NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 25 May 2017 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

AGENDA

No.	Item	Lead	Recommendation
1	Apologies for Absence *PM, AE, KF, JW*	Chair	
2	Declarations of Interest	Chair	
3	Minutes of the Meeting held on 30 March 2017	Chair	Approval
4	Matters Arising	Chair	Discussion
Statutory Annual Reports: *to follow*			
5	Final Annual Accounts 2016/17	Cath Leech	Approval
6	External Audit – Assurances from Management and those charged with Governance	Cath Leech	Information
7	Annual Report 2016/17	Mary Hutton	Approval
Standing Items and Update Reports:			
8	Patient's Story *Macmillan Next Steps Cancer Rehabilitation*	Becky Parish	Information
9	Public Questions	Chair	Information
10	Chair's Update	Chair	Information
11	Accountable Officer's Update	Mary Hutton	Information
12	Performance Report	Cath Leech	Information
13	Gloucestershire Sustainability and Transformation Plan Update	Mary Hutton	Information
Items for Approval:			

14	CCG 2017-18 Annual Budget Update	Cath Leech	Approval
15	Organisational Development Strategy	Ellen Rule	Approval
Items to Note:			
16	General Practice Forward View – Updated Plan	Helen Goodey	Information
17	Assurance Framework	Cath Leech	Information
18	Audit Committee Annual Report	Colin Greaves	Information
19	Integrated Governance and Quality Committee Minutes	Julie Clatworthy	Information
20	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
21	Joint Commissioning Partnership Board Minutes	Mary Hutton	Information
22	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 27 July 2017 at 2pm in Board Room at Sanger House			

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

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Agenda Item 3

Governing Body

Minutes of the Meeting held at 2.00pm on Thursday 30 March 2017 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Dr Andy Seymour	AS	Clinical Chair
Mary Hutton	MH	Accountable Officer
Alan Elkin	AE	Lay Member – Patient and Public Engagement and Vice Chair
Mark Walkingshaw	MW	Director of Commissioning Implementation and Deputy Accountable Officer
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Cath Leech	CL	Chief Finance Officer
Dr Charles Buckley	CBu	GP Liaison Lead – Stroud and Berkeley Vale Locality
Peter Marriner	PM	Lay Member - Business
Julie Clatworthy	JC	Registered Nurse
Joanna Davies	JD	Lay Member – Patient and Public Engagement
Dr Tristan Lench	TL	GP Liaison Lead – Forest Locality
Colin Greaves	CG	Lay Member - Governance
Dr Will Haynes	WH	GP Liaison Lead – Gloucester Locality
Dr Caroline Bennett	CBe	GP Liaison Lead – North Cotswolds Locality
Sarah Scott	SS	Director of Public Health, GCC
Dr Raju Reddy	RR	Secondary Care Doctor
Kay Haughton *(representing MAE)*	KH	Deputy Director of Nursing
Kim Forey *(non-voting)*	KF	Joint Director of Integration
In attendance:		
Becky Parish *(item 6)*	BP	Associate Director of Engagement and Experience
Zoe Barnes	ZB	Corporate Governance Support Officer
Ryan Brunsdon	RB	Board Administrator
Elaine Dainty *(item 12)*	ED	Project Support Officer
There were 3 members of the public present.		

1 Apologies for Absence

1.1 Apologies were received from Helen Goodey (HG), Margaret Willcox

(MWi), Marion Andrews-Evans (MAE) and Ellen Rule (ER).

1.2 The meeting was confirmed as quorate.

1.3 AS noted that there were a number of Governing Body GPs stepping down from their roles at the end of the first four years of the CCG. AS thanked CBu, TL, RR and MGe for their hard work and contributions as members on the Governing Body.

2 Declarations of Interest

2.1 All GPs declared a general interest however no specific interests were received.

3 Minutes of the Meeting held on Thursday 26 January 2017

3.1 The minutes of the meeting held on Thursday 26 January 2017 were approved as an accurate record.

4 Matters Arising

4.1 28.07.2016 Agenda Item 9.15 – Performance Report – It was confirmed that a Patient Reported Outcome Measures (PROMs) update was included within the experience section of the performance report. **Item closed.**

4.2 24.11.2016 Agenda Item 8.4 – AO Report – A paper outlining the progress of the Workplace Wellbeing Charter was included on the agenda (item 12). **Item closed.**

4.3 24.11.2016 Agenda Item 12.16 – Performance Report – The Social Prescribing procurement evaluation framework had been forwarded to members via email on the 01.02.2017. **Item closed.**

4.4 26.1.2017 Agenda Item 8.8 – Urology data – MW confirmed that the cancer performance data had been updated to exclude the urology service data. **Item closed.**

4.5 26.1.2017 Agenda Item 9.6 – Gloucestershire Sustainability and Transformation Plan (STP) – MH advised that the link to the Sharepoint site where minutes from STP meetings were saved would be shared, and requested that the Lay Members advise if they could not access this. **Item closed.**

4.6 26.1.2017 Agenda Item 14.3 – West of England Academic Health Science Network Report (WEAHSN) Mortality Reviews
- MH confirmed that the plan for structured mortality reviews for Gloucestershire Hospitals NHS Foundation Trust (GHFT) would be confirmed in the next couple of weeks. **Item to remain open.**

5 Public Questions

5.1 ZB confirmed that there had been no questions received from the public.

6 Patient's Story

6.1 BP presented the routine patient's story in which the focus this month was on the Chatterbox engagement methodology.

6.2 Chatterbox was a portable method of engaging with the public and had been piloted in Gloucester City, and also presented an opportunity to test touch screen and paper based surveys.

6.3 The public were also videoed with their consent to give their views on how to stay healthy. Examples of some of these videos were presented to the Governing Body.

6.4 RR queried what the sample size was of the participants. BP advised that the objective of this form of engagement was to encourage younger people to give their views on health issues, and had proven effective.

6.5 BP advised that the cost of the service was low at £400 per day to include the technology and two staff from Chatterbox to help set it up. BP added that the public needed encouragement to take part.

6.6 WH suggested that going out to different areas with the County may result in different responses. BP confirmed that the device was portable which was useful for going out to different areas, and languages could also be changed if necessary.

6.7 CBu queried what useful information would be taken from the questions asked, and suggested that more focus should be given on particular issues. BP accepted this point and advised that in the future it would be advertised beforehand to encourage more

people to participate.

6.8 RR requested further information on the costs of the Chatterbox over longer periods of time, and whether it would be more cost effective than other methods of engagement. BP confirmed that Chatterbox would not be the only solution.

6.9 <u>RESOLUTION:</u> The Governing Body noted the presentation.

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

7.1 AS presented the report which was taken as read, and highlighted a summary of key issues that arose during January 2017 and March 2017.

7.2 The key issues arising included the Primary Care and Locality Development update, Clinical Programmes and meetings attended.

7.3 AS highlighted the Holocaust Memorial Service held at the Friendship café in Gloucester on the 27 January 2017 which he had attended and noted that this was a particularly well-attended and organised event.

7.4 AS also highlighted his attendance at the Gloucestershire Young Carers Annual Twilight Event and the Knife Crime Summit, a multi-agency meeting which considered the health impacts of knife crime.

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

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

8.1 The Accountable Officer introduced the report which was taken as read, and provided a summary of key issues arising during February and March 2017.

8.2 MH highlighted the key issues from the report and advised that there was a new model for urgent and emergency care in place as part of the Sustainability and Transformation Plan (STP). MH

added that this work was exciting in bringing the system together.

8.3 MH noted the OOH procurement transition which was well underway.

8.4 MH highlighted point 3.1 of the report and advised that delayed discharges had improved significantly.

8.5 MH discussed the additional social care funding for Gloucestershire and outlined point 4.4 of the report which described the funding details. It was noted that this was part of the Better Care Fund but was led by social services.

8.6 MH discussed the Cultural Commissioning section of the report and advised that she had attended the All Party Parliamentary Group round table where an Artlift representative was present. Gloucestershire had been noted as being exemplar in the policy report to the Department of Health, NHS England and Public Health England.

8.7 Social Prescribing was discussed and it was confirmed that the new service would commence on 1 October 2017 jointly procured with Gloucestershire County Council (GCC). MH informed members that the CCG had been accredited under the Workplace Wellbeing Charter on the 29 March 2017 and more work had commenced.

8.8 SS noted the Fitbit challenge referenced within the Workplace Wellbeing Charter and advised that GCC were undertaking the 4 week pledge and would be looking forward to more challenges with the CCG.

8.9 CBu raised concerns regarding the current problems within social care around recruitment and queried what more could be done. KF responded and advised that the Chief Executive of GCC was continuing to begin discussions about how communications methods could be altered to improve recruitment rates. KF noted that this was particularly important for domiciliary care and it was important to make this an attractive career. KF advised that a meeting had been arranged to discuss updating the market strategy.

8.10 <u>RESOLUTION:</u> The Governing Body noted the contents of

this report.

9 Performance Report

9.1 MW presented the Performance Report which provided an overview of the CCG's performance against both organisational objectives and national performance measures for the period to the end of February 2017. MW advised that there were a number of positive areas to note however as it was an exceptions report therefore would highlight the key areas of concern.

9.2 The report was broken down into the five sections of the CCG Performance Framework as highlighted in Section 1 and would be presented as such:

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

Clinical Excellence

9.3 MW discussed the clinical excellence section of the report and advised that the performance level for Cancer and Improving Access to Psychological Therapies (IAPT) had not been achieved at the required level.

9.4 MW noted the Referral to Treatment (RTT) targets as outlined on page 24 of the report and advised that the impacts of the implementation of TrakCare were having significant impacts upon performance. MW informed members that there had been a number of practical actions in place to recover performance including additional lists and actively working with patients who would like to move to other providers for their care. It was advised that further work was ongoing within Gloucestershire Hospitals NHS Foundation Trust (GHT) on capacity issues and the CCG information team had been providing good input into the process.

9.5 MW discussed A&E performance, in particular the 4 hour recovery plan managed by the A&E Delivery Board. There were a number of issues in place for the plan including the GP in ED project and Primary Care streamlining work and a new cohort ward for medically stable patients. MW added that both of these remedies

were beginning to have an impact.

9.5.1 MW advised that GHT had had a further visit from the National Emergency Support Team who had revisited bed related breaches, and work was ongoing around how to make the best use of the additional investment, with emphasis on non-bed related solutions.

9.6 MW presented the cancer performance and advised that there had been deterioration in the 62 day standard. It was advised that the new one stop MAD Clinics had gone live and there had been an increase in the volume of patients using the GP Care service. It was noted that weekend lists had also been utilised to manage long waits.

9.6.1 JC requested further assurance that the work underway by the Trust's Chief Executive was robust, including confirmation on the frequency of the Clinical Quality Review Group (CQRG) meetings. MW confirmed that GHT recognised that more work was required and that operational management had been strengthened. It was advised that there was assurance that no harm had been given to patients as a result of incidents and the Clinical Quality Review Group issue had been raised, and was confirmed as being back on track with bi-monthly meetings.

9.6.2 KH added that GHT had developed a new policy on completing full Root Cause Analysis of all patients who had breached the wait targets.

9.6.3 The Governing Body expressed their general concerns over the worsening performance of GHT; MH advised that she had met with the Chief Executive who would be meeting with the Governing Body to discuss a number of performance issues, and that a further meeting would also be held with the Chair & Chief Executive and MH and AS.

9.7 KF discussed the IAPT performance and noted that all involved were focused on improving this, including work completed through the monthly programme board, and bi-monthly provider board. KF advised that there had been a programme of change trajectory last summer which had been signed by NHS England (NHSE) and next month performance was expected to be back on target. It had been agreed with NHSE that a 12% target would be reached

by March 2017, and currently this was at 9%. KF added that with regards to 12 week and 18 week waits, people who had been waiting the longest would be seen first, and this was expected to be back on target for September next year.

9.7.1 CG noted that the update was encouraging however raised concerns regarding the skill mix and recruitment and queried if this was at the desired level. KF confirmed that staff had to undergo a six month course which would mean that they could not be instantly qualified and therefore delayed the recruitment process.

Patient Experience

9.8 KH presented the Patient Experience performance information and noted the mortality update which was included within the CCG risk register and monitored through the Integrated Governance and Quality Committee (IGQC).

9.8.1 KH advised that GHT had written a strategy on mortality and a report had been compiled on learning from deaths by the West of England Academic Health Science Network (WEAHSN).

9.9 KH noted that the impacts from the implementation of TrakCare would impact on the Friends and Family Test (FFT) data next month.

9.10 Patient Reported Outcome Measures (PROMs) were reported as being better than last year.

Partnerships and Staffing

9.11 MW noted the ongoing work with partners around the STP, work with the voluntary sector and plans for the Easter break.

9.12 MW highlighted pages 60 – 61 of the report and advised that there had been further investment in staff training of which further details would be brought to the next meeting.

Finance and Efficiency

9.13 CL presented the finance section of the report as at month eleven, and advised that the CCG was planning to achieve a surplus and that the significant risks to this had been mitigated.

9.14 CL informed members that QIPP performance had improved and

additional savings had been identified. There had been a decrease in the rate of strokes within the County as a result of changes to anti-coagulant prescribing which was positive.

9.15 It was noted that there would be a key change within month twelve, an increase of £8m due to the release of reserve to the bottom line. HLR pointed out that it was important to link the quality of care to the finances. CG supported this point and commended the team for their work on the budget.

9.16 RR queried if the ED performance figures noted at point 2.3.2 of the report were relating to Gloucestershire or Secondary Care. MW confirmed that there were a number of elements that make up the standard however the national focus was on the hospital standard.

9.17 MH noted the surplus and advised that this was more than just numbers, as Gloucestershire had a small net surplus when all budgets were added together. AS added that, taken together, all organisations were performing well overall as a system despite the current financial pressures.

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

- **noted the performance against local and national targets and the actions taken to remedy the current performance position;**
- **noted the financial position as at month 11;**
- **noted the risks identified in the finance and efficiency report and;**
- **noted the progress of the QIPP schemes.**

10 Gloucestershire Sustainability and Transformation Plan (STP)

10.1 MH presented the report which provided an update on progress of the STP since the last Governing Body meeting.

10.2 MH advised that there was an STP Advisory Group that week of which an update report could be circulated to members.

10.3 It was noted that there had been rapid progress of the STP since its initiation in December 2015 and signs of transformation were beginning to be shown, with work underway to build infrastructure.

10.4 MH highlighted the work of the Enabling Active Communities programme and noted that since the start of the introduction of Slimming World, patients had lost a total of 85,472.3kg which was equivalent to seven double decker buses. There was also significant work underway with diabetes prevention and the daily mile programme within schools.

10.5 MH discussed the clinical programme approach successes and noted that the dementia programme work was well underway and within eye health, sight loss in children had been prevented in 50 children's eyes per year compared to the previous system.

10.6 MH highlighted the circulatory, MSK and Mental Health programmes.

10.7 MH advised that Providers were committed to working with the CCG through the New Models of Care Board, and the One Place Urgent Care system had seen a reduction in avoidable admissions.

10.8 MH noted the system enablers including the workforce strategy, IT strategy and advised that there was now a whole system Project Management Office which was supporting more joined up working.

10.9 It was noted that there would be financial challenge to deliver the STP and that the organisations were driven to meet this for next year.

10.10 MH informed members that the engagement report results would be available soon and were initially demonstrating encouraging results.

10.11 HLR advised that the collaborative working seemed intuitive and demonstrated that people want to work together which was positive.

