you chosen this procurement route?	
What additional external involvement will there be in scrutinising the proposed decisions?	
How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision?	

*\*Taking into account all relevant procurement regulations including, but not limited to, the NHS Procurement, Patient Choice and Competition regulations (No.2) 2013*

**Additional question when qualifying a provider on a list or framework or preselection for tender (including but not limited to any qualified provider) or direct award (for service where national tariffs do not apply):**

Question:	Comment / Evidence:
How have you determined a fair price for the service?	

**Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers:**

Question:	Comment / Evidence:
How will you ensure that patients are aware of the full range of qualified providers whom that can choose?	

**Additional questions for proposed direct awards to GP providers:**

Question:	Comment / Evidence:
What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
In what way does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

## Appendix 2

### Form of Declaration of Conflict of Interest for Bidders / Contractors

*(Bidders / potential contractors / service provider declaration form: financial and other interests)*

Notes (instructions) for completion:

- All potential bidders / contractors / service providers, including sub-contractors, members of a consortium, advisors or other associated parties (Relevant Organisations) are required to identify any potential conflicts of interest that could arise if the Relevant Organisation were to take part in any procurement process and / or provide services under or otherwise enter into any contract with the CCG.
- If any assistance is required in order to complete this form, the Relevant Organisation should contact a member of the CCG's procurement team.
- The complete form should be sent to the Procurement Team, NHS Gloucestershire CCG, Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester GL3 4FE.
- Any changes to interests declared either during the procurement process or during the term of any contract subsequently entered into by the Relevant Organisation and the CCG must be notified to the CCG by completing a new declaration form and submitting it to the CCG's procurement team.
- Relevant Organisations completing this declaration must provide sufficient detail of each interest so that a member of the public would be able to understand clearly the sort of financial or other interest the person concerned has and the circumstances in which a conflict of interest with the business of running of the CCG might arise.
- If in doubt as to whether a conflict of interest could arise, a declaration of the interests should be made.

Interests that must be declared are:

- The Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing the service or other work for the CCG.
- A Relevant Organisation or Relevant Person is providing service or other work for any other potential bidder in respect of this project or procurement process.
- The Relevant Organisation or any Relevant Person has any other connection with the CCG, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG or any of its members or employees judgements decisions or actions. Whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person

Declarations:

<b>Name of Relevant Organisation:</b>	
<b>Type of Interest:</b>	<b>Details of Interest:</b>
Provision of services or other work for CCG	
Provision of services or other work for any other potential bidder in respect of this project or procurement process	
Any other connection with the CCG, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG or any of its members employees judgements, decisions or actions	

<b>Name of Relevant Person</b> (complete for all Relevant Persons)		
<b>Type of Interest:</b>	<b>Details of Interest:</b>	<b>Personal interest or that of a family member, close friend or other acquaintance?</b>
Provision of services or other work for CCG		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		
Any other connection with the CCG, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG or any of its members employees judgements, decisions or actions		



**Decision Not to Tender**

<b>Project Manager:</b> <i>(Name)</i>	
<b>Project Director:</b> <i>(Name)</i>	
<b>Date:</b>	
<b>Reference Number:</b>	

<p><b>1. Project Title and Background:</b> <i>(Include summary of proposed service and cross reference to annual operating plan)</i></p>
<p><b>2. Proposed Contract:</b> <i>(Include proposed provider, contract duration and proposed commencement date)</i></p>
<p><b>3. Market Assessment:</b> <i>(Summary of outcome of market assessment supporting the proposal)</i></p>
<p><b>4. Financial Assessment:</b> <i>(Anticipated total aggregated contract value)</i></p>
<p><b>5. Reasons for Not Tendering::</b> <i>MUST ensure that reasons are permitted in accordance with the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. See Annex 1 for summary of Regulations.</i></p>

<b>6. Risk Assessment:</b> <i>(Identify risks to patients if proposal is rejected / Identify risks to GCCG if proposal is accepted)</i>
<b>7. Due Diligence:</b> <i>(Basic financial and quality assurance checks must be undertaken in respect of proposed service provider. This will include: financial viability, economic standing, clinical capacity &amp; capability, governance, affordability / value for money)</i>
<b>8. Stakeholder Engagement:</b> <i>(Is the proposal acceptable to patients? Include findings of any patient engagement)</i>
<b>9. Procurement Comments:</b> <i>(Confirmation that the narrative provided in 5 (above) complies with current legislative requirements as summarised in Annex1 1)</i>

<b>Approved / Rejected by GCCG Governing Body / Core Executive Team in accordance with Prime Financial Policy:</b> <i>(Signature)</i>	
<b>Date:</b>	
<b>Comments:</b>	

## Summary of the National Health Service (Procurement, Patient Choice and Competition (No.2) Regulations 1 April 2013

Reg No.	Narrative:
<b>Two</b>	<p><b><u>Objective</u></b></p> <p>When procuring health care services for the purposes of the NHS, a relevant body must act with a view to:</p> <ul style="list-style-type: none"> <li>(a) Securing the needs of the people who use the services,</li> <li>(b) Improving the quality of the services, and</li> <li>(c) Improving efficiency in the provision of the services,</li> </ul> <p>Including through the services being provided in an integrated way including with other healthcare services, health-related services, or social care services.</p>
<b>Three</b>	<p><b><u>Procurement - General Requirements:</u></b></p> <p>When procuring health care services for the purposes of the NHS, a relevant body must comply with paragraphs 2 to 4:</p> <p>(2) The relevant body must:</p> <ul style="list-style-type: none"> <li>(a) Act in a transparent and proportionate way, and</li> <li>(b) Treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership.</li> </ul> <p>(3) The relevant body must procure the services from one or more providers that:</p> <ul style="list-style-type: none"> <li>(a) Are most capable of delivering the objective referred to in regulation 2 in relation to the services, and</li> <li>(b) Provide best value for money in doing so.</li> </ul> <p>(4) In acting with a view to improving quality and efficiency in the provision of the services the relevant body must consider appropriate means of making such improvements, including through:</p> <ul style="list-style-type: none"> <li>(a) The services being provided in a more integrated way including with other health care services, health-related services, or social care services),</li> <li>(b) Enabling providers to compete to provide the services, and</li> <li>(c) Allowing patients a choice of provider of the services.</li> </ul> <p>(5) A relevant body must, in relation to each contract awarded by it for the provision of healthcare services for the purposes of the NHS, maintain a record of:</p> <ul style="list-style-type: none"> <li>(a) In the case of a contract awarded by the Board, details of how in awarding the contract it complies with its duties as to effectiveness, efficiency etc, improvement in quality of services and promoting integration;</li> <li>(b) In the case of a contract awarded by a CCG, details of how in awarding the contract it complies with its duties as to effectiveness, efficiency etc, improvement in quality of services and promoting integration.</li> </ul>

<p><b>Five</b></p>	<p><b><u>Award of a new contract without a competition:</u></b></p> <p>A relevant body may award a new contract for the provision of health care services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider.</p> <p>For the purposes of paragraph 1, a relevant body is not to be treated as having awarded a new contract:</p> <p>(a) Where the rights and liabilities under a contract have been transferred to the relevant body from the Secretary of State, a Strategic Health Authority or a Primary Care Trust; or  (b) Where there is a change in the terms and conditions of a contract as a result of:</p> <p>(i) A change in the terms and conditions drafted by the Board under regulation 17 of the 2012 Regulations (terms and conditions to be drafted by the Board for inclusion in commissioning contracts), or  (ii) New terms and conditions drafted by the Board under that regulation.</p>
<p><b>Six</b></p>	<p><b><u>Conflicts of Interest in purchasing health care services and supplying such services</u></b></p> <p>A relevant body must not award a contract for the provision of health care services for the purposes of the NHS where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract.</p> <p>In relation to each contract that it has entered into for the provision of healthcare services for the purposes of the NHS, a relevant body must maintain a record of how it managed any conflict that arose between the interests in commissioning the services and the interests involved in providing them.</p> <p>An interest referred to in paragraph 1 includes an interest of:</p> <p>(a) A member of the relevant body,  (b) A member of its governing body,  (c) A member of its committees or sub-committees or committees or sub-committees of its governing body, or  (d) An employee.</p>
<p><b>Ten</b></p>	<p><b><u>Anti-Competitive Behaviour:</u></b></p> <p>When commissioning health care services for the purposes of the NHS, a relevant body must not engage in anti-competitive behaviour(a), unless to do so is in the interests of people who use health care services for the purposes of the NHS which may include:</p> <p>(a) By the services being provided in an integrated way (including with other health care services, health-related services, or social care services); or  (b) By co-operation between the persons who provide the services in order to improve the quality of the services.</p> <p>(2) An arrangement for the provision of health care services for the purposes of the NHS must not include any term or condition restricting competition which is not necessary for the attainment of:</p> <p>(a) Intended outcomes which are beneficial for people who use such services; or  (b) The objective referred to in regulation 2.</p>

**Dispute Resolution Form**

1. Complainant Contact Details:

<b>Name:</b>	
<b>Address:</b>	
<b>Telephone Number:</b>	
<b>Email Address:</b>	
<b>Date:</b>	
<b>Name and title of the person(s) authorised to represent the complainant:</b>	

2. Acceptance Criteria:

<b>Evidence that each of the acceptance criteria has been met:</b>
<p><u>Acceptance Criteria 1:</u></p> <p><i>The content of the dispute is covered by NHS Improvement's (formerly Monitor) complaints procedure and that no legal proceedings have commenced.</i></p> <p><u>Evidence 1:</u></p>
<p><u>Acceptance Criteria 2:</u></p> <p><i>There is complete disclosure of all relevant and applicable information. Any individuals connected to the complaint are available to provide further evidence or testimony and the GCCG is not precluded from requesting more detailed information to make an informed decision.</i></p> <p><u>Evidence 2:</u></p>
<p><u>Acceptance Criteria 3:</u></p> <p><i>To provide confidence to parties that the process is fair and transparent, enhancing willingness to participate in the market.</i></p> <p><u>Evidence 3:</u></p>

Acceptance Criteria 4:

*The GCCG is the commissioner or lead commissioner for the service in question.*

Evidence 4:

Acceptance Criteria 5:

*The dispute is not trivial or vexatious*

Evidence 5:

Acceptance Criteria 6:

*The dispute is raised within 3 months of the disputed event occurring.*

Evidence 6:

3. Basis of Complaint:

**Details of the basis of the dispute and which principles are breached:**

4. Evidence:

**Any supporting evidence available:**

5. Summary Statement:

**A statement as to the desired outcome or resolution:**

This form should be completed and forwarded by email or post to:

David Porter  
Head of Procurement  
NHS Gloucestershire Clinical Commissioning Group  
Sanger House  
5220 Valiant Court  
Delta Way  
Gloucester Business Park  
Brockworth  
Gloucester  
GL3 4FE

Email: [david.porter6@nhs.net](mailto:david.porter6@nhs.net)

**Agenda Item 12**

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Assurance Framework 2016/17</b>
<b>Executive Summary</b>	<p>The attached Assurance Framework for 2016/17 provides details of the assurances that will be provided to the Governing Body regarding the achievement of the CCG's objectives.</p> <p>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.</p>
<b>Key Issues</b>	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.
<b>Risk Issues:</b>	The absence of a fit for purpose Assurance Framework could result in gaps in control or assurances not being identified and addressed.
<b>Original Risk</b>	8 (2x4)
<b>Residual Risk</b>	4 (1x4)
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None

<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note this paper and the attached Assurance Framework.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Cath Leech Chief Finance Officer

**Governing Body**

**Thursday 28<sup>th</sup> July 2016**

**Assurance Framework 2016/17**

**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; and
- identify the assurances that will be received by the Governing Body regarding the effectiveness of those controls.

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

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

**2. The Assurance Framework**

2.1 The Assurance Framework is based upon the six summary objectives outlined in the 5 Year Plan for 2014/19.

2.2 The document outlines the principal high-level risks, control systems and assurances 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 objective is monitored separately through the performance management process.
- 2.4 This version of the Assurance Framework was considered at the June 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
<b>Objective 1: Develop strong, high quality, clinically effective and innovative services.</b>									
L2	Risk to the quality, resilience and sustainability of Primary Care due to GP practices running at maximum capacity and certain practices not being financially viable.  Increasing examples in 2016/17 of practices becoming unsustainable, with this likely to continue through 2016.  Furthermore - NHS Property Services are notifying practices occupying health centres of significant increases in facility costs in 2016/17.	Ian Goodall Helen Edwards Andrew Hughes Stephen Rudd Jenny Bowker	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; Exercising Delegated Commissioning Responsibilities; close working with member practices.		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 pilots, funding identified to support Primary Care initiatives. Localities working together on new ways of working. (March 2017)
T13	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 Kathryn Hall	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		NHS England in process of procuring extra bed capacity nationally. 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 to GRH or Wotton Lawn.  Opportunities for co-commissioning with NHS England are being explored.  Local work ongoing includes changing the 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). (March 2017)
<b>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.</b>									
Q5	Risk to financial performance if prescribing costs are in excess of the agreed budget.	Teresa Middleton	8 (2x4)	16 (4x4)	The primary care prescribing budget has been agreed and will be monitored.		Performance reports		Prescribing savings plan is a total of £3.99m. This is made up from £3.5m from primary care prescribing and 0.49m from secondary care Drug partnership. There are robust plans (upwards of 25 individual plans) in place to deliver this savings target, which are monitored through the fortnightly Medicines Optimisation Programme Group regularly reporting to core team meetings. (March 2017)
C5	(Discharge) Risk that the number of medically stable patients remaining in hospital exceeds agreed target.	Maria Metherall	16 (4x4)	12 (3x4)	GSRG, UC Programme Board, 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.		Continual monitoring and review via the SRG 4-hour Improvement Plan and consolidated with focus on admission avoidance and system-wide flow. Monitoring and review to be undertaken through the UC Programme Board and SRG. (August 2016)

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
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, UC Programme Board, 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.		Continual monitoring and review via the SRG 4-hour Improvement Plan and consolidated with focus on admission avoidance and system-wide flow. Monitoring and review to be undertaken through the UC Programme Board and SRG. (August 2016)
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, insufficient 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. Attendance at Trust internal cancer performance meeting. 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. Waiting times have been included on G-Care as part of the referral process. Some patient transfers underway for long waiters, although this is primarily in General Surgery and Urology. Increase in Urology community outpatient services. (August 2016)
C28	(Admission Avoidance) Risk of failing to achieve the emergency admission reduction in line with the QIPP plan.	Maria Metherall	12 (3x4)	16 (4x4)	GSRG, Urgent Care Programme Board, CPG/Frail Older people/Paediatric/ICT strategic Group. BCF forum/Risk strat programme board. Internal performance report contract board, UCW, sitreps, escalation monitoring, 7 day countywide steering group.		Performance Reports to Governing Body, weekly situation report, project status updates.		Monitoring via the GSRG High Impact Four Hour Improvement Plan and Four Hour Recovery Plan. Work with GCS to increase SPCA focus on admission avoidance and assurance that all GPs are using the service. OPAL - establish business case for community OPAL model. (August 2016)
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 Sustainability and Transformation plan within the Health Community has commenced with the first draft submission due at the end of June 2016.
					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
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 IGQC and Governing Body	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.	There is a detailed action plan for improving the operational performance and rate of patient referrals for Rapid Response. The Rapid Response referral activity continues to be closely monitored by (i) ICT Performance & Delivery Group (monthly meetings) & (ii) Rapid Response sub group (weekly meetings) (iii) Regular briefing sessions with ICT Programme Sponsor. IT access issues relating to the new ICT Patient Case Review webpage are being resolved by CSCSU which involves (i) transferring the webpage from CSCSU to the GCCG network (ii) resolving specific access issues for GPs who are designated to undertake the patient case reviews. The draft ICT service specification including associated schedules (Occupational Therapy, Physiotherapy and Community Nursing) will be reviewed as part of the GCS Service Development Improvement plan process. (August 2016)
<b>Objective 4: Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.</b>									
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.	Andrew Beard Sarah Hammond	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 2018/19 at the earliest. (August 2016)
<b>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.</b>									
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	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. (June 2016)
A3	Failure to build positive relationships with local media could impact on the ability of the CCG to promote engagement opportunities.	Anthony Dallimore, 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. (March 2017)

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
Q7	Lack of compliance with national targets for <i>C Difficile</i> and MRSA could result in a lower quality of care for some patients.	Teresa Middleton, Karyn Probert	12 (4x3)	3 (1x3)	Countywide HCAI action plan. Monthly monitoring of incidents of <i>C Difficile</i> and MRSA. Countywide HCAI Committee oversees action plan implementation and monitors progress.		Performance reports, Bimonthly <i>C Difficile</i> working group, Strategic Countywide HCAIs group.		Bi-monthly Strategic Countywide Healthcare Acquired Infections (HCAIs) Group. Ribotyping all <i>C Difficile</i> cases. Annual review of Countywide Antibiotic Formulary. Bimonthly CCG <i>C Difficile</i> working group. Regular communications with all prescribers. Involvement in sharing good practice with Area Team Workshop. Explore faecal transplantation as a method to reduce relapse of <i>C Diff</i> in patients as per NICE interventional procedures guidance (IPG) (March 2017).
C32	<b>2015/16 Impact of Care Act 2014:</b> 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 (June 2016)
C33	<b>Impact of Children &amp; Families Act 2014:</b> 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, and in preparation for Ofsted / CQC Inspection process which launches in		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 and in the preparation for inspection regime. (June 2016)
<b>Objective 6: Develop strong leadership as commissioners at all levels of the organisation, including localities.</b>									
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 2017).

**Agenda Item 13**

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Sustainability and Transformation Plan (STP) Update</b>
<b>Executive Summary</b>	This paper provides a further update from the June 2016 STP Board Paper, subsequent to the submission of the Gloucestershire draft outline STP to NHS England on 30 <sup>th</sup> June 2016. Our STP will be further refined over the summer until a final draft is prepared in the Autumn 2016.
<b>Key Issues</b>	Good progress has been made towards developing the Gloucestershire STP. The outline plan has been shared with NHS England and once feedback is received we expect to make progress towards development of the final plan by the Autumn 2016.
<b>Risk Issues: Original Risk Residual Risk</b>	The main risks currently inherent in the development of the STP are the capacity and capability of programme and project teams to deliver, and the challenge of developing a shared resources plan for Gloucestershire.
<b>Financial Impact</b>	The STP sets out a system wide resources plan for Gloucestershire for the next five years.
<b>Legal Issues (including NHS Constitution)</b>	The STP includes a commitment to ensure compliance with NHS Constitution Standards and meet the requirements set out in the national planning frameworks.
<b>Impact on Health Inequalities</b>	The STP includes a clear commitment to reduce health inequalities.
<b>Impact on Equality and Diversity</b>	The STP includes a commitment to ensure equality and value diversity and, therefore, there will be a net positive impact as a result of

	developing and implementing the plan. An equality impact assessment will be completed for the STP.
<b>Impact on Sustainable Development</b>	The STP supports sustainable development.
<b>Patient and Public Involvement</b>	Patients and the public are involved in developing the STP through the work done on Joining Up Your Care. Patient and public representatives are engaged through the stakeholder events planned as we develop the STP.
<b>Recommendation</b>	The Governing Body is asked to: <ul style="list-style-type: none"> <li>• note the submission of the Gloucestershire draft outline STP which was submitted to NHS England on 30/06/2016;</li> <li>• note the Gloucestershire STP progress update as of July 2016; and</li> <li>• note the Gloucestershire STP Board Update Slides and Community Partner Briefing appended to this paper.</li> </ul>
<b>Author</b>	Sadie Trout - Head of Planning Ellen Rule -Director of Transformation
<b>Designation</b>	See above
<b>Sponsoring Director (if not author)</b>	Ellen Rule Director of Transformation and Service Redesign

**Governing Body**

**Thursday 28<sup>th</sup> July 2016**

**Sustainability and Transformation Plan Update**

**1 Introduction**

- 1.1 The national planning guidance from NHS England tasks local systems to develop a shared system level strategic plan to set out how local systems will deliver the Five Year Forward View; the Sustainability and Transformation (STP) plan. Gloucestershire is working to a local footprint for the STP. Our system submitted an outline plan as required by the 15th April which has been shared widely across our system, and has been assessed as being a 'low risk' system. Subsequently on 30<sup>th</sup> June 2016 the draft outline STP for Gloucestershire 'One Gloucestershire – Transforming Care, Transforming Communities' was submitted to NHS England.
- 1.2 Our STP has brought together the health and care leaders in Gloucestershire to drive the delivery of improved health and care based on the needs of our local population. Together we have identified the areas that we believe can be transformed by working together in a new way, driving genuine and sustainable transformation in patient experience and health outcomes over the longer-term.
- 1.3 Our STP framework does not replace existing local bodies, or change local accountabilities - it is a shared endeavor to work together and improve future care, and this plan does not seek to capture everything we do every day in our health community to improve care. What it describes are the areas where we have agreed that working together is in the best interests of our county, and where we believe the biggest step changes can be achieved.

**2 Development and Submission of the Gloucestershire STP**

- 2.1 As described in the June 2016 Board Update Paper, the Gloucestershire STP builds on the strategic commitments set out in the joint strategy: Joining Up Your Care and responds to the three

gaps in the Five Year Forward View. Our shared transformation work programme sets out clear ambitions for radical improvement informed by national and local benchmarking, to ensure we have a sustainable health and care system for Gloucestershire – for now and for the future.

- 2.2 Following the April submission to NHS England that outlined the high level priorities and footprint response to the challenges within health and care in Gloucestershire and also provided a direction of travel for our system over the next 5 years, significant progress has been made to produce our draft outline plan. The development of the Gloucestershire STP was supported by a number of collaborative workshops and development sessions driven by our local STP governance model that led to the agreement of our local system context, shaped our key priorities and identified the enabling strategies that would be able to meet the challenges associated with the delivery of our plan.
- 2.3 Additionally, led by the countywide Resources Steering Group (RSG), the system came together to undertake a footprint review of our baseline financial position in response to the challenge of closing the ‘finance and efficiency gap’. Workshops were then held with Gloucestershire Strategic Forum members to identify the solutions that would address the gap, which have been incorporated within the financial template of STP submission.
- 2.4 The draft outline STP for Gloucestershire was submitted to NHS England on 30<sup>th</sup> June 2016. The submission of the plan was then followed by a face to face conversation with the national leadership in the NHS in July 2016. The NHS leadership will review the plan to provide a categorisation of the level of assurance and undertake a risk assessment as to the level of development and financial balance of our plan. Following this review, clarity regarding the dates of completing the full plan are anticipated; it is expected a full plan submission will be required in the autumn (2016).

### **3 Communication and Engagement**

- 3.1 A communication and engagement strategy and plan has been developed to support the STP approach, to ensure comprehensive and planned engagement and communication with interested parties

throughout the life time of the programme. As part of this plan a Gloucestershire STP branding, 'One Gloucestershire' has been developed and agreed by organisations to provide consistency and familiarisation with staff, the public and all key stakeholders.

- 3.2 The communication and engagement plans will continue to progress, taking into consideration the anticipated autumn submission of a full STP plan. During this period work is ongoing to update key stakeholders, such as the circulation of a Community Partner Briefing (attached) and develop our approach to lay membership within our STP governance model.

## **4 Leadership and Governance**

- 4.1 Our system has agreed a collaborative leadership approach for our STP, with system leaders taking ownership of key STP work programmes on behalf of partners across Gloucestershire. Each STP footprint is required to identify a formal lead; Mary Hutton (GCCG Accountable Officer) has been nominated as the Gloucestershire STP footprint lead.
- 4.2 Work is ongoing to develop the required processes and documentation to support plan delivery across our governance model, including the development of a Memorandum of Understanding (MOU), which is to be adopted across organisations. The MOU sets out the way we have agreed to work across the system, confirming the approach of sharing risk, information sharing and governance and clinical governance to support integrated working.
- 4.3 Key priority programme boards i.e. Clinical Programmes Board, will commence inaugural meetings in July and August 2016, whilst further development of our STP programme architecture is undertaken to ensure programmes have clear plans for delivery, appropriate performance reporting, and consider the Kings Fund overarching principles for integration.

## **5 Timetable**

- 5.1 The national planning guidance sets out a forward calendar of key dates. The key dates for the board to note are as follows:

<b>Timetable</b>	<b>Date</b>
Feedback from NHSE and NHSI re Assessment and Review of STPs	End July 2016
Finalise STP	Autumn 2016

## **6 Recommendations**

6.1 The Governing Body is asked to:

- note the submission of the Gloucestershire draft outline STP which was submitted to NHS England on 30/06/2016;
- note the Gloucestershire STP progress up date as of July 2016; and
- note the Gloucestershire STP Board Update Slides and Community Partner Briefing appended to this paper.

## **7 Appendices**

7.1 Appendix 1 - Community Partner E-bulletin  
Appendix 2 - Gloucestershire STP Board Update Slides

# Community Partner E-bulletin – Issue 1

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## What is the STP?

[The Five Year Forward View](#), published by the Chief Executive of the NHS, Simon Stevens, is a compelling vision and strategy for the NHS.

The vision described the opportunities and challenges facing the NHS for the future, expressed as three key ‘gaps’: the Health and Wellbeing Gap, the Care and Quality Gap and the Finance and Efficiency Gap.

In line with this, we have been developing our local five year Sustainability and Transformation Plan (STP) for Gloucestershire which is currently in outline form. It describes our overall approach to achieving an improved and more sustainable health and care system.