10.12 PM noted that the report was useful however suggested that it would be helpful to see the time chart as we progress through the STP. MH confirmed that the measurement strategy would describe the timeline. AS added that this was an evolving document.

10.13 <u>RESOLUTION:</u> The Governing Body noted the high level summary of achievements within the first year of the STP (Year 0).

11. <u>Budgets 2017/18</u>

11.1 CL presented the budgets paper for 2017/18 and noted that this built upon draft budgets already presented to the Governing Body.

11.2 CL advised that the budget had been set as required by NHS England financial planning parameters which were outlined at point 2 of the report. This year had been challenging for the CCG in achieving the budget.

11.3 CL noted that the signed contracts had been included however some small contracts remained unsigned. It was confirmed that there were no risks in terms of contract value.

11.4 It was advised that there were a number of investments including those as prioritised by the CCG Priorities Committee.

11.5 CL noted a number of additional key points from the paper including:

- Better Care Fund nationally mandated to increase by inflation of 656k;
- The CCG's budget assumes savings programme of £20.5m;
- Limited reserve available therefore looking to accelerate the savings programme;
- Risk management.

11.6 CL highlighted appendix 7, the Financial Management Framework and advised that the contingency reserve had been reduced to reflect the current position in line with this framework.

11.7 CL noted the submission of the bid for capital funding which was currently being reviewed by NHSE and highlighted the table at point 15 of the report outlining these schemes.

11.8 CBu queried the medicines expenditure and queried if this was transformational or transactional. CL confirmed that this was transactional and that the medicines budget was at a certain growth and reflected change already made.

11.9 PM queried if there would be cost improvements within the first month of the financial year. CL confirmed that there would be improvements however it would be difficult to anticipate these due to the impacts of the implementation of TrakCare and there were a number of risks within the system.

11.10 RESOLUTION: The Governing Body:

- **formally approved the proposed 2017/18 budgets;**
- **approved the 2017/18 Financial Management Policy and;**
- **noted the risks inherent within the plan.**

12 Workplace Wellbeing Charter

12.1 MH introduced the paper which was brought forward to demonstrate progress made within the CCG on workplace health initiatives to create a happy and healthy workforce.

12.2 MH advised that there were eight key areas of the Workplace Wellbeing Charter which present an opportunity for organisations to consider how they would benefit from introducing the scheme. 31 organisations had committed to completing the charter with 8-10 of these expected to be accredited within the next few years.

12.3 ED attended the meeting to discuss the results from the evaluation completed for the CCG and outlined the methodology for accreditation which involved a review of evidence, voluntary interviews and focus groups.

12.4 ED confirmed that the CCG had received 'Silver' or 'Excellent' in all areas of the charter except for healthy eating which received a bronze. As a result, the CCG had been accredited under the programme as of 29 March 2017.

12.5 MH added that 7 GP Practices had signed up to the Charter to date.

12.6 RESOLUTION: The Governing Body:

- **noted the progress to date on the implementation of the workplace wellbeing charter across the county and;**
- **noted the CCG's accreditation of the Workplace Wellbeing Charter.**

13 Assurance Framework

13.1 CL presented the Assurance Framework (AF) which was taken as read and advised that there were a number of red rated risks to note.

13.2 The red rated risks within the AF were T13, C6 and F24.

13.3 CG noted that T13 regarding specialised services for children and young people with mental health problems had remained high for some time and queried if there was anything that could be done to reduce the risk. It was advised that the specialised commissioning team would be coming to present to the Governing Body to discuss the issues within children's mental health further.

13.4 WH highlighted risk F24 regarding the implementation of Trakcare. MW advised that this issue was part of a separate assurance process with a trajectory against each area which was currently under review.

13.5 CBu noted that the date for risk L2 should now read 2017/18 instead of 2016/17 and this was accepted.

13.6 CBu suggested that there should be a risk relating to overall mortality within the assurance framework, and not just limited to fractured neck of femur as this was a significant issue.

13.7 Concerns were raised regarding hospital letters within cardiology and it was confirmed that this had been raised at the Integrated Governance and Quality Committee (IGQC) and had previously been rectified; however the backlog of un-typed letters was growing again. AS confirmed that the Local Medical Committee (LMC) had written to the Chief Executive of GHT who had given a detailed response to this matter; it seems that this may have been delayed in forwarding to GPs. AS added that he and HLR were due to meet the Medical Director of GHT to discuss some of these issues further.

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

14 Report from West of England Academic Health Science

Network (WEASHN) Board

14.1 The report from the West of England Academic Health Science Network Board was taken as read.

14.2 RESOLUTION: The Governing Body noted the report which was provided for information.

15 Integrated Governance and Quality Committee (IGQC) Minutes

15.1 The minutes of the Integrated Governance and Quality Committee held on the 15 December 2016 were presented for information.

15.2 JC advised members that there was a new process for the implementation of safeguards which was noted.

15.3 RESOLUTION: The Governing Body noted the IGQC minutes from the 15 December 2016.

16 Audit Committee Minutes

16.1 The minutes from the Audit Committee held on the 13 December 2016 were noted.

16.2 JC requested that the relevant final audit reports were also forwarded to the next meeting of the IGQC.

16.3 RESOLUTION: The Governing Body noted the Audit Committee minutes from 13 December 2016.

17 Primary Care Commissioning Committee (PCCC) Minutes

17.1 The Governing Body were presented with the minutes from the PCCC held on 24 November 2016 for information.

17.2 RESOLUTION: The Governing Body noted these minutes.

18 Any Other Business

18.1 There were no items of any other business.

19 The meeting closed at 15:45pm.

20 Date and Time of next meeting: Thursday 25 May 2017 at 2pm in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body: Signed (Chair):_____ Date:_____

NHS
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Agenda Item 4

Governing Body
Matters Arising – May 2017

Item	Description	Response	Action with	Due Date	Status as at 25/05/17
26.1.2017 Agenda Item 12.3	Assurance Framework	JC queried when STP related risks would begin to appear within the assurance framework / risk register. It was confirmed these would be visible in due course.	MH	25 May 2017	Due in May
26.1.2017 Agenda Item 14.3	WEAHSN Report – Mortality Reviews	JC queried if GHFT would be part of the structured mortality reviews and MH advised she would confirm if this was planned. **30.3.2017** - *MH confirmed that the plan for structured mortality reviews for Gloucestershire Hospitals NHS Foundation Trust (GHFT) would be confirmed in the next couple of weeks.*	MH	25 May 2017	For confirmation
30.3.2017 Agenda Item 13.3	Assurance Framework – T13	CG noted that risk T13 regarding specialised services for children with mental health problems had remained high for some time and queried if there was anything that could be done to reduce the risk. It was agreed that the specialised commissioning team would be coming to present to the Governing Body to discuss issues within Children's mental health further.	KF	25 May 2017	For update

Item	Description	Response	Action with	Due Date	Status as at 25/05/17
30.3.2017 Agenda Item 13.7	Assurance Framework – Cardiology letters	Concerns were raised regarding Hospital letters as the back-log of un-typed letters was growing again. AS confirmed that the LMC had written to the Chief Executive of GHFT who had given a detailed response to this matter; it seems this may have been delayed in forwarding to GPs. AS added that he and HLR were due to meet the Medical Director of GHFT to discuss some of these quality issues further.	AS/HLR	25 May 2017	For update

Agenda Item 10

Governing Body

Meeting Date	**Thursday 25 May 2017**
Report Title	**Clinical Chairs Report**
Executive Summary	This report provides a summary of key updates and issues arising during April and May 2017.
Key Issues	The key issues arising include: • Primary Care & Locality Development Update • Daily Mile initiative underway in 43 primary schools • Building work on new Churchdown Surgery underway • Dying Matters Awareness Week 2017 • Primary Care Streaming in Emergency Department • STP Consultation : Changes to the Urgent and Emergency Care System • Meetings attended
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	None
Management of Conflicts of Interest	None
Financial Impact	None
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None

Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note this report which is provided for information.
Author	Dr Andy Seymour
Designation	CCG Clinical Chair
Sponsoring Director (if not author)	

Agenda Item 10

Clinical Chairs Report

Thursday 25 May 2017

1 Introduction

1.1 This report provides a summary of key updates and issues arising during April and May 2017.

2 Primary Care & Locality Development Update

2.1 We received encouraging feedback from NHSE on our original GPFV – Transformation Plan which was submitted at the end of December. GCCG made a further submission to NHSE in early March and we have now received feedback and RAG ratings for assurance purposes. The ratings received from the local NHSE team are as follows:

GP Access	Care Redesign & development	Investment in Primary Care	Workforce	Practice Infrastructure	DCO Assessment

This strong rating across our plan recognises the significant progress we have made in Gloucestershire in planning and implementing the General Practice Forward View (much of which is integral to the ambitions set out in our Primary Care Strategy) at pace. While 'Workforce' has been given an Amber rating, we have been informed that all areas across South Central have been awarded this rating given the current pressures in primary care.

2.2 All 16 clusters have identified and agreed their transformational schemes, with all supporting not only primary care to be more sustainable by working at scale and diversifying the workforce, but also supporting the wider system. An update is given by cluster below:

Transformation scheme	Progress update
Clinical Pharmacists • Cheltenham:	Three employment models emerged and have been accommodated:

Central • Cheltenham: Peripheral • Forest of Dean • Aspen and Saintbridge • Hadwen Quedgeley and Rosebank • Inner City Gloucester • South Cotswolds • Stroud central • Stonehouse and Frampton • Stroud rural • Tewkesbury, Newent & Staunton	• CCG employed – recruited to positions for all existing schemes and in post. Aspen and Saintbridge opted for this model in Feb and their pharmacist will start in May. S&BV clusters opted for CCG employment in April and adverts have been placed. • Practice employed – recruitment supported by GCCG; now recruited and working in practices. • GDOC employed – Cheltenham clusters. Interviews held and job offers made. Awaiting start dates.
Repeat Prescribing Hub • Berkeley Vale	GDoc hosting service and have been supported by GCCG Medicines Management Team. Went live in April for two practices and will be rolled out across cluster during May and available for all cluster practices in June.
Urgent Care • Cheltenham: St Pauls	St Paul's have scoped their urgent visiting service working across all practices in the building. Now working with SWAST to deliver the service – still anticipating a start date in Q1 2017/18.
Frailty service • North East Gloucester • South East and GHAC • North Cotswolds	Visiting services / community matron for the elderly developed by these three clusters.

2.3 All three Cheltenham clusters have commenced their care navigation training programme, as has Forest of Dean. All other clusters have either chosen or are in the process of choosing their provider (of either care navigation or clinical correspondence

handling) and will be commencing shortly. We will continue working with all clusters to ensure they benefit from this training, which aims to direct patients to the most appropriate service through upskilling the GP Reception team and also releasing GP and nurse appointments to those who most need them and also freeing-up GP time from administrative work that could be done by upskilled administration staff.

2.4 All 12 cluster bids for the General Practice Resilience Programme that we supported in 16/17 have now been approved and funding released. The Primary Care and Localities team are providing support to these clusters on now implementing their plans, with some additional change management support where required. We are also working with the four remaining clusters earmarked for 17/18 to develop their plans.

2.5 Our Time for Care Programme will commence shortly. Having met with NHS England Sustainability and Improvement national team to plan out an approach for Gloucestershire we have agreed to:

- hold a local 2-day General Practice Improvement Leaders Programme pre-Summer;
- submit an expression of interest for the Productive General Practice Programme for those GP practices who can commit to the programme (funding nationally for 20% of all practices for October – December;
- Create a Releasing Time for Care Programme focussed on the High Impact Actions that Gloucestershire practices wish to prioritise.

2.6 The Choice+ project in Gloucestershire has been funded through the Prime Minister's Challenge Fund (PMCF), and as such, Gloucestershire will receive £6/head of funding (weighted) in 17/18 to deliver additional GP access. During this reporting period, we have contacted all cluster leads to determine their interest in piloting alternative, innovative models to commence in October 2017. In the meantime, we are working with GDoc to continue the existing Choice+ project to ensure patient access to these extended appointments continues.

2.7 In terms of workforce, we plan to continue the 'beagpingloucestershire' campaign with the BMJ in 2017/18 to provide an integrated branded microsite and branding for practices

to utilise for their recruitment, with content updates planned in year. We will be working with NHSE to explore international recruitment opportunities. We have received 13 expressions of interest from our GP practices for employing International GPs as part of our recent workforce survey. For our newly qualified GP scheme, we are supporting the 8 ST3s to join the scheme. If successful, this will retain them within the Gloucestershire GP workforce and facilitate their gaining experience with at least two practices during the scheme, alongside additional mentorship and peer support.

2.8 In terms of estate, considerable progress is being made across all three strands of the GCCG work programme:

- Committed / Legacy schemes
- Primary Care Infrastructure Plans / new proposals (including ETTF)
- Improvement Grants (including ETTF)

2.9 A comprehensive update against the entire Estates programme was presented to the Primary Care Commissioning committee (PCCC) in March.

2.10 The Primary Care and Contracting team are currently undertaking a series of post payment verification audits on the PCO for 2016/17. The Primary Care Offer for 2017/18 has been developed by the Locally Enhanced Services Group in discussion with the Local Medical Committee and has been offered to Practices.

3 Daily Mile initiative underway in 43 primary schools

3.1 The Gloucestershire Daily Mile initiative is now underway, with 10,000 pupils from 43 primary schools committed to walking, jogging or running a mile every day between now and the summer holidays. A launch event was held at Cheltenham Racecourse at the end of April.

3.2 The ambition is to increase daily physical activity levels for pupils in a realistic and sustainable way to improve children's health and wellbeing and combat rising childhood obesity rates. Evidence shows that a short exercise break from curriculum brings benefits to both pupils and teachers by helping children to be healthier, more productive and alert.

3.3 Active Gloucestershire is leading the roll-out of the initiative, which is part of their Active Schools programme supported by the CCG, Gloucestershire Public Health, Hartpury College and Cheltenham Racecourse.

4 Building work on new Churchdown Surgery underway

4.1 Work started recently on a new surgery development in Churchdown.

4.2 The premises are being built on Parton Road and will be able to cater for up to 20,000 patients, accommodating the anticipated rise in patients due to further housing planned for the area.

4.3 The new building will take around 12 months to complete and will be built to modern, comfortable, state-of-the-art specifications with additional consulting rooms, nurse treatment areas and excellent facilities for reception and administration staff.

4.4 Subject to the construction schedule, the building will be available for use from spring 2018.

4.5 The CCG has already approved the development and provided the required funding.

5 Dying Matters Awareness Week 2017

5.1 During this year's national Dying Matters Awareness Week (8 – 14 May), the CCG and NHS partners have been encouraging people to think about what they can do to prepare themselves and others for the inevitable reality of death and dying.

5.2 The NHS Information Bus has been visiting locations around the county promoting awareness of the benefits of becoming more active in planning for a "good" death, whether our own death or that of a loved one.

5.3 People are also being encouraged to think about this in advance of ill health and to consider supporting friends, family or neighbours when they are affected by these issues, such as following bereavement or planning a funeral.

5.4 The theme for this year's Dying Matters week, "What Can You Do", challenges people to do something practical such as making a will or caring for a dying relative.

5.5 GCSNHST have produced a series of short films for Dying Matters Awareness Week and these have been promoted via social media.

6 Primary Care Steaming in Emergency Departments

6.1 We were successful in a joint bid between Gloucestershire Hospitals NHS Foundation Trust and the CCG against the £100 million A&E capital funding outlined in the spring Budget by the Chancellor. This is targeted at easing pressure on Emergency Departments in time for winter 2017/18 through developing primary care GP triage/streaming.

6.2 Gloucestershire secured £960k to support the development of streaming in our Urgent Care System and we are in discussion with system partners to consider how we can further support the capital investment necessary to establish Urgent Treatment Centres.

7 STP Consultation : Changes to the Urgent and Emergency Care System

7.1 Work continues on the Urgent and Emergency care element of our STP consultation.

7.2 This includes plans to consult on Urgent Treatment Centres; a new Integrated Clinical Hub and streaming and assessment services within our acute hospitals.

7.3 This work has included engaging with our GP localities and commencing the detailed work on the anticipated impacts on activity and financial flows and working through the workforce implications of any planned changes.

8 Meetings

- 4th April – Gloucestershire Service Reconfiguration – Stage 1
- 6th April – GSF Away Day
- 10th April – Visit to Lechlade Medical Centre

- 11th April – Reducing Clinical Variation (RCV) Board
- 13th April – Tier 4 Bariatric Surgery Workshop
- 2nd May – GP Practice Visit to Regent Street Surgery, Stonehouse
- 5th May – Matthew Swindells' visit to Gloucestershire
- 8th May – Secondary Doctor Interviews
- 8th May – Meeting with Bishop Rachel of Gloucester
- 11th May – LMC Meeting
- 12th May – Whole System Change – Group Model Building
- 15th May – Board 2 Board – CCG/GHFT
- 15th May – GP Practice Visit to Chipping Surgery, Wotton-under-Edge
- 18th May – Priorities Committee

9 Recommendation

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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Governing Body

Meeting Date	**Thursday 25 May 2017**
Title	**Accountable Officer's Report**
Executive Summary	This report provides a summary of key update and issues arising during April 2017 and May 2017.
Key Issues	The key issues arising include: • Healthwatch Gloucestershire (HWG) new provider: Evolving Communities Community Interest Company (CIC) – update • Primary Care Out of Hours (OOH) – transition to new provider • Five Year Forward View Delivery Plan : Urgent and Emergency Care • Non- Emergency Patient Transport Services (PTS): Eligibility Criteria • New GP Premises in Kingsway • Clinical Programmes • Joint Commissioning Update • Meetings attended
Risk Issues: **Original Risk** **Residual Risk**	None.
Financial Impact	None.
Legal Issues (including NHS Constitution)	None.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note this report which is provided for information.

Author	Mary Hutton
Designation	Gloucestershire CCG Accountable Officer
Sponsoring Director (if not author)	

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Gloucestershire Clinical Commissioning (GCCG)
Accountable Officer's Report

1 Introduction

1.1 This report provides a summary of key updates and issues arising during April 2017 and May 2017.

2 Healthwatch Gloucestershire (HWG) new provider: Evolving Communities Community Interest Company (CIC) – update

2.1 The contract with the new HWG provider, Evolving Communities CIC, commenced from 1 April 2017. The service is commissioned by Gloucestershire County Council, supported by the CCG, and the specification is different from the previous requirements, with a greater emphasis on targeted participation and research.

2.2 The restructuring of the staff team is now complete and offices in a central county location in Quedgley have been secured. Telephone numbers and the HWG web address, where legacy HWG reports can be found, are unchanged.

2.3 The new HWG provider has a new structured approach to volunteering, which will have an impact on HWG participation in CCG groups going forward. In the short term, HWG participation will be undertaken by the Chair and CEO of HWG, with a view to transferring participation to other members of the HWG staff or volunteering resource where appropriate over time.

2.4 Details of the HWG volunteering options can be found at the link below:

https://www.healthwatchgloucestershire.co.uk/volunteering/volunteering-roles/

In summary, there will be three levels of volunteering:

Board Members will be Non-executive Directors of Evolving Communities CIC and will set the strategic direction and oversee the operational management of the organisation. Board Members also get involved in specific areas of activity, including engaging with local people to gather their views on health and care services.

Local Healthwatch Volunteers will be the voice of Healthwatch Gloucestershire and people in the community. They will talk to people, gather opinions about local health and care services (good or bad) and spread the word about the ways HWG can help people. They will also act as ambassadors for HWG at events and meetings and make sure HWG views and the views of local people are heard and taken seriously.

Authorised 'Enter and View' Volunteers will conduct visits and spend time talking to patients, carers and relatives as well as developing report findings.

Healthwatch Project Volunteers will help to deliver important health and social care projects which benefit people in Gloucestershire. They will compile research and feedback from members of the public and help to organise health and social care events and consultations or provide assistance with day-to-day administration for the team of staff and volunteers at HWG. They may also get involved with specific projects which are important them.

Healthwatch Associates will be interested in the work of HWG and be kept up to date with information about events and activities as well as taking part in surveys and consultations. They can also be part of a Readers Panel, which involves looking at leaflets and documents for various health and social care agencies and making suggestions on how they can be improved.

2.5 The CCG recognises the valuable contribution HWG has made in Gloucestershire over the past five years and looks forward to working with HWG staff and volunteers going forward

2.6 CCG staff should contact a member of the CCG Engagement Team if they have any queries about the new HWG arrangements.

3 Primary Care Out of Hours (OOH) – transition to new provider

3.1 OOH will be provided by Care UK from the 1st June 2017. As Governing members will be aware Care UK is our existing NHS 111 provider and as the biggest providers of primary care Out of Hours services in England Care.

3.2 A great deal of work has been undertaken to manage the transition to the new provider. Care UK has worked successfully to engage with the GP workforce and all key partners within the urgent and emergency care.

3.3 At time of writing the remaining issues being worked on relate to final estates and IM&T arrangements.

4 Five Year Forward View Delivery Plan : Urgent and Emergency Care

4.1 The Five Year Forward View and associated Delivery Plan for Urgent and Emergency Care was launched in April 2017.

This plan focusses on the following seven key areas:

- Testing innovative new models of service that enable patients to enter their symptoms online and receive advice online or a call back.

- Developing the response patients receive when they call 111. By the end of 2017/18 the percentage of calls receiving clinical advice should exceed 50%.

- By March 2019 patients and the public will have access to evening and weekend appointments with General Practice.

- Standardising access to 'Urgent Treatment Centres' through booked appointments via NHS 111. These facilities will have an increasingly standardised offer - open 12 hours a day and staffed by clinicians, with access to simple diagnostics.

- The ambulance service will offer a more equitable and clinically focused response that meets patient needs in an appropriate time frame with the fastest response for the sickest patients.

- In Emergency Departments we will develop new approaches prioritising the needs of the sickest patients. Our frail and elderly patients will get specialist assessments at the start of their care and those patients who could be better treated elsewhere, will be streamed away from Emergency Departments.

- We will speed up the assessment process and ensure that patients are sent home as soon as possible and if home is not the best place for their immediate care, they will be transferred promptly to the most appropriate care setting for their needs.

4.2 Gloucestershire's progress against these priorities has been assessed and shared with A&E Delivery Board members. This suggested that good progress has been made in all areas and aligns for our wider STP agenda. Despite the collaborative system work, performance against the ED 4 hour maximum wait standard remains the highest area of concern for delivery for our patients.

5 Non- Emergency Patient Transport Services (PTS): Eligibility Criteria

5.1 In common with other CCGs we have begun a process to review and assess compliance with the eligibility criteria for non-emergency Patient Transport Services. We have commenced this work with the other CCGs who we contract with for PTS with Arriva Transport Solutions Limited.

5.1.2 This provides an opportunity to reinforce compliance with national guidance on eligibility for these services but also to build upon this including developing innovative local solutions to ensure that this resource is targeted at those who really need it and in a way which ensures improvements in performance.

Further information on any proposed changes will follow.

6 New GP Premises in Kingsway

6.1 Members should note that over the last year, the CCG has been working closely with Rosebank Health to help make a new surgery in Kingsway a reality and has put in significant additional investment to support this. The new surgery development serving the people of Kingsway and the surrounding area has now been granted planning permission.

6.2 The new surgery will be able to cater for around 13,000 patients, significantly improving access to primary care services for the local population. The new building, which will take around 12 months to complete, will be built to modern, state-of-the-art specifications, and will include ten consulting rooms alongside four rooms which can be used flexibly for treatments and minor operations.

6.3 Now that planning permission has been granted, Rosebank Health are keen to progress the development as quickly as possible and anticipate that subject to the construction schedule, the building will be available for use from autumn 2018.

6.4 The new premises will mean that patients can benefit from facilities that are fit for modern healthcare and will support the provision of high quality care. The new surgery will also offer an attractive work environment for GPs and other members of the practice team.

7. Clinical Programmes

7.1 Workplace Wellbeing Charter

As part of the STP's commitment to improve the health and wellbeing of our local workforce, The CCG commissioned Health@Work to accredit 40 organisations throughout 2017 to the National Workplace Wellbeing Charter. The National Workplace Wellbeing Charter is a health, safety and wellbeing award scheme which has shown to be effective in creating workplace cultures that support good health and wellbeing for employees and delivers tangible business benefits.

7.1.1 40 organisations have committed to work toward accreditation which involves benchmarking against a set of eight key areas of the Charter which include: Leadership, Absence Management, Health and Safety, Mental Health and Wellbeing, Smoking, Physical Activity, Healthy

Eating, Alcohol and Substance Misuse.

7.1.2 Examples of organisations who have recently achieved accreditation within Gloucestershire include: UCAS, EDF Energy, NHS Gloucestershire CCG, GFirst LEP and Cheltenham Borough Council

7.2 Respiratory

7.2.1 Integration of services across the health community continues. There is growing enthusiasm for an innovative approach to prevention strategies that incorporates standard services with Patient Activation Measures (PAM). Alongside this annual review and self-management guidance and strategies are being produced to provide signposting in an attempt to improve variation and quality of contact with COPD patients. The Winter Review scheme is now in its evaluation stage and alongside the MDT work within localities there has been lots of positive learning that will inform our continued service development.
Patient pathways are being mapped out supported by financial modelling. The future service model will be supported by clear care pathways and redesigned roles.

7.3 Diabetes

7.3.1 National Diabetes Treatment and Care Programme

The STP was successful in securing funding from the National Diabetes Treatment and Care Programme with £175k provided for the diabetes foot pathway for 2017/18 and £55k for improvements to structured education for diabetes.

The foot pathway funding will provide an additional:

- 0.5 WTE consultant diabetologist
- 2 x 1.0 WTE podiatrists

7.3.2 This funding will also provide improved working with the vascular and orthopaedic surgeons, orthoptists, microbiology, tissue viability, radiology and plaster technicians. The new pathway is intended to provide rapid MDT assessment and treatment for patients with a limb-threatening or life-threatening diabetic foot problem within an acute setting. The new service will also ensure inpatients have access to the

new MDT diabetic service. It is expected that the CCG, GHT and GCS will then become compliant with NICE guidelines.

7.3.3 Structured education is 1 of the 8 care processes for people with diabetes. This additional funding will enable GHT (Type 1) and GCS (Type 2) to provide a more holistic approach for patients to take a more personal responsibility for their prevention and self-care. This additional funding will enable the CCG to:

- Support practices to improve the coding in primary care for capturing structured education
- Ensure fully compliant with NICE guidance
- Ensure education is made more accessible for harder to reach patient groups
- Make better use of specialist diabetes nurses and dieticians and open up opportunities for health science graduates

7.4 Mapmydiabetes

7.4.1 Mapmydiabetes is an online self-management programme for patients with Type 2 with diabetes, including NICE endorsed structured education.

7.4.2 The programme is funded by the South West Academic Health Sciences Network (AHSN) and the over the last six month the CCG has been piloting the Mapmydiabetes programme in two localities, Gloucester City and the Forest of Dean. There are now over 500 patients with Mapmydiabetes accounts. A full evaluation of Mapmydiabetes pilot is expected by the end of June 2017 and the CCG will share with findings in a future report to the Governing Body.

7.4.3 A new Diabetes Digital Coach Test Bed is due to be implemented by the AHSN in September 2017 and will continue to provide the structured education part from Mapmydiabetes. The new Test Bed will also provide a self-management programme on diet, health, well-being and insulin management, sourced from four other companies. The intention is to roll out use of this new tool across the other localities.

7.4.4 The CCG has identified a small amount of funding for Mapmydiabetes to continue until the launch of the new Diabetes Digital Coach Test

Bed. Match funding will be provided by Mapmyhealth and the AHSN to ensure a smooth transition for patients.

7.5 Cancer

7.5.1 The Cancer Clinical Programme Group are pleased to report continued positive progress with our system redesign work to improve the health and wellbeing outcomes for people Living With & Beyond Cancer. We would particularly like to highlight the innovative community based project Macmillan Next Steps Cancer Rehabilitation is now celebrating its first anniversary. During this time the team has successfully developed and operationally tested:

- targeted 1:1 cancer rehabilitation from specialist allied health professionals, including support from a specialist physiotherapist or dietician.
- patient education and healthy lifestyle support through a range of workshops and programmes
- colleague education for health and social care professionals to build skills and joined-up working across the county.

7.5.2 The aim of the project is to enable people to live healthier, happier and more active lifestyles. In the first year over 250 people affected by cancer have been supported by the project and nearly 500 staff have engaged in the education programmes. We are commencing full evaluation of the project benefits which include more confident self-management; improved long term outcomes and a more sustainable use of our health system resources.

8 Joint Commissioning Update

8.1 Transforming Care

8.1.1 The CCG continues to meet its commitment to deliver timely CTRs (Care and Treatment Reviews) for each person placed in in-patient units whether placed in county or out of county. Blue light Meetings are also routinely held to attempt to prevent all further admissions wherever possible.

8.1.2 Mortality reviews for people who were identified with a learning disability are now happening across the county. It is early days in terms of generating such reviews but the long term expectation is that this will provide learning on how to improve health inequalities.

8.1.3 The Experts by Experience Quality Checking through Inclusion Gloucestershire has now been extended to patients in in-patient units. This has evolved after considerable piloting of the best methodology and approach to follow.

8.1.4 Detailed planning is underway for the Big Health Check day on the 10th May at Oxstalls Sports Centre. Once again this year it is expected that several hundred people with a Learning Disability will be in attendance. GPs are also attending a workshop on learning disabilities delivered at the same location.

8.1.5 The GEM (Going the Extra Mile) project is now up and running. This project provides work opportunities for those people furthest from the labour market. Funded by the Big Lottery Fund this programme provides employment mentoring to a wide range of people with a disability.

8.2 Multi-Disciplinary Teams (MDTs)

8.2.1 The jointly developed MDT framework was presented for sign off at the New Models of Care Board. Pilot sites and implementation process currently being agreed with clusters and a set of evaluation metrics is being developed.

8.3 Frailty – South Cotswolds Project

8.3.1 Continued work with the Frailty Service team to establish the offer for the identified cohort with mild, moderate, and severe frailty
Develop the 'frailty in-reach' model with GHFT and GWH. This is being led by a Sr. Community Matron.

8.3.2 A further engagement workstream is around actively sharing principles and learning from the South Cotswolds with other frailty projects developing in the county through Quality Service Improvement

Redesign project.

8.3.3 Continued engagement with stakeholders is undertaken via the South Cotswold Frailty Clinical Programme Group.

8.3.4 Work continues on the project which will be evaluated by the University of Gloucestershire.

8.4 Better Care Fund Updates

8.4.1 The Better Care Fund (BCF) Policy Framework was published at the end of March and final guidance is awaited. In the meantime the Local Government Association has published guidance and in Gloucestershire work is ongoing to develop our plan for 2017-19.