## The challenge

Our plan needs to help us meet a number of major challenges:

- a growing population with more complex needs
- increasing demand for services and rising public expectations
- the escalating cost of drugs and new medical technology
- retaining and recruiting enough staff with the right skills and expertise
- considerable pressure on NHS and social care finances – the health and care community is facing a financial gap of circa. £270m over the next five years unless we make radical changes to the way we deliver services and support for local people

## What do we want to achieve and how can it be done?

The long-term ambition is to have a Gloucestershire population which is:

- less dependent on health and social care services
- living in healthy, active communities and benefitting from strong networks of community services and support

- able to access consistently high quality, safe care when needed, in the right place, at the right time

In order to deliver this, we need to stay true to the principles set out in our 'Joining up your Care,' programme which was shaped by local people.

However, it is clear that if we are going to meet the growing challenges set out above, we will need to accelerate the pace of change and be even more ambitious and innovative in how we organise services and use the money and other resources available to us.

Moving forward we will need to:

- place a far greater emphasis on prevention and self-care, supported by additional investment in helping people to help themselves
- reduce variation – ensure doctors and nurses right across the county are following best clinical practice and that we always make wise decisions on use of medicines
- place a greater emphasis on joined up community-based care and support, provided in patients' own homes and in community centres, supported by specialist staff and teams when needed
- continue to bring together specialist hospital based services and resources into 'Centres of Excellence'

## **STP priority areas**

### **Enabling Active Communities**

We will work with communities to 'build capacity' – developing networks of community-based services and support and making it easier for voluntary and community agencies to work in partnership with us.

We will deliver a shared self-care and prevention plan to close the health and well-being gap. This will also address how individuals with mental health needs can access ill-health prevention screening and health support.

The STP also builds on our system's approach to social prescribing, which will mean more members of the public with non-medical needs can be referred by their GP to sources of community and social support.

We will also strengthen carer support.

Initiatives include:

- promoting healthy workplaces through the Workplace Wellbeing Charter
- adopting a range of innovative technologies to enable individuals and communities to self-care i.e. Diabetes
- working together with our local authorities leading on a programme to tackle obesity supported by Leeds Beckett University and Public Health England
- training primary schools to support the 'Daily Mile'
- supporting over 2,500 individuals through our social prescribing programme
- supporting the whole of Gloucestershire's health and social care workforce to ensure they have the skills to promote health improvement and self-care
- ensuring a range of carer services are commissioned across the county in line with the Care Act
- investing an additional £1.7 million to support our prevention and self-care plan

### **One Place, One Budget, One System**

#### **The 30,000 'Place based' model**

We will pilot a new 'Place based model' in Gloucestershire.

This is a local community model with GP practices at its core working with health, social care and the voluntary and community sector, covering populations of around 30,000 people.

Alongside this, we are also reviewing urgent care services across the county with joined up services at a local level.

The 30,000 model will be big enough to give scale e.g. input from service providers and small enough to support the feeling of a coherent community that can meet local needs and support local people.

#### **Urgent care services**

Alongside this, we are also reviewing urgent care services across the county with joined up services at a local level.

We aim to provide better support for self-care and prevention and help people with urgent care needs get the right advice in the right place, first time.

We will ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and recovery.

Our outline plan includes:

- development of our 30,000 model community pilots in areas of Gloucestershire
- further development of social prescribing (see *Enabling Active Communities*)
- development of a network of integrated urgent care centres across Gloucestershire
- development of an Urgent Care clinical hub that can provide signposting, advice and guidance to patients and book appointments
- an urgent care digital platform providing 24/7 access to service information for both the public and health and social care staff
- provision of a responsive mental health crisis service

### **The Clinical Programme Approach**

This is about developing and improving countywide, 'joined up' care pathways (the person's journey through care) so that patients receive the right advice, care and treatment at the right time.

Each Clinical Programme Group (CPG) covers a condition or group of conditions e.g. cancer, eye health.

We want to ensure patients get the right treatment when they need it, but also receive the right self-management or self-care advice and support at an early stage.

Our STP includes a focus on the respiratory care pathway. One of the reasons we are looking at it is because of the high and increasing number of respiratory hospital admissions.

Other priority areas we have identified are: Dementia, Circulatory conditions and Diabetes.

Our approach to these programmes will be informed by the learning from current pathway work.

Our outline plan includes:

- completing implementation and lessons learned from our Eye Health, Musculoskeletal (MSK) and Cancer clinical programmes
- developing and implementing the new pathways
- in the longer term, systematically reviewing key programmes of care based on best practice evidence

### **Clinical variation**

This means promoting best clinical practice by all health and care professionals working right across the county so that patients consistently receive high quality, cost effective care.

It also means using the money available for medicines wisely. This includes prioritising what is spent based on what will achieve the maximum health benefit, ensuring that the right patients get the right choice of medicines and ensuring patients take medicines correctly and avoid taking them unnecessarily.

We also want to promote conversations between clinicians and patients so that patients understand the risks, as well as the relative benefits of treatments, choose care that is evidence based and work together to reduce duplication (e.g. tests and follow up appointments).

Our outline plan includes:

- designing a new and joint 'Best use of Medicines' programme
- developing a public 'Choosing Wisely' programme covering medicines and treatment/care choices
- reviewing rates of outpatient follow up care and reviewing diagnostic provision
- carrying out reviews and learning programmes to reduce clinical variation

### **Other areas of work that support all priorities**

Our STP also sets out a number of supporting programmes we are working on to support these priorities across the health and social care community.

This includes:

- **a Quality Academy** – to support quality improvement, service development and innovation. We will deliver learning programmes, coaching, on-line resources and education materials
- **Joint IT Strategy** – development of a local digital roadmap for Gloucestershire, including a public facing website and directory of services
- **Primary Care Strategy** – to support our goal of joined up care in communities - including urgent care, help address current workforce challenges in GP practices and increase access to appointments for patients.
- **Joint Workforce Strategy** – to help develop a sustainable local health and care workforce.
- **Joint Estates Strategy** – to make the most of our estates and shared accommodation.

## What is the current status of our plan?

Our STP is currently a draft outline plan.

Following review by NHS England, we anticipate receiving clarity on dates for the full plan in July and currently expect to submit it in the autumn.

We expect to develop proposals based on STP priorities for discussion with the public over the course of the year and we will be working on a public guide to the STP this Summer to start to aid conversations.

The size of the challenge is great and we can't do it alone. We will need to work in collaboration with community partners, patients, carers and the public to develop the detailed proposals for change.

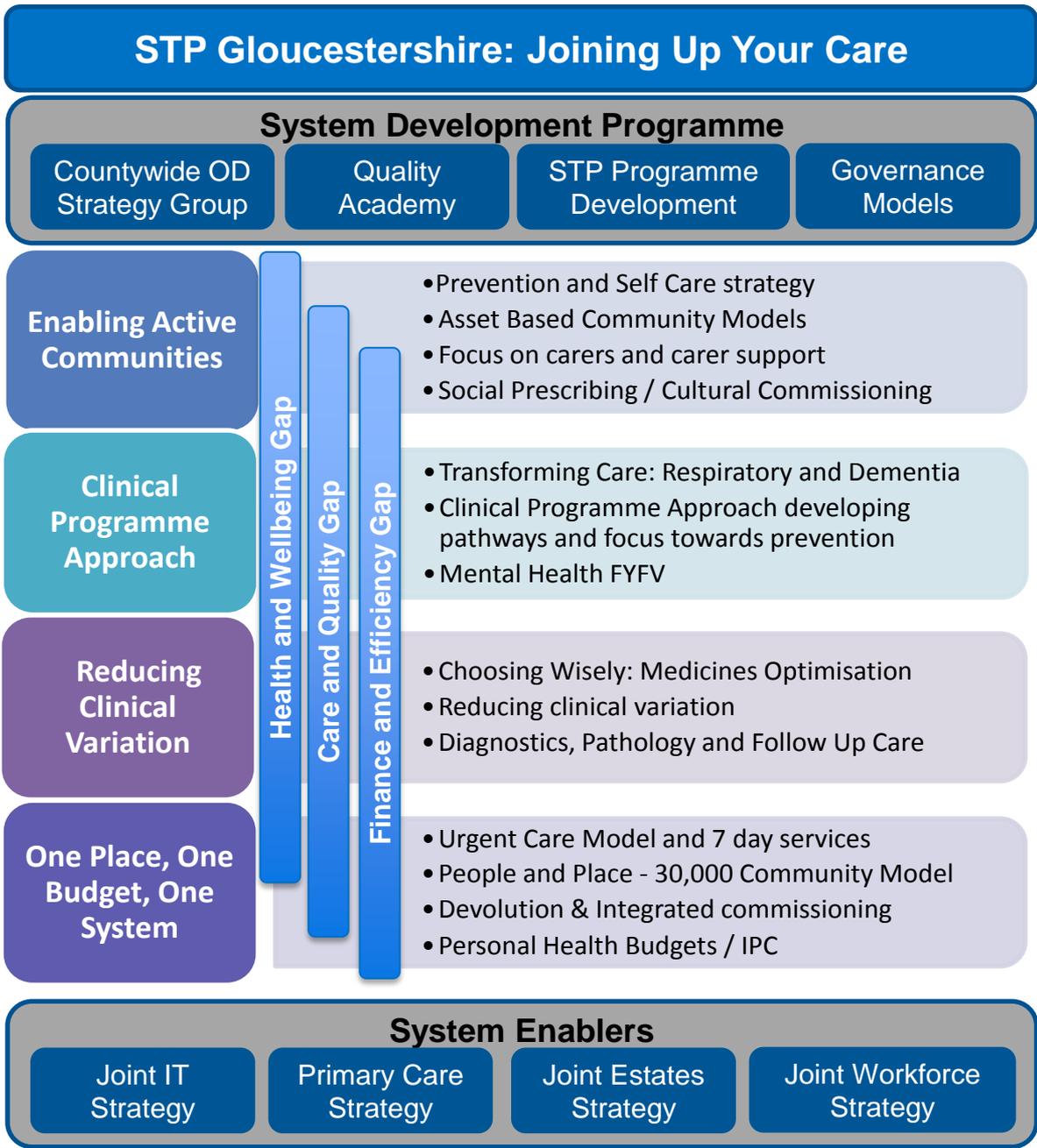
# Sustainability and Transformation Plan



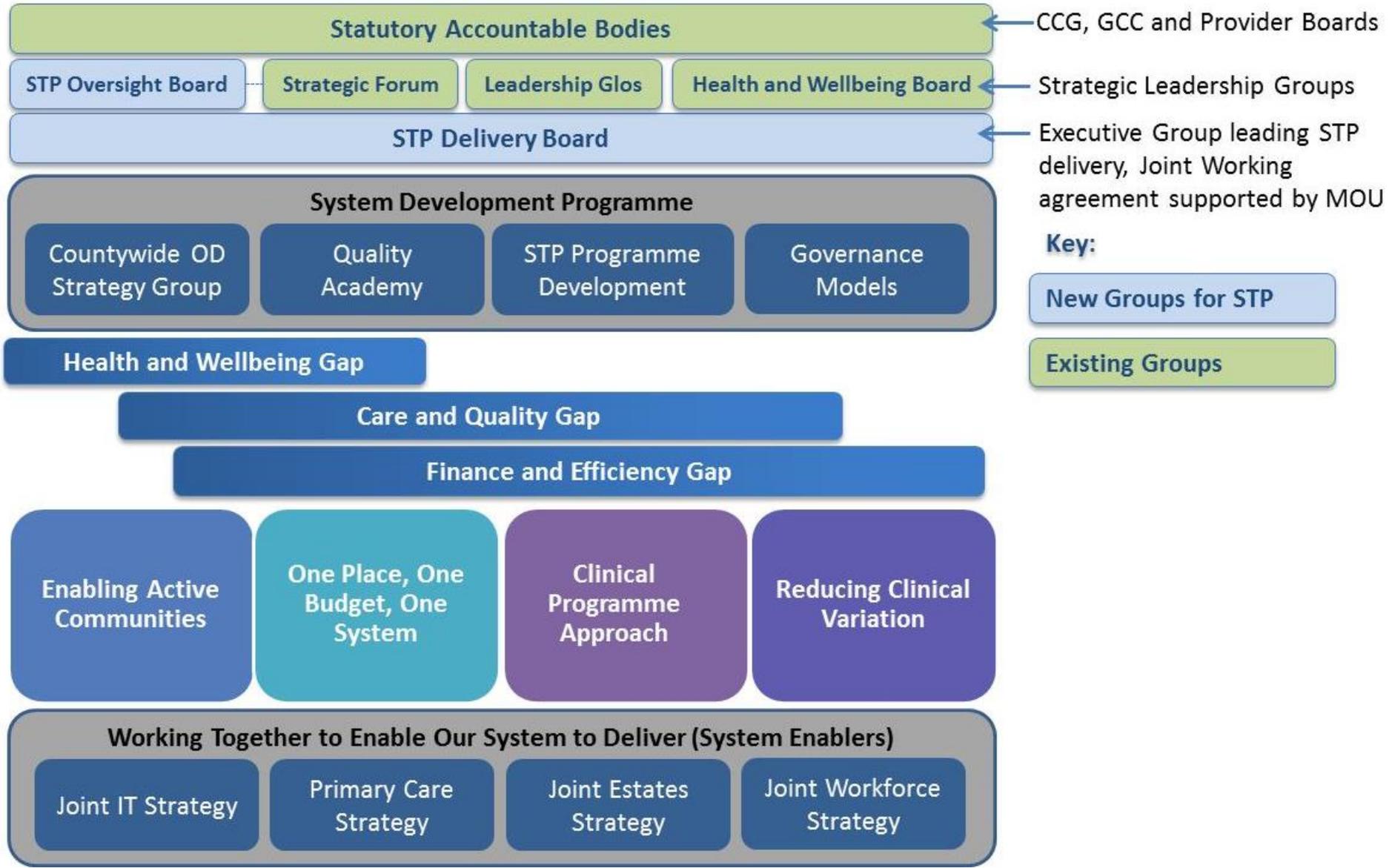
*One*  
Gloucestershire

Transforming Care, Transforming Communities

# Plan on a Page



# Governance Model



- Our STP footprint is in financial balance, but the challenge remains significant over the five year planning horizon.
- Our plan identifies opportunities to make savings across our system, split across our priority areas.
- The system is committed to owning and resolving the issues we have identified to meet the significant challenge and we are working together to agree a clear plan.
- There will inherently be additional costs in delivering change in terms of supporting service change and capacity needed to design and deliver our STP programme at scale and pace.
- Our financial programme assumes that we will invest in transformation funding across the footprint through the lifecycle of the plan.

Enabling Active Communities

- Radical Self Care and Prevention Plan

One Place, One Budget, One System

- Place Based Commissioning
- Reset Urgent care and 30,000 community Model

Clinical Programme Approach

- Reset Pathways for Dementia and Respiratory
- Deliver the Mental Health FYFV

Reducing Clinical Variation

- Choosing Wisely Medicines Optimisation
- Diagnostics Review

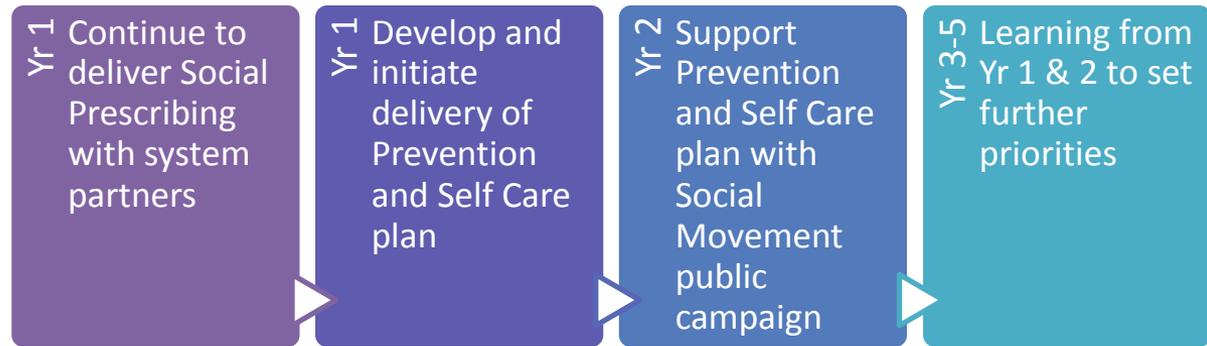
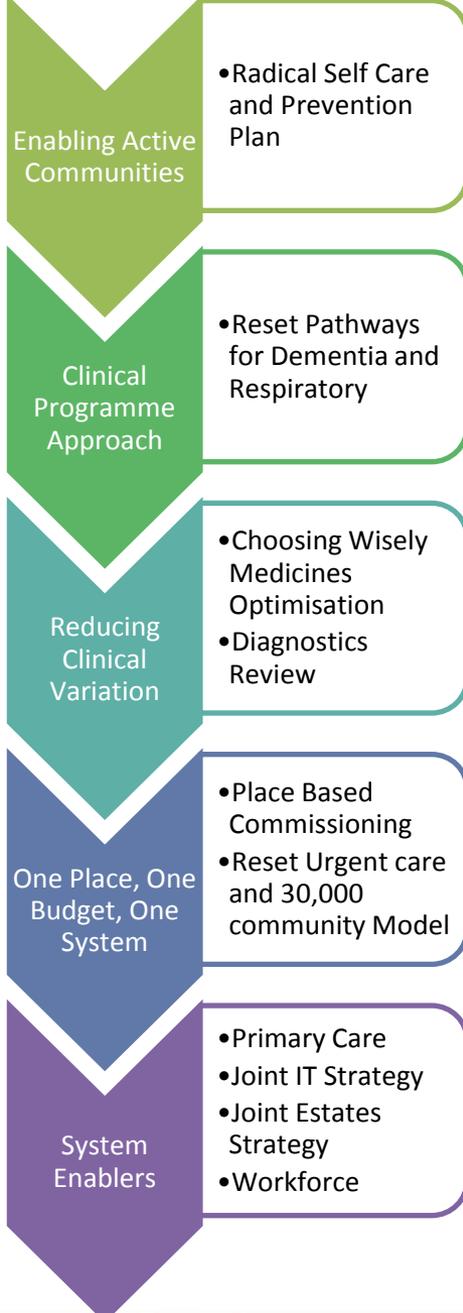
System Enablers

- Primary Care
- Joint IT Strategy
- Joint Estates Strategy
- Workforce

# Our Delivery Priorities

# Enabling Active Communities

**Enabling Active Communities** - We will develop a new sense of personal responsibility and improved independence for health, building community capacity and ensure we make it easier for voluntary and community agencies to work in partnership with us. We will use this approach to deliver a **radical Self Care and Prevention plan** to close the **Health and Wellbeing gap** in Gloucestershire



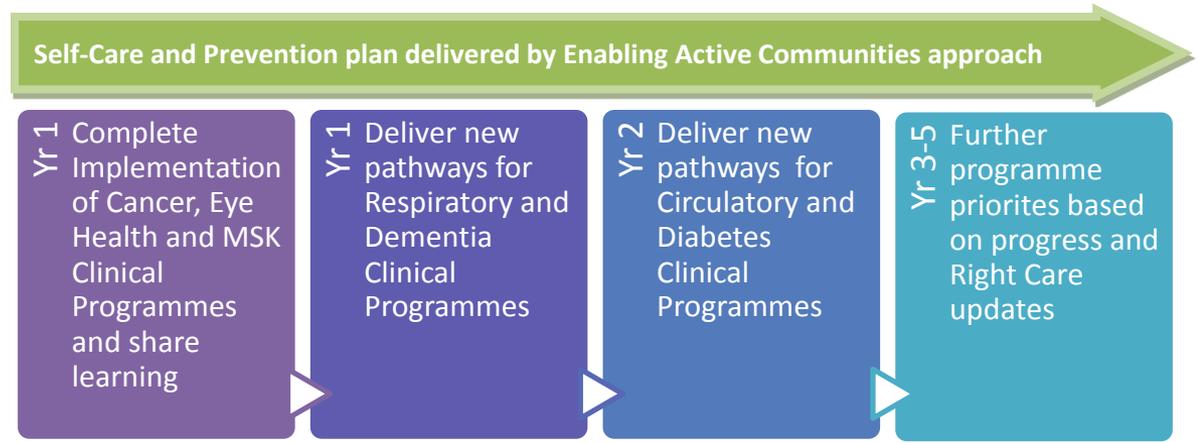
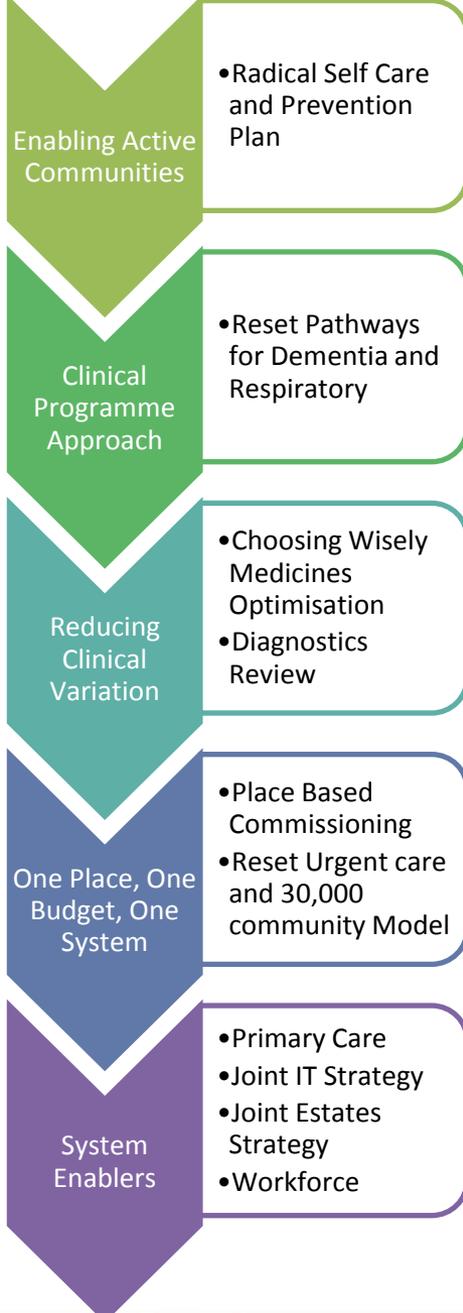
**Including:**

- Work-place Wellbeing Charter
- Whole System approach to Obesity
- Diabetes Prevention Programme – Diabetes NHSE Digital Test Bed
- Closer working with system partners and VCSE, supported by Devolution
- System to support person-led care and personalised care planning i.e. IPC

Programme Leaders: Margaret Wilcox, Linda Uren and Mary Hutton

# Clinical Programme Approach

**Clinical Programme Approach** - We will work together to **redesign pathways of care**, building on our success with Cancer, Eye Health and Musculoskeletal redesign, challenging each organisation to remove barriers to pathway delivery. Our first year will focus on delivery of new pathways for **Respiratory and Dementia** to help us close the **Care and Quality Gap**.



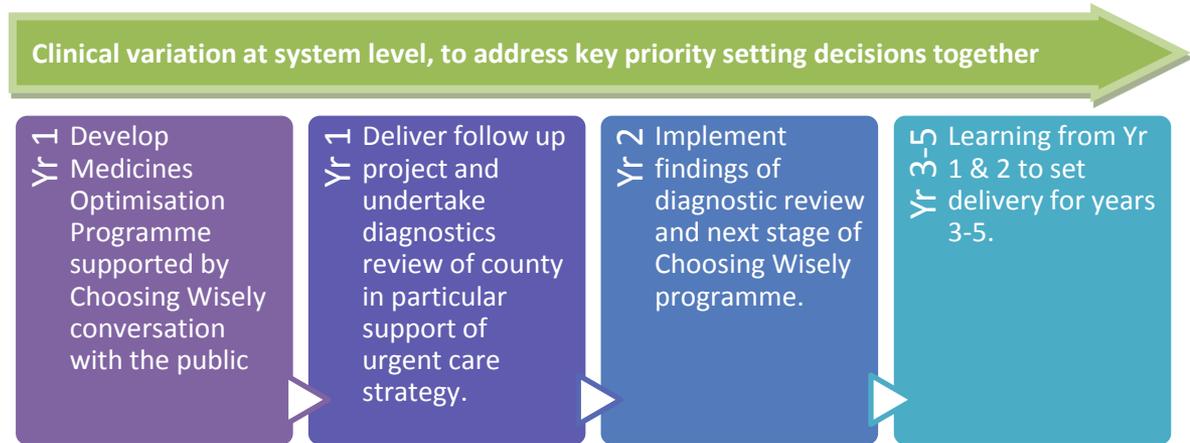
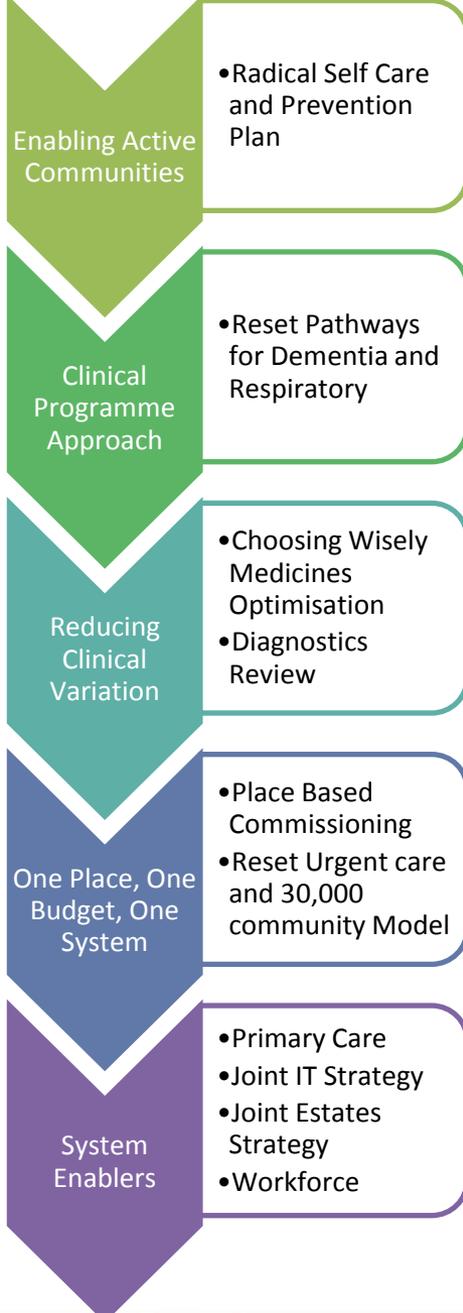
**Including:**

- Reorganising care pathways and delivery systems to deliver right care, in the right place, at the right time.
- Additional focus on ‘Designing for Delivery’
- Ensure integrated approaches across our commissioning boundaries i.e. Specialised Commissioning
- Progress the Collaborative Commissioning Processes (NHSE) and plans for delegated commissioning.