8.4.2 The Gloucestershire BCF Plan will provide an overview of achievements to date, to include our challenges and set out the areas we will be developing over the next two years to meet those challenges. These areas include the development of the Integrated Commissioning Hubs, frailty pathways, integrated personalised commissioning, virtual wards and the housing agenda.

8.4.3 In addition to agreeing to pool the Disabled Facilities Grant now aligned to the BCF to deliver a joint housing action plan, Gloucestershire system partners have signed up to a Memorandum of Understanding to deliver a joined up strategy for housing and to improve health outcomes through housing.

8.5 Dementia

8.5.1 Gloucestershire's current dementia diagnosis rate is 68% which is above the national target. Work is ongoing to establish diagnosis rates for those under 65 years of age and those in minority ethnic groups.

The STP Dementia Board has four work-streams as follows:

- Clinical pathways
- Workforce development
- Equality Impact Assessment

- Community Capacity Building

8.6 Carers

8.6.1 Work is ongoing to improve contract monitoring and understanding of delivery against the service specification. This will enable better understanding of what is required to ensure we make full benefit of the existing contracts and improved arrangements into the future.

8.6.2 Gloucestershire's Carers Strategy is under review and work is underway to map the existing offer to carers. The next steps will include broader stakeholder engagement to reflect the needs of carers and develop sustainable community based options.

8.7 Rehabilitation

8.7.1 The Rehabilitation Steering Group is responsible for developing a programme to provide specialist rehabilitation services in Gloucestershire. The Stroke Rehabilitation Business Case is being reviewed with partners to ensure it aligns to STP ambitions.

Work is also ongoing to improve wider rehabilitation and commissioning in:

- Postural management
- Wheelchair services
- Acquired Brain Injury pathway

9. Meetings attended

4 Apr	Gloucestershire Service Reconfiguration - Stage 1 Strategic Sense Check
5 Apr	Joint Commissioning Partnership Executive (JCPE)
6 Apr	STP Delivery Board
6 Apr	Gloucestershire Strategic Forum (GSF)
12 Apr	Enabling Active Communities Commissioning Group

13 Apr	NHS Gloucestershire CCG/Grant Thornton
19 Apr	KPMG - STP Dinner. Bristol
20 Apr	NHSCC Board Day, London
25 Apr	STP Governance Roundtable, London
28 Apr	Meeting with Mark Harper MP
02 May	Regent Street Surgery GP Practice Visit
03 May	Joint Commissioning Partnership Executive (JCPE)
04 May	STP Delivery Board
05 May	Matthew Swindells NHSE visit
08 May	Secondary Care Doctor Interviews
08 May	Meeting with Bishop of Gloucester
10 May	Q4 Assurance Meeting, Chippenham
11 May	Locality Exec meeting
11 May	New Models Of Care Board (NMOC)
15 May	Chipping Surgery GP Practice Visit
16 May	Optum - Interactive Accountable Care Event, London
17 May	The Nelson Trust, Women's Centre, Gloucester
18 May	Dementia Event, Gloucester
22 May	STP Leaders Event, London
23 May	Healthwatch Quarter 4 Partners meeting
23 May	Gloucestershire Strategic Forum (GSF)
24 May	Sustainability and Transformation Plan Conference, London

9 Recommendations

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

NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Agenda Item 12

Governing Body	**Thursday 25 May 2017**
Title	**Performance Report**
Executive Summary	This performance framework report provides an overview of Gloucestershire CCG performance against organisational objectives and national performance measures for the period to the end of March 2017 and an update on April 2017 where data is available.
Key Issues	These are set out in the executive summary within the report.
Risk Issues: **Original Risk** **Residual Risk**	All risks are identified within the relevant sections of this report.
Management of Conflicts of Interest	None declared.
Financial Impact	This report gives detail on the financial position to the end of March. The key change is the release of the 1% system risk reserve in month 12 to the CCG's bottom line leading to an increase in the CCG's surplus position.
Legal Issues (including NHS Constitution)	These are set out in the main body of the report.
Impact on Health Inequalities	Not applicable.
Impact on Equality and Diversity	There are no direct health and equality implications contained within this report.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public	These are set out in the main body of the report.

Involvement	
Recommendation	The Governing Body is asked to: • Note the performance against local and national targets and the actions taken to remedy the current performance position. • Note the financial position as at month 11. • Note the risks identified in the Finance and Efficiency report. • Note progress on the QIPP schemes.
Author & Designation	Sarah Hammond, Head of Information and Performance Andrew Beard, Deputy CFO Ian Goodall, Associate Director of Strategic Planning
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

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 30th April 2017

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

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 is also monitoring 2016/17 seasonal flu vaccination performance, medicines optimisation, 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.
- Improvement and Assessment Framework (IAF) indicators show 3 Performing well & 3 Needs Improvement
- The Care Quality Commission has completed 80 inspections of the GP practices and 3 were rated outstanding, 75 as good, 2 requires improvement. 1 practice has not had an inspection.

Challenging performance:

- Delivery of cancer targets continues to be challenging.
  - 62 days cancer is below STF target at 70.6% for March and 75.1% at Year end
- 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 element of the service. IAPT access is currently 8.2% against a target of 15%
- 4 hr A&E target performance in April was 82.9% which was 4.8% below our STF trajectory target.

Patient experience – **Green**.

Patient Experience - Perspective highlights:

- The Practice Participation (PPG) Group network held a successful meeting in April 2017. The meeting focussed on Cancer: Macmillan Next Steps; Living With and Beyond Cancer - Diet & Exercise; Engaging patients; Holistic Needs Assessment (HNA) & Treatment Summaries; A Patient's Story; and Cancer Patient Reference Group (PRG).
- Patient Engagement and Experience continues to develop across a wide range of GCCG projects – a particular recent focus has been Renal, Respiratory and Diabetes CPG work.
- GHNHSFT have agreed to undertake focused work on patient experience for people using the urgent care pathway in the Trust as this has not previously been systematically monitored.

Good performance

- Comprehensive experience and engagement activity supporting CCG and STP work programmes.
- GHNHSFT have gone from being among the worst to being among the best for response rates, with satisfaction ratings remaining stable. Over 90% would recommend GHFT in the Inpatient Test, Over 80% would recommend GHFT in the ED Test; 2g and GCS also remain stable. Primary Care FFT results also point towards positive satisfaction ratings which are above the national average. But with poor response rates, these can be nothing more that indicators.
- FFT - GHNHSFT have exceeded the national averages for the collection for both Inpatient and ED Friends and Family Tests

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

Partnerships - Perspective highlights:

- Gloucestershire is working to a local footprint for the development and implementation of the Sustainability and Transformation Plan. Our system published our plan and accompanying short guide and survey on 11/11/2016. A communication and engagement plan has been developed to support the STP approach, to ensure comprehensive and planned engagement and communication with the public and key stakeholders. The plan is a two phase approach; with Phase One covering a three month engagement with the public, patients, community partners and staff regarding new models of care and new ways of working and Phase Two covering more detailed proposals for service change to commence during the summer 2017. Phase 1 engagement concluded at the end of February 2017. The draft Outcome of Engagement Report has been prepared and will be circulated widely amongst partners and made available to the public.

Staff – **Green**.

Staff - Perspective highlights:

- Staff sickness level for April is 2.6%, which is in line with agreed standard.

Finance and efficiency – Green

Finance and Efficiency - Perspective highlights:

- The 2016/17 unaudited year end position is a surplus of £17.551m. This is an increase of just over £8m which relates to the release of the headroom or system risk reserve following notification from NHS England.

Good performance

- The accounts were submitted on 26th April and the external audit of the draft accounts commenced the day after submission.
- The better payment practice code performance for the year to date (for non-NHS invoices by value) is 98.82% which is above the target figure of 95%.
- Prescribing continues to show a reduction in growth from the same period last year.
- QIPP schemes for 16/17 total £18.042m and the final position showed slippage of £1.790m; this included the impact of additional schemes that had previously been identified which in totality accounted for a 90% achievement rate.

Challenging performance:

- Activity in other Trusts showed significant pressure in year, particularly Winfield & Oxford University Hospitals.

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

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

Performance framework

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

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

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

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

2.1 Clinical Excellence

2.1.1 Clinical Excellence – Period up to 30th April 2017

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

<table>
<tr><th>PERSPECTIVE 1</th><th>Clinical Excellence</th><th>Amber</th></tr>
<tr><td colspan="2">Success criteria: 1. Regular, robust information is available to provide assurance that our service providers are delivering quality, safe & clinically effective services.</td><td>Green</td></tr>
<tr><td colspan="3">Key performance indicators</td></tr>
<tr><td colspan="2">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).

Number of NICE TAs published and relevant to CCG
<table>
<tr><th></th><th>Q1 (April - Jun 15)</th><th>Q2 (July- Sept 15)</th><th>Q3 (Oct- Dec 15)</th><th>Q4 (Jan -Mar 16)</th><th>Total</th><th>Q1 (Apr - Jun16-</th><th>Q2 (Jul - Sept 16)</th><th>Q3 (Oct - Dec 16)</th><th>Q4 (Jan - Mar 16)</th></tr>
<tr><td>Number issued</td><td>6</td><td>12</td><td>18</td><td>12</td><td>48</td><td>9</td><td>14</td><td>14</td><td></td></tr>
<tr><td>Number relevant to GCCG</td><td>4</td><td>7</td><td>5</td><td>3</td><td>19</td><td>5</td><td>2</td><td>4</td><td></td></tr>
</table></td><td>Green</td></tr>
<tr><td colspan="2">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.
The Clinical Effectiveness Group (CEG) is a sub group of CCG Integrated Governance and Quality Committee (IGQC). The CEG meets bi-monthly and identifies areas of best practice or concern in relation to quality outcomes or evidence based practice. It also monitors compliance or deviations from published NICE Guidance. Where concerns are identified a ‘Pink Slip’ is sent to the provider (via the appropriate CQRG) which asks for information and highlights the area of concern. On behalf of the CCG it seeks assurance that these are being addressed by appropriate action plans. These together facilitate an auditable process around ensuring best practice.
The National Audit Review Group (NARG) is a sub group of the CEG which enables the CCG to review national clinical audit results and to gain assurance that providers of these services conform to these recognised standards of care (also by means of a ‘Pink Slip’).</td><td>Green</td></tr>
</table>

Success criteria: 2. *Commissioning high-quality primary care services through the utilisation of exercising Delegated Commissioning responsibilities*	Green
Key performance indicators	
Commission all Gloucestershire practices through a 'Primary Care Offer' enhanced service for 2017/18 that focuses on clinical quality.	Green
Measure Primary Care Quality across three key domains: "Planning for Quality"; "Quality Improvement"; "Quality Assurance"	Green
Success criteria: 3. *Progress in implementing the Primary Care Strategy and General Practice Forward View (GPFV) in Gloucestershire*	Green
Key performance indicators	
To develop a comprehensive GPFV Plan, aligned with our Primary Care Strategy, that sets out how we will achieve the commitments set out within the GPFV and our local Strategy.	Green
All 16 clusters are supported to have local plans to deliver the components of the GPFV Plan and Primary Care Strategy; moving towards integrated locality working structures with providers.	Green
Success criteria 4. Progress to develop outcomes for CPGs *CPG success criteria & KPIs Outcomes – CPG programme/timelines in outline in appendix, KPIs re staying to timetable, output etc, narrative to focus, in brief, on one CPG area per month*	In development
Success criteria: 5*. Key local and National standards relating to Patient Experience*	Amber
Key performance indicators	
Achievement of key local and National standards relating to Clinical Excellence – see section 2.2 to 2.9	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.***

KPI: Commission all Gloucestershire practices through a 'Primary Care Offer' enhanced service for 2017/18 that focuses on clinical quality.

Following the success of the Primary Care Offer (PCO) in the last two years, we have further developed the PCO for 2017/18, with a particular focus on frailty. In developing the new PCO for 2017/18 we have engaged fully with local GPs, LMC and other stakeholders to ensure that the specification is evidence based.

The themes and the responsibilities of practices has been succinctly summarised in the table below. Future reports will detail progress against this PCO.

Primary Care Offer Theme	Responsibilities
Cancer Management	*Living With and Beyond Cancer training for Practice Nurses*
Practice based audit	*Quarterly clinical audits and implementing agreed actions*
Amber drugs and post-op wound care	*Prescribing Amber Meds and Post-Op wound care for registered patients*
Engagement	*Engagement with CCG and locality commissioning meetings, events and visits; GP attendance at Pain Master Classes*
Diabetes	*Identify and refer suitable patients to the National Diabetes Prevention Programme (NDPP).*
Patient Safety	*Sign up to Safety (SU2S) action plans in place*
Prescribing	*All practices to minimise off formulary prescribing in four domains:* 1. *Gluten Free* 2. *Do Not Prescribe items, e.g. Coproxamol* 3. *Sip Feeds* 4. *Lower cost Pregabalin*
Frailty	*In addition to the national requirements within the*

GP contract:

- *GP, PM & PN frailty leads identified within each practice*
- *Medication reviews for all moderately and severely frail patients; focus on polypharmacy and peer review*
- *Closer relationships and immediate two-way communication with the OPAL service*
- *Training, education and awareness sessions attendance for all leads, including masterclasses, podcasts and dementia training.*
- *MDT approach – commencing with practice based and moving to working as clusters*
- *Supporting carers*
- *Proactive falls prevention*
- *Frailty assessment and consistent coding*

Given that 'frailty' forms such a significant new way of working for practices to implement, we have committed this will remain unchanged for the next two years to maximise the opportunity for embedding the changes, and thereby maximising the outcomes for patients.

KPI: Measure Primary Care Quality across three key domains: "Planning for Quality"; "Quality Improvement"; "Quality Assurance"

The Primary Care Clinical Quality Review Group (CQRG) is one of the CQRGs mentioned earlier within this document, and reports progress to the Primary Care Commissioning Committee to ensure transparency and assurance that quality and patient safety issues are raised and addressed appropriately.

Reporting across the three measures:

- *Planning for Quality:*
  - *Five Practice Nurse Facilitators covering the seven localities with work plans in place;*
  - *Education and training programme for practice nurses arranged;*
  - *Community Education Provider Network (CEPN) – supporting the workforce development, planning and education of primary care.*

- *Quality Improvement:*
  - *Medicines optimisation – Supporting the PCO (see above) implementation; assisting with pharmacists in different roles across*

primary care (from prescribing supporting to patient facing independent prescribing clinical pharmacists);
- *Collaborative system wide working – e.g. STP OD and workforce strategy group and Capability Thematic Group – further contributing to primary care education and development.*
- *Antimicrobial resistance (AMR) – sustainably reducing inappropriate antibiotic prescribing in primary care.*
- *Improving quality and timeliness of the Hospital Transfer Pathway for Care Home residents.*
- *GCCG Safeguarding Team facilitating bespoke Adult Level 2 Training.*

- *Quality Assurance*
  - *All friends and family test (FFT) results are utilised alongside the national GP patient survey data to measure the current patient satisfaction. Gloucestershire has compared well to the national average and this will continue to be monitored.*
  - *A PPG network has been established, with the April meeting focusing on cancer. Individual PPGs are also regularly inviting GCCG to meetings; allowing qualitative feedback collection.*
  - *CQC inspections have been completed for almost all practices in Gloucestershire. The Primary Care CQRG is offering support to all practices considered to 'Require Improvement'.*

2.1.4

Success criteria: 3. Progress in implementing the Primary Care Strategy and General Practice Forward View (GPFV) in Gloucestershire

KPI: To develop a comprehensive GPFV Plan, aligned with our Primary Care Strategy, that sets out how we will achieve the commitments set out within the GPFV and our local Strategy.

The first draft of GCCG's General Practice Forward View (GPFV) Plan, aligned as a Plan of our Gloucestershire Primary Care Strategy, was submitted to NHSE in December 2016. An updated plan was requested by NHSE in March 2017 and in this reporting period we received the following RAG ratings by theme:

GP Access	Care Redesign & development	Investment in Primary Care	Workforce	Practice Infrastructure	DCO Assessment

This strong rating across our plan, understood to be one of the best in the South, recognises the significant progress we have made in Gloucestershire in planning and implementing the GPFV at pace. While 'Workforce' has been given an Amber rating, we have been informed that all areas across South Central have

been awarded this rating given the current pressures in primary care.

A final GPFV plan has been developed this month, for submission to NHS England at the end of May 2017, following sign off by the Primary Care Commissioning Committee and Governing Body. This sets out how will we deliver against our own commitments as follows:

- *Our Primary Care Vision*
- *Primary Care Investment*
- *Primary Care Workforce*
- *Access*
- *Technology*
- *Estates*
- *Workload*
- *Organisational form*
- *Engagement*
- *Risks and mitigations*
- *Governance*

KPI: All 16 clusters are supported to have local plans to deliver the components of the GPFV Plan and Primary Care Strategy; moving towards integrated locality working structures with providers.

In the implementation of our Primary Care Strategy and GPFV Plan, 16 clusters have emerged and been supported to develop collaborative ideas and schemes to the point of now over 50 projects are in progress across the county. The Locality Development team is being restructured to better provide coordinated support to our localities, clusters and practices across all initiatives. This will be in place by end of May, resulting in the same Locality Manager supporting all initiatives within a locality and the clusters within that locality. All localities also have an identified GP Provider Lead, who sits on the New Models of Care Board, and one of which represents Primary Care on the STP Delivery Board. For those localities with clusters, we have also funded a GP Cluster Lead.

The schemes being progressed across the county can be summarised against the following themes:

1. *Practice Transformation*

2. *Practice Resilience*

3. *Care Navigation and Clinical Correspondence*
4. *Extended Access*
5. *Time for Care*

These are described in a little more detail below:

1. Practice Transformation

Scheme	Progress update
Clinical Pharmacists	Eleven clusters chose Clinical Pharmacists, with their practices working together to equitably share the resource between them, in order to diversify the skill mix in general practice. GCCG have been working with all eleven clusters to determine employment models and support recruitment, with clusters having now either employed or in the final process of recruiting.
Repeat Prescribing	One cluster has set-up a back-office repeat prescribing hub for all their practices. Based on evidence from models established in Swindon and Coventry & Rugby, GCCG has supported the set-up with GDOC as host employers. The scheme is currently rolling out across the cluster.
Urgent Care	One cluster is developing a shared urgent visiting paramedic service to relieve pressure on the practices within the cluster, working with SWAST.
Community Matron / Visiting service for the elderly	Three clusters are developing, or have launched, elderly care services that for patients in their own home; reducing pressure on general practice and helping frail patients stay healthy and in their own homes.

2. Practice Resilience

Twelve cluster bids were approved in 2016/17:

- *Cheltenham x 2 clusters*
- *Forest of Dean*
- *Gloucester City x 5 clusters*
- *South Cotswolds*
- *S&BV x 3 clusters*

The majority of schemes include ideas to create standard back-office processes and protocols, joint working initiatives and exploring 'at scale' relationships.

We are now working with remaining four clusters on their plans to ensure all 81 practices benefit from the same level of resilience funding.

3. Care Navigation and Clinical Correspondence

All of our clusters have chosen their providers and are either implementing, or about to commence, their training. The aim is to reduce practice and GP workload and ensure patients are seen more quickly by the right professional for their need.

4. Extended Access

As a successful former GP Access Fund site, through which we delivered 'Choice+' appointments in primary care, GCCG receive £6/head of patient in 2017/18 to deliver extended access. For 2017/18, we have extended the contract with GDOC to continue to deliver Choice+, but will be testing pilot sites across the county from October 2017 to deliver this differently and more innovatively to NHS England's latest requirements. During May 2017, we have sought expressions of interest from localities and clusters and will be working through these are reporting in the next iteration of this report which clusters will be progressing with in-year pilots in preparation for our model from April 2018.

5. Time for Care Programme

GCCG, working with the LMC, placed an expression of interest for this programme with NHSE. We were successful in that and are now working with clusters to implement the following:

- *Local General Practice Improvement Leaders Programme – 2 day condensed from the 6 day national programme; to be held in Gloucestershire. Date set for 11-12 July 2017.*

- *Productive General Practice Programme – hands-on support in practice to focus on development skills and techniques, while creating an action plan of initiatives for each individual practice and support to implement. Hoping to get 2 cohorts of up to 12 practices; commencing October 2017.*

- *Releasing Time for Care Programme – focused on the NHSE 10 High Impact Actions. Working to Spring 2018 start date.*

Integrated Working

Within the Stroud & Berkeley Vale and Gloucester City localities, they have commenced integrated working with providers within a 'place-based' approach. This has involved developing needs assessments at individual cluster level, along with an overarching locality board that the clusters are accountable to.

Projects include work with 2gether Trust to establish dementia nurses in practices, MDT meetings across providers and Mental Health nurse specialists working in inner-city Gloucester practices alongside primary care.

We will be using the learning from this work, and elsewhere, to develop our locality and cluster infrastructure to more integrated working structures and will report progress through 17/18 as a transition year ready for new structures by April 2018.

2.3

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

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. Sections 2.3.1 to 2.8 covers constitutional targets and local key performance indicators. Section 2.9 looks at the Improvement and Assessment Framework (IAF). This has been introduced by NHS England to replace the existing CCG framework. It is designed to fit in with the STP plans and supplies metrics for adoption in the plans as markers for success.

Issues identified in the following areas:

- *Cancer 62 day GP referral*
- *Incomplete RTT performance*
- *A&E 4 hour target*

As part of the 2017/18 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	87.7%	89.5%	89.2%	88.3%	92.2%	91.0%	90.0%	88.1%	77.4%	80.0%	80.0%	83.5%

RTT incomplete pathways: National standard 92%

RTT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed Trajectory	73.8%	75.0%	76.1%	77.2%	78.4%	79.5%	80.6%	81.8%	82.9%	84.0%	85.2%	86.3%

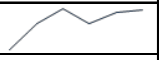
62 Day cancer: National standard 85%

62 day Cancer Waits	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreed Trajectory	77.7%	79.4%	80.1%	85.4%	85.2%	85.2%	85.3%	85.5%	85.3%	85.4%	85.4%	85.2%

The finalised trajectories were submitted on the 30th March, 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.

Unscheduled care:

The following dashboard provides a 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 Category 1 response	70%	Mar	76.6%	●	72.5%	●	
Ambulance Category 1 T response	75%	Mar	85.6%	●	83.6%	●	
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	87.7%	Apr	82.9%	◆	82.9%	◆	
4-hour A&E target GCS MIU	95%	Apr	99.6%	●	99.6%	●	
12 hour trolley waits	0	Apr	0	●	0	◆	

2.3.1

SWAST Ambulance indicators

Key performance and activity indicators:

- At the end of March, the SWAST Category 1 year to date position was 72.5% (Ambulance Response Programme was initiated 18/04 & ARP v2.2 started on the 15th Oct 16.)
- Ambulance incidents have decreased in 2016/17 by 1.7% when compared to the same period in 2015/16. March incidents with response were 8.6% lower than contract.
- Gloucestershire Conveyance to A&E has increased compared to 2015/16 (42.1%), with 45.1% of incidents resulting in conveyance to A&E. However given the reduction in demand and the implementation of the new Ambulance response programme, caution should be applied when comparing the data as between the two periods the provider has implemented a different model of dispatch.

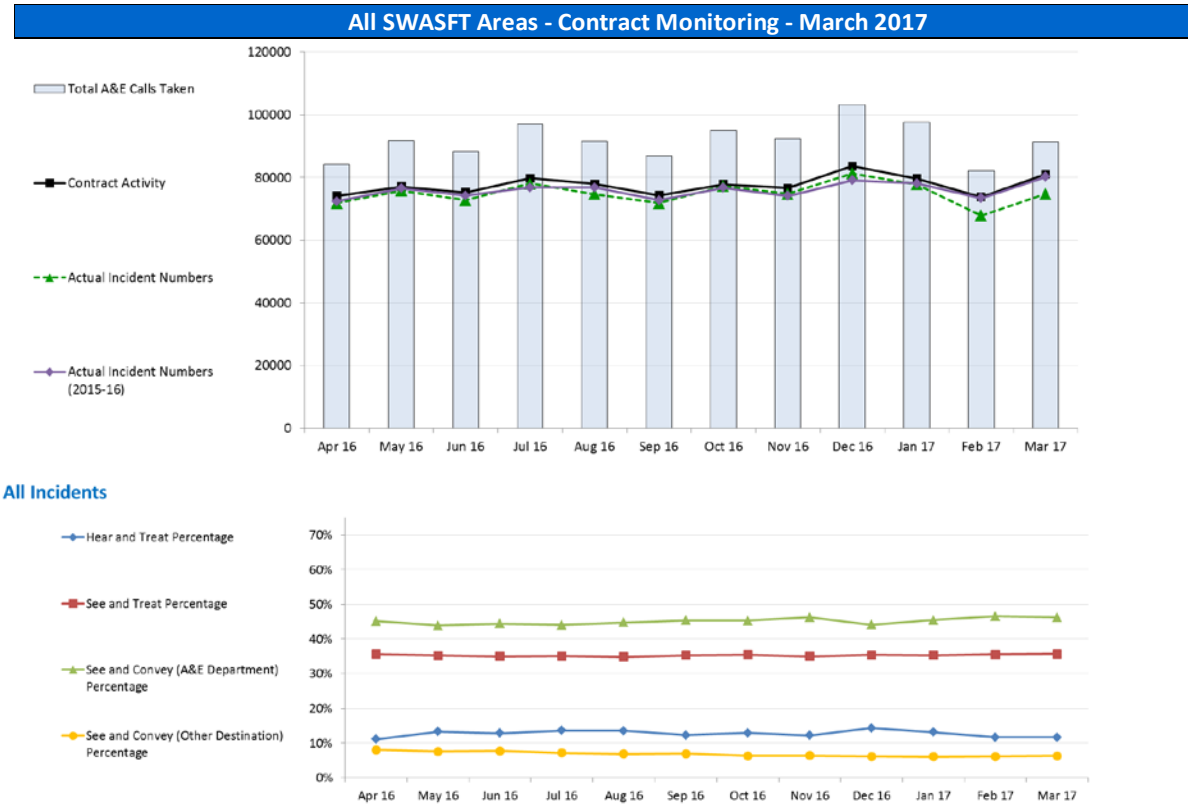
A demand management plan for Gloucestershire is in place with SWASFT and identified as part of the Improvement Plan and the Right Care 2 Programme.

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.

Performance is now measured against the Category 1 8 minute response, which in March was 76.6%, with a year to date of 72.5%. Category 1 T 19 minute response was 85.6% with a year to date of 83.6%, which is a positive position.

The SWAST contract position which includes growth on 2015/16 shows ambulance incidents -5% against the contract position (-4820 incidents) for 16/17. The level of growth within the 2016/17 contract was 3%.

Across 2016/17, hear and treat cases accounted for 12.8% of activity, conveyance to A&E increased by 3% compared to 2015/16. Conveyance rate for 2016/17 is 45.1% with 40,541 of incidents resulting in an A&E attendance, which is the best in the country for non-conveyance.



All Incidents

All Incident Types	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	YTD
Total Incidents (With Duplicate Calls Removed)	71880	75799	72745	78118	74734	71872	77303	74796	81305	77855	67924	74798	899129
Hear and Treat	8021	10076	9333	10682	10132	8819	9984	9171	11683	10227	7952	8743	114823
Hear and Treat Percentage	**11.16%**	**13.29%**	**12.83%**	**13.67%**	**13.56%**	**12.27%**	**12.92%**	**12.26%**	**14.37%**	**13.14%**	**11.71%**	**11.69%**	**12.77%**
See and Treat	25597	26708	25477	27383	26043	25396	27411	26212	28771	27483	24166	26722	317369
See and Treat Percentage	**35.61%**	**35.24%**	**35.02%**	**35.05%**	**34.85%**	**35.34%**	**35.46%**	**35.04%**	**35.39%**	**35.30%**	**35.58%**	**35.73%**	**35.30%**
See and Convey (Total)	38262	39015	37935	40053	38559	37657	39908	39413	40851	40145	35806	39333	466937
See and Convey (Total) Percentage	**53.23%**	**51.47%**	**52.15%**	**51.27%**	**51.59%**	**52.39%**	**51.63%**	**52.69%**	**50.24%**	**51.56%**	**52.71%**	**52.59%**	**51.93%**
See and Convey (A&E Department)	32468	33268	32304	34406	33420	32634	35005	34612	35844	35368	31611	34601	405541
See and Convey (A&E Department) Percentage	**45.17%**	**43.89%**	**44.41%**	**44.04%**	**44.72%**	**45.41%**	**45.28%**	**46.28%**	**44.09%**	**45.43%**	**46.54%**	**46.26%**	**45.10%**
See and Convey (Other Destination)	5794	5747	5631	5647	5139	5023	4903	4801	5007	4777	4195	4732	61396
See and Convey (Other Destination) Percentage	**8.06%**	**7.58%**	**7.74%**	**7.23%**	**6.88%**	**6.99%**	**6.34%**	**6.42%**	**6.16%**	**6.14%**	**6.18%**	**6.33%**	**6.83%**

Year to date the incident outcomes have remain fairly flat with a slight increase in Hear and treat in November onwards which could be attributed to the introduction of ARP v2.2 (12.8%). We have also seen a slight reduction across the year in the total See and Convey figures (Year End: 51.9%).

NB: The rise in A&E conveyance can be linked to the change in the CAD system within the SWAST North Division. Prior to the change the old CAD had all hospital wards and MIU's etc. programmed into the Mobile data terminals (MDT) on the ambulances. The new CAD doesn't currently have the same level of detail in it currently and so there may be instances where the final destination of the patients is not recorded correctly. SWAST are aware of the issue and are working to resolve it as soon as possible.

2.3.2 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 (STF trajectory for April – 87.7%).

- ED Performance for April was was 82.9%, which is 4.8% below the STF YTD trajectory (87.7%).

- ED Attendances at GHFT have risen by 3% when comparing April 2016 to April 2017. April A&E attendances this year were 319 more (11,096) than April 2016 (10,777).

The system have an agreed improvement plan for 4 hours, this is supported 11 work programmes within the Trust. Specific areas of focus are the reduction in emergency admissions and a reduction in acute bed base capacity. Key actions are split between operational and strategic they include:

Strategic (STP Urgent and Emergency Care)

- Development of Urgent Care Treatment Centres;
- Development of new pathways for patients direct to assessment units;
- Development of an Integrated Clinical Hub.