Programme Leader: Deborah Lee

# Reducing Clinical Variation

**Reducing Clinical Variation** - We will elevate key issues of clinical variation to the system level and have a new joined up conversation with the public around some of the harder priority decisions we will need to make. Our first priority will deliver a **'Choosing Wisely for Gloucestershire' Medicines Optimisation** and undertake a **Diagnostics Review**. This programme will also set the dial for our system to close the **Care and Quality Gap**.



**Including:**

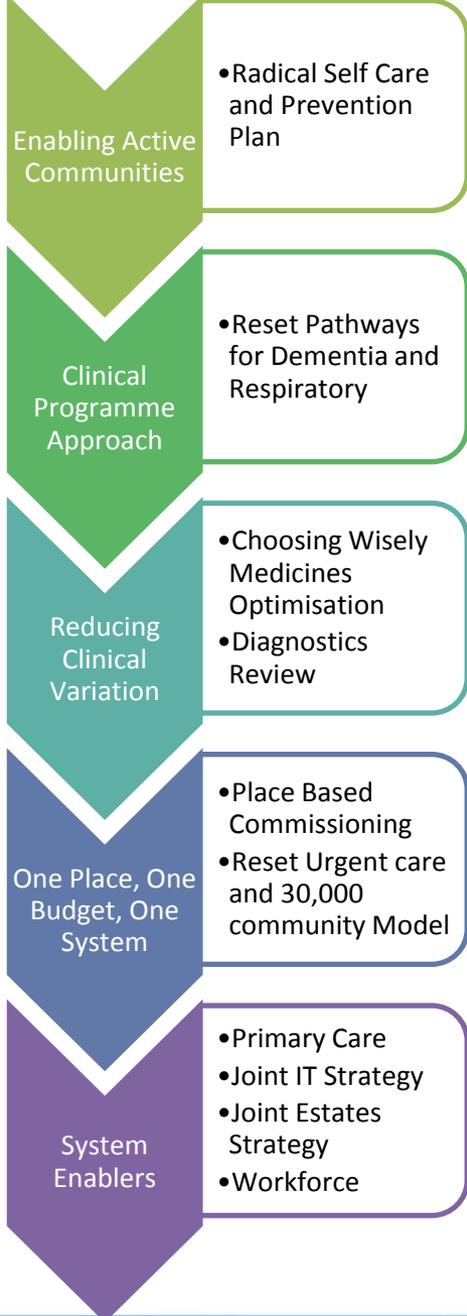
- Managing Clinical Variation in Primary Care
- New innovative medicines optimisation approach for patients living with pain
- Strengthening Clinical Pharmacist support to our local GP practices.

Programme Leaders: Paul Jennings

# One Place, One Budget, One System



**One Place, One Budget, One System** - we will take a place based approach to our resources and deliver best value for every Gloucestershire pound. Our first priority will be to **redesign our Urgent Care system and deliver our 30,000 community model**. We will take a whole system approach to beds, money and workforce to reset urgent and community care to deliver efficiently and effectively. This will ensure we close the **Finance and Efficiency Gap**, and move us towards delivery of a **new care model** for Gloucestershire.



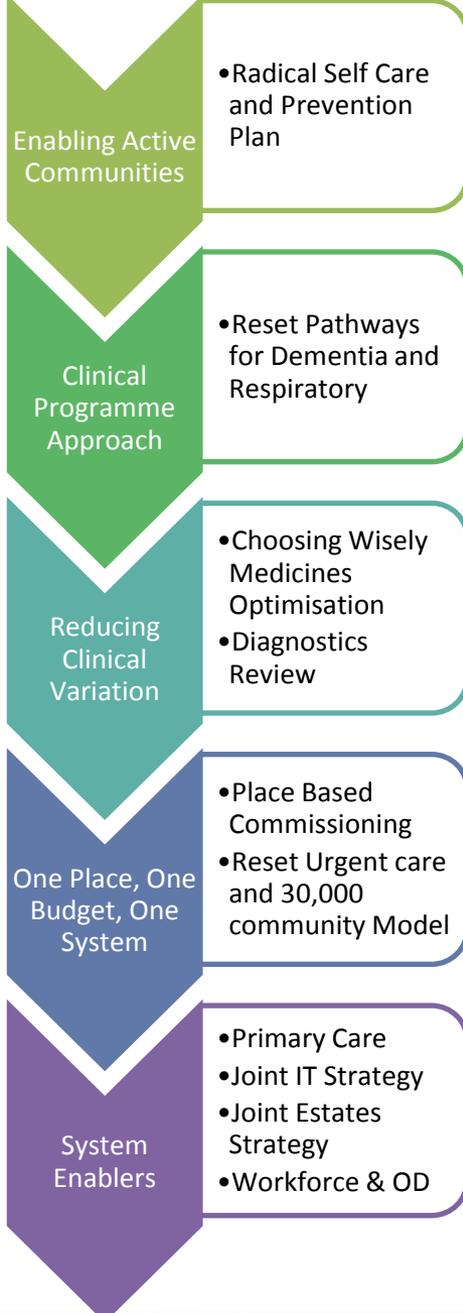
## Including:

- 7 day services across our urgent care system by 2021
- Integral part of the Severn Urgent and Emergency Care Network Plan
- Locality led New Models of Care pilots to 'test and learn'
- Design and implement models of care based upon the needs of local population across organisational boundaries.

Programme Leaders: Mary Hutton and Paul Jennings

# System Enablers

We will work together to deliver a range of **System Enablers** as follows:



- **Workforce and Organisational Development**

- Established OD and Workforce Strategy Group – representative of STP partners - developed work programme that focuses on Culture, Capability and Capacity.
- Adopting the values and behaviours agreed by the system and developing our senior leaders to model and cascade these.
- Investing in skills and leadership to support people to work in new ways.
- Agree a model for distributed leadership which supports people to lead our 12 STP priorities across the system.

Programme Leader: Shaun Clee

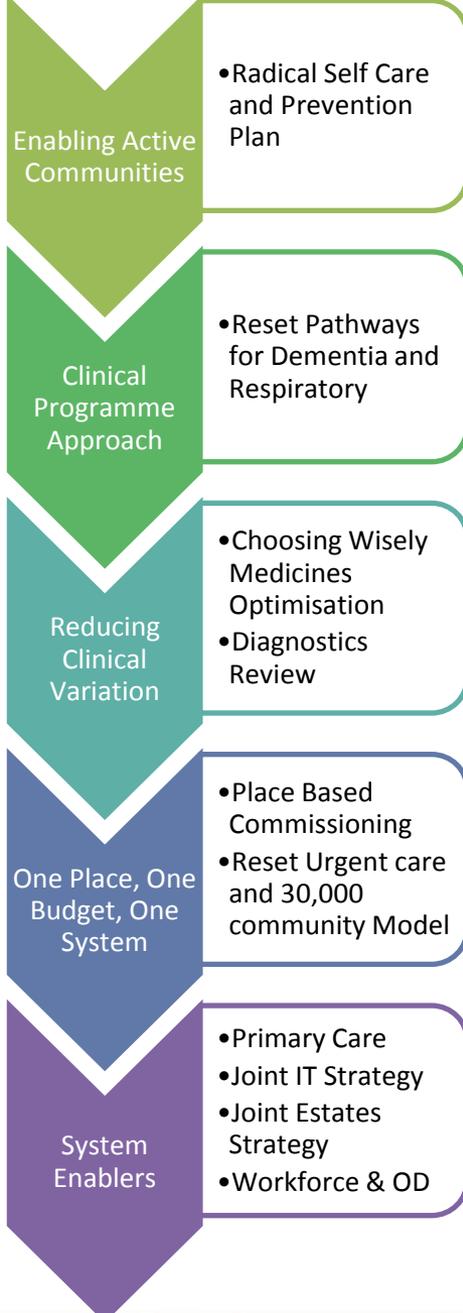
- **Quality Academy**

- A system wide approach to quality and service improvement.
- Engagement with West of England Academic Health Science Network and NHS Quality Service Improvement and Redesign College to ensure application of latest thinking.
- Support including coaching, access to on-line resources, action learning sets.
- Support Primary Care to make the transition needed as part of New Models of Care.

Programme Leaders: Deborah Lee and Shaun Clee

# System Enablers

We will work together to deliver a range of **System Enablers** as follows:



- **STP Programme Development and Governance Models**

- Sustained work with system partners, clinicians and through stakeholder engagement to inform our plan development e.g. development of shared Communications and Engagement Plan, Finance and Resource Plan and performance reporting.
- Development of Memorandum of Understanding (MOU) across our priorities including Kings Fund 10 Overarching Principles for integration.

Programme Leaders: Mary Hutton and Paul Jennings

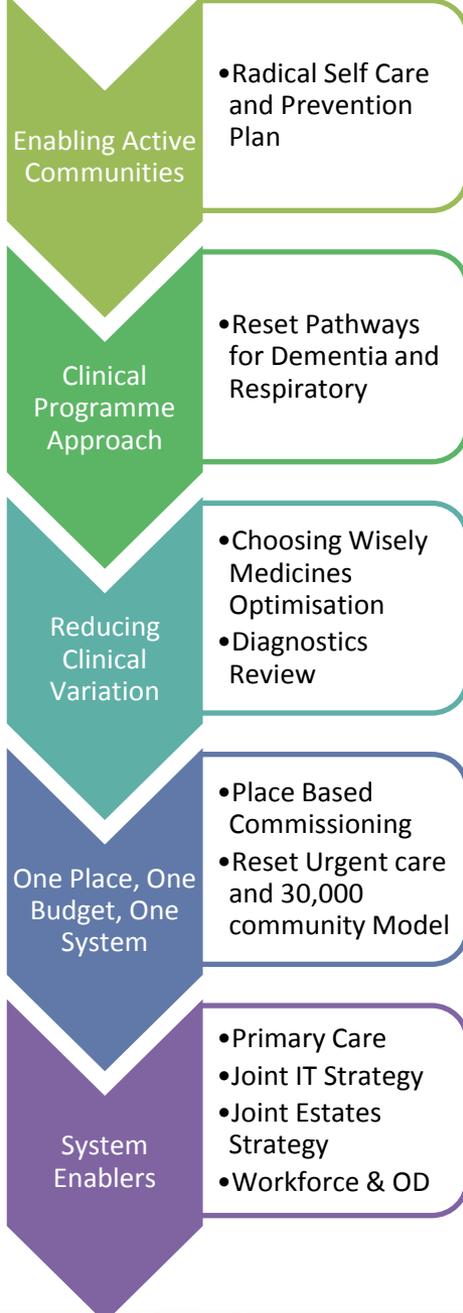
- **Joint IT Strategy**

- Local Digital Roadmap Footprint developed for Gloucestershire aligned to our STP boundary.
- Joining Up Your Information (JUYI)
- Digitally enabling people to support our Self Care Agenda.
- Support staff in the adoption of new technologies and utilise data to support commissioning. Using technology to support more efficient working.
- Working towards a paper free NHS by 2020.

Programme Leader: Shaun Clee

# System Enablers

We will work together to deliver a range of **System Enablers** as follows:



- **Primary Care Strategy**

- Developing a resilient primary care sector that supports joined up care closer to home.
- Support to primary care workforce and infrastructure, offer increased access for patients, how primary care will work more collaboratively at scale.

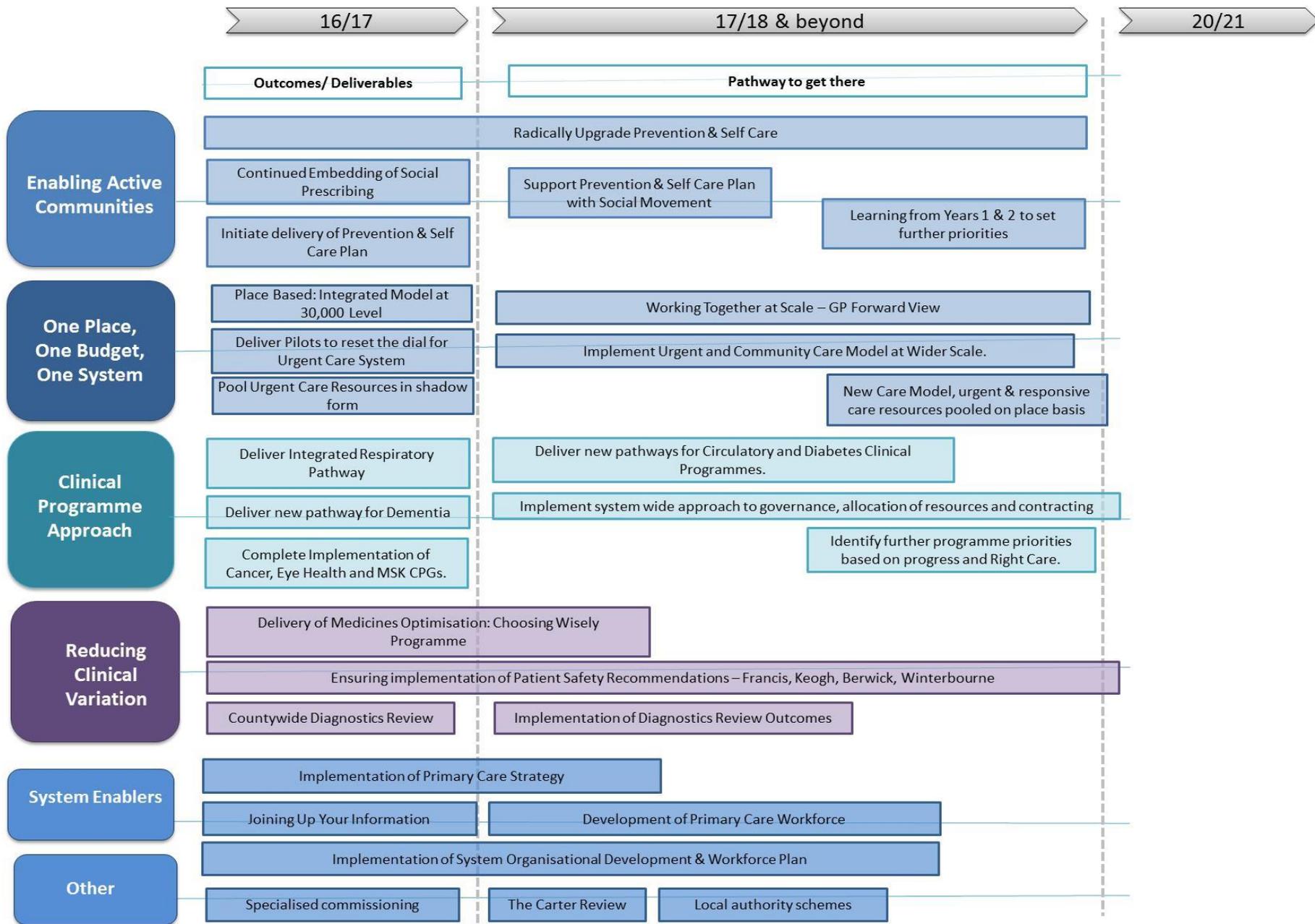
Programme Leader: Andy Seymour

- **Joint Estates Strategy**

- One Gloucestershire Estates Group established, including:
  - County and District Councils
  - Police, Fire and Ambulance Services
  - Gloucestershire Hospitals NHS Foundation Trust
  - Gloucestershire Care Services
  - 2Gether NHS Foundation Trust
  - Gloucestershire Clinical Commissioning Group
- Utilising opportunities to better utilise public sector assets across the wider estate within the county – develop a wider strategy across the Gloucestershire estate.
- Primary Care Infrastructure Plan 2016/2021 developed – key priorities for developing new models of care.

Programme Leader: Pete Bungard

# Implementation Plan



**Governing Body**

<b>Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>General Practice Forward View Investment Plan</b>
<b>Executive Summary</b>	<p><b>Introduction</b> This paper provides an update on our response to the General Practice Forward View and supports the 30,000 place-based model.</p> <p><b>Background</b> We are currently developing our Primary Care Strategy, which reflects the ambitions within the Five Year Forward View and the more recent General Practice Forward View, along with our local Sustainability and Transformation Plan (STP).</p> <p>The General Practice Forward View sets out a range of investment in primary care and makes a commitment that CCGs will provide £171 million of practice transformational support.</p> <p>GCCG has responded to this, in support of both the Primary Care Strategy and our STP, by inviting all practices to collaborate into groups, or “clusters”, with a total registered list size of 30,000 patients or more to develop an expression of interest for innovative, transformative ideas that improve patient outcomes along with the sustainability of primary care and the wider Gloucestershire health economy. We have a proposed funding value of £1.2 million, representing approximately £2 per head of population.</p> <p>In addition, we also asked localities for</p>

nominations for a GP Forward View Workstream, who had the mandate from the locality to represent primary care within the New Models of Care Board.

These GPs have been instrumental in bringing together their localities to form 'clusters' of 30,000+ patients.

**Our clusters and their submissions**

<b>Locality</b>	<b>Collaborations</b>
<b>Cheltenham</b>	Three clusters based on geography (c. 50,000 patients each)
<b>Forest of Dean</b>	All eleven practices in one cluster (c. 60,000 patients)
<b>Gloucester City</b>	Four clusters predominantly based on geography (c.31,000 – 52,000 patients each)
<b>North Cotswold</b>	All five practices in one cluster (c. 29,000 patients)
<b>South Cotswold</b>	All eight practices in one cluster (c. 58,000 patients)
<b>Stroud &amp; Berkeley Vale</b>	Four clusters based on geography (c. 18,000 – 39,000 patients each)
<b>Tewkesbury, Newent and Staunton</b>	All four practices within one cluster (c. 43,000)
<b>Total</b>	15 clusters

This has represented a significant amount of effort in a short period and has provided the stimulus for practices to start working together

	<p>‘at scale’.</p> <p>We have so far received 14 bids from these 15 clusters. They can be broadly categorised into three themes:</p> <ul style="list-style-type: none"> <li>• clinical pharmacists in primary care;</li> <li>• urgent care; and</li> <li>• frailty provision</li> </ul> <p>For inner-city Gloucester, mental health workers also feature as part of their proposed scheme.</p> <p>Common across the clusters has been an ambition within their ideas to keep patients at home, improve quality and safety and as a result reduce spend across the healthcare system.</p> <p>To ensure we maintain the momentum with these clusters and to capitalise on the excellent work so far, we are seeking delegated authority from the Governing Body to the following members of staff to approve the individual schemes:</p> <ul style="list-style-type: none"> <li>• Accountable Officer;</li> <li>• Chief Finance Officer;</li> <li>• Audit Committee Chair and Lay Member for Governance; and</li> <li>• Primary Care Commissioning Committee Chair.</li> </ul> <p>The schemes are firmly placed within our ambitions for place-based care and provide the foundations for developing new models of care across the county.</p>
<b>Key Issues</b>	<p>Two of our practices are yet to be included within a cluster. GCCG Primary Care and Localities Directorate and the GP lead are</p>

	<p>working to resolve this.</p> <p>One cluster has yet to submit a bid, which is in development.</p>
<p><b>Risk Issues:</b>  <b>Original Risk</b>  <b>Residual Risk</b></p>	<p>It is essential we do not lose momentum at this point. We therefore require delegated authority to avoid the risk of practices and clusters disengaging due to time delays.</p>
<p><b>Financial Impact</b></p>	<p>The £1.2m will be identified from existing budgets reprioritised to drive the transformation agenda as per our commitment to delivering the General Practice Forward View.</p>
<p><b>Legal Issues (including NHS Constitution)</b></p>	<p>There are no known legal issues at this time.</p> <p>These bids, and our approach to delivering place-based care, particularly reinforces our support to the fifth of the seven key principles in the NHS constitution regarding working in partnership and across organisational boundaries in the interests of patients, local communities and the wider population. In addition, the right for patients to expect assessment of health requirements locally and to commission services accordingly.</p>
<p><b>Impact on Health Inequalities</b></p>	<p>Inherent within the place-based approach is the identification of health inequalities at a local level and devising plans to mitigate these. This has already started within these clusters and will only develop further as they mature.</p>
<p><b>Impact on Equality and Diversity</b></p>	<p>No known issues</p>
<p><b>Impact on Sustainable Development</b></p>	<p>Providing enhanced primary care provision locally will result in less travel for patients to acute sites.</p>
<p><b>Patient and Public Involvement</b></p>	<p>Where schemes result in locally different services, patient engagement will be undertaken by those clusters. This has already been identified and clusters will work with GCCG Patient Engagement and Experience team in achieving this.</p>

<b>Recommendation</b>	<p>The Governing Body is asked to delegate authority for approval of the schemes to the:</p> <ul style="list-style-type: none"> <li>• Accountable Officer;</li> <li>• Chief Finance Officer;</li> <li>• Audit Committee Chair and Lay Member for Governance; and</li> <li>• Primary Care Commissioning Committee Chair.</li> </ul>
<b>Author</b>	Bronwyn Barnes Stephen Rudd
<b>Designation</b>	Programme Manager, Primary Care, Localities and Variation Head of Primary and Locality Development
<b>Sponsoring Director (if not author)</b>	Helen Goodey Director Locality Development and Primary Care

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>West of England Academic Health Science Network Board Report</b>
<b>Executive Summary</b>	The attached document is the twelfth quarterly report produced by the West of England Academic Health Science Network.
<b>Key Issues</b>	The following key issues are referred to in the report: <ul style="list-style-type: none"> <li>• Quarter 1 highlights;</li> <li>• Sustainability and Transformation Plans;</li> <li>• Annual Report 2015/16;</li> <li>• Stakeholder Survey; and</li> <li>• West of England Local Clinical Research Network.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	None
<b>Financial Impact</b>	None
<b>Legal Issues (including NHS Constitution)</b>	None
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note this report which is provided for information.
<b>Author</b>	Deborah Evans
<b>Designation</b>	WEAHSN Managing Director
<b>Sponsoring Director (if not author)</b>	Mary Hutton Accountable Officer

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## Report from West of England Academic Health Science Network Board,

13 June 2016

### 1. Purpose

This is the twelfth 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](http://www.weahsn.net) for information.

### 2. Highlights of our work in Quarter 1 2016/17

We have had the usual busy start to the year and highlights include:

- We have launched our Primary Care Patient Safety Collaborative – with 16 GP practices drawn from across the West of England. We will work together on patient safety culture, quality improvement, incident reporting and lessons learnt
- Our acute trusts joined by Taunton and Somerset NHS Trust are keen to work together with us to implement the forthcoming national programme on a structured approach to hospital mortality review and to share best practice. Dr Kevin Stewart of the Royal College of Physicians addressed our launch workshop.
- “Design Together, Live Better 2” – our innovation crowd sourcing programme is underway following a highly successful launch event in Swindon attended by 55 people.
- Our Diabetes Digital coach test bed is underway. Over the next two years we will recruit 12,000 people with diabetes in the West of England and encourage them to use a variety of digital self-management tools to support their self-care.
- We have 52 Improvement Coaches currently in training drawn from 20 of our member organisations. The aim is to develop staff who already have skills in improvement science so that they can coach colleagues and lead quality improvement at work. The Improvement Coach training is being supplemented by masterclasses. The first one “The Habits of an Improver” was given by Bill Lucas. Watch the film here <http://www.weahsn.net/news/the-habits-of-an-improver/>
- In partnership with Avon Primary Care Research Collaborative and the NIHR Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC west) we have developed online evidence and evaluation toolkits <http://www.weahsn.net/what-we-do/using-evidence-based-healthcare/evidence-and-evaluation-toolkits/> We are offering training session on using the toolkits in every CCG.
- We have formed an Emergency Department Safety Collaborative to support rollout of the ED safety checklist across the West of England. We also held a master class on 25 April which was attended by 22 delegates from Emergency Departments across the country.

- Improving Medicines Safety on discharge from hospital - three of our acute trusts are using a system called PharmaOutcomes to notify community pharmacists when a patients medication has been changed in hospital so that waste can be avoided. We will go on to introduce medicines reviews which may reduce re-admissions to hospital.