Operational:

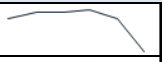
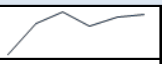
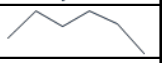
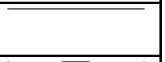
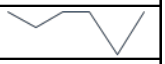
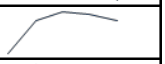
- GP in ED (Front and back door) – supporting attendance/ admittance avoidance;
- Pathway compliance including enhanced utilisation of AEC/OPAL as existing schemes
- Evaluation of the Clinical hot advice offer;
- Working with 111 on enhanced clinical validation to reduce 999/ED dispositions;
- Reviewing staffing models and corresponding capacity within SWASFT to enhance 999 service offer, since completed through the rota review and investment in additional Double Crewed Ambulances;
- Working with community provider to actively reduce current community hospital length of stay;
- Enhancing role of single point of clinical access to support admission avoidance including access to specialised advice line within the acute trust;
- Ongoing work within the acute trust to deliver SAFER principles of discharge;
- Development of discharge to assess beds with progression on home-based pathways in conjunction with Gloucestershire County Council;
- Development of the Care Navigator role;
- Development and implementation of the Discharge Support tool for front-

line staff;
- Additional investment in the 'pull model' to support patients known to services to be supported out of hospital.

These actions align to the Five Year Forward View Delivery Plan, and are supported through two task and finish groups that report to the A&E Delivery Board. One is focused on the task of reducing attendances and admissions and one is focused on supporting onward care. The A&E Delivery Board is a system level partnership that collaborates to achieve delivery of the 4 hour performance standard.

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
Referral to treatment (RTT)							
% of incomplete Pathways that have waited less than 18 Weeks	92%	Nov	88.3%	◆	91.7%	■	
Zero RTT pathways greater than 52 weeks	0	Mar	10	◆	116	◆	
Cancer waiting times							
% of patients seen within 2 weeks of GP referral for suspected cancer	93%	Mar	94.3%	●	89.1%	◆	
% of patients seen within 2 weeks of an urgent referral for breast symptoms cancer is not initially suspected	93%	Mar	94.8%	●	92.9%	■	
Cancer - first definitive treatment within 31 days of a cancer diagnosis	96%	Mar	97.9%	◆	97.0%	●	
Cancer - subsequent treatment for cancer within 31 days - surgery	94%	Mar	88.5%	◆	96.0%	●	
Cancer - subsequent treatment for cancer within 31 days - Drug Regime	98%	Mar	96.7%	●	99.6%	●	
Cancer - subsequent treatment for cancer within 31 days - Radiotherapy	94%	Mar	96.5%	●	98.7%	●	
Cancer - first definitive treatment within 62 days GP referral	85.0%	Mar	70.6%	◆	75.1%	◆	
Cancer - first definitive treatment within 62 days screening service	90%	Mar	93.9%	●	92.9%	●	
Cancer - first definitive treatment within 62 days upgrade	85%	Mar	100.0%	●	96.1%	●	
Diagnostic waiting times							
% of patients waiting more than 6 weeks diagnostic test	1.0%	Mar	3.10%	◆	1.9%	■	
Local community waiting times							
% referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	95%	Mar	94.7%	■	97.6%	●	
% referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks	95%	Mar	96.3%	●	96.7%	●	
% referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	95%	Mar	95.1%	●	95.3%	●	
% referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	95%	Mar	93.8%	■	95.7%	●	
% referred to the Podiatry Service who are treated within 8 Weeks	95%	Mar	87.4%	◆	94.9%	■	
% referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	95%	Mar	90.0%	◆	91.4%	■	
% referred to the Adult Physiotherapy Service who are treated within 8 Weeks	95%	Mar	91.0%	◆	91.5%	■	
% referred to the Parkinson Nursing Service who are treated within 8 Weeks	95%	Mar	100.0%	●	99.1%	●	
% referred to the Diabetic Nursing Service who are treated within 8 Weeks	95%	Mar	98.0%	●	98.1%	●	

***STF Trajectory**

2.4.1

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

Due to the implementation of the GHFT TrakCare System, data post November 2016 is not yet available. We are currently working with the Trust to resolve these issues which include offering support from the CCG data/information team and we have regular weekly meetings for GHFT to update the CCG on any data quality or data completeness issues.

In March there were 10 patients who were waiting longer than 52 weeks for treatment. 4 at GHFT. 3 in Urology & 1 in Cardiology. All the breaches had 'To Come In' (TCI) dates in April.
The CCG is working with the Trust to ensure that any April breaches are known and offered choice of provider where possible, alongside prioritising booking.

There were also 5 breaches at NBT; 4 in Neurosurgery and 1 in T&O. There was also 1 breach at the Royal Orthopaedic Hospital in T&O. All patients have either received a date for surgery or discharged as clinically appropriate.

The CCG regularly receive updates on the progress of treatment for Gloucestershire patients at out of county providers. Commissioners are provided with assurance that all patients have been clinically reviewed and we regularly request patient TCI dates. The CCG Governing Body is asked to note the regional and national issues relating to spinal surgery waiting times Performance management is being undertaken in conjunction with the lead commissioner for planned care, through the access and performance meeting

For the Trusts where we are an associate commissioner, we receive the monthly performance position highlighting the issues and have an opportunity to challenge progress. Some of the key recovery actions taken locally include:

- A Risk of Harm report sent to GHFT Quality & Performance Committee
- GHNHSFT RTT Recovery plan has been drafted and sets out plans to recover performance by speciality. GHNHSFT are also investigating how to expedite recovery with CCG support
- Additional surgical lists running on weekends in March specifically targeting >48 week wait patients and long waiting cancer patients
- Outsourcing of capacity to NHS Contracted provision at speciality level –

specifically under pressure specialities T&O, General Surgery and Gynaecology
- Further communication to GPs to raise awareness of current pressures and performance at GHFT – regular waiting times of other providers are routinely shared to referrers
- Referral pathways being discussed with CPG leads re 52 week waiters - Ensure early warning flag system at 35 weeks is in place and robust.

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 267 new users visit the site in April bringing the total number of unique visitors to the site to 1,499. The site was visited 3,943 times with 14,089 pages viewed.

G-care

https://g-care.glos.nhs.uk

April 2017

Total Users	1,499	
New Users	267	
Site Views	3,943	
Page Views	14,089	

Top Pages Viewed	1.Irritable Bowel Syndrome (IBS) 2. Obesity 3. Palpitations 4. Falls Prevention 5. Type 2 Diabetes
Top Referral Forms	1.Healthy Lifestyles Services 2. Slimming World Weight Management 3. Gloucestershire Respiratory Service 4. Colorectal Cancer- Suspected 5. Gloucestershire Community Drug & Alcohol Service
Pathways currently in review for publication for May 2017	1. Oral Nutritional Supplements (ONS/Sip Feeds 2. Coeliac Disease 3. Rectal Bleeding

Content Updates	1. 2gether Eating Disorder Service- information added 2. Home Oxygen Assessment Service- information added 3. Balance & Stability Classes-Stroud updated 4. Gloucestershire Familial Hypercholesterolaemia Cascade Screening Service- information added 5. Supporting Clinical Judgement & Patient Safety (NEWS)- video added
Top Site Searches	1. Slimming World 2. Diabetes 3. DVT 4. Podiatry 5. Physiotherapy

2.4.2 **Cancer waiting times**

2 Week Cancer waits

Performance against the 2-week wait continued to meet target with performance of 94.3% in March. There were 106 breaches of which the main areas of concern are:
Upper Gastro intestinal (38 breaches)
Breast (22 breaches)
Lower Gastro intestinal (20 breaches)
Other breaches were in Gynaecology (6), Haematological Malignancies (2), Head & Neck (5), Skin (5), and Urology (8). GHNHSFT have put in place actions to recover performance which include:

- **2WW Appointment Booking Project**: CPG team have run an information campaign in Q3 with practices to ensure patients understand the importance of attending 2WW appointments. A new joint "task & finish" project to be launched this week to understand problems and implement short-term improvements.
- **Referral Pathways**: There has been extensive discussion about the shift that is evident from routine referrals to 2WW referrals. This was expected as a result of the new NICE guidelines, however as a system there is a need to have a full appreciation of any other factors and understand the

current availability and waiting times for routine appointment too as part of this pathway work. A number of potential solutions were discussed, these will be investigated further.

62 day cancer waits

Performance against the 62-day wait target has improved slightly from 70.5% in February to 70.6% in March with 50 breaches, of which 19 were in Urology, 10 in Lower GI, 6 in Head & Neck, 6 in Lung, 4 in Gynaecology, 2 in Haematological, 2 in Other, and 1 in Upper Gastro intestinal.The Trust has submitted a new recovery plan with recovery due by end June 2017. Other actions for recovery include:

- The implementation of the new service model,one-stop Multi Assessment Diagnosis Clinics, partially commenced in December, and is now fully operational. This is designed to deliver a better patient experience and efficient use of services;
- Demand and Capacity mapping: with CCG supporting key specialities to determine any potential gap and map these against workforce and commissioning requirements. Following this a review of workforce gaps future and potential will be taken forward by the Trust.

104 day breaches

There were 20 over 104 day breaches reported at the end of March. The number of patients in this category is tracked weekly by the Trust, the CCG have requested weekly updates to be shared. These detail the progress on the breach reporting / review of clinical harm reports that are being progressed by the Trust with a clear reduction.

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

- GHNHSFT have plans to expand the current multidisciplinary and diagnostic clinics which will shorten patient pathways. This has commenced with delivery showing early signs of improvement but with a recognisable backlog still remaining.

GP Care is operating a clinical assessment service in conjunction with GHNHSFT and GCCG. In the 16 months (November 15 to February17) since the service was commissioned it has accepted 1790 referrals and has so far seen 1417 of those patients. On average, to date 74% of patients complete their pathway with GP Care, with 26% going on to GHFT for surgery.

GCCG have agreed a recovery trajectory with GHNHSFT with performance against the standard being achieved by June 2017. 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 Audiology service.

Performance in March at 3.1% has failed to meet the target (STP target of 1%) with 229 breaches. The specialities in which the CCG are not meeting target are;

Audiology 39 breaches (12.5%)
Echocardiology 164 breaches (38.1%)
Peripheral Neurophys 2 breaches (1.3%)
Urodynamics 4 breach (13%)
Gastroscopy 9 breaches (1.8%)
Flexi Sigmoidoscopy 1 breach (1.8%)

Year end performance is 1.9% against an YTD STP target of 1.3%. The underlying cause for poor performance in Audiology is a lack of audiologists which has caused a delay to some treatments.

The Trust continues to use agency staff to meet the required target, and has appointed under graduates to 6 vacancies who will commence later this summer, though it is recognised this service is still under pressure.

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%	Mar	68.0%	●	68.0%	●	
Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	95%	Mar	100.0%	●	98.0%	●	
IAPT Access rate: Access to psychological therapies for adults should be improved	15%	Mar	8.20%	◆	8.20%	◆	
The proportion of people who complete therapy who are moving towards recovery	50%	Mar	46.0%	■	47.0%	■	
IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	75%	Mar	44.0%	◆	35.0%	◆	
IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	95%	Mar	94.0%	◆	86.0%	◆	
CYPS Mental Health	Threshold	Month	Performance		YTD		
Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	98%	Mar	99.0%	●	99.0%	●	
95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	95%	Q4	99.0%	●	99.0%	●	
Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	80%	Q4	98.0%	●	89.0%	●	
Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	95%	Q4	99.0%	●	96.0%	●	

Dementia diagnosis rate (DDR)

2.5.1 Dementia diagnosis rate in March 2017 was 68% which has met the 67% target. The CCG has a robust plan in place to maintain the figure and has completed regular case finding audits.

Using Quality Improvement and Clinical Programme Approach methodologies, the Primary Care Dementia Pathway is being reviewed through extensive stakeholder engagement that includes those living with dementia. The review includes key national targets such as DDR and post diagnostic support, and has already identified a number of key issues such as secondary care responsibility for prescribing and monitoring dementia drugs leading to duplication and gaps in annual review. The focus of dementia in the local Sustainability and Transformation Plan will facilitate the shift to support primary care diagnosis of dementia.

Improving Access to Psychological Therapies (IAPT) -The proportion of people who complete therapy who are moving towards recovery

2Gether NHSFT 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 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 with March just below target at 46%,and Year-end figure also slightly below the target at 47%. This has however had impacted on the Access to IAPT services figure which is 8.2% against a target of 15%

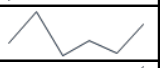
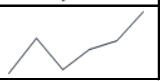
A member of the national IAPT Team is supporting 2G. They have also had an on-site visit from the NHSE Intensive Support team. 2G have created an improvement plan for access and recovery which has been shared with the CCG, which includes an internal productive review and the providing of an E-provision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

Patient transport:

2.6

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 and the CCG is closely monitoring the Arriva Transport Services Ltd (ATSL) remedial action plan and performance improvement trajectory.

Patient transfer services	Threshold	Month	Performance		YTD performance		6 month trend
Arrival within 45 minutes before, to 15 minutes after, booked arrival time	95%	Apr	84.8%	◆	84.8%	◆	
Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey	85%	Apr	78.5%	◆	78.5%	◆	
Where booked on the day of travel, patients not to wait more than 4 hours for their (outbound) journey (within two hours for end of life patients)	85%	Apr	83.0%	■	83.0%	■	

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

2.6.1

Inbound on-time arrival is an area where performance remains challenging. March's report shows a slight improvement on the previous month, with 84.8% of patients arriving within key performance indicators (KPI) timescales.

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

The response timeframe for these is one hour from the time the patient is 'made ready'. Analysis for March shows that 78.5% were achieved within the one hour compared to the target of 85%. Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys.

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

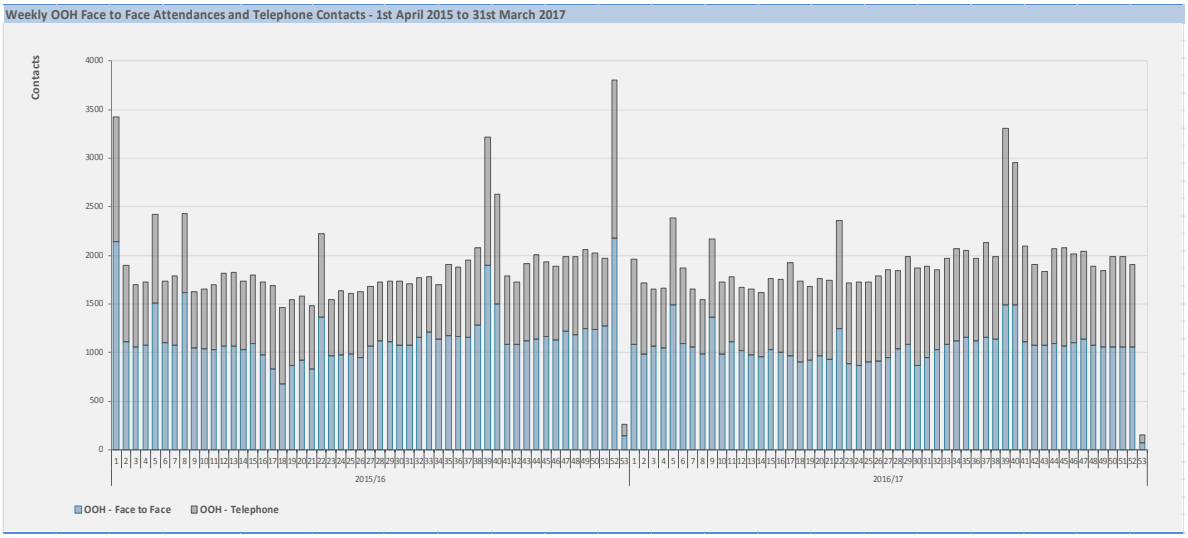
March 2017 saw an improvement in performance to 83%. The high number of on the day bookings made by the Acute Trust for discharge and transfer, particularly those made at the end of the day, remain challenging for ATSL. In the 16/17 contract with GHFT a CQUIN around on the day transport bookings has 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.