### **3. Sustainability and transformation plans**

The AHSN has allocated Anna Burhouse, Natasha Swinscoe and Deborah Evans to work with the Chief Executive leaders of the Sustainability and Transformation Plans for Gloucestershire, BNSSG and BaNES, Swindon and Wiltshire respectively. We are working with the STPs to define our support offer to each of them.

### **4. Annual Report 2015/16**

Our Annual Report is out! Read it here. <http://www.weahsn.net/who-we-are/reports/annual-report-2015-16/> The Year in Numbers is attached to this report.

### **5. Stakeholder survey**

The second annual AHSN stakeholder survey is due to be released late June / early July. Last year we had over 120 responses; the highest amongst AHSNs and the most positive responses. This reflects the very strong engagement we have with all CCGs, NHS Trusts and social enterprises across the West of England and the strength of our partnerships.

This year's results will count towards our "re-licencing" for the five years so we will be looking forward to a very a strong response and will contact stakeholders once the timetable is confirmed

### **6. West of England Local Clinical Research Network**

We are working ever more closely with the NIHR West of England Local Clinical Research Network whose job is to increase the numbers of patients enrolled in research trials.

We have a joint "Join Dementia Research" project through which we have recruited 1,500 West of England residents to take part in dementia studies.

**Deborah Evans,  
Managing Director  
June 2016**

# The year in numbers

**1,606**

1,606 clinical and non-clinical staff took part in patient safety, informatics and quality improvement events on key themes, including sepsis, falls prevention, medicines optimisation, early warning score, and emergency laparotomy.

**£2.1 million**

Our new Diabetes Digital Coach Test Bed is receiving £1.65 million in funding from the Department of Health, with further funding from our partner companies taking the project value over £2 million.



**6**

Working with Royal United Hospitals Bath, the Health Foundation and Sheffield Microcoaching Academy, we have trained six local clinicians and managers in improving patient flow across three care pathways.

**26**

26 different organisations are actively involved in our Safer Care Through Early Warning Scores programme.



**20**

Up to 20 primary care practices are joining our new Primary Care Collaborative.



**40,000**

Since its launch, OpenPrescribing.net has attracted 40,000 visitors.



**116**

116 healthcare professionals have benefitted from advanced skills-based training to enhance leadership, patient safety and flow, innovation and evaluation.



**85%**

In our stakeholder survey, 85% of our members believe we are effective at building a culture of partnership and collaboration.



**52**

52 primary care practices in Gloucestershire are taking part in phase two of Don't Wait to Anticoagulate.



**4**

Four new websites were launched to support NHS commissioners and clinicians: OpenPrescribing, Don't Wait to Anticoagulate, Evaluation and Evidence Works.



**291**

We have given advice to 291 companies wanting to work with the health sector, providing 154 business assists.



**£9.5 million**

To date, we have helped secure £9.5 million in funding for SMEs for the development of innovative healthcare solutions.



**133**

133 atrial fibrillation (AF) patients are now being anticoagulated as a result of phase one of Don't Wait to Anticoagulate, which worked with 11 primary care practices over four months. Modelling shows this saved between five and seven strokes and up to £163,205.



**100+**

More than 100 people participated in the Design Together, Live Better project to share their ideas for new healthcare innovations.

**1,400**

Join Dementia Research recruited 1,400 people across the West of England in its launch year.



**137,315**

To date, 137,315 patients have benefitted from having their Connecting Care record viewed by clinicians.



**29**

29 of our initiatives have influenced and informed national thinking and guidance.



**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Integrated Governance and Quality Committee (IGQC) minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the IGQC meeting held on the 21 <sup>st</sup> April 2016.
<b>Key Issues</b>	<p>The following principal issues were discussed:</p> <ul style="list-style-type: none"> <li>• Fractured Neck of Femur;</li> <li>• Risk Register</li> <li>• Assurance Framework;</li> <li>• Policies;</li> <li>• Information Governance update;</li> <li>• Learning Disability Mortality;</li> <li>• National Maternity Services Review;</li> <li>• Experience and Engagement Report;</li> <li>• Quality Report; and</li> <li>• Primary Care Quality report.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.

<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Julie Clatworthy IGQC Chair and Registered Nurse

**Integrated Governance and Quality Committee (IGQC)**

**Minutes of the meeting held on  
Thursday 21<sup>st</sup> April 2016, Board Room, Sanger House**

<b>Present:</b>		
Julie Clatworthy	JC	Chair
Dr Charles Buckley	CBu	GP Liaison Lead – Stroud Locality
Dr Caroline Bennett	CBe	GP Liaison Lead – North Cotswold
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Colin Greaves	CG	Lay Member – Governance
Cath Leech	CL	Chief Finance Officer
Mark Walkingshaw	MW	Director of Commissioning Implementation
Valerie Webb	VW	Lay Member – Business

<b>In Attendance:</b>		
Dr Will Haynes (Item 5)	WH	GP Liaison Lead – Gloucester
Caroline Smith	CS	Senior Manager Engagement and Inclusion
Helen Ford	HF	Senior Commissioning Manager
Cate White	CW	Project and Business Manager Quality Team
Fazila Tagari	FT	Board Administrator

**1. Apologies for Absence**

1.1 Apologies were received from Alan Elkin, Dr Helen Miller, Mary Hutton and Sarah Scott.

**2. Declarations of Interest**

2.1 There were no declarations of interest received.

**3. Minutes of the meeting held on 3<sup>rd</sup> March 2016**

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

- Section 12.8.1 to be amended to read ‘JC

*requested that Section 5.1 stated who the Accountable Emergency Officer was accountable to and requested that the job title was also specified.'*

#### **4. Matters Arising**

##### **4.1 IGQC115 Safeguarding Children Policy**

MAE agreed that she would discuss the action relating to the national guidance with Helen Chrystal.

##### **4.2 IGQC139 and IGQC140 Sustainable Development Policy**

MAE advised that the feedback had been forwarded to Georgina Smith to consider. However, it was noted that her employment contract had been terminated by GCS and that the CCG had negotiated an independent contract agreement with Georgina. **Item Closed.**

##### **4.3 IGQC144 Experience and Engagement Report**

MAE advised that the national guidance had been issued relating to primary care engagement and that BP had considered the issues from the report.

##### **4.4 IGQC146 Quality Report**

The Clinical Effectiveness Group Terms of Reference were covered under the Quality Report. **Item Closed.**

##### **4.5 IGQC150 Quality Report**

The Royal College of Surgeons report on fractured neck of femur was being discussed under the Fractured Neck of Femur update. **Item Closed.**

##### **4.6 IGQC156 Quality Report**

The Southern Health Mazars review was covered under the Quality Report. **Item Closed.**

##### **4.7 IGQC157 Quality Report**

The details regarding the Serious Incident involving the Gloucestershire Diabetic Eye Screening programme was covered under the Quality Report. **Item Closed.**

##### **4.8 IGQC158 Quality Report**

Updates regarding the Transforming Care workstream had been circulated. **Item Closed.**

4.9 **IGQC159 Quality Report**

An update regarding the seasonal flu campaign was being arranged for the June 2016 meeting.

4.10 **IGQC160 CQC Inspection Report – 2gether Trust**

It was confirmed that a formal letter of congratulation was sent to 2gether. **Item Closed.**

4.11 **IGQC161 Knee Arthroscopy and Irrigation**

MW advised that the source of evidence and the number of patients undergoing this procedure had been confirmed and included within the revised policy. **Item Closed.**

5. **Fractured Neck of Femur**

5.1 WH provided a verbal update regarding fractured neck of femur and provided a brief overview of the issues. Gloucestershire is a national outlier from the National Audit Office (NAO) hip fracture database.

5.2 WH highlighted that Gloucestershire had been identified as the national outlier for mortality within 28 days for fractured neck of femur. However, issues such as co-morbidity needed to be considered.

5.3 It was noted that GHFT had invited the Royal College of Surgeons to see if they could offer an independent review of the service and that actions plans had been established in response to their report. The report had not been shared with IGQC.

5.4 WH advised that the CCG had also arranged a workshop which included representations from GHFT and SWASFT. WH stated that a conference call with Watford Hospital was undertaken as they had been a national outlier and had made significant improvements, and the CCG was keen to learn from them.

- 5.5 WH articulated that the time between a fall resulting in a fracture and the operation was a critical period although there were inconsistent views regarding the time on which to operate on fractured neck of femur patients particularly if they were not medically fit.
- 5.6 WH advised that high quality anaesthetic care was crucial to the effective management of patient care and appropriate mobilisation. Anaesthetic changes to improve the outcomes were being put in place as well as improved core training opportunities. The rates of nerve-block provision were seen as a significant success. WH suggested that other areas of improvement included the coordination of the process of care in the hospitals.
- 5.7 Members noted that the elderly care team, (orthogeriatrics), were vital to the process. WH advised that one member from this team had resigned and that there were difficulties recruiting to this position.
- 5.8 WH also advised that generally most Trusts did not operate at two different sites and therefore this could be an element to consider. However, the primary factor in reducing mortality was the speed of surgical intervention.
- 5.9 JC queried if the two sites were integrated as one team although they operated on two sites. WH advised that there were variances between the two sites but these were partly by design i.e. one site operated for 24 hours.
- 5.10 VW queried if the process was duplicated at both sites and was advised that it was to a certain extent.
- 5.11 CBu sought assurance that a robust action plan had been developed and that there was a real commitment to improve outcomes. WH suggested that a further workshop was arranged and that the action plan was monitored by the CCG.
- 5.12 CBe advised that a Clinical Quality Review Group

meeting was held to focus on fractured neck of femur and voiced disappointment with the lack of clinical representations from GHFT at the meeting.

- 5.13 JC considered that CCG should receive the Royal College of Surgeons report and the associated action plan. CG felt that this should be formally escalated at a senior level.
- 5.14 WH advised that the new chief executive would be commencing her role shortly and felt that this could be a potential opportunity to highlight this matter.
- 5.15 WH also felt that there should be a mechanism to flag issues at a senior level systematically.
- 5.16 MW questioned what the next steps were if there was insufficient assurance on the plans. JC queried if there were any contractual or quality levers to address the situation. CBu stated that robust milestones were required in the action plan in order to benchmark progress effectively.
- 5.17 The committee questioned if the CCG quality powers could be exercised and if a quality summit should be held. MAE agreed that she would confirm this. MAE
- 5.18 CG suggested that the newly appointed Clinical Chair could include areas of concerns in his open letter to the providers.
- 5.19 **RECOMMENDATION: The Committee noted the verbal update; recommended that Fracture Neck of Femurs risk rating was reassessed for the CCG Risk Register and a report should be provided to the Governing Body.**

*WH left at 9.50*

## **6. Risk Register**

- 6.1 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.

- 6.2 The Risk Register comprised a total of 45 risks, five of which were graded as 'red' as outlined in Appendix 1. In addition, the Committee was asked to consider the closure of two further risks.
- 6.3 JC requested an update regarding Risk No T13 which related to specialised services for children and young people with mental health problems. MW advised that pressure was being placed on specialised commissioners and that additional arrangements were being made to review cases as and when they emerge. MW emphasised that it should be recognised that this was reliant on specialised commissioners procuring additional capacity. Members voiced disappointment regarding the upward movement of the risk rating in relation to this risk.
- 6.4 JC requested an update regarding Risk No C6 relating to the Emergency Department 4 hour wait. MW advised that there had been a series of actions which had been undertaken to improve performance. Actions included Monitor re-opening their investigation, a risk summit being held and the appointment of an improvement director. The CCG was also providing support to address any system issues.
- 6.5 JC highlighted Risk No C18 relating to the Individual Funding Request (IFR) Policy and felt that the rating was too low, particularly as these were open to legal challenge. CBU advised that there had been an effective process to ensure that policies were developed with engagement from the secondary care clinicians in order that it was developed with clinical evidence.
- 6.6 MW provided an update regarding Risk No C28 relating to admission avoidance and noted that this was red due to information still being awaited.
- 6.7 The Committee requested that a brief narrative of the AP

red risks was outlined in future reports.

- 6.8 JC queried if Risk No A2 relating to building positive relationships with key local stakeholders should be reassessed following CCG's 360° survey. AP agreed to raise with MH. AP
- 6.9 It was agreed that the rating for Risk No Q17 relating to the mortality rates for fractured neck of femur would be reviewed. MAE
- 6.10 **RECOMMENDATION: The Committee:**
- reviewed the paper and the attached Risk Register; and
  - approved the deletion of the two risks (Risk Nos L5 and Q11) detailed on Appendix 2.

## 7. Assurance Framework

- 7.1 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 was taken as read.
- 7.2 **RECOMMENDATION: The Committee noted this paper and the attached Assurance Framework.**

## 8. Policies for Approval

### 8.1 Annual Leave

- 8.1.1 AP presented the Annual Leave Policy and advised that the policy adhered to national guidance. The policy had been considered by the Joint Staff Consultative Committee, Policy Working Group and the Core Leadership meeting.
- 8.1.2 JC queried section 4.5 relating to cancellation of leave and suggested if it should include responsibility to respond to service pressures. AP agreed to review this

section.

8.1.3 JC requested that the annual leave entitlement was explicit to state that agency staff or interims were excluded from this entitlement. AP agreed to liaise with HR.

8.1.4 CG drew attention to section 4.1 relating to allocation and stated that staff were entitled to request annual leave greater than three weeks. MW clarified that this related to block of three weeks and agreed that this would be coherent in the policy.

**8.1.5 RECOMMENDATION: The Committee approved the Policy subject to the changes above.**

## **8.2 Travel and Expenses**

8.2.1 AP presented the Travel and Expenses Policy and advised that the policy was based on national guidance. The policy had been considered by the Joint Staff Consultative Committee, Policy Working Group and the Core Leadership meeting.

8.2.2 JC queried if the road safety policy linked with the Health and Safety policy. AP advised that the Health and Safety Policy was currently being reviewed.

8.2.3 JC enquired about the procedure for journeys where their base was their home. It was agreed that AP would confirm the eligibility requirements with HR for Governing Body members and clarify the position. AP

**8.2.4 RECOMMENDATION: The Committee approved the Policy subject to the changes above**

## **9. Information Governance Update**

9.1 CL presented the paper which provided an update on the organisation's information governance arrangements. The paper was taken as read.

9.2 It was noted that the IG toolkit had been submitted and

that the CCG was showing strong achievement of level two.

- 9.3 CL advised that the training requirements for the following year were being reviewed as it was considered that the current approach was not fully effective. It was proposed that the face to face IG training would be delivered through teams in order to be more targeted to the department.
- 9.4 CL advised that the records management audit had been completed and that training sessions were being proposed to be held in April 2016.
- 9.5 Members noted that the countywide IG Group was monitoring the Joining Up Your Information project and any information sharing agreements.
- 9.6 CBu understood that there were potential IG issues with the SmartCare programme in terms of the JUYI project. CL understood that there was an issue with capacity and that this was being addressed.
- 9.7 CG sought assurance that the security of the website was robust against malicious attack. CL advised that a review was being undertaken on the hosting and management of the website including cost effectiveness.
- 9.8 CG also sought assurance following the recent data breach and if this would inform the IG training going forward. CL confirmed that a full review had been undertaken which included modifying the mandatory training requirements.
- 9.9 **RECOMMENDATION: The Committee:**
- **noted the notes from the Information Governance Group meeting;**
  - **noted from the Gloucestershire Information Governance Working Group; and**
  - **noted the contents of this report.**

## **10. Learning Disability Mortality Briefing**

- 10.1 MAE presented the briefing report which provided an update on the work being undertaken nationally around mortality rates for people with learning disabilities. The paper was taken as read.
- 10.2 CBU advised that GP practices held a register for patients who were identified as having a learning disability.
- 10.3 MAE advised that Gloucestershire was a pilot site and was working with Bristol University.
- 10.4 It was noted that a Local Mortality Review Group had been established which would collate and analyse mortality data for people with learning disabilities within Gloucestershire. The findings from the review would help inform best practice and future service delivery.
- 10.5 JC queried the governance arrangements for the Group particularly who it was accountable to. MAE agreed to confirm. **MAE**
- 10.6 RECOMMENDATION: The Committee noted the report.**

*HF and CS joined the meeting at 10.40*

## **11. National Maternity Services Review**

- 11.1 HF introduced the report which provided an update on the progress of any service developments following the national review of the maternity services as part of the NHS Five Year Forward View. The paper was taken as read.
- 11.2 HF considered that following an initial evaluation of the national review, Gloucestershire was in a relatively good position. Gloucestershire already offered the full birth choice offer recommended by the national review which included freestanding birth units, Midwife led alongside birth units, home births and consultant led

delivery suites.

- 11.3 There had been a service review of maternity services in 2013/14 which provided a good baseline going forward.
- 11.4 HF advised that the areas for further developments included continuity of care and that this needed to be driven jointly with NHS England.
- 11.5 It was noted that the CCG were awaiting the outcome of the national pioneer sites pilot work and the central development work being taken forward by NHS England which was vital to enable some of the core changes to be implemented e.g. small geographical team of midwives.
- 11.6 HG advised that a further recommendation was that a review was undertaken on the current payment mechanism.
- 11.7 The report also recommended that women developed a personalised care plan, with their midwife, which sets out decisions about their care and was updated as the pregnancy progressed. It was also proposed that women were also able to fully discuss the benefits and risks associated with the different options.
- 11.8 CBu felt that the implications on staff should also be considered, particularly if choice had been offered to patients that were at high risk and had been unsuitable for home births. CBu stated that a balancing view and caveats should be placed as this placed enormous pressure on staff.
- 11.9 HF stated that the review also considered the implications when things go wrong, The report recognised that there should be greater consistency for a standardised investigation process.
- 11.10 RECOMMENDATION: The Committee noted the content of the report.**

*HF left at 10.48*

## **12.1 Experience and Engagement Assurance Process**

- 12.1.1 CS presented the report which proposed a new Experience and Engagement report structure to the IGQC. The paper was taken as read.
- 12.1.2 MAE advised that the new format had been agreed by AE who was content with the proposed structure.
- 12.1.3 CS advised that the report would include exception reporting of qualitative data.
- 12.1.4 JC suggested that this linked with the clinical safety information and also linked with the Project Management Office (PMO) toolkit, including contract monitoring so that the CCG has an integrated assurance process across our services.
- 12.1.5 **RECOMMENDATION: The Committee noted this paper and supported the suggested reporting arrangements.**

## **12.2 Experience and Engagement Report**

- 12.2.1 CS introduced the report which provided an overview of key experience and engagement activity undertaken by the CCG during Quarters 4 of 2015/16. The report was taken as read.
- 12.2.2 CS informed members that the PMO would systematically coordinate the reporting of the impact of experience and engagement on CCG programmes and projects using Health Perform.
- 12.2.3 JC enquired of the plans to address the Friends and Family Test (FFT) low response rates in primary care. CS advised that a Patient and Participation Group (PPG) event had been held on the 8<sup>th</sup> April 2016 and it was anticipated that the PPGs could encourage practices to promote this further.

- 12.2.4 CG requested an update on the progress on the remaining PPGs which were yet to be established. CS advised that good progress had been made and that currently there were only two remaining and that these were being addressed. It was noted that this was a contractual requirement.
- 12.2.5 CBU questioned the value of the FFT results and the information that can be extracted to produce meaningful results. CBU suggested if the questions could be more subjective in order to provide informative data. MW emphasised that there were other key workstreams being undertaken in the system i.e. clinical case studies and patient experience projects in order to drive quality improvements.
- 12.2.6 It was noted that previous Patient Environment Action Team (PEAT) reports had been replaced with Patient-Led Assessments of the Care Environment (PLACE) surveys.
- 12.2.7 MAE recognised that further patient experience work was required which included collating information regarding staff feedback. CS advised that the CCG was working with GHFT and that a detailed questionnaire was being developed.

*MW and CL left at 11.00*

- 12.2.8 MAE advised that the CSU had been working with Insights who had developed a powerful approach to soft intelligence management. This approach was achieved by using the Insight database which collated and analysed and reported quality data to the CCG. The Insights database was used to record all types of patient experience feedback including feedback from focus groups, consultations, surveys, social media, patient opinion and NHS Choices.
- 12.2.9 **RECOMMENDATION: The Committee noted the contents of this report.**

*CS left at 11.05*

### **13. Quality Report**

- 13.1 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.
- 13.2 MAE considered that there was limited research and development as a commissioning organisation. MAE advised that she did attend the countywide research and development group although this was primarily based around medical research.
- 13.3 MAE advised that Katy McIntosh had been appointed as the named GP for Safeguarding Adults and Children. CW advised that she would be introduced to the Governing Body shortly.
- 13.4 MAE updated members regarding incidents and Quality Alerts and that the two key themes which were consistently highlighted were around hospitals discharge and delays.
- 13.5 CBu highlighted a Serious Incident relating to a patient within urology and emphasised the importance of the issue being addressed. It was noted that this incident was excluded from the current reporting period as it was still within the initial stages.
- 13.6 JC requested that footnotes were included within the report to provide details of any Never Events that occur.
- 13.7 JC requested that a briefing report regarding the urology service was presented at the next meeting. MAE
- 13.8 MAE advised that the Quality Team were liaising with the CPG Team in order to develop a standard process where quality issues were considered when a new service was being developed and to ensure that these were explicit in the contract.

- 13.9 The Committee were assured regarding the mitigating actions that had been undertaken to resolve issues following the Serious Incident involving the Gloucestershire Diabetic Eye Screening programme.
- 13.10 JC stated that she was pleased to see the work that 2gether had undertaken considering the Mazars' report on the Southern Health NHSFT.
- 13.11 MAE informed members that the CQC would be undertaking a review of all the learning disability providers and how they handled the reporting of Serious Incidents.
- 13.12 MAE expressed concerns regarding the cancer 62 day wait and advised that performance against the target had been significantly challenging. It was noted that currently the most challenged specialities were urology. JC questioned if the service model was outdated to meet demand.
- 13.13 MAE advised that Hannah Williams had provided a brief update on district nursing and that this was outlined in section 11.2 of the report.
- 13.14 Members were informed that GCS had undertaken a full review into the number of falls within Community Hospitals as there had been an increase. MAE advised that GCS had not identified any particular trends or themes. The CCG had facilitated a visit to the Charlton Lane Hospital in order to discuss falls prevention with colleagues from 2gether and to share best practice. It was noted that this visit had been positive.
- 13.15 MAE drew attention to section 14 of the report relating to Health Care Acquired Infections and noted that a countywide antibiotic prescribing group had been established to maintain a consistent approach to tackling antimicrobial resistance and achieving the Quality Premium.
- 13.16 CBe understood that there had been resourcing issues

with microbiologists and was advised that this needed to be addressed internally with GHFT.

13.17 VW suggested that issues could be highlighted in the opening letter from the new Clinical Chair and it was considered that these issues could also be highlighted as part of the draft quality accounts. JC

13.18 JC highlighted that the seasonal influenza immunisation rates were low for staff.

13.19 JC requested that Craig Robinson was invited to the next meeting to provide a brief update on the stroke and TIA improvement plan. FT

13.20 MAE reported that three MRSA cases had been reported and noted that these were hospital acquired infections (post 48 hours).

13.21 The Committee reviewed the Clinical Effectiveness Group Terms of Reference (ToR) and requested that it was brought in line with the CCG template for committee meetings. Although the ToR was research light, CBU felt that the reports from the CSU regarding NICE updates and NHS outcomes tool had been useful. It was noted that the ToR would be kept under review. JC requested that the dates should include date approved, review date and the author should be by job title.

**13.22 RECOMMENDATION: The Committee:**

- **noted the contents of this report; and**
- **approved the Clinical Effectiveness Terms of Reference contained at Appendix 2. (Subject to change the changes above)**

#### **14. Primary Care Quality Report**

14.1 MAE presented the Primary Care 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.

- 14.2 JC highlighted that this report would develop in the future as more data became available.
- 14.3 JC drew attention to the Queen's Nursing Institute (QNI) General Practice Nurses Survey and enquired if this survey would be replicated locally in order to understand the local workforce issues. MAE concurred that a local survey would need to be undertaken. MAE
- 14.4 CBU requested an update on the progress of recruiting the Practice Nurse Facilitators. MAE advised that three nurses had been appointed to date covering Forest of Dean and Tewkesbury, Cheltenham and Cotswold Locality. It was noted that Gloucester and Stroud were still in progress of being recruited with a view to appoint by June/July 2016.
- 14.5 MAE advised that the CQC had now commenced a planned schedule of inspections for Gloucestershire practices. It was anticipated that this would conclude by the end of September 2016, which would exclude any practices which had been subject to mergers. MAE informed that one practice had been rated as 'outstanding' and the remaining as 'good'.
- 14.6 CBU suggested that an analysis of the CQC reports was undertaken in order to identify best practice which can be shared with other practices who were awaiting inspections. MAE advised that a presentation was presented at a previous Quality Surveillance Group by the area CQC lead which highlighted key themes emerging from the inspections. MAE suggested that this could be shared.
- 14.7 MAE highlighted that a nurse employed by the CCG has been made a Queens Nurse. It was noted that this was a highly regarded position.
- 14.8 **RECOMMENDATION: The Committee noted the contents of this report.**

**15. Any Other Business**

15.1 VW informed members that she had resigned and was due to leave at the end of May 2016. The Committee thanked VW for all her valuable support.

**16. The meeting closed at 12.00pm.**

***Date and time of next meeting: Thursday 23<sup>rd</sup> June 2016 in the Board Room at 9am.***

Agenda Item 17

Governing Body

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Audit Committee minutes</b>
<b>Executive Summary</b>	<p>The attached minutes provide a record of the Audit Committee meeting held on the:</p> <ul style="list-style-type: none"> <li>• 8th March;</li> <li>• 10th May; and</li> <li>• 24th May 2016.</li> </ul>
<b>Key Issues</b>	<p>The following principal issues were discussed:</p> <p><b><u>8<sup>th</sup> March</u></b></p> <ul style="list-style-type: none"> <li>• Internal Audit;</li> <li>• External Audit;</li> <li>• Counter Fraud;</li> <li>• Sponsorship and Hospitality Registers;</li> <li>• QIPP;</li> <li>• Waivers of Standing Orders;</li> <li>• Aged Debtors;</li> <li>• Final Accounts timetable and plan;</li> <li>• Draft Annual Governance Statement; and</li> <li>• South Central and West CSU – Report on internal controls.</li> </ul> <p><b><u>10<sup>th</sup> May</u></b></p> <ul style="list-style-type: none"> <li>• Draft Statutory Accounts;</li> <li>• NHS Shared Business Services Employment Services report;</li> <li>• Head of Internal Audit Opinion;</li> <li>• Annual Governance Statement;</li> <li>• Draft Audit Committee Annual Report; and</li> <li>• South Central and West CSU – Report on internal controls.</li> </ul>

	<p><b><u>24<sup>th</sup> May</u></b></p> <ul style="list-style-type: none"> <li>• Internal Audit;</li> <li>• Draft External Audit Report;</li> <li>• Statutory Accounts;</li> <li>• Annual Governance Statement; and</li> <li>• CSU Bridging letter.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Colin Greaves Audit Committee Chair and Lay Member

**NHS Gloucestershire CCG**  
**Audit Committee**

**Minutes of the meeting held on Tuesday 8 March 2016**  
**Board Room, Sanger House**

<b>Present:</b>		
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

<b>In Attendance:</b>		
Cath Leech	CL	Chief Finance Officer
Liz Cave	LC	Director, Audit, Grant Thornton
Laura Hallez	LH	External Auditor, Grant Thornton
Natalie Tarr	NT	Internal Audit, PWC
Andrew Beard	AB	Deputy Chief Finance Officer
Lee Sheridan	LS	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

**1. Apologies**

1.1 Lynn Pamment, PWC.

**2. Declarations of Interests**

2.1 There were no relevant interests declared.

**3. Minutes of the Meeting held 8 December 2015**

3.1 The minutes were approved subject to the following adjustment requested by LC:

- Point 6.1.2 to be adjusted to read 'Progress made' instead of 'arrangements in place'.

3.2 **Recommendation: The minutes were approved as an accurate record subject to the amendment.**

#### 4. Matters Arising

4.1 Please read in conjunction with the attached matters arising log.

4.2 **16.09.14 Item 7.5** – CL advised that the staff survey had been completed and ended on the 29 February and that a question had been included within it regarding Counter Fraud. The results from the survey were being collated and would be shared in due course. **Item to remain open.**

4.3 **29.09.15 Item 5.3.12** – NT noted that the internal audit tracker outlined the actions following the Business Continuity audit and that these had been followed up and validated. More training was also planned for business continuity. **Item therefore closed.**

4.4 **29.09.15 Item 19.4** – AB circulated the Financial Controls Environment Assessment action plan and explained the columns. CL advised that an item was included within the last Accountable Officer's report to the Governing Body. CG advised that he had raised this issue at the Audit Committee Chairs' Forum and also with Grant Thornton, especially regarding the need for another assessment. It was agreed an update would be given at the July Audit Committee. **Item to be on July agenda.**

4.5 **29.09.15 Item 8.7** – It was advised that the bi-monthly finance updates were well received by the Development Sessions however the Committee agreed that these should be presented earlier within the agenda. CL confirmed that the presentations were reviewed for confidentiality and then forwarded onto localities for their information. It was noted that a review would take place as planned in June/September. **Item to remain open.**

4.6 **8.12.15 Item 5.1.5** – CL advised that an update regarding QIPP was presented at a Development Session in January and that IG was working on QIPP in terms of 2016/17 planning. CG noted that he was confident there was grip on QIPP achievement however assurance was needed moving forward. CL noted that the business case template had been reviewed and any issues arising were being bounced back to leads as appropriate. **Item to remain open.**

4.7 **8.12.15 Item 8** – ZB informed members that she and CL had met to discuss a way forward with conflicts of interest assurance amongst Practices and had contacted peers to ascertain their approaches to the issue. The CCGs contacted did not have processes in place. The Committee discussed this matter further and it was agreed that CL, AP and ZB would meet again and would await the NHSE conflicts of interest guidance refresh for further advice. **Item to remain open.**

4.8 **The Committee noted the actions completed.**

## 5. **Internal Audit**

### 5.1 Progress Report

5.1.1 NT presented the Internal Audit update report.

5.1.2 NT highlighted the following key issues from the report:

- Final reports issued included on the agenda (5.2);
- Follow up agreed for Information Governance;
- Partnership working review completed;
- Reports were being drafted for Continuing Healthcare, Funded Nursing Care and Corporate Governance;
- Staff survey ongoing with regards to risk management in order to gain more responses.

5.1.4 **Recommendation: The Committee noted the contents of the internal audit update report.**

## 5.2 Reports

### 5.2.1 Core Financial Systems

5.2.1.1 NT advised that this audit presented an overall low risk finding and highlighted the headlines within the report which were:

- One low risk finding relating to the budget holder matrix;
- One advisory finding regarding debtor invoice request forms;
- Prior year recommendations.

5.2.1.2 AB confirmed that budget holders had received training and reminders were sent out regarding how to correctly approve invoices, in relation to the finding regarding the budget holder matrix.

## 5.2.2 Primary Care Co-Commissioning

5.2.2.1 NT informed members that this audit had presented an overall medium risk rating with 3 medium risk findings and 2 low risk findings.

5.2.2.2 NT outlined the recommendations which related to:

- NHSE holding financial information that the CCG did not have access to;
- Challenge and review of accruals;
- Financial reporting to the Primary Care Commissioning Committee (PCCC) and Primary Care Operational Group (PCOG).

5.2.2.3 CG noted that the report was welcomed and was excellent.

5.2.2.4 HLR queried what information NHSE were holding and AB advised that this was financial information at a Practice level which was resulting in the CCG holding detailed financial information separately on a spreadsheet. CL added that the CCG accepts that this was not good practice; this has been flagged to NHS England. Members of the finance team had attended the national working groups to try to influence a change in the system to allow better practice in reporting however the working relationship between NHSE and the CCG was positive.

5.2.2.5 CG queried if the report should be forwarded to NHSE for actions where appropriate and this was discussed further. It was agreed that CL would pull out some of the recommendations from the report and compose an email to NHSE. LC added that Grant Thornton felt that there were no significant concerns with the ledger and suggested that the CCG consider what they would want NHSE to do as a result, and include this within the email.

5.2.2.6 It was agreed that more extensive financial briefings would be forwarded to the PCCC at future meetings. AE suggested that

there should be a review later in the year against any changes that arise nationally.

### 5.2.3 Personal Health Budgets

5.2.3.1 NT noted the areas of good practice identified and highlighted the finding regarding the financial reviews not being conducted in a timely manner. This was a medium risk rated finding.

5.2.3.2 HLR queried if the funds were available within a patient's bank account and it was confirmed that a patient would have a separate bank account for personal health budgets. AE noted that this area could be a matter of concern for counter fraud. The Committee discussed the potential need to put resources into this area in the future. CG suggested a review later in the year and CL confirmed that internal audit would follow up as part of the annual review. AE raised concerns that the Governing Body might not have an oversight of PHBs, therefore it was agreed that an item would be included on a Development Session agenda.

### 5.2.3.4 Recommendation: The Committee noted the contents of the follow up report.

### 5.3 Internal Audit Recommendation Tracker

5.3.1 NT highlighted the key issues from the tracker which were:

- Information Governance would be revisited and then this action would be closed;
- No updates received regarding Quality Monitoring and Human Resources this time;
- Comments column – actions closed/open.

5.3.2 The Committee noted that the table continues to provide a useful update on actions.

### 5.3.3 Recommendation: The Committee noted the recommendations tracker.

### 5.4 Draft Risk Assessment and Internal Audit Plan 2016/17

5.4.1 NT presented the plan and highlighted the annual areas for

review and the new areas for review, and the comments column.

5.4.2 It was noted that the NHSE Conflicts of Interests (COI) guidance was under review and new requirements would be imposed upon CCGs as a result. CG advised that everybody would be required to complete COI training and that it was likely that internal audit would then review this as part of their annual reviews. The Committee therefore agreed that this would be scheduled into the internal audit plan within quarter 3 or 4 to allow embedding time following the publication of revised guidance. NT highlighted the timing of the review and suggested bringing forward the risk management and medicines management reviews to accommodate the additional areas.

## **6. External Audit update report**

6.1 LC presented the Audit Plan for the CCG and highlighted the challenges and opportunities on page 5 of the report. LC noted that the CCG had robust financial health in comparison to other CCGs.

6.1.1 LC highlighted page 8 of the report regarding materiality and noted the 2% of gross revenue expenditure.

6.1.2 LC discussed the significant risks identified including pooled/aligned budgets. LC gave assurance that this was being looked at carefully and an event had been held recently by Grant Thornton which had identified different ways of treating pooled budgets risks.

6.1.3 LC also noted the following from the report:

- Value for Money
- Fees
- Recommendations

6.1.4 CG advised that the Audit Committee was not charged with being responsible for Governance as stated within the report, this function lay with the Governing Body. LC agreed to amend.

## **6.2 Progress Report**

6.2.1 LH discussed the progress report and highlighted the key issues which were:

- Work completed to date
- Work underway on the for Value for Money conclusion;
- Information and Guidance;
- Annual report
  - Grant Thornton workshops
  - Gloucestershire CCG highlighted as an area of good practice for annual report formatting;
- Better Care Fund and pooled budgets;
- National Audit Office.

**6.3 Recommendation: The Committee noted the contents of the update report.**

## **7. Counter Fraud update**

7.1 LS presented the Counter Fraud (CF) update report.

7.2 LS advised that the annual report was prepared in draft pending the end of the financial year.

7.3 LS discussed the ongoing case relating to the CCG in which the investigation had now been completed. The case was now referred to the Crown Prosecution Service and the outcome of their review of the case was awaited.

7.4 It was confirmed that the 2015/16 action plan was now complete.

7.5 The Committee noted the referral analysis table and the self-review tool process summary.

7.6 LS presented the draft 2016/17 action plan which was agreed in principle, awaiting LS and CL to meet to agree a few minor alterations. LS advised that the team would like to build a better relationship with internal audit for 2016/17.

7.7 The Committee discussed the matter of the management of charging overseas visitors for healthcare. LS advised that new developments had been made last week and all Gloucestershire parties had met to discuss a way forward. Further information

would be available in due course.

7.8 Concerns were raised about the assurance of self-assessment tool completed by local Trusts. LS reported there were no concerns at present. It was noted that the CCG's self-assessment tool would be presented at the July Audit Committee.

7.9 **Recommendation: The Committee noted the annual report and approved it subject to updating and agreed the draft 2016/17 action plan.**

## 8. Registers

8.1 AP presented the registers and ZB highlighted the changes made to the sponsorship register. ZB advised that following comments made by Core team where the registers are also presented, the register had been spilt into rebates and other sponsorship.

8.2 AE queried the hospitality received by Teresa Middleton (TM) (HR001) which was also raised at the last meeting. ZB advised that she had received confirmation from TM that this was an advisory board attendance in which she was asked to give her expertise in terms of community pharmacy.

8.3 AE raised concerns about CCG staff accepting sponsorship from Pharmaceutical companies and this matter was discussed further by the Committee. AS added that some GP Practices accept sponsorship and some don't and that it would therefore be helpful for the CCG to agree a stance. It was agreed that ZB and AP would summarise the key points to consider and that an item would be added to a Development Session meeting for the Governing Body to agree their views.

8.4 **Recommendation: 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 (at month nine) and highlighted the following issues:

- Overall position;

- Slippage on the programme;
- Urgent care;
- Referrals;
- QIPP Schemes.

9.2 HLR queried what the impact would be of the pilot projects currently in discussion, on the delivery of QIPP. CL advised that comprehensive work was undertaken by the Project Management Office team and includes the measurement of impacts which would be considered as part of QIPP delivery monitoring.

9.3 CG noted that the change in the format of the report from the last committee meeting was helpful.

9.4 CG queried why prescribing was stated as closed when the report last time included a number of projects against it. IG confirmed that this was a prospective scheme which had now been removed.

**9.5 Recommendation: The Committee noted the report on QIPP delivery at month nine including the savings delivery forecast position.**

## **10. Summaries of Procurement Decisions**

10.1 There were none to report.

**10.2 Recommendation: The Committee noted the report.**

## **11. Register of Waivers of Standing Orders**

11.1 CL presented the waivers report.

11.2 Waiver 187/12/2015 regarding Communications was noted as being agreed in December.

11.3 The Committee discussed waiver 188/01/2016 – Mental Health Commissioning. It was noted that this may be an area of potential concern although was right to invest in. VW highlighted the date of the signature which was incorrect and should read 25/01/2016.

11.4 CL advised that waiver 190/02/2016 – Children's

Commissioning/LD was coming to an end as the budget would be moving across and going through the Integrated Community Equipment Service (ICES). CL reported that ICES would be making sure they use limited suppliers.

**11.5 Recommendation: The Committee noted the paper which was provided for information.**

## **12. Aged Debtor Reports**

12.1 AB discussed the aged debtor report.

12.2 AB advised that the NHS debt had decreased significantly since the time of writing of the report.

12.3 AB discussed the Non NHS Debtors and noted that the GDoc debt had now been paid and that the amount relating to the Aneurin Bevan Health Board had also been agreed and was awaiting payment. It was noted that the Personal Health Budget review was not an overpayment but was money due to come back as per process.

12.3.1 HLR queried were personal health budgets would appear within reporting and AB confirmed that this information would be included on the aged debtor report as a package figure, although was not officially a debt.

**12.4 Recommendation: 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. Final Accounts Timetable and Plan**

14.1 AB discussed the final accounts timetable and highlighted the key dates for the deadlines for submission of the 2015/16 accounts:

- 22 April 2016 unaudited accounts to the Department of Health and External Auditors;

- 27 May 2016 final date for accounts to be audited and sent to NHSE;
- 2 June 2016 final date for submission of audited accounts
- Audit Committee scheduled for 10 and 24 May;
- Extraordinary Governing Body meeting scheduled for 26 May to formally approve the accounts.

14.2 AB noted that the CCG had attended an annual report workshop held by Grant Thornton.

14.3 It was also noted that there is a separate timetable for the CCG annual report which is maintained by the Associate Director of Communications.

14.4 LH confirmed that external audit were happy with the proposed timetable and plan, accepting the tight deadlines for the signing of the accounts.

**14.5 Recommendation: The Committee noted the national and external timetable for the production of the CCG's Annual Accounts and Report (Appendix 1).**

## **15. Annual Governance Statement – Draft**

15.1 AP presented the draft annual governance statement and highlighted the prescribed areas (in black font) and the CCG additional areas (in blue font).

15.2 AP advised that there were some incomplete areas as some information would need to be included at year end and invited comments from the Committee.

15.3 CG queried if Joanna Davies, Lay Member should be included on the Remuneration Committee and AP noted that JD's CCG Committee attendance was currently under discussion.

15.4 AS suggested that the other invited members (i.e. Healthwatch) of the Primary Care Commissioning Committee should also be listed within the statement.

**15.5 Recommendation: The Committee accepted the draft annual governance statement.**

**16. South, Central and West Commissioning Support Unit (SCWCSU): Report on Internal Controls**

16.1 CL discussed the circulated report which provides assurance to the CCG as a customer of the CSU of their internal controls relating to payroll. CL advised that a further report would be due at the end of April 2016.

16.2 The report highlights minor issues but no significant concerns for the CCG.

16.3 CL confirmed that she would circulate the action plan to members.

**16.4 Recommendation: The Committee noted the contents of the report and the actions being taken to address the issues identified.**

**17. Losses and Special Payments Register**

17.1 There were none to report.

**18. Any Other Business**

18.1 There were no items of any other business.

**The meeting closed at 11:20am.**

**End of year meeting timetable:**

**Tuesday 10 May at 2016 10:30am in the Board Room, Sanger House**  
(Extraordinary Meeting – review of draft accounts)

**Tuesday 24 May 2016 at 9:00am in the Board Room, Sanger House**  
(Extraordinary Meeting – review of final accounts)

**Tuesday 12 July 2016 at 9:00am in the Wheatstone Room, Sanger House** – Next full Audit Committee

**NHS Gloucestershire CCG  
Audit Committee**

**Minutes of the meeting held on Tuesday 10<sup>th</sup> May 2016  
Board Room, Sanger House**

<b>Present:</b>		
Colin Greaves (Chair)	CG	Lay Member, Governance
Valerie Webb	VW	Lay Member, Business
Alan Elkin	AE	Lay Member, Patient and Public Experience
Dr Hein Le Roux	HLR	GP Liaison Lead, Stroud and Berkeley Vale

<b>In Attendance:</b>		
Cath Leech	CL	Chief Finance Officer
Andrew Beard	AB	Deputy Chief Finance Officer
Rupert Boex	RB	Financial Accountant
Mary Hutton	MH	Accountable Officer
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Corporate Governance Support Officer

**1. Apologies**

1.1 There were no apologies received.

**2. Declarations of Interests**

2.1 There were no relevant interests declared.

**3. Draft Statutory 2015/16 Annual Accounts**

3.0.1 CL introduced the draft unaudited 2015/16 Annual Accounts. It was noted that the external audit of the accounts was currently underway and that, to date, no material issues had been raised.

3.0.2 AB highlighted the summary including the CCG position against statutory duties. Members noted that the unaudited Annual Accounts were submitted to the Department of Health and External Auditors in accordance with the statutory deadline of 22nd April 2016.

- 3.0.3 AB reported that the CCG had remained within its programme and running cost allocations with a reported surplus of £9,456k. The original planned surplus for the year was £7.3m.
- 3.0.4 AB advised that the cash holdings at the end of the year were £23k and total cash drawings were within the maximum cash drawdown limit set by NHS England (NHSE).
- 3.0.5 AB advised that the performance against the better payment practice code had been achieved and that the CCG had achieved its 95% target in both value and volume of invoices.
- 3.0.6 Members noted that the CCG had provided £1,282k in relation to retrospective CHC claims, which was an increase from the previous year. All other retrospective claims had been accounted for by NHSE.
- 3.0.7 AB advised that the 2015/16 GHFT contractual position was agreed after the submission of the draft accounts. Whilst the movement was not material, the CCG had decided to adjust for this change and was reviewing other assumptions to mitigate its impact overall. This was a movement of £1.5m with an agreed contract outturn of £300.25m. The agreement of balances position will be amended to reflect this change too.
- 3.0.8 It was noted that the final submission date for the audited accounts was the 27<sup>th</sup> May 2015 and that the external auditors commenced their on-site audit on the 25<sup>th</sup> April and would finish the audit by the end of May; on-site work was scheduled to be completed by the 11th May.
- 3.0.9 AB advised that the CCG must publish their annual report and full accounts on its website no later than 10<sup>th</sup> June and that the accounts must be presented to the public at an annual public meeting that must be held no later than 30<sup>th</sup> September 2016.
- 3.0.10 CG sought assurance on the process of the annual report and accounts being published on the website by the 10<sup>th</sup> June. It was agreed that a confirmation would be emailed to the Audit Committee members when these were published.
- 3.0.11 AB highlighted the performance against key targets and advised the CCG received a Capital Resource Limit of £200k in 2015/16. It

incurred capital expenditure of £151k and therefore underspent its allocation by £49k. It was advised that the Capital Resource Limit was mainly for the purchase of GP check-in screens and replacement smartboards.

3.0.12 AB drew attention to section 4.2 of the summary report and advised that there was a typographical error and that it should read as '*in the financial year, the CCG underspent it's running cost allocation by £1,455k*'.

3.0.13 AB highlighted section 5 regarding the Note to the Accounts and advised that this conformed to the NHSE standard approach although this could be tailored to suit the needs of the CCG (noting that this was very limited). However, the two issues below needed to be highlighted to members which were pertinent to the 2015/16 position. These were:

- critical judgements in applying the CCG's accounting policies; and
- key sources of estimation uncertainty.

3.0.14 It was noted that other operating revenue income had decreased in 2015/16. A gross income of £20,518k was reported during 2015/16 compared to £21,108k for 2014/15. This was mainly related to the reclassification of drug rebate monies from revenue to net expenditure between financial years.

3.0.15 **Operating expenses** had risen in year by 15.81%. AB noted the following points:

- the majority of this increase related to co-commissioning costs which were new in 2015/16;
- there was an increase of £12m from the previous year relating to the purchase of healthcare from non-NHS bodies and this mainly related to the Better Care Fund;
- pay costs had also increased by 19.9% during the year. The increase represented approximately 40 additional staff being recruited; 30 permanent staff and 10 agency/other staff. The increase in permanent staff related to the insourcing of services previously contracted from the CSU and increases in CHC staff, primary care staff and transformation staff. Agency staff related to Joining Up Your Care (JUYC) and

cross border work.

- 3.0.16 **Operating Leases** - This information related to the arrangement between NHS Property Services regarding buildings and printer hire costs. It was noted that following the delegation of primary care responsibilities to the CCG, there was also a note that covered the nature of the relationship with GP practices for premises.
- 3.0.17 **Property, plant and equipment** - IT equipment was purchased at a cost of £151k. It was also noted that Transport equipment (the information bus) was depreciated and valued at £20k at the end of the period. RB highlighted that the information bus would be fully depreciated at the end of the year.
- 3.0.18 **Receivables** – there was a small reduction of outstanding debts from the previous year accounts with a total of £332k at the end 2015/16. The provision for impairment of receivables also reduced to £52k (from £83k) in the year.
- 3.0.19 **Payables** – It was noted that £11,596k was outstanding for NHS creditors at the end of the year. These included:
- GHFT £2,411k
  - GCS £1,977k
  - Contracted agreements of £800k

Accruals for costs owing to non-NHS bodies were £24,422k and mainly related to two months of prescribing costs where final figures for February and March were not available when the accounts closed.

- 3.0.20 **Provisions** - It was noted that there was an increase in the provisions provided for Continuing Health Care (CHC) retrospective claims which was £1,282k at 31st March 2016 (£682k for 2014/15). A provision of £500k for primary care had also been made which related to cover any potential continuity of service issues and practice development costs.
- 3.0.21 **Related Party Transactions** – AB advised that an additional column had been added to include payment to practices under delegated co-commissioning arrangements in order to aid understanding. CG noted that this was a statutory requirement to

CL

include this information. CL advised that GPs would be sent individual information relating to their practices. MH requested that a note was added to this section to explain that this information related to the payment to the practices and not payment to the individual GP concerned.

3.0.22 MH drew attention to the summary at the bottom of section 17 of the accounts and advised that some of the words had been omitted '*during the year the clinical commissioning group has had a significant number of .....*' CL agreed to review this.

3.0.23 MH suggested that a separate Primary Care Annual Report should be composed as she felt that it did not reflect a true picture of what was happening in the system. It was agreed that this would be useful and going forward it could be included in the annual report.

**3.0.24 Recommendation: The Committee noted the content of the draft accounts.**

**3.1 Assurances from management and those charged with Governance**

3.1.1 CL advised that these had been provided to the external auditors by the Chief Finance Officer and Chair of the Audit Committee in order to provide additional assurances regarding the governance and internal control processes operated by the CCG.

3.1.2 The Committee noted the letters and the response from management to the External Auditors. CL advised that minor amendments would be made to the response from management to reflect updated positions as the report had been drafted in February.

**3.1.3 Recommendation: The Committee noted the report.**

**3.2 Going Concern**

3.2.1 CL presented the Going Concern paper which set out the concept and the evidence used to demonstrate the CCG was a going concern.

3.2.2 A review had been carried out to determine whether the CCG was a going concern, the outcome of which determined the basis of the

way that the CCG prepared its accounts. The review indicated that the CCG was a going concern and that the CCG's accounts should be prepared on this basis.

3.2.3 CL updated members regarding the assessment process noting that the CCG achieved its surplus each year and had prepared a balanced budget for 2016/17.

3.2.4 CG highlighted that the surplus for 2015/16 and 2016/17 were identical. CL advised that the paper was written in February and that this would be updated to reflect the changes in the account.

3.2.5 **Recommendation: The Committee reviewed and confirmed the assessment that the CCG was a going concern and that it was appropriate for the accounts to be prepared on this basis.**

#### **4. NHS SBS Employment Services Report**

4.1 CL presented the service auditors report and advised that these were produced to deliver assurance over the internal controls and control procedures operated by support service organisations to their customers and their auditors.

4.2 The Committee welcomed the report and were assured of the process going forward.

4.3 **Recommendation: The Committee noted the report which was provided for information.**

#### **5. Head of Internal Audit Opinion**

5.1 CL presented the report which included the Head of Internal Audit's annual opinion.

5.2 The Committee noted that the opinion was that the CCG's governance, risk management and control in relation to business critical areas was generally satisfactory with some improvements required. It was noted that the partnership working review report was still in progress and should be finalised shortly.

5.3 AP advised that the wording in the opinion section had been changed following representations made to the internal auditors.

5.4 MH suggested that CG met the internal auditors to clarify the points that had been given. CL advised that she was meeting the internal auditors following the committee meeting that day and would raise this query.