Out Of Hours

2.7

The SWASFT Out of Hours Service commenced on 1st April 2015; there have been 100,245 OOH contacts made in 16/17 with an average of 1,928 contacts per week.

The graph below shows the total number of weekly OOH contacts split by face to face and telephone; face to face contacts predominantly include Treatment Centre, Walk In, Home Visit and ED/MIU Referral contacts. The marked increase in weeks 22 and 52 co-incide with the late August bank holiday and Easter holiday respectively, with weeks 1, 39 and 52 (in 15/16), and week 39 (in 16/17) also falling during bank holiday periods.



The average number of face to face contacts per week stands at 1066, accounting for 55% of all contacts. The last few weeks have seen an average level of activity.

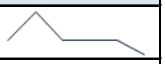
The dashboard below provides performance data for “walk in” patients to the Out of Hours service. This is not currently a pathway that is encouraged within Gloucestershire and SWAST are working to ensure that where patients access the service via this route that information is being provided on the recommended NHS111 access route. This ensures that patients are provided with signposting advice based upon clinical need and that they only attend the OOHs service when their clinical condition dictates. It is however essential that when patients do walk into the service that they are assessed in a timely way and prioritised. SWAST are continually reviewing their staffing skill mix to ensure that staffing levels are able to respond to arrivals within the Primary Care Centres.

National Quality Requirements		Mar-17	Year end compliance
Requirement 10: (Walk in)	All immediately life threatening conditions to be passed to the ambulance service within 3 minutes following face to face clinical assessment in PCC	**100%**	**100%**
Requirement 10a: (Adult Walk in)	For urgent adult patients - % definitive face to face clinical assessments started within 20 minutes of arrival in PCC.	**84.27%**	**84.47%**
Requirement 10a: (Children Walk in)	Children, who are ill and have an urgent OOH need, will receive definitive clinical assessment within 15 minutes of arrival in PCC	**72.63%**	**74.57%**

Clinical quality:

2.8

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	Mar	0	-	9	-	
Number of MRSA infections (GHNHSFT)	0	Mar	0	-	3	-	
Number of C.diff infections (Health Community)	157	Mar	2	■	138	■	
Number of C.diff infections (GHNHSFT)	37	Mar	8	◆	39	■	
Mixed sex accommodation							
Mixed-sexed accommodation breaches	0	Apr	4	◆	155	◆	
Other quality indicators							
Number of Never Events	0	Mar	0	●	1	◆	

Number of MRSA infections (Health Community)

2.8.1

There have been 12 MRSA cases attributed to the community reported year to end April 2017. A Post Infection Review (PIR) of each case was undertaken within 14 days as required by Public Health England. Two were attributed to GHNHSFT, one was attributed to GCSNHST and 9 attributed to the Health Community.
Included in these 12 MRSA cases were two contaminants and three that were attributed to a third party (no healthcare intervention that could have resulted in MRSA bacteraemia infection).

Number of total C. difficile infections (Health Community)

2.8.2

The threshold for 2016/17 has remained the same with 157 for the wider health community, and 37 for GHFT.

Year to end April 2017 performance is 177 in the wider health community with 39 of these cases of C. diff reported at GHNHSFT. A Root Cause Analysis is undertaken for each incident of C.diff. Primary and Secondary Care carry out the analysis together. This process looks at risk factors, trends and includes robust action plans

Number of Escherichia coli infection (Health Community)

2.8.3

In 2015/16 there were 286 cases of E.Coli. There was no threshold set for E.Coli infections in 2016/17. Year to end performance is 283 community acquired cases of E.coli reported in the wider health community. E.Coli is to be a high priority for action in 2017-18. The threshold for 2017/18, set by NHSE is 257.

Season influenza uptakes rates

2.8.4

Uptake rates for week 04 (29.01.17) for all groups except for 64 yrs and over and 6mths to 2 years are comparable to % uptake last year. Compared to National end of season ambitions most groups uptake % is 5% or more below the comparator %. NHS England continue to support practices to achieve National ambitions.

Reported healthcare workers flu vaccination rates for week ending 29 January 2017:

- 2gether 77.2%,
- GHNHSFT 57.8%,
- GCS 56.8%
- Gloucestershire GP practices 62%.

Mixed Sex Accommodation breaches

2.8.5

During April, there were 4 breaches affecting 18 patients. Any breaches reported, are reviewed against the delivering same sex accommodation decision matrix agreed with GHNHSFT, NHSE and the CCG.

The New CCG Improvement and Assessment Framework

2.9

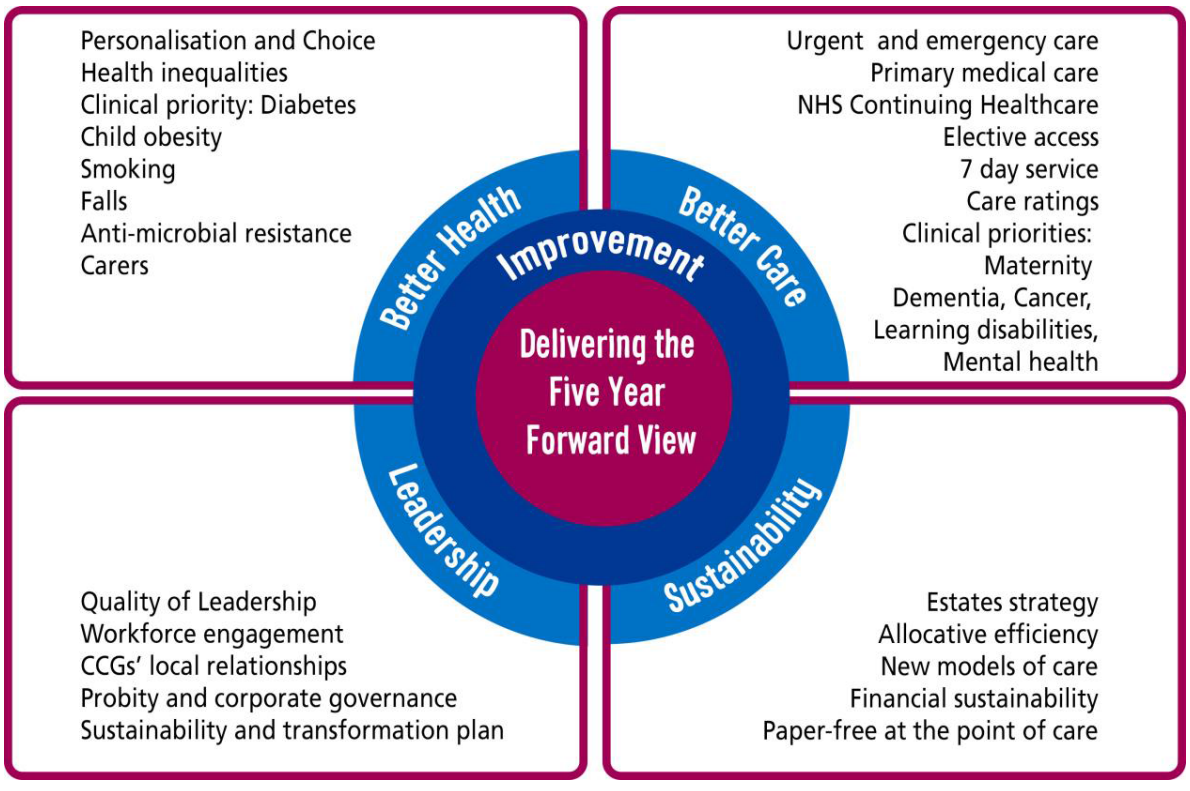
NHS England has introduced a new Improvement and Assessment Framework for CCGs from 2016/17 onwards, to replace both the existing CCG Assurance Framework and separate CCG performance dashboard.

The new CCG Improvement and Assessment Framework is designed to fit with the forthcoming Sustainability and Transformation Plans. It supplies metrics for

adoption in those plans as markers of success.

Components: 4 domains; 6 clinical priorities. The 4 domains consist of 60 Key performance indicators, some of which are being developed in year.

- **Better Health:** this section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve;
- **Better Care:** this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas;
- **Sustainability:** this section looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends;
- **Leadership:** this domain assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity for example in managing conflicts of interest.



We have received the initial baseline results in July and they have been updated in January 2017.

Improvement & Assessment Framework Dashboard						
Theme	Top Performing	Performing Well	Needs Improvement	Greatest Need for Improvement	N/A	Data Not Yet Available
Better Health	5	7	1	0	1	0
Better Care	8	8	2	5	7	2
Sustainability	0	1	0	0	4	3
Well Led	0	0	0	0	5	1
Total:	13	16	3	5	17	6

The rankings have been based on our position from all 209 CCGs on the MyNHS website and our ratings have been based on our ranking position as follow;
If ranked 1-52 - we have assumed we are 'Top performing'
If ranked 53-104 - we have assumed we are 'Performing well'
If ranked 105-156 - we have assumed we are 'Needs Improvement'
If ranked 157-209 - we have assumed we are 'Greatest need for Improvement'

6 Clinical Priority Areas

New 'Ofsted style' ratings (Top performing, Performing well, Needs Improvement and Greatest need for improvement), with assessments overseen by independent groups, will be assigned in the following 6 clinical priority areas:

- Mental health – chair, Paul Farmer, Chief Executive of MIND;
- Dementia – chair, Jeremy Hughes, Chief Executive of the Alzheimer's Society;
- Learning disabilities – chair, Rob Webster, Chief Executive of the NHS Confederation and Gavin Harding, Learning Disability Advisor, NHS England (acting as co-chairs);
- Cancer – chair, Sir Harpal Kumar, Chief Executive of Cancer Research UK;
- Diabetes – chair, Chris Askew, Chief Executive of Diabetes UK.
- Maternity – chair, Baroness Julia Cumberlege, Chair of National Maternity Review

Process

The first assessment for each of these six clinical priorities was published on the MyNHS website in September 2016 with baseline performance and informs whether NHS England intervention is needed.

The aim is to ensure that data will be available at least quarterly for nearly all of these metrics. NHS England's regional teams will ensure that the framework is discussed with CCGs during the year, through a rolling programme of local conversations drawing on expertise and insight from the national programme teams.

The formal annual assessment against the 2016/17 framework will be

published in summer 2017. Each CCG will receive an annual headline assessment in one of four categories. The assessment will be a judgement, reached by taking in to account the CCG's performance in each of the indicator areas over the full year. To ensure that the framework is being applied consistently, regional and national moderation will take place. NHS England's Commissioning Committee will oversee the process and sign off the ratings. The Committee will also track progress in-year. Ratings will be published.

The current assessment for the 6 areas is:

6 Clinical Priority Areas: January 2017	
Cancer	Needs Improvement
Dementia	Performing Well
Diabetes	Performing Well
Learning Disabilities	Needs Improvement
Maternity	Performing Well
Mental Health	Needs Improvement

Cancer

2.9.1

Cancer	Cancers diagnosed at early stage	People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral
Needs Improvement	54.4% of patients diagnosed at an early stage	79.8% of people treated within 62 days
	One-year survival from all cancers	Cancer patient experience
	71.3% one-year survival	8.7 is the average score given by patients asked to rate their care on a scale from 1 to 10 (10 being best)

The main reason we are currently rated as Needs Improvement in Cancer is due to the 62 day cancer target being in the bottom quartile nationally. Improvement in this one indicator out of the bottom quartile will see our rating improve to Performing well. We have a 62 day cancer recovery plan agreed with GHNHSFT and expect performance to recover by March 2017.

It should be noted that Gloucestershire CCG has been identified as one of the CCGs with the most improved position in country on one-year cancer survivorship, and that we can also report significant improvements in cancer patient experience over the last 3 years. Nationally 2020 objectives have been set for these key indicators and our cancer clinical programme is ensuring we have the appropriate work plans in place.

Mental Health

2.9.2

Mental Health	Improving Access to Psychological Therapies recovery rate	People with 1st episode of psychosis starting NICE-recommended treatment within 2 weeks of referral	Children and Young People's Mental Health Services - Transformation
Needs improvement	50% of people who finished treatment moving to recovery (Dec 16) YTD Dec 47%	86.7% of 15 people with first episode of psychosis starting treament with a NICE-recommended package of care treated within 2 weeks of referral	70% Percentage compliance with a self-assessed list of minimum service expectations for Children and Young People's Mental Health, weighted to reflect preparedness for transformation
	Crisis Care and Liaison Mental Health Services - Transformation	Out of area placements for acute mental health inpatient care - transformation	
	85% Percentage compliance with a self-assessed list of minimum service expectations for Crisis Care, weighted to reflect preparedness for transformation	25% Percentage compliance with a self-assessed list of minimum service expectations for Out of Area Placements, weighted to reflect preparedness for transformation	

Mental Health is a particular area of concern for the CCG with the IAPT recovery rate performing in the bottom quartile nationally. We have also received a Needs immediate attention for our self-assessment return on out of area placements for acute mental patients. Improvement in both these Key performance indicators will see our rating rise to Performing well.

The CCG and 2G have agreed a recovery plan for the improvement of the IAPT recovery and access rate and have been supported by the NHS England intensive support team. Actions have included redesigning the IAPT pathway which was implemented in November 2016. The CCG has had discussions with the provider around improving the reporting of out of area placements. Monthly reports are available via sharepoint and are reviewed at Contract Performance meetings. As of December 2016 there were 3 acute OAPs. We are now reporting full compliance in the Q3 self-assessment return.

Learning Disabilities

2.9.3

Learning Disabilities	Reliance on specialist inpatient care for people with a learning disability and/or autism	Proportion of people with a learning disability on the GP register receiving an annual health check
Needs improvement	39 per million registered population	31% of people on the GP Learning Disability Register that received an annual health check during 15/16

Improvements are required in reducing our reliance on specialist inpatient care for people with a learning disability and/or autism in order to improve our rating to Performing well. The current identified numbers of patients in receipt of inpatient care is being challenged at a national level as there appears to be a discrepancy between the national Transforming Care Programme and specialist commissioning numbers.

Gloucestershire is well placed to improve our local resilience with regards to an increase in the range and type of community based provision. A new assessment and treatment unit, plus place of safety beds are coming on stream in the new year. These bed based services will augment our already successful learning disabilities intensive support service (LDISS).

Commissioners are working on a system wide improvement and promotion plan in order to increase the take up of annual health checks. Our current performance of 31% (national average of 31%). It is hoped that the current plans will improve this further and improve our overall rating.

Diabetes

2.9.4

Diabetes	Diabetes patients that have achieved all the NICE-recommended treatment targets	People with diabetes diagnosed less than a year who attended a structured education course
Performing well	**40.8%** **In the top half of performers.** **75.9% participation in the NDA.**	**4.7%** **75.9% participation in the NDA.**

In order to move to Top performing we will need to improve the number of people with diabetes diagnosed less than a year who attended a structured education course, so that our performance is significantly above the national average of 5.7% (approx. 4% improvement).

The most recent national diabetes audit (NDA) participation figures show that the participation rate in Gloucestershire has increased from 75.9% in 14/15 to 91% in 15/16. It has been recognised that the documentation of completed structured education is poor across England because it relies on practices in primary care coding completion of Structured Education. In Gloucestershire, the face to face courses are delivered by GCS in the community.
Practices are informed about patients who have attended the education courses but they do not prioritise coding patients as completing courses because;

- they don't recognise that this is what is being measured centrally
- they are not incentivised to do it by QOF and

- It is a low administrative priority.