5.5 **Recommendation: The Committee noted the contents of the report.**

## 6. Annual Governance Statement

6.1 AP presented the draft Annual Governance Statement and advised it was based upon a template provided by NHS England as part of the CCG Annual Reporting Guidance. AP advised that the draft statement had been submitted to NHS England and invited comments from the Committee.

6.2 AP advised that the black text represented wording prescribed by NHS England and the blue text had been added by the CCG.

6.3 AP advised that the final Head of Internal Audit Opinion would be added when received.

6.4 MH requested that the mission statement was amended to reflect the current values and vision statement. AP

6.5 **Recommendation: The Committee reviewed the draft Governance Statement and recommended approval to the Governing Body subject to the changes above.**

## 7. Draft Audit Committee Annual Report

7.1 CG presented the draft Audit Committee Annual Report. CG advised that a reference relating to the payroll could be included and would be discussed with CL.

7.2 CG advised that the final Head of Internal Audit Opinion would be incorporated into the final report.

7.3 **Recommendation: The Committee accepted the draft Audit Committee Annual Report which would be updated for the May 2016 Governing Body meeting.**

## 8. CSU Report on Internal Controls

- 8.1 CL presented the service auditor report for the CSU which provided assurance over the internal controls and control procedures operated by support service organisations to their customers and their auditors. The report covered the period 1<sup>st</sup> October 2015 – 29<sup>th</sup> February 2016.
- 8.2 The only area tested which was applicable to Gloucestershire CCG was payroll services and noted the CSU had developed an action plan to remedy all areas identified within the report. The CCG controls were also tested by the CCG's internal auditors and there was no evidence to indicate that incorrect payments have been made.
- 8.3 It was noted that the CSU Director of Finance has issued a bridging letter to CCGs to provide assurance that controls did not change in March.
- 8.4 **Recommendation: The Committee noted the contents of the report.**

## **9. Any Other Business**

- 9.1 The Committee thanked Dr Andy Seymour for his contribution during the past three years and recognised the support he had provided to the Committee. It was noted that Dr Andy Seymour was appointed to the Clinical Chair position and therefore was precluded from the Committee as a member following this appointment.
- 9.2 It was also noted that VW was leaving at the end of May 2016 and that further committee members would be sought in due course.
- 9.3 CG highlighted that the Audit Committee that was being held on the 27<sup>th</sup> September 2016 conflicted with the Annual General Meeting and proposed that this meeting was rescheduled. FT

**The meeting closed at 11:55am.**

**End of year meeting timetable:**

**Tuesday 24 May 2016 at 9:00am in the Board Room, Sanger House**  
(Extraordinary Meeting – review of final accounts)

**Tuesday 12 July 2016 at 9:00am in the Wheatstone Room, Sanger House – Next full Audit Committee**

**NHS Gloucestershire CCG  
Audit Committee**

**Minutes of the meeting held on Tuesday 24<sup>th</sup> May 2016  
Board Room, Sanger House**

<b>Present:</b>		
Colin Greaves (Chair)	CG	Lay Member, Governance
Valerie Webb	VW	Lay Member, Business
Alan Elkin	AE	Lay Member, Patient and Public Experience
Dr Hein Le Roux ( <i>part meeting</i> )	HLR	GP Liaison Lead, Stroud and Berkeley Vale

<b>In Attendance:</b>		
Cath Leech	CL	Chief Finance Officer
Andrew Beard	AB	Deputy Chief Finance Officer
Liz Cave	LC	Director, Audit, Grant Thornton
Laura Hallez	LH	External Auditor, Grant Thornton
Lynn Pamment ( <i>part meeting</i> )	LP	Audit Manager, PWC
Natalie Tarr	NT	Internal Audit, PWC
Rupert Boex	RB	Financial Accountant
Mark Walkingshaw (Item 3.1.1)	MW	Director of Commissioning Implementation
Miriam Street (Item 3.1.1)	MS	Senior Commissioning Manager
Fazila Tagari	FT	Corporate Governance Support Officer

**1. Apologies**

1.1 There were no apologies received.

**2. Declarations of Interests**

2.1 There were no relevant interests declared.

**3. Internal Audit Update**

3.1 Final Report

### 3.1.1 Continuing Healthcare (CHC) / Funded Nursing Care (FNC)

- 3.1.1.1 NT presented the report and advised that the audit had presented an overall high risk rating. The review identified a total of seven findings; two high, two medium, one low and two advisory findings.
- 3.1.1.2 MW and MS attended the meeting to discuss the findings from the report and the actions being undertaken to address the recommendations.
- 3.1.1.3 The high risk findings related to:
- the number of instances of non-compliance with CHC/FNC processes; and
  - domiciliary care invoices not matched to CareTrack.
- 3.1.1.4 MS provided a summary of the background issues and noted that CareTrack had been purchased by the CCG. However, the system had not been robustly implemented and inaccurate data had been migrated. This had led to performance management issues. MS advised that admin resources had been put in place to support the cleansing of the database.
- 3.1.1.5 The medium risk findings related to:
- significant variances in monthly forecasting; and
  - lack of a formal process for making value for money assessments.
- 3.1.1.6 The low risk findings related to the policies and procedures being out of date as these had been approved in 2013.
- 3.1.1.7 VW requested further details around the prior year recommendations which had still been outstanding. NT advised that these related to CHC/FNC funding review procedures not being followed and the filing of supporting documentation.
- 3.1.1.8 CG expressed concerns regarding the processes being implemented and queried if additional resources would be required to address these issues. MW acknowledged the issues and advised that six additional CHC nurses and two administrations posts had been appointed to provide support to the team.

- 3.1.1.9 CL advised that a review had been resourced jointly with Gloucestershire County Council (GCC) to review the processes. She also noted that a joint project manager was in post to resolve any issues.
- 3.1.1.10 MS highlighted that the financial functions had been brought back in-house in order to ensure that robust control measures were in place.
- 3.1.1.11 MS advised that GCC was procuring a new domiciliary care provider and had specified the implementation of electronic call monitoring as part of the specification, which should provide a cost effective tool to monitor activity and also improve value for money.
- 3.1.1.12 LC enquired if there had been executive ownership of the issues and was advised that a joint review was being undertaken which was being sponsored by the executives of the respective organisations. It was noted that this work would be reported to the Joint Commissioning Partnership Executive (JCPE) meeting. MS advised that she also meets the Brokerage and Partnership Team from the council regularly to resolve any operational issues.
- 3.1.1.13 The Committee welcomed the report as a mechanism to deliver improvements and look forward to receiving further assurances of the improvements being made. LP advised that contingency days would be used to revisit this area in Quarter 3.

## 3.1.2 Corporate Governance

- 3.1.2.1 NT presented the report and advised that the audit had presented an overall low risk rating with two low risk findings.
- 3.1.2.2 NT advised that the recommendation regarding policies from the prior year review remained in place as sufficient progress had not been made. NT highlighted that three out of the seven policies had not been available on the staff intranet at the time of testing.
- 3.1.2.3 The other recommendation related to the timely submission of committee papers. It was noted although these were sent out within the required timescales; however, papers were not always received by the Corporate Governance Team in line with their deadlines which did not provide sufficient review period prior to

circulation.

3.1.2.4 NT advised that the prior year recommendation in relation to the conflicts of interests register and the procurement decisions register had been implemented. NT also noted the number of areas of good practice.

3.1.2.5 The Committee acknowledged that the timely submission of papers was an ongoing issue for the Corporate Governance Team.

3.1.2.6 CG requested that the policies were kept up to date on the staff intranet.

### 3.1.3 Information Governance Toolkit

3.1.3.1 NT presented the report and advised that the audit had been completed in two phases with an overall low risk rating. The first phase was completed in February 2016 and second phase in March 2016.

3.1.3.2 NT advised that the first phase of the review identified that there had been insufficient evidence to attain level two. However, following the second phase of the visit, it was noted that all of the requirements to obtain a level two had been achieved.

3.1.3.3 NT advised that the timing of review for the following year would be reconsidered which had also been discussed with management.

3.1.3.4 CL advised that a new Information Governance Manager had recently being recruited, which would help mitigate any issues with timing.

### 3.1.4 Joining Up Your Information

3.1.4.1 LP presented the report and highlighted that the report was produced in December 2015 and noted that the timing of the review coincided whilst the project was within the initial stages of being established. The review highlighted one medium and five low risk rated findings.

3.1.4.2 AE sought assurance regarding the consistency of staff. CL

advised that the CSU contract had been extended for a further two years which should provide stability. Members noted that a key member of staff was leaving and that there was a succession plan and shadowing taking place to ensure a smooth transition.

### 3.1.5 Risk Management

3.1.5.1 NT presented the report and advised that the audit had presented an overall low risk rating with three low risk findings.

3.1.5.2 The three low risk findings related to:

- risk management was not a standing item on the agendas of the directorate team meetings;
- no record was maintained to monitor the risk management training each directorate had received and whether any individuals had missed such training; and
- the risk register does not effectively demonstrate that risks were being mitigated and monitored efficiently.

3.1.5.3 Members noted that the prior year recommendation still remained and was ongoing.

3.1.5.4 NT advised that as part of the review, a survey was sent to all CCG employees in relation to risk management within the CCG. The result of the survey was detailed in Appendix 1 of the report. Members noted the limited response rate to the survey.

3.1.5.5 CG stated that he was disappointed with the number of departments that did not have a nominated risk leader; however, he acknowledged that management would address these issues going forward.

3.1.5.6 CL considered that risks were dealt with routinely as common practice and recognised that a formal process should be established for the identification and management of risks.

### 3.1.6 Partnership Working

3.1.6.1 NT presented this report and advised that the audit had presented an overall low risk rating with one medium and two low risk findings.

3.1.6.2 The medium risk finding related to the absence of signed agreements.

3.1.6.3 The low risk findings related to:

- lack of assigned owners and target dates for actions arising at Joint Commissioning Partnership Executive (JCPE) and Joint Commissioning Partnership Board (JCPB) meetings; and
- the JCPE and JCPB Terms of References required a review.

## 3.2 Recommendation Tracker

3.2.1 NT presented the Tracker and noted that the majority of the recommendations had been completed and that the only outstanding actions related to the JUYI and that this was due to the recommendation not yet being due.

## 3.3 Final Annual Report 2015/16

3.3.1 LP presented the report and drew attention to the executive summary which detailed the Head of Internal Audit Opinion. It was noted that the CCG was rated as 'generally satisfactory with some improvements required'.

3.3.2 LP explained the two factors underpinning the opinion. It was noted that at the time of the Business Continuity Review, this was identified as high risk and acknowledged that the recommendations had subsequently been implemented and the CHC review which was also identified as a high risk.

3.3.3 Members noted that the number of findings had increased from the previous year. However, it had been agreed that the risk areas would be prioritised during the first quarter of the 2016/17 programme.

3.3.4 The Committee welcomed the report and considered that it was a fair opinion.

3.3.5 CG drew attention to page 6 of the report regarding the implications for management and highlighted that the narrative

was incorrect. LP advised that a pro-forma template had been used and would correct this.

3.3.6 CG requested that a meeting was arranged between internal audit and audit committee members. FT

### 3.4 Annual Plan 2016/17

3.4.1 LP presented the Internal Audit Annual Plan for 2016/17 which was provided for information.

3.4.2 CL advised that the plan had been adjusted to focus on the high risk areas i.e. CHC.

**3.4.3 Recommendation: The Committee approved the 2016/17 Internal Audit Annual Plan.**

### 3.5 Internal Audit Charter

3.5.1 LP presented the Internal Audit Charter which was provided for information.

**3.6 Recommendation: The Committee noted the reports.**

## **4. Draft External Audit Report**

4.1 LC presented the report and advised that the audit identified only a few adjustments in the accounts and did not affect the CCG's comprehensive net expenditure position.

4.2 LC advised that the audit had been complex compared to previous years due to:

- accounting for the Better Care Fund and other aligned budgets with GCC;
- the accounts included GP Co-Commissioning for the first time; and
- the accounts were amended to reflect the final settlement with GHFT during the audit.

4.3 LC advised that there were no issues affecting the regularity opinion and Value for Money conclusion. However, a number of

recommendations had been made.

4.4 LC outlined the key risk related to the pooled budgets as the accounting arrangements for this were complex and there was a risk of material misstatement and the potential for irregular expenditure. The review identified that the majority of the CCG's budgets in respect of joint commissioning were aligned budgets rather than pooled budgets and it was agreed that a disclosure note was included to make it clear the pooled budget note related to an aligned budget.

4.5 LC advised that the audit work had not identified any issues in respect of the accounting for the CCG's co-commissioning arrangements. LC advised that there had been an issue with obtaining information from NHS England and thanked the finance team for their support.

4.6 Members noted that in terms of the adjustment to the accounts for secondary care commissioning, the review concluded that these were not material to the accounts and were consistent with the CCG accounting policies.

4.7 The audit also identified that the CCG did not have a signed section 75 agreement with GCC for its Better Care Fund budgets; it was noted that this had been subsequently signed by both parties.

4.8 LC updated members on the Value for Money conclusion and noted the 83% QIPP achievement and recommended that the reporting arrangements for the reconciliation of QIPP achievement to activity levels needed to be more transparent. CL advised that the reporting arrangements were being reviewed and it was proposed that this would be reviewed on a quarterly basis.

4.9 CG requested that a meeting was arranged between Grant Thornton and Audit Committee members. FT

4.10 LC expressed thanks to the finance team for the support whilst undertaking the audit.

4.11 **Recommendation: The Committee noted the report.**

## 5. Statutory 2015/16 Annual Accounts

5.1 AB presented the audited 2015/16 Annual Accounts and advised that only minor changes had been made since the draft submission of the accounts.

5.2 AB highlighted the main changes within the report and advised that these were:

- the GHFT contract outturn had been amended to the agreed value of £300,250k;
- additional disclosures relating to the Better Care Fund within accounting policies; and
- reclassification of expenditure relating to NBT between non-NHS and NHS categories.

5.3 CG noted that the staff sickness level had slightly increased from the previous year. AB advised that this information had been extracted from the national figures.

5.4 **Recommendation: The Committee accepted the accounts and agreed to recommend the accounts for approval to the Governing Body meeting on 26<sup>th</sup> May 2016.**

## 6. Annual Governance Statement

6.1 CG presented the Annual Governance Statement which was provided for information.

6.2 It was noted that this was incorporated into the Annual Report that had been submitted to NHS England.

6.3 **Recommendation: The Committee noted the 2015/16 Annual Governance Statement.**

## 7. CSU Bridging Letter

7.1 CL presented the signed bridging letter from the CSU Director of Finance which provided assurance that controls did not change in March following the Service Auditor Report.

## 8. Any Other Business

- 8.1 CG thanked the finance team for their work on producing and finalising the annual accounts.
- 8.2 The Committee thanked VW for her contribution during the past three years and recognised the support she had provided to the Committee. It was noted that VW was leaving at the end of May 2016.

**The meeting closed at 10:22am.**

**Date and time of next meeting: Tuesday 12 July 2016 at 9:00am in the Wheatstone Room, Sanger House**

DRAFT

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Auditor Panel minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the inaugural Auditor Panel meeting held on the 8th March 2016.
<b>Key Issues</b>	The following principal issues were discussed: <ul style="list-style-type: none"> <li>• Auditor Panel update; and</li> <li>• procurement of External Auditors.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Colin Greaves Auditor Panel Chair and Lay Member

**NHS GLOUCESTERSHIRE CCG**

**Minutes of the Inaugural Auditor Panel meeting held  
 Tuesday 8 March 2016  
 Board Room, Sanger House**

<b>Present:</b>		
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

<b>In Attendance:</b>		
Cath Leech	CL	Chief Finance Officer
Alan Potter	AP	Alan Potter
Zoe Barnes	ZB	Corporate Governance Officer

**1. Apologies**

1.1 None

**2. Declarations of Interests**

2.1 None

**3. Auditor Panel Update**

3.1 It was noted that the CCG was compliant with Auditor Panel guidance.

**4. Update on Procurement of External Auditors**

4.1 CL discussed the process for the procurement of external auditors for Gloucestershire CCG and advised that there could be a joint procurement with other CCGs awarding to one or more companies.

4.2 CL noted that an evaluation panel would need to be considered.

4.3 The following issues were discussed:

- Independence versus cost;
- Auditors (PWC and KPMG) would not be able to bid for those CCGs where they held an internal audit contract;
- Specification developing nationally;
- Procurement start date in order to meet the national timescales;
- The learning from the Joining Up Your Information procurement process.

4.4 It was agreed to support a joint procurement with BGSW CCGs.

4.5 It was noted that the CSU procurement team would support the procurement.

4.6 CL advised that BANES CCG currently use KPMG for internal audit but the other CCGs in the South West patch use PWC. All CCGs would be going out to procurement for external audit.

4.7 **Recommendation: The Panel agreed to support the joint procurement.**

## 5. Any Other Business

5.1 There were no items of any other business.

**The meeting closed at 11:50am.**

**Date and time of next meeting: To be decided.**

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Primary Care Commissioning Committee (PCCC) minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the PCCC meeting held on the 31 <sup>st</sup> March 2016.
<b>Key Issues</b>	<p>The following principal issues were discussed:</p> <ul style="list-style-type: none"> <li>• Primary Care Workforce Plan;</li> <li>• Primary Care Infrastructure Plan;</li> <li>• Primary Care Quality Report;</li> <li>• 2016/17 Budget proposals;</li> <li>• Primary Care Contracts;</li> <li>• Prime Minister's GP Access Fund;</li> <li>• applications for practice boundary change; and</li> <li>• Draft Primary Care Infrastructure Plan.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Alan Elkin PCCC Chair and Lay Member

## Primary Care Commissioning Committee

### Minutes of the Meeting held on Thursday 31<sup>st</sup> March 2016 in the Board Room, Sanger House, Gloucester GL3 4FE

<b>Present:</b>		
Alan Elkin	AE	Chair
Andrew Beard	AB	Deputy Chief Finance Officer
Julie Clatworthy	JC	Registered Nurse
Colin Greaves	CG	Lay Member - Governance
Mary Hutton (part meeting)	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Andy Seymour	AS	Deputy Clinical Chair
<b>In attendance:</b>		
Jeanette Giles	JG	Head of Primary Care Contracting
Becky Parish (part meeting)	BP	Associate Director Patient and Public Engagement
Bronwyn Barnes	BB	Programme Manager: Primary Care, Localities and Variation
Cllr Dorcas Binns	DB	Chair of the Health and Wellbeing Board
Barbara Piranty	BPI	Chief Executive of Healthwatch Gloucestershire
Andrew Hughes (part meeting)	AH	Locality Implementation Manager
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 4 members of the public present.		

#### **1 Apologies for Absence**

1.1 Apologies were received from Marion Andrews-Evans.

#### **2 Declarations of Interest**

2.1 AS declared the following interests:

- Agenda Item 6 – as the CQC inspections report for his practice was included in Appendix 2;

- Agenda Item 7.2 – 2016/17 Budget Proposals; and
- general interest as a GP member.

2.2 The Chair considered that in view of nature of these interests, it was not necessary to exclude AS from the discussions.

### **3 Minutes of the Meeting held on Thursday 28<sup>th</sup> January 2016**

3.1 The minutes were approved subject to the amendments below:

- Section 6.6 to be amended to read '*CG highlighted that the branch surgeries were actually located in South Gloucestershire*'
- Section 8.2, bullet point 2 to be amended to read '*how are we going to get to where we need to be*'.

### **4 Matters Arising**

4.1 24.09.2015 AI 5.8 – Springbank Procurement Update – AP agreed that he would follow up the NHS England action in relation to forwarding the nurse led paediatric nurse model from Swindon.

4.2 24.09.2015 AI 5.9 – Springbank Procurement Update – The update regarding Springbank was covered under Agenda Item 9.1. **Item Closed.**

4.3 28.01.2016 AI 6.13 – Application to close branch surgeries in Hawkesbury Upton and Wickwar from Culverhay Surgery – DB confirmed that the Primary Care report was forwarded to the Health and Wellbeing Board. **Item Closed.**

### **5 Primary Care Strategy**

#### **5.1 Primary Care Workforce Plan**

5.1.1 BB introduced this draft report which was taken as read. BB advised that the CCG had been working closely with stakeholders such as its member practices, Health Education England (HEE) South West and the Gloucestershire Local Medical Committee (LMC) to provide greater consistency of support to the sustainability of the primary

care workforce in the county.

- 5.1.2 BB advised that the draft Primary Care Workforce Plan was focused on:
- the recruitment, retention and return of the GP workforce using the structure of the GP workforce 10 point plan;
  - the education and training of the Practice Nurse workforce; and
  - new skill mixes in primary care, with new roles to support the current primary care professionals including the addition of the prescribing pharmacist role.
- 5.1.3 Members were informed that the CCG undertook a short survey to which 78 of the 81 practices had responded. It was highlighted that 40% of practices were currently carrying GP vacancies.
- 5.1.4 BB advised that the CCG have agreed to provide significant investment in order to support member practices in the recruitment of general practitioners, by producing a multi-media campaign (print, online, social media) and the provision of recruitment advertisements for practices with the British Medical Journal (BMJ) during 2016/17. The campaign would promote Gloucestershire as a place to work in as a general practitioner, and also highlight the benefits of the county's healthcare system alongside the benefits to residents such as recreational, sporting and cultural activities.
- 5.1.5 It was noted that the Gloucestershire Community Education Provider Network (CEPN) was due to be set up in Quarter 1 of 2016/17 following funding approval from HEE South West. The CEPN would further support the training and education requirements for the entire Primary Care workforce, providing greater consistency of training and education to benefit the entire primary care system in the county.
- 5.1.6 AS advised that a national roadmap was still awaited which was due to be issued in January 2016.
- 5.1.7 CG suggested that the cost implications associated with the Plan should be outlined. CG suggested that the syntax of the pharmacist section within the report needed further attention as he felt that it

was not consistent with other sections of the report.

5.1.8 JC queried if there were any plans for the CCG Practice Nurse Coordinator to be part of the Primary Care Workforce and Education Group. BB advised that the Terms of Reference for this Group was being reviewed.

5.1.9 JC requested that further work on the skill mix was undertaken particularly regarding allied health professionals and physicians assistants.

5.1.10 JC also requested that this work needed to be mapped through for patients and that a one-stop healthcare approach was considered.

5.1.11 AE sought assurance that there would be sufficient financial resources allocated to deliver these plans. CL advised that funds had been set aside and that these would need to be worked through during the business case development process.

5.1.12 BPi enquired on the wider patient engagement plans and it was noted that this was being developed. BPi suggested that a proactive approach was embedded as part of the process.

5.1.13 DB queried if the Committee should probe on the statistic that 30% of GPs who were on long term sickness as indicated in the survey and enquired on the support available for GPs. AS advised that the CCG would not get involved with specific details regarding the sickness although LMC and Occupational Health had facilities available to support the GPs.

**5.1.14 RESOLUTION: The Committee:**

- **considered the contents of the draft plan;**
- **provided comments and feedback on the key aspects;**
- **suggested areas for refinement where further information was required; and**
- **confirmed that regular updates regarding the development of this plan should be provided at meetings.**

**5.2 Primary Care Infrastructure Plan 2016 – 2021**

- 5.2.1 AH presented the Plan which was taken as read. The Plan was previously presented at the January 2016 Committee meeting. The following key amendments had been made:
- an additional section relating to the out of hospital service strategy had been added to the Plan;
  - appendices had been updated to include all practices. However, it was highlighted that Prices Mill Surgery was inadvertently deleted and would be corrected in the final version;
  - refinement to patient flow assumptions in the Stroud area as a result of the closure of St Luke's surgery;
  - slight refinement to strategic priorities; and
  - updated financial framework to take into account land cost assumptions and changes to some schemes.
- 5.2.2 AH updated members on the financial assumptions associated with the project and it was noted that an assumed land cost of £0.5m per scheme had been allocated. A capital cost of approximately £40m had been assumed which would be invested by the Practice or by the 3rd party developers. It was noted that the revenue cost equated to approximately £3m.
- 5.2.3 AE queried the assurance process in delivering this plan considering that this would be a major transformation project. AH advised that he was working closely with the Regeneration Teams and developers and felt that there were positive outcomes to be gained which could present additional opportunities particularly if it was the right outcome for the patients. AH highlighted that the Cheltenham development was making good progress although it was noted that other developments could be challenging.
- 5.2.4 JC suggested that a link to the health needs and inequality should be added to the Plan.
- 5.2.5 JC drew attention to page 29 of the report and requested clarity that the priorities supported the CCG commissioning intentions.
- 5.2.6 JC highlighted that the Plan should also align with the Health and Wellbeing Board Plan to ensure that the work was joined up.

- 5.2.7 AE queried how this would link with the locality plans. AH informed members that he was working with the practices to coordinate the proposals for the Primary Care Transformation Fund application and advised that a reference to the locality plans would be included within the application.
- 5.2.8 AE highlighted that there were GP practices that were working in outdated buildings. AH advised that staff had become accustomed with their working environment and that it was important that staff had suitable working conditions in the future. AH advised that there was a clear strategic intention for a case for change business case. CL advised that she was aware of the financial impact associated with the business cases and that these would be worked through a robust prioritisation process.
- 5.2.9 BPi queried the timeline for the engagement process as the report indicated that this was scheduled around January- March 2016 and if there was any feedback from this process. AH advised that a discussion of the Strategy was undertaken at a Gloucestershire Patient Participation Group (PPG) event in January 2016 and that he also attended individual PPGs and locality stakeholder group meetings. AH considered that patients and key stakeholders would be fully involved in the process. BPi considered that buy-in from an early process was important in order to gain support from stakeholders.
- 5.2.10 DB understood that there were difficulties acquiring land in certain areas and queried the approach to counter this. AH concurred that there was a challenge around land availability and that this was a key risk associated with the project and would be worked through with the councils.
- 5.2.11 AH advised that a final proof read of the document would be undertaken.
- 5.2.12 **RESOLUTION: The Committee agreed to recommend the Plan to the Governing Body for approval.**

## **6 Primary Care Quality Report**

- 6.1 MH introduced the Primary Care 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.
- 6.2 MH advised that if the Committee felt that any further information was required in future reports then, they should contact the Quality Team who would support these requests if the information was available.
- 6.3 MH drew attention to the following key areas:
- serious incidents;
  - complaints and concerns;
  - safeguarding;
  - Primary Care Clinical Quality Review Group;
  - GP services Friends and Family Test;
  - GP patient survey;
  - Patient Participation Groups (PPG);
  - CQC inspections;
  - Medicines Optimisation; and
  - Workforce.
- 6.4 DB enquired if the new GP lead for Safeguarding Adults and Children would attend as a representative to the Adults and Children Safeguarding Board. AS advised that the CCG was sufficiently represented at these Boards (MAE and AS were members) and that the GP would liaise with the representatives.
- 6.5 JC highlighted that the Primary Care Quality Report was not an assurance report and that the assurance was provided by the IGQC.
- 6.6 AS drew attention to section 6.2.5 regarding the GP patient survey and highlighted that Gloucestershire results were higher than the national average. The Committee commended the results recognising that there was further work to address the lower quartile results.
- 6.7 AS drew attention to section 8.4 and clarified that the primary care offer included an '*incentive requiring a 1% reduction on **optimising***

*antibiotic prescribing'*

6.8 BP explained that the GP patient survey was usually undertaken twice a year and highlighted that this was now being reduced to once a year. BP advised that she was investigating the reasons for this.

6.9 BP advised that there were issues with the Friends and Family Test (FFT) response rates and informed members that she was presenting the FFT to the PPG Network Meeting being held on the 8<sup>th</sup> April 2016. It was anticipated that the PPGs could encourage practices to promote this further.

6.10 **RESOLUTION: The Committee noted the report.**

## 7 **Finance**

### 7.1 **Delegated Primary Care Commissioning Financial Report**

7.1.1 AB presented the report which was taken as read. The report outlined the financial position on delegated primary care co-commissioning budgets.

7.1.2 AB advised that the CCG reported an underspend of £111K against delegated primary care co-commissioning budgets as at the end of February 2016 which represented a marginal increase to the underspend reported in the previous month. AB advised that the CCG were forecasting a breakeven position for 2015/16.

7.1.3 AB updated members on the reporting arrangements and advised that a standing report would be presented at future meetings.

7.1.4 **RESOLUTION: The Committee noted the contents of the paper.**

### 7.2 **2016/17 Budget Proposals**

7.2.1 AB presented the report which outlined the assumptions applied in setting the draft budgets for 2016/17 for delegated co-commissioning within the CCG. The report was taken as read.

- 7.2.2 AB advised that the budgets had been worked through with the Primary Care Team and it was noted that there were minor changes made to the statement of financial entitlement and that these had been reflected within the proposed budgets. AB advised that there were some risks associated with the changes and that an update would be provided at the next Committee meeting in May 2016. CL
- 7.2.3 AB advised that assumptions had been made for the impact of new developments which are likely to become operational in 2016/17 and that these were being reviewed with PropCo.
- 7.2.4 Members were advised that the primary care allocation included the funding which was previously held by NHS England for functions including primary care information governance. These services were currently provided by the CSU and it was highlighted that this cost would equate to approximately £200K per year. This represented a significant risk to the CCG and it was advised that further clarification had been requested from NHS England.
- 7.2.5 AS requested clarification on section 2.3.3 of the report regarding the 1% pay uplift and it was advised that this was a net uplift.
- 7.2.6 CG suggested that the initiatives which had been discussed earlier i.e. workforce should be included in the budgets and it was clarified that certain parts of the workforce strategy was not chargeable to the delegated budget.
- 7.2.6 **RESOLUTION: The Committee (AS abstained from voting) approved the primary care budget proposals and recommended that the Governing Body approved the budget.**

## **8 Primary Care Contracts**

### **8.1 Stow Surgery new premises development**

- 8.1.1 AH presented the report and provided a background context to the report. AH advised that the former NHS Gloucestershire Primary Care Trust approved a new surgery for Stow in March 2013 where the size and the financial envelope had been agreed.

- 8.1.2 AH advised that the practice was working with a third party developer to deliver the scheme but planning permission was refused on the Gypsy Field site which was preferred by the partners of the surgery. However, it was noted that planning permission had been granted on a site very close to the preferred site. AH stated that the priority for the CCG was that a long term provision of suitable primary care premises for a growing population was secured.
- 8.1.3 Members were informed that the practice had been working with third party developer since summer 2015 to finalise details for the development. The CCG have agreed to honour the previous commitment recognising that this was an alternative site.
- 8.1.4 However, it was noted that in order to obtain final approval to proceed, the District Valuer (DV) would need to review and confirm the Value for Money (VfM). AH stated that the DV had met with the practices and developers and that although the VfM report would not be available until late April 2016, he had ongoing discussions with the DV who had indicated that there should be no significant issues.
- 8.1.5 CG sought assurance that full support from the respective parties had been received and would not create strong media interest and it was considered that there was a small risk associated with this development possibly from the unsuccessful developer. AH articulated that the CCG interests were ensuring that there was good infrastructure in place to secure future provision for patients.
- 8.1.6 JC sought assurance that a due diligence process had been undertaken and that there was minimum risk of a legal challenge. MH responded that these would be reviewed as the scheme progressed.
- 8.1.7 **RESOLUTION: The Committee:**
- approved in principle to proceed to the already committed new Stow Surgery premises development subject to the District Valuer Value for Money report; and
  - delegated responsibility to AE and MH for final approval following receipt of the Value for Money report.

## **8.2 Prime Minister's GP Access Fund – moving to APMS contract with GCCG**

- 8.2.1 AH presented the report and provided a background context. AH advised that a countywide bid covering all 82 practices in Gloucestershire and managed through the jointly owned GP Provider company (GDOC) was submitted for the Prime Minister's Challenge Fund in January 2015. This funding was to support practices to trial new and innovative ways of delivering GP services and making services more accessible to patients. It was advised that £4m of funding was secured for one year.
- 8.2.2 AH advised that originally, the programme was due to be completed by March 2016 and any onward funding of services would need to be agreed with the CCG. Due to delays in commencing services, NHS England had agreed that £1.326m financial slippage can be carried over into the 2016/17 financial year to support three of the services; Choice+; Rapid Response+ and Specialist Nursing until September 2016.
- 8.2.3 It was noted that as part of the extension to the programme, it had been proposed that the time limited APMS contract transferred to the CCG from April 2016 until September 2016. This will be managed by the Primary Care and Localities Team along with the other APMS contracts held by CCG, with monthly contract meetings to oversee service delivery including financial and activity performance.
- 8.2.4 Members noted that the largest part of the programme had been Choice+ representing over 50% of the total investment and was expected to be the main service that would need to be considered for onward funding by the CCG. However, prior to this, a thorough evaluation would need to be undertaken and a business case will be prepared by GDOC, for consideration by GCCG.
- 8.2.5 Members noted that other strategic programmes were expected to be taken forward over the next few months and were likely to affect commissioning requirements. This would include a programme of work to review the design of primary and community based urgent care, which would commence in April. The purpose and focus would be to understand the current service provision and the delivery of the 7 day primary urgent care.

#### 8.2.6 **RESOLUTION: The Committee:**

- **considered the contents of the report;**
- **noted the progress made on the range of services provided through the Prime Minister's GP Access Fund;**
- **formally endorsed the novation and transfer of the time-limited APMS contract from NHS England to the CCG from April 2016; and**
- **noted that onward funding would require a business case to be presented to the Primary Care Commissioning Committee.**

#### 8.3 **Application for change to GP practice boundary – Mythe Medical Practice**

- 8.3.1 JG introduced the report and provided a background context to the report. JG advised that the Mythe Medical Practice had requested approval to move their boundary and decrease their practice area.
- 8.3.2 JG informed members that Mythe Medical Practice was formed from the merger of Watledge Surgery and Jesmond House Surgery.
- 8.3.3 JG advised that the practice was requesting that an area to the north of Tewkesbury was removed which was within the Jesmond House boundary and to remove an area which was currently served by both practices.
- 8.3.4 It was noted that the practice had proposed the rationalisation of the practice area would enable them to cope with future demand from the number of housing developments planned for Tewkesbury in the coming years.
- 8.3.5 JG advised that Mythe Medical Practice was proposing that existing patients from all the removed areas were retained, but that any new patients would not be registered with the exception that they would consider the addition of new babies to families that were already registered) from those areas.
- 8.3.6 JG reported that 189 patients were currently registered with Mythe Medical Practice in the area that would be affected and that 47% of

the patients in the area affected were over the age of 50.

- 8.3.7 Members were informed that the practice had confirmed there were no nursing homes, care homes or other residential care establishments in the areas that would be removed from the boundary.
- 8.3.8 It was noted that the practice had only registered three patients from these areas in the previous twelve months, suggesting that patients moving into the area had chosen to register with alternative practices. The area affected was relatively sparsely populated and had no special characteristics.
- 8.3.9 JG advised that neighbouring practices had been consulted within Gloucestershire and Worcestershire including Gloucestershire Local Medical Committee (LMC), Worcestershire LMC and Worcestershire CCG. The feedback from the consultation was outlined in section 3.5 of the report. It was noted that the practice had also received support from the PPG.
- 8.3.10 JG advised that a Quality and Sustainability Impact Assessment was undertaken and it was noted that the overall impact was assessed to be low.
- 8.3.11 JG drew attention to Appendix 1A and highlighted that there were areas of population within Worcestershire which were affected by this boundary change proposal and that this meant that they would only be covered by one Gloucestershire practice if the application was approved. It was indicated that there was approximately six dwellings where patients would no longer have a choice of GP practice.
- 8.3.12 AE queried if the rationale regarding impending developments was considered by the Primary Care Operational Group as part of the discussion when considering this application. AS drew attention to Appendix 1A and highlighted that there was minimum area coverage affected by this and considered that there would be an increase in practice mergers and felt that practical measures should be utilised.
- 8.3.13 RESOLUTION: The Committee:**

- considered the recommendation from the Primary Care Operational Group meeting on 15<sup>th</sup> March 2016; and
- agreed the boundary change request.

## **9 Verbal updates on previous PCCC decisions**

### **9.1 Springbank Surgery**

9.1.1 JG provided an update regarding Springbank surgery and achieved progress in the following areas:

#### **9.1.2 Clinical:**

- access improved by participation in winter pressures initiative and increase in same day appointments;
- establishment of chronic disease clinics in asthma, COPD and diabetes;
- provision of family planning session by specialist nurse;
- practice nurse training; and
- partner cover for 3 days a week at present, aiming to minimise the use of locums

#### **9.1.3 Practice:**

- growth in the list size by 150 patients in four months;
- change in clinical system to System One which would improve clinical coding; and
- practice to have own N3 connection commencing on 30<sup>th</sup> March 2016.

#### **9.1.4 Patient Engagement:**

- attended 2 meetings with PPG with positive response from the community; and
- patients were appreciative of the continuity of regular doctors.

#### **9.1.5 Collaborative Working:**

- met with 2gether Trust on mental health provision for primary care;

- close working with Hester's Way Neighbourhood Project;
- close working relationship with Cheltenham Pharmacy on site to fully maximise co-location;
- met with Gloucestershire Care Services over reception cover for the dental practice; and
- meeting with County Community Projects over social prescribing.

9.1.6 **RESOLUTION: The Committee noted the verbal update.**

## 9.2 PMS review

9.2.1 JG advised that a letter was sent to the PMS practices on the 21st December 2015 confirming the CCG reinvestment decisions in order that they could fully understand the impact of the changes on their practice.

9.2.2 The letter provided an explanation of the reinvestment of the PMS premium and an indication of the financial impact for their practice as well as outlining arrangements for ongoing consideration of reinvestment of the PMS premium as this was released over the next 5 years. It included a revised PMS Review schedule for their practice.

9.2.3 JG advised that no informal disputes had been raised and that the deadline was the 29<sup>th</sup> January 2016. JG advised that the PMS practices would be receiving their new contracts from the 1<sup>st</sup> April 2016.

9.2.4 **RESOLUTION: The Committee noted the verbal update.**

## 9.3 List Cleansing

9.3.1 JG provided an update on the list cleansing process and advised that the number of FP69 flags (removal of patients whose address was unknown) at the beginning of the process was 49,511. It was noted that as of 23rd March 2016, 68% had been updated. The practices have now had the flags extended on their systems to the 30<sup>th</sup> June 2016 as agreed and the payment to help with this work had been made to the practices.

9.3.2 It was advised that an email had been sent out to practices reminding them about the extension and the number of outstanding flags would be monitored and ensure practices were supported.

9.3.3 **RESOLUTION: The Committee noted the verbal update**

**10 Any Other Business**

10.1 There were no items of any other business.

**11 The meeting closed at 12:46.**

**12 Date and Time of next meeting: Thursday 26<sup>th</sup> May 2016 in the Board Room at Sanger House.**

Minutes Approved by Gloucestershire Clinical Commissioning Group  
Primary Care Commissioning Committee:

Signed (Chair):\_\_\_\_\_ Date:\_\_\_\_\_

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Priorities Committee minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the Priorities Committee meetings held on the 28 <sup>th</sup> April and 19 <sup>th</sup> May 2016.
<b>Key Issues</b>	<p>The April meeting considered the following areas:</p> <ul style="list-style-type: none"> <li>• the scoring evaluation and business cases agreement; and</li> <li>• North Cotswolds Clinical Pharmacists.</li> </ul> <p>The May meeting considered:</p> <ul style="list-style-type: none"> <li>• programmes and investments;</li> <li>• medicines optimisation;</li> <li>• Improving Access to Psychological Therapies;</li> <li>• Crisis Café in Gloucester City; and</li> <li>• Home Enteral Feeding Team.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None

<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Dr Andy Seymour Clinical Chair

## Gloucestershire Clinical Commissioning Group

Minutes of the Priorities Committee held at 2.00 p.m.  
on Thursday 28<sup>th</sup> April in the Board Room, Sanger House

### Present:

Dr Helen Miller (HM)	Clinical Chair
Alan Elkin (AE)	Lay Member, PPE and Vice Chair
Marion Andrews-Evans (MAE)	Executive Nurse and Quality Lead
Sola Aruna (SA) <i>part meeting</i>	Public Health Consultant (GCC)
Dr Caroline Bennett (CBe)	GP Liaison Lead - North Cotswolds Locality
Dr Charles Buckley (CBu)	GP Liaison Lead - Stroud & Berkeley Vale Locality
Joanna Davies (JD)	Lay Member, PPE
Dr Malcolm Gerald (MGe)	GP Liaison Lead – South Cotswold Locality
Colin Greaves (CG)	Lay Member, Governance
Dr Will Haynes (WH)	GP Liaison Lead - Gloucester City Locality
Cath Leech (CL)	Chief Finance Officer
Dr Tristan Lench (TL)	GP Liaison Lead - Forest Locality
Dr Hein Le Roux (HLR)	GP Liaison Lead – Stroud and Berkeley Vale
Ellen Rule (ER)	Director of Transformation and Service Redesign
Dr Andy Seymour (AS)	Deputy Clinical Chair
Mark Walkingshaw (MW)	Director, Commissioning Implementation
Dr Jeremy Welch (JW)	GP Liaison Lead - Tewkesbury Locality

### Apologies:

Mary Hutton (MH)	Accountable Officer
Helen Goodey (HG)	Director of Primary Care and Locality Development
Julie Clatworthy (JC)	Registered Nurse
Valerie Webb (VW)	Lay Member - Business
Dr Raju Reddy (RR)	Secondary Care Doctor
Sarah Scott (SS)	Director of Public Health

### In Attendance:

Alan Potter (AP)	Associate Director of Corporate Governance
Fazila Tagari (FT)	Corporate Governance Officer
Sadie Trout (ST)	Programme Manager

#### 1. Apologies for Absence

1.1 Apologies were noted as above.

#### 2. Declarations of Interest

2.1 All GPs declared a general interest relating to Primary Care matter.

### **3. Minutes of the Meeting held on the 10<sup>th</sup> March 2016**

3.1 The minutes were approved as an accurate record.

### **4. Matters Arising**

4.1 **8.10.2015 Item 5 – Acupuncture** JW advised that decommissioning had occurred in Tewkesbury and that a charitable trust had been set up. **Item Closed.**

### **4.2 8.10.2015 Item 6 – NOACs**

**6.4** It was noted that the practice level prescribing figures were covered under the Medicines Management workstream.

**6.11** The action relating to HCAs monitoring domiciliary INRs would be covered under the pathology review.

**6.13** This action relating to undertaking a communication exercise can be closed.

**Items closed.**

### **5. Scoring Evaluation and Business Cases Agreement**

5.1 ER gave a presentation which outlined the priorities for 2016/17 following the scoring evaluation process.

5.2 The presentation covered:

- the financial position;
- disinvestment;
- current position on the priorities process;
- proposed weightings;
- investment; and
- prioritised list.

5.3 The Committee noted that £1.5m had been budgeted to fund investments for 2016/17.

5.4 ER highlighted that to date, 13 members had submitted scores and proposed weightings. It was noted that the weightings had been taken as an average and was aggregated into the scoring matrix.

5.5 The proposed scores were weighted as follows:

- Strategic fit: 20%;
- Addressing Health Inequalities:15%;
- Quality and Outcomes: 20%;
- Deliverability: 20%; and
- Cost effectiveness: 25%

5.6 The prioritised list were ranked as follows:

1. Primary Care
2. Cancer
3. Homeless Healthcare Team
4. Patient information and self-care website
5. Developing capacity within the voluntary, community and social enterprise (VCSE)
6. Healthy habits, healthy communities
7. Health coaching for behaviour change
8. GP Education in Gloucestershire

5.7 It was noted that the mental health funding would be financed from an alternative source which had been set aside through the contracts.

5.8 ER also advised that a further business case would need to be considered which related to the North Cotswold Locality.

5.9 ER advised that the GP members' scores regarding the primary care priority had not been taken into account and that the score presented reflected the scoring provided by the non-GP members.

5.10 ER invited views from members regarding the expenditure of the £1.5m and how they would like this apportioned. ER advised that it was not necessary to allocate the entire funds at this stage. MGe felt that there should be contingency funds set aside.

5.11 ER suggested that the first seven priorities were considered and that the GP education proposal was reviewed in May whilst awaiting further details. The Committee agreed this approach.

5.12 MGe emphasised the importance of GP education and felt that it was an important element of the delivery i.e. McMillan Master Classes. ER advised that this would be considered at the May 2016 Priorities Committee.

- 5.13 CBU suggested that there should be a small fund reserved for innovation.
- 5.14 The Committee agreed that they were happy with the scoring evaluation process. The Committee approved the following schemes;
1. Primary Care
  2. Cancer
  3. Homeless Healthcare Team
  4. Patient information and self-care website
  5. Developing capacity within the voluntary, community and social enterprise (VCSE)
  6. Healthy habits, healthy communities
  7. Health coaching for behaviour change

*All GP members left the meeting at this point to discuss the next item about the North Cotswold Clinical Pharmacists paper excluding HM as she was not directly affected by the discussions.*

## **6. North Cotswold Clinical Pharmacists**

- 6.1 AE took the chair.
- 6.2 In view of the interest declared by GP members, it was agreed that Standing Order 3.6.3 would be invoked reducing the quoracy to those present.
- 6.3 ER tabled a draft paper regarding a pilot for clinical pharmacists for the North Cotswold Practices. It was noted that this pilot could be rolled out to other localities although recognising that there were high costs associated with the pilot.
- 6.4 The pilot aimed to reduce locality prescribing overspends by introducing 2 WTE Clinical Pharmacists to work across all 5 North Cotswold practices.
- 6.5 ER provided a background context to the issues and felt that this was a positive move by the locality in order to drive improvements and that the CCG should support this development. CL added that historically North Cotswold had been the highest outlier on practice prescribing.
- 6.6 HM considered that robust Key Performance Indicators (KPIs)

should be established and would need to be reviewed continuously.

- 6.7 ER enquired about the NHS England pilot and was advised by HM that this pilot was intended to help GPs manage the demands on their time. This also included providing extra help to manage long-term conditions, advice for those on multiple medications and better access to health checks. Members noted that this was a different pilot model compared to the proposed pilot for North Cotswold.
- 6.8 MW highlighted that the North Cotswold locality had issues with prescribing overspend recognising that they required intensive support in order to improve performance.
- 6.9 HM felt that the pilot should be differentiated from the NHS England pilot.
- 6.10 CG expressed concerns regarding dispensing habits. ER informed members that the General Medical Council (GMC) was developing new conflicts of interest guidance for dispensing practices and that the new guidance should also be issued nationally.
- 6.11 CG suggested that the pilot started in-year and that the finance was spread over two years. It was agreed that pilot should not run on a recurrent basis.
- 6.12 JD expressed concerns regarding one of the key risks identified which related to the buy-in from all five practices. JD felt that this was central to the successful delivery of the project and enquired if financial contribution could be considered in order to secure buy-in.
- 6.13 CL advised that the pilot was being run for a year and that the CCG would hold the employment rights. CL highlighted that the employment risks would be with the CCG and questioned the employment terms and conditions as the post would be a fixed term contract and felt that the long term proposals would need to be considered.
- 6.14 JD felt that there was a significant amount of pump priming and that the long term benefits needed to be considered as well. JD felt that the practices should be thinking about sustainability in order that change management was embedded as a long term approach.
- 6.15 The Committee agreed that the pilot should be distinct from the NHS England pilot and suggested that this was named as

'Pharmacy Support Plus'.

- 6.16 CL advised that this investment would be based on sign up from the locality to achieve a QIPP saving of £400k within 2016/17. It was felt that there was a lot of focus to deliver savings in year one and that there should be a programme of work to evidence recurrent impact.
- 6.17 HM suggested that the pilot should be monitored on a regular basis in order to track performance and that any remedial actions could be undertaken systematically if this were necessary.
- 6.18 **RECOMMENDATION: The Committee (HM abstained from voting) supported the proposals on a fixed term basis with a clear evaluation and review process in place.**

*All GP members re-joined the meeting*

- 6.19 The GP members were updated regarding the above proposal and the decision that had been undertaken.
- 6.20 CBu queried how this pilot could be separated from the prescribing improvement plan. CL advised that it would run concurrently with the plan.
- 6.21 HM took the chair.

## **7. Any Other Business**

- 7.1 HM advised that new conflicts of interest guidance would be issued shortly and that further training would be provided.

**The meeting closed at 15:20pm.**

**Date and time of next meeting:** Thursday 19<sup>th</sup> May 2016 at 2pm in the Boardroom, Sanger House.

**Circulation:** GCCG Governing Body and attendees and at today's meeting

**Gloucestershire Clinical Commissioning Group**

Minutes of the Priorities Committee held at 2.00 p.m.  
on Thursday 19<sup>th</sup> May in the Board Room, Sanger House

**Present:**

Dr Andy Seymour (AS)	Clinical Chair
Alan Elkin (AE)	Lay Member, PPE and Vice Chair
Mary Hutton (MH)	Accountable Officer
Julie Clatworthy (JC)	Registered Nurse
Valerie Webb (VW)	Lay Member - Business
Dr Raju Reddy (RR)	Secondary Care Doctor
Sarah Scott (SS)	Director of Public Health
Joanna Davies (JD)	Lay Member, PPE
Dr Malcolm Gerald (MGe)	GP Liaison Lead – South Cotswold Locality
Colin Greaves (CG)	Lay Member, Governance
Dr Will Haynes (WH)	GP Liaison Lead - Gloucester City Locality
Cath Leech (CL)	Chief Finance Officer
Dr Tristan Lench (TL)	GP Liaison Lead - Forest Locality
Dr Hein Le Roux (HLR)	GP Liaison Lead – Stroud and Berkeley Vale
Ellen Rule (ER)	Director of Transformation and Service Redesign
Mark Walkingshaw (MW)	Director, Commissioning Implementation
Margaret Willcox (MWi)	Director of Adult Social Care

**Apologies:**

Helen Goodey (HG)	Director of Primary Care and Locality Development
Dr Jeremy Welch (JW)	GP Liaison Lead - Tewkesbury Locality
Dr Caroline Bennett (CBe)	GP Liaison Lead - North Cotswolds Locality
Marion Andrews-Evans (MAE)	Executive Nurse and Quality Lead

**In Attendance:**

Ian Goodall (IG)	Associate Director of Operational Planning and Programme Management
Mark Gregory (MGr)	Medicines Management Lead
Karl Gluck (KG)	Lead Commissioner for Mental Health
Zoe Riley (ZR)	Commissioning Manager (Planned Care)
Annemarie Vicary (AV)	Head of Planned Care
Fazila Tagari (FT)	Corporate Governance Support Officer
Sadie Trout (ST)	Programme Manager
Charlotte Waddon (CW)	Board Administrator

**1. Apologies for Absence**

1.1 Apologies were noted as above.

## **2. Declarations of Interest**

2.1 All GPs declared a general interest relating to prescribing.

2.2 MGe declared an interest relating to dispensing.

## **3. Minutes of the Meeting held on the 28<sup>th</sup> April 2016**

3.1 The minutes were approved as an accurate record.

## **4. Matters Arising**

4.1 **28.04.16 Item 6.17 – North Cotswold Clinical Pharmacists –**  
Update to be provided at the September 2016 meeting.

## **5. Structured discussion of programmes and investments for 2016/17**



Priorities Committee  
Presentation 19.05.1

5.1 ER presented the attached PowerPoint which provided an overview of four proposed schemes to be implemented in 2016/17 for discussion.

5.2 ER provided an update on the progress to date on the prioritisation process and advised that nine schemes had been authorised to business case development and that £1.2m recurrently had been committed from the £1.5m investment fund available.

## **6. Medicines Optimisation**

6.1 MGr presented a disinvestment proposal to support an amendment to the CCG black list (medications that the CCG believed should not be used).

6.2 These were for:

- gluten free foods;
- enteral nutrition - SIP Feeds;
- oral erectile dysfunction drugs – Non-Sildenafil.

- 6.3 MGr informed members of the progress to date and advised that the Drugs and Therapeutic Committee members approved the changes in principle in April 2016.
- 6.4 It was noted that the QIPP target for 2016/17 was £4.4m and highlighted the savings opportunities as outlined in slide 9 of the PowerPoint presentation. The risks and issues were outlined in slide 10 of the presentation.
- 6.5 MGr advised that an Equality Impact Assessment had been undertaken for all three proposals.
- 6.6 Gluten Free Food
- 6.6.1 MGr advised that the proposal was to stop the prescribing of Gluten Free Food and noted that these were widely available in supermarkets at a reasonable value.
- 6.6.2 MGr provided a background context to the proposal and advised that these were historically provided for over 30 years and that other CCGs had reviewed the appropriateness of this spending and as a result ceased prescribing i.e. Norfolk CCG.
- 6.6.3 Resolution: The Committee voted unanimously in favour of the proposal to stop providing gluten free foods on prescription.**
- 6.7 SIP Feeds
- 6.7.1 MGr advised that the proposal was to end the NHS prescription by Primary Care prescribers of non-tube enteral feeding with 'sip feeds' and other orally taken food products.
- 6.7.2 Members noted that advice had been sought and that all patients with possible malnutrition should be assessed with a MUST (Malnutrition Universal Screening Tool) and should be offered advice based on the 'Food First' approach.
- 6.7.3 MGr explained that patients with Dysphagia, End of Life and End Stage Dementia would be excluded from the policy.
- 6.7.4 MGe expressed some concern that the eligibility criteria for patient exclusion groups might be considered by some to be narrow. MGr advised that further details should emerge from the consultation process which would provide further clarity.

- 6.7.5 AS queried how this would be monitored as he felt that this could be challenging for primary care. MGr advised that a robust process would need to be developed and that this would be clearer following the consultation process.
- 6.7.6 WH queried the proportion of patients that had been prescribed SIP Feed that were from care homes, palliative care and frailty groups. MGr advised that he would need to investigate this. WH felt that further details were required in order to support effective decision making.
- 6.7.7 MH enquired how Gloucestershire benchmarked against other areas and it was noted that this was average.
- 6.7.8 RR suggested that a pilot was undertaken and implemented for low risk groups and that this could be rolled out to other groups based on the outcome of the pilot.
- 6.7.9 ER considered that further discussions were required and ER suggested that a meeting was held to discuss this proposal in detail.
- 6.7.10 AS suggested that a reminder of the current guidelines were issued in the 'What's New This Week' bulletin.
- 6.7.11 Resolution: The Committee voted in favour of awaiting the outcome of further discussions and consideration of the details of the proposal to restrict SIP feeding prescribing.**
- 6.8 Non-Sildenafil
- 6.8.1 MGr advised that the proposal was to limit the prescription of Non-Sildenafil by switching to generic Sildenafil and only offer the option of generic sildenafil for future patients.
- 6.8.2 WH enquired about the non-compliance rates with the guidance for prescribing Non-Sildenafil by clinicians and was advised that previous guidelines stated that sildenafil was only prescribed for Erectile Dysfunction patients who meet treatment criteria and also recommended the use of the lower cost product, generic sildenafil.
- 6.8.3 WH stated that the current recommendation from local secondary care specialists for the prescribing of Tadalafil for penile

rehabilitation following prostate surgery needs to be addressed separately as this was a significant indication for the current levels of non-sildenafil prescribing.

- 6.8.4 RR understood that there was limited evidence to support the use of Non-Sildenafil and queried if learning can be learnt from other CCGs and what controls they had implemented.
- 6.8.5 AS questioned the monitoring process and the consequence of a GP prescribing non-sildenafil. MGr advised that a robust strategy would need to be developed to manage any relevant follow-up prescribing.
- 6.8.6 MGe suggested if this could be added to the Individual Funding Request (IFR) process.
- 6.8.7 The Committee agreed that usage was monitored during the next four months.
- 6.8.8 MH advised that the type of consultation process required for each of these proposals would need to be worked through with the engagement team and that any feedback would be reported back.
- 6.8.9 The Committee agreed that an evidence based summary should be provided for consideration before agreement to the proposal of also not allowing non sildenafil prescribing for penile rehabilitation following prostate surgery.
- 6.8.10 **Resolution: The Committee voted unanimously in favour of the proposal for the restriction of non-generic sildenafil prescribing for erectile dysfunction. This would include the addition of non-sildenafil drugs as an IFR and supporting prescribing guidance and policy documentation would be developed.**

## **7. Improving Access to Psychological Therapies (IAPT)**

- 7.1 KG presented a proposal regarding IAPT and provided a background context to the issues particularly the challenges meeting the access targets.
- 7.2 KG advised that the current access target was 15% and the target recovery rate was 50%. It was noted that the recovery rate target had been satisfactory.

- 7.3 KG advised at the time an estimated approx. additional investment of £940k was required but it was also proposed that some issues could be addressed through the integration of the Let's Talk and Primary Mental Health Service. The merged service was commissioned via 2gether and became known as the Mental Health Intermediate Care Team (ICT).
- 7.4 KG advised that during 2015, it became apparent that there was an issue with 2gether performance with regards to the recovery rates although the access target had increased to 19%.
- 7.5 KG advised that the Mental Health Intensive Support Team conducted a review of the service which made a number of recommendations which included the removal of reporting nursing activity.
- 7.6 It was noted that the changes to the model should enable the achievement of the target recovery rate of 50%, but it was likely that the access target would drop to below 11% from current position of circa 19%.
- 7.7 The report references significant hidden waits (3 months for step 2, 6 months for step 3) that were not visible to the commissioner. Further work would be required to understand these wait times and what resource might be required to address these in both the short term and longer term.
- 7.8 KG advised that the report also indicated that there was a current resource gap of 22 WTE therapists (circa £900k) that were required in order to deliver the national standard.
- 7.9 KG proposed that an investment of £300k recurrent funding was required to train new therapists and £110k non-recurrent to explore the potential for introducing online real time therapy at steps 2 and 3 within the pathway with IESO digital.
- 7.10 MH expressed concerns regarding the hidden waiting times relating to the step 2/3 psychological therapies and requested further clarity regarding the issues. MW recognised that detailed work was being undertaken to address the issue but highlighted that this would be a starting point and that any outcome would be reported at a future meeting.

7.11 CG queried if £300k was a realistic assumption and if there should be additional funding. KG advised that further work on the capacity modelling was being undertaken jointly with 2gether which should release some capacity. It was noted that the report also identified low productivity and suggested that the current workforce, if well supported, could deliver more clinical time.

7.12 **RECOMMENDATION: The Committee voted unanimously in favour of the proposals to invest funds in IAPT.**

## **8 Crisis Cafe in Gloucester City (Mental Health)**

8.1 KG presented a proposal for a piloted within Gloucestershire to provide a viable alternative for individuals with mental health issues. It was proposed that a crisis café was provided offering a range of hot and cold drinks, offering support from trained staff and volunteers as well as social interaction and peer support.

8.2 Access to the service would either be through self-referral (drop in) or through referral from mental health teams, ED, GPs, Social Services and the Police.

8.3 This proposal also offers an opportunity to expand and develop third party voluntary and community sector organisations in Gloucestershire, and to build relationships between different organisations.

8.4 KG advised that the service would run for 7 day a week offering support and advice for those with Mental Health needs between 6pm and 11pm.

8.5 It was proposed that the crisis café was trialled in The Cavern to extend the already well established provision on offer from Kingfisher Treasure Seekers.

8.6 KG requested that a proposed investment of £89k was required to trial the crisis café model in Gloucester City for 12 months. It was agreed that this would be non-recurrent funding.

8.7 SS highlighted that a Drugs and Alcohol support service was located within Gloucester City and suggested if this could be interlinked. MH advised that they had been approached and the operating hours provided had not been suitable.

**8.8**      **RECOMMENDATION: The Committee (MWi abstained from voting) voted unanimously in favour of the investing in a pilot for 12 months in the crisis café.**

**9**          **Home Enteral Feeding Team (HEFT)**

9.1        ZR presented a paper relating to HEFT and provided a background context to the issues.

9.2        ZR highlighted that the service was not currently resourced to match patient numbers and the patient case mix. It was noted that patient numbers had increased approximately by 36% from 2010 to current levels and that the case mix had also changed, with an increase in the complexity of patients i.e. paediatric patients and patients with learning difficulties.

9.3        ZR highlighted that both these patient groups required considerably more resources than a standard adult patient.

9.4        Members were informed that the National STAR College also had a cohort of students that required considerable resource from the service. This cohort has grown over the years (9 in 2010 to 28 in 2016). ZR stated that they had also recently lowered their age threshold from 18 to 16.

9.5        ZR advised that due to the service not being sufficiently resourced to meet its current population base, this had an impact to the quality of the service. It was noted that this issue had also been included in the GHFT Risk Register.

9.6        It was noted that the Nutricia contract was due to deliver savings due to a reduced cost on feed products. However, the forecast overspend for 15/16 was £174k. After financial analysis, the overspend had been attributed to a higher than expected use of the plastic items required for home enterally fed patients.

9.7        ZR considered that clinical input from the service was required in order to provide further clarity on any overspends as these could be due to misuse or over ordering of some of these items by patients or care homes.

9.8        The proposal of an increased recurrent funding of £151k in addition to their current block funding was requested.

9.9 MH queried if a QIPP target for the contract had been established and was advised that this was not currently within the QIPP programme.

9.10 RR suggested that a parent education programme was developed. AV advised that an education programme was already in place but due to resourcing gaps, this had not been consistently undertaken.

9.11 **RECOMMENDATION: The Committee approved the proposal to invest funding for the HEFT subject to further QIPP targets being identified.**

## 10. Next Steps

10.1 ER tabled a paper which provided details of possible options. These were:

- option 1 – approve all the proposal even though the total amount exceeds the £1.5m ‘investment pot’;
- option 2 – only approve the proposals to fund recurrently and non-recurrently within the remainder of the £1.5m ‘investment pot’;
- option 3 – only approve the proposals to fund recurrently within the remainder of the £1.5m ‘investment pot’; and
- option 4 – reconsider these proposals against previous decisions to recurrently fund within the £1.5m ‘investment pot’.

10.2 AS considered that a re-scoring process should be undertaken and that the GP education was included as a benchmark figure.

10.3 MH articulated that the mental health services should be a priority due to the performance issues within Gloucestershire and suggested that a QIPP target for HEFT was set in order to release some savings. MW considered that there was a potential opportunity for the savings target but further scoping was required.

10.4 MH suggested that other sources of funding could be sought to fund CL for IESO Digital for the IAPT service. CL advised that the Tech Fund could be a possible source of funding and agreed that she would explore this.

## 11. Summary of Proposals/Recommendations

- 11.1 Gluten Free – approved subject to agreement of consultation process.
- 11.2 SIP Feeds – await further details
- 11.3 Non-Sildenafil – approved the restriction of non-generic sildenafil with monitoring of usage over the next four months.
- 11.4 IAPT
- approved further investment into IAPT
  - IESO Digital – to seek other sources of funding.
- 11.5 Crisis Café – approved for one year as a pilot.
- 11.6 HEFT – approved subject to further QIPP Targets being identified.

## **12. Any Other Business**

- 12.1 AS advised that his three year reign as a CCG Appointed Governor at GHFT had ended and was seeking volunteers to take up this position. It was noted that this meeting was held bi-monthly on Wednesday at 5.30pm.

**The meeting closed at 15:15pm.**

**Date and time of next meeting:** Thursday 9<sup>th</sup> June 2016 at 2pm in the Boardroom, Sanger House.

**Circulation:** GCCG Governing Body and attendees and at today's meeting

**Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 28<sup>th</sup> July 2016</b>
<b>Title</b>	<b>Joint Commissioning Partnership Board Minutes</b>
<b>Executive Summary</b>	The attached minutes provide a record of the Joint Commissioning Partnership Board meeting held on the 10 <sup>th</sup> December 2015.
<b>Key Issues</b>	<p>The following principal issues were discussed:</p> <ul style="list-style-type: none"> <li>• Joint Commissioning Partnership Finance Report;</li> <li>• devolution update;</li> <li>• impact of spending review;</li> <li>• GCS contract update; and</li> <li>• integration update.</li> </ul>
<b>Risk Issues: Original Risk Residual Risk</b>	Not applicable
<b>Financial Impact</b>	Not applicable
<b>Legal Issues (including NHS Constitution)</b>	Not applicable
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	The Governing Body is requested to note these minutes which are provided for information.
<b>Author</b>	Alan Potter
<b>Designation</b>	Associate Director of Corporate Governance
<b>Sponsoring Director (if not author)</b>	Mary Hutton Accountable Officer

**Gloucestershire County Council & Gloucestershire Clinical  
Commissioning Group  
Joint Commissioning Partnership Board (JCPB)  
Thursday 10 December, 2015 9:30am – 11:00am  
Meeting Room 2, Shire Hall**

**Minutes**

*These minutes may be made available to public and persons outside of the Gloucestershire NHS and Gloucestershire County Council community as part of the community's compliance with the Freedom of Information Act*

Present:

Cllr. Paul McLain (Chair)	PMcL
Cllr. Dorcas Binns	DB
Kim Forey	KF
Cath Leech	CL
Dr Helen Miller	HM
Sarah Scott	SS
Linda Uren	LU

In Attendance:

Stella Moran (Minutes)	SM
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Apologies:

Mary Hutton	MH
Jo Walker	JW
Mark Walkingshaw	MWa
Margaret Willcox	MWi

1.0	Apologies Apologies were received from Mary Hutton, Jo Walker, Mark Walkingshaw and Margaret Willcox	
2.0	Minutes from the last meeting and Matters Arising	
	<p>The minutes from the last meeting held on 11 June 2015 were agreed as a true record.</p> <p>Action 001: CAMHS update - Simon Bilous (SB) to be contacted to confirm whether the App is available to download, and advise by email.</p> <p>Action 002: CAMHS update - SB provided a briefing note for the Health &amp; Well Being Board meeting on 21 July, 2015.</p> <p>Linda Uren (LU) reported that the Transformation Plan had been accepted.</p>	

3.0	Joint Commissioning Partnership Finance Report – Cath Leech	
	<p>Cath Leech (CL) presented a copy of the report which was discussed at JPCE on 9 December 2015.</p> <p>The net variance across all agreements is an underspend of £0.4m</p> <p>The significant variances and movements are;</p> <p>£0.8m overspend on Mental Health Services, representing forecasts for the GCC-funded S75 services. The main pressure area is External Care. Discussions continue between representatives from GCC, 2G and the CCG within the Short Life Working Group, to address both budgetary and contractual issues. The overspend has decreased by £0.1m, again relating to External Care.</p> <p>The reported position for the Community Equipment Service (CES) is an £0.4m overspend, based on equipment costs for the first five months of the year and projected savings under the CES Financial Recovery Plan.</p> <ul style="list-style-type: none"> <li>• The projected overspend before forecast further savings is £0.8m, which includes £0.3m of banked savings. A further £0.3m savings are forecast.</li> <li>• Based on current year contributions (including CHC), GCC would pick up £0.13m of this cost, CCG £0.27m (of which £0.04m relates to GHNHSFT).</li> </ul> <p>Telecare budgets are forecast to be over-spent by £0.15m, after offset of £0.5m Care Act funding agreed for Telecare. The underlying overspend (£0.65m) is due to an increased staffing establishment and equipment purchases, following expansion of the service to support commissioning intentions.</p> <p>As the £0.5m is taken from Care Act Grant linked to implementation which is now delayed, there is a risk that funding could be recouped or have a changed focus, in which case it wouldn't be available. The DoH has not confirmed their stance. The funding has been agreed on a non-recurrent basis, so there would be a cost pressure for future years if levels of expenditure aren't reduced.</p> <p>£0.15m overspend relating to joint funded care packages (£0.2m last month). This has been a pressure during 13/14 and 14/15.</p> <p>The CCG currently advance £20m over the year towards CHC/FNC and the original budget shown in JCPE reports only referenced this advance. The CCG also funds an additional £11m which is now included in JCPE reports for completeness. The forecast underspend on CHC/ FNC, based on seven months of payments is £1.9m (£1.0m last month); the current position being subject to a detailed review of commitments and triangulation of data between GCC and CCG systems.</p> <p>BCF – no change for funding next year.</p>	

	<p>Kim Forey (KF) advised the Integrated Community Equipment Service (ICES) was providing more equipment and delivering more quickly, which was a positive sign. Savings are on track. The service is being monitored by JCPB. Donna Miles is leading on this.</p> <p>Linda Uren (LU) confirmed that there were many social care pressures. Mental Health ongoing costs are a worry as there has not been much recovery. Work continues with 2gether Trust. Contractual incentives are being considered. The integrated workforce will focus on core assessments and reviews.</p> <p>Helen Miller (HM) stated that as social care improvements are implemented associated mental health services and mechanisms will also improve. Budget alignment and joint commissioning should improve services. A pilot scheme - 'Community/Personal Health package' for vulnerable people is currently being evaluated by Vikki Walters (VW). Conversations are taking place between, the employment service, 2gether, health and social care in relation to employment support.</p> <p>VW is working with voluntary organisations who are leading on a bid to obtain European Social Funding (ESF) (£3.2m x 2 years) to assist vulnerable people into employment. Confirmation of success is expected 16 June 2016.</p> <p>LU asked if joint commissioning is achieving objectives.</p> <p><b>Action 001:-</b> Vikki Walters, Karl Gluck, and Jennifer Taylor to be invited to JCPE to discuss where issues lie, areas for priority and other opportunities.</p> <p><b>Action 002:-</b> Question for JCPB 'Are we commissioning effectively for mental health services?'</p>	
4.0	Devolution update – Dr Helen Miller	
	<p>Helen Miller (HM) reported that the Devolution debate was interesting. Richard Graham attended.</p> <p>NHS England has published the principles and criteria – NHS will stay with the Secretary of State.</p> <p>Gloucestershire has submitted a bid. Elements of the bid have been accepted although Housing and Governance have been challenged. Approval is expected in January 2016.</p> <p>Government have 75% control of the local budget.</p> <p>LU asked what differences devolution would make as we are already looking at integrated commissioning and opportunities.</p> <p>It was agreed that devolution would bring combined authority - elected members and non-elected members were equal partners in the governance structure.</p>	

	<p>District councillor's need to have a full understanding of the devolution principles and criteria, their accountabilities and ensure that where different arrangements apply they are within the Government guidelines.</p> <p>LU advised that Safeguarding and Community Safety are being brought together due to the impact of radicalisation and domestic homicide. The Council will need to look at the role of the Safeguarding Board for the future and review the Community Safety structure locally going forward. Currently there is no county infrastructure for Community Safety and there are variations in enforcement across districts.</p> <p>The Community Safety Partnership (CSP) has a duty to undertake safeguarding reviews. However a recent review (Holly Gazzard – Tewkesbury Borough Council) had no input from the County Council. Due to an increase in radicalisation 'Wardship' is being used more frequently.</p>	
5.0	Impact of spending review – Linda Uren	
	<p>LU advised that information was being shared and a settlement was expected to be agreed at the Cabinet meeting next week.</p> <p>The Education Support Services are revising statutory responsibilities. Many schools are becoming academies. Lower school funding rates are being received however the National Funding Formula should be of benefit.</p> <p>The New Homes Bonus is currently shared 80% Districts, 20% County this is expected to switch to 20% Districts, 80% County.</p> <p>Council tax proposals relating to the Government offer of LA charging an additional 2% year on year specifically for social care provide opportunities to invest in certain areas whilst making savings in other areas. Investment in social care will be targeted.</p> <p>HM commented that the public must be made aware of the limitations of care packages. Expectations need to reflect the Care Act legislation. Care packages should be explained so that the service user understands that provision of services meet 'needs' and not 'wants'.</p> <p>Cath Leech (CL) advised that prevention and health promotion are priority messages to influence changes in behaviours. Many items obtainable via prescription/NHS are readily available on the high street, such as:</p> <ul style="list-style-type: none"> <li>• Gluten free products</li> <li>• Hearing aids</li> </ul> <p>Debates are currently being held to decide what will be available. The public need to be encouraged to source items themselves rather than relying on the NHS.</p> <p>CL provided a hand-out itemising the 2015 spending review and impact on the NHS.</p> <ul style="list-style-type: none"> <li>• NHS England spending to increase by £8bn in real terms by 2020-21 and Department of Health spending to decrease (25% cut).</li> </ul>	



- NHSE £8Bn front loaded (£5.3bn in the next 2 years) as outlined in Simon Stevens 5 year Forward view.
- Reflection of pressure on social care in spending review, but consideration as to whether it's enough and therefore resulting impact on NHS services.
- Better Care Fund (BCF) continues, Government funding to be made available to Local Authorities of £1.5bn in 2019/20 for the BCF.
- 3.9% real terms cut to Public Health over the next 5 years which does not align with the 5 year Forward View.

Sarah Scott (SS) explained that Public Health is looking at how to reshape services in view of the cuts.

- 2.2% reduction in first year
- 2.5% year after
- 2.6% for two years after

There are issues with HIV/contraception/sexual health/abortion and pregnancy clinics as each attract different funding which will present challenges.

Commitments within the £8bn for the NHS include:

- Additional £600m in mental health, increasing access to talking therapies every year by 2020.
- NHSE mental health Taskforce due to report 2016 to inform plans, including perinatal mental health and coverage of crisis care.
- £1 billion investment in new technology over the next 5 years to deliver better connected services for patients.
- Reforms to the funding system for health students by replacing grants with student loans and abolishing the cap on the number of student places for nursing, midwifery and allied health subjects.
- Plans to sell nearly £2bn assets over the next five years to release land to build at least 26,000 new homes.
- Encouraging long term partnerships between NHS and the private sector to modernise buildings, equipment and services and deliver efficiencies.

CL advised that an aging population puts pressure on care services, and staffing levels are critical in delivering efficient services. Pay differences between councils causes problems as this attracts staff across the county borders.

The introduction of the National Living Wage does not impact the council directly; however it does impact on packages of care delivered by providers. Work continues with Jo Walker on a new framework effective from 1 April 2016.

6.	<p><b>GCS contract update</b></p> <p>CL advised that the Transformation Care Agenda was under discussion. Gloucestershire deferred joining the Foundation Trust route and the existing three year contract comes to an end in March 2016. A one year extension to the contract has been requested.</p> <p>A decision is expected mid January to confirm status TDA – Foundation Trust. Different rules for commissioning will apply. It will be a rolling contract and rights will change. If not successful a review will be required – followed by procurement which will involve a lot of work.</p> <p>PMcL asked whether this was the best model for the County.</p> <p>CL advised that the Gloucestershire Strategic Forum was looking at the options for service pathways.</p> <p>PMcL asked whether the findings would be made available.</p> <p>CL advised that the NHS Improvement Agency were holding discussions and testing different models. The Accountable Care Organisation is testing the capitation model. Learning is being shared by Manchester and Nottingham.</p> <p>There are still some organisational boundaries and conversations are yet to be held.</p> <p><b>Action 003:-</b> GSF Transformation update to be included in JCPB agenda.</p>	
7.	<p><b>Integration update</b></p> <p>CL and LU are working together to create the plan which is required by 2017 for integration in 2020. Currently only have headline information. Commissioning has been successful and discussions have already begun.</p> <p>A meeting is scheduled for 17 December 2015 and operational guidance should be available 24 December 2015.</p> <p>A visit to Plymouth is planned – they have already undertaken full integration including libraries and education and are reported to have good governance.</p> <p>Gloucestershire will undertake a staged approach to integration.</p> <p>Workshop sessions have taken place and Lead Commissioners are to begin the process.</p>	
8.	<p><b>AOB</b></p>	
	<p>CL advised that a letter concerning the Transformation Care Agenda for Learning Disabilities has been received and requires a joint response from NHS and Margaret Willcox. Chris Haynes is compiling a Memorandum of Understanding as an intention of advice for NHSE with a letter of authorisation.</p>	
	<p>Date of Next Meeting: TBC March 2016</p>	

DRAFT

**Table of Actions**

Agenda Item	Action No.	Action:	Lead	Status
3. Joint Commissioning Partnership Finance Report	001	Vikki Walters, Karl Gluck and Jennifer Taylor to be invited to JCPE to discuss where issues lie, areas for priority and other opportunities.	LU	
3. Joint Commissioning Partnership Finance Report	002	Question for JCPB 'Are we commissioning effectively for mental health services?'	LU	
6. GCS contract update	003	GSF Transformation update to be included in JCPB agenda.		