It has been recognised nationally that both completion of Structured Education programmes and coding on completion needs to be improved.

The implementation of Mapmydiabetes across Gloucestershire should increase the number of people offered and attended structured education (although we still need to qualify how we can ensure this is coded appropriately on completion).
The Diabetes Treatment and Care transformation Programme has allocated £40m for 17/18 and 18/19 and is asking for bids from CCGs to improve the recording of structured education and increase the uptake of structured education. It is expected that CCGs will increase the documented attendance by 10% year on year until 2021

At their next meeting, the Diabetes CPG will be deciding on details of their bid which ***could*** involve:

- Use of health trainers to provide some of the structured education programme (to increase provision and offer alternative times and venues)
- Use of administration staff to code attendance of SE programmes centrally or in practices
- Alternative methods of informing practices of patients who have attended education allowing for more efficient coding
- Use of the CES to incentivise appropriate coding
- Working with GHNHSFT to ensure patients with Type 1 diabetes receive SE and that this is documented in primary care (for NDA).

We will also need to maintain our performance for diabetes patients that have achieved all the NICE-recommended treatment targets at above 40.2%.

NDA data suggest that we achieve targets for adult patients above the age of 65 (Type 2 diabetes) but fall below expectations for all adult type 1 patients and adult patients with type 2 diabetes under the age of 65 year.
We also underperform with children under the age of 18 with type 1 diabetes.

The intention is to work with GHNHSFT to improve treatment targets for type 1 diabetes (and investigate whether the correct data is on primary care systems for NDA purposes). We will also consider how we improve treatment targets for adult type 2 patients under 65 years.

Dementia

2.9.5

Dementia	Estimated diagnosis rate for people with dementia	Dementia care planning and post-diagnostic support
Performing well	**68.3%** of the estimated number of people with dementia have a recorded diagnosis	**79.1%** of patients with dementia whose care plan has been reviewed in the preceding 12 months

Latest performance figures published in December for our dementia diagnosis rate at 68.3%. If we could also improve our Dementia care planning and post-diagnostic support result by 1% or more, then we would move into Top performing.

The Primary Care Clinical Audit Team (PCCAG) is working with practices on case finding patients with dementia on practice lists. The MiQUEST query identifies those who may have dementia but do not have a diagnosis, and support is offered by the Community Dementia Nurses to review those with the practice team to facilitate a primary care or secondary care diagnosis as appropriate. It is anticipated that the impact of the audit will in Q4 16/17.

The primary care dementia pathway is currently undergoing review, with potential service redesign to address a number of issues. For example,

- closer collaboration between the Community Dementia Nurses and Alzheimer's Society Dementia Advisers
- timely and appropriate use of information
- support for those with Vascular Dementia and Mild Cognitive Impairment

Improved annual dementia review is being addressed in a GP Cluster Pilot, where CCG is working with 2gether NHSFT to review the current secondary care prescribing and review guidance for dementia drugs (ACIs) which has led to an inequitable process of annual review and reduced Community Dementia Nurse capacity.

The GP Cluster Pilot is utilising the STP Quality Improvement methodology and resources (QSIR) to progress this work and roll out in other localities. This in in collaboration with primary and community services to develop an integrated approach to dementia by:

- offering an equitable and consistent annual review for all those diagnosed with dementia

- developing a dementia hub in practices that will ensure timely annual reviews and specialist support where need or symptoms change, avoiding crisis response

Maternity

2.9.6

Maternity	Neonatal mortality and stillbirths	Women's experience of maternity services
Performing well	6.2 stillbirths and neonatal deaths per 1000 births. A similar rate to most other CCGs	83.1 is the score out of 100 based on six survey questions. Among the CCGs with the highest scores
	Choices in maternity services	Maternal Smoking at Delivery
	70.1 is the score out of 100 based on six survey questions. Among the CCGs with the highest scores	8.7% of 1729 mothers smoked at delivery

We will need to improve either the Neonatal mortality & stillbirths or Maternal smoking at delivery performance so it is statistically significantly better than the national average figures (7.1% Stillbirths, 10.2% Smoking). If we are able to do this we should move into the Top performing rating.

Maternity services are performing well and the ambition is for services to become 'Top rating'. In order to achieve this the CCG in partnership with GHNHSFT and key partners will implement the action plan associated with the National Maternity Review 'Better Births' Report (2016) to ensure we continue to improve women's experience of maternity services and reduce stillbirths and neonatal mortality by :

- Developing and implementing different ways of engaging women and families in diverse communities in conjunction with Health watch and GHNHSFT through social media and other means.
- Work with women, families and stakeholders to improve women's experience of postnatal care
- Implement the action plan relating to Saving Babies Lives, aiming to reduce stillbirths via smoking cessation and monitoring

movements and growth of babies.

- Develop community hubs and integrating better together services that support women and families in the early years including health visiting and children's services.

3.1 Patient Experience

3.1.1 Patient Experience – Period up to 30th April 2017

PERSPECTIVE 2	Patient Experience	Green
Success criteria 1: *Patient safety is at the heart of the work of the CCG and is considered when planning service change and developments.*		Green
Key performance indicators		
Outcomes measures for patient safety have been developed based on the CCG Outcome framework and sign up for safety initiative.		Green
Quality Impact Assessments are undertaken for all new proposed initiatives and service developments. This is considered by the QIPP assurance board before decisions are made to support new initiatives. Mitigation is planned where necessary to ensure patient safety.		Green
Success criteria 2: Reporting: *Improve reporting of patient experience including FFT (Marion Andrews-Evans)*		Green
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in patient and staff FFT		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average in patient and staff FFT score		Green
All providers of NHS funded services commissioned by GCCG participating in National Patient Survey Programme (2015/16)		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average results in National Patient Survey Programme (2015/16)		Green
Success criteria 3: The CCG has a programme of case reviews in place across urgent care reporting into system resilience to influence service redesign including CPGs.		Green
Key performance indicators		
CCG has a programme of case reviews across urgent care, which feed into System resilience / clinical programme groups as appropriate.		Green
Focus on emergency admissions and discharge.		Green
Success criteria 4: *National targets-PROMs*		Green
Key performance indicators		
All providers of NHS funded services commissioned by GCCG participating in PROMs (2015/16)		Green
All providers of NHS funded services commissioned by GCCG achieving at or above national average PROMs results (2015/16)		Green
Success criteria 5: *All active Clinical Programme Groups are working with patients to ensure experience is incorporated into the programme and outcomes*		Green

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

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

The CCG has a strong focus on patient safety and this forms a standing item on the agenda of the Clinical Quality Review Groups. In addition the CCG is fully involved as an active member of the South West Patient Safety Collaborative, and is represented on the collaborative board.

Members of the Quality Team recently organised a meeting with safety leads from all of our main providers. This meeting aimed to improve communication and working relationships between partners. The meeting concluded with a commitment to improve cross-organisational working and to develop a Framework for the management of safety across the county. It is our intention to help reduce variation across partners, whilst recognising the need for different organisational approaches.

Whilst developing the Framework, we will also be widening the focus of core safety work to include Primary Care; in April NHS England confirmed that they had delegated their 'Safety' functions, including the management of Serious Incidents, to the CCG.

We also continue or work with the West of England Academic Health Science Network and will be represented at the National Patient Safety Collaborative learning event in London at the end of May.

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/

In February 2017 GHNHSFT again exceeded the national averages for the collection for both Inpatient and ED Friends and Family Tests, leading to a green rating this month for response rates, the %recommend results remain below the national average for both acute measures. Whilst neither GCSNHST nor 2gether NHSFT report response rates performance remains strong and roughly in line with the national picture. The area of focus remains on improving the use of FFT in primary care and encouraging the patient participation groups to become involved in the use of this information to improve where necessary practice experience.

		Dec-16		Jan-17		Feb-17	
		Provider	Nat Ave	Provider	Nat Ave	Provider	Nat Ave
GHT Inpatients	Response Rate	20.50%	22.60%	24.50%	23.60%	29.40%	25.10%
	% Recommend	90%	95%	89%	96%	91%	96%
	% Not	4%	2%	6%	2%	4%	1%
GHT A&E	Response Rate	13.50%	11.00%	18.60%	12.30%	21.90%	12.70%
	% Recommend	78%	86%	86%	87%	80%	87%
	% Not	15%	8%	9%	7%	14%	7%
GCS	Response Rate						
	% Recommend	96%	95%	96%	95%	96%	96%
	% Not	2%	1%	2%	1%	2%	1%
2g	Response Rate						
	% Recommend	88%	86%	90%	88%	90%	88%
	% Not	2%	6%	4%	4%	5%	5%

3.1.4 Success criteria 3: 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 data is now published in the NHS Digital online catalogue. This catalogue contains the official statistical publications HSCIC produces about health and care in England. It also contains results from surveys, audits, reports and other statistics.

This information is produced for, and used by, a number of organisations, bodies and individuals. Its uses include health research, resource planning and improving services. It may also be of interest to patients and the public.
http://www.content.digital.nhs.uk/searchcatalogue

The latest PROMs data was published in February 2017
Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2016 to September 2016
http://proms-maps.000webhostapp.com/20170209/1617_Feb17.html

The latest PROMs data indicates 'unreported' and 'not an outlier' scores for Gloucester and Cheltenham Hospitals. A query had been sent to NHS Digital requesting an explanation regarding the 'unreported' data accessible via the website.

Success criteria 4: 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. Currently engagement work is focussing on the Respiratory and Cancer CPGs. The CCG public information bus has also been used to support the work of CPGs.

Success criteria 5: Develop patient experience work within primary care through working with PPGs to help inform and influence commissioning across the whole spectrum

GCCG has established a Gloucestershire Patient Participation Group (PPG) Network.

The focus of the most recent event, held on 21 April 2017, was Cancer. Presentations included Macmillan Next Steps; Living With and Beyond

Cancer - Diet & Exercise; Engaging patients; Holistic Needs Assessment (HNA) & Treatment Summaries; A Patient's Story; and Cancer Patient Reference Group (PRG).

PPG members asked for a dedicated presence on the CCG website for information to support their activities. This is currently in development.

Members of the CCG Engagement Team continue to be invited to attend a number of individual PPG meetings to discuss developments and to provide advice and guidance. Recent discussions have focussed on a possible merger between practices and new capital developments. In March and April 2017, groupings of PPGs came together at two events in Stroud and Dursley to debate PPG support and developments.

The CCG is currently surveying practices to ascertain the status of their individual PPGs. Response rate is currently approximately 50%. A reminder has been sent to practice managers to complete the survey as all GP practices are contractually required to establish and maintain a PPG

4.1 Partnerships

4.1.1 Partnerships – Period up to 30th April 2017

PERSPECTIVE 3	Partnerships	Green
Success criteria 1: *Building effective partnership working by putting in place a joint planning and governance framework to improve outcomes for the Gloucestershire population*		Green
Key performance indicators		
Developing a plan for Gloucestershire, via Gloucestershire Strategic Forum, to identify the most appropriate service roadmap for Gloucestershire to take forward the five year forward view		Green
GSF work plan – develop further and deliver with partners including GCC. GSF work plan now the STP work plan.		Green
Further develop and maintain system wide BCF forum encompassing all providers across health and social care, independent sector and voluntary sector and housing.		Green
Success criteria 2: *Work with the voluntary sector alliance to take forward the work with the voluntary and community sector in Gloucestershire.*		Green
Key performance indicators		
Roll out social prescribing and build on the existing evaluation to take forward learning		Green
Develop the “kitemark” for voluntary sector organisation		Green
Develop an arts on prescription model for physical and mental health as part of the cultural commissioning offer within social prescribing		Green
Build capacity in the voluntary sector (re work with VCS)		Green
Success criteria 3: *Effective urgent care pathway to enable more patients to stay in their own home*		Green
Key performance indicators		
Effective relationships across adult social and health care to enable: i) Reduce non-elective admissions which can be influenced by effective collaboration across the health and care system.		Green
ii) Reducing inappropriate admissions of older people (65+) in to residential care		Green
iii) Rehabilitation / reablement, increase in effectiveness of these services whilst ensuring that those offered service does not decrease		Green

iv) Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.	Green
v) To develop a system which measures patient experience of integration over time, allowing any improvements to be demonstrated.	**Deferred to 17/18**
vi) Enhancing quality of life for people with care and support needs.	**Deferred to 17/18**

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.

The external evaluation of social prescribing by the University of the West of England (UWE) has been received and was presented to Governing Body in November. There were particularly positive impacts on the well-being of people who had participated in the programme and also a significant reduction in GP time in terms of appointments, home visits and telephone calls. In conjunction with Gloucestershire County Council the CCG has tendered the service. New providers are expected to be operating from early June 2017.

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. The VCS Alliance undertook a survey of the impact of social prescribing on organisations in the county and the findings are included in the UWE report.

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)

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.

5.1 Staff

Staff – Period to 30th April 2017

PERSPECTIVE 4	Staff	Green
Success criteria 1: *Attracting and retaining high quality staff aligned to the CCGs vision and values*		Green
Key performance indicators		
Turnover - % of employees leaving the organisation		0.33%
Number of current Vacancies in structure		3
Success criteria 2: *Personal development processes that are linked to the strategic plan*		**Green**
Key performance indicators		
All staff should have a PDP (90% target) and should have had an appraisal in the last 12 months		**96%**
95% of staff who have completed their mandatory training by the end of March 2017		**63%**
Success criteria 3: *Staff are Happy and Motivated*		Green
Key performance indicators		
Staff sickness levels		**2.6%**
Staff Survey		**Completed**
Completion of updated OD plan		**Completed**

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

Monthly turnover in April was 0.33%. The number of leavers in April is 1, giving a monthly average of 1 leaver per month.

As at the end of March 2017, there were 3 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. A full audit is underway to ensure all PDPs have been completed and recorded.

5.1.4 **Staff are Happy and Motivated**

Staff survey has taken place, and the results have been collated and used to inform the 2017 staff survey.

Staff sickness level for April was 2.6 %, and year to date is 2.6%, which is lower than the GCCG ceiling set.

6.1 Perspective 5. Finance and Efficiency

6.1.1 Finance and efficiency – Period to 31st March 2017

Summary:

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

- The CCG has delivered a surplus of £17.551m, after the release of the 1% system risk reserve funding of £8,088k, which was in line with the revised target.

- There was some slippage on QIPP schemes within the financial year. This is both in terms of implementation and associated investments as well as in terms of benefit realisation. The impact of this slippage on the 2017/18 position has been built into the budget.

- The quality premium allocation of £511k has been included within programme budgets (as per national guidance), and associated expenditure has been incurred in ways that improve both the quality of care/health outcomes and reduce health inequalities as follows:

Description	£'000
Learning Disability Services	170
Facts 4 Life	124
Art on prescription	60
Healthcare for children with complex needs	157
TOTAL	**511**

- A revised urgent care reset plan has been developed by the community to address urgent care over performance.

- The better payment practice code performance (for non-NHS invoices by volume) is 97.78% which is in line with the targeted figure.

6.2 Resources

The CCG's resource limit (see Appendix 2) is £839.2m. This includes all primary care co-commissioning delegated budgets. In month, there were allocations totalling £506k, Learning Disabilities transformation funding (£76k), Retained Doctors scheme (£26k) and funding to for the additional charge from Property Services in the move to charging Market Rent (£404k) - this was in addition to the £577k received previously.

6.3 Expenditure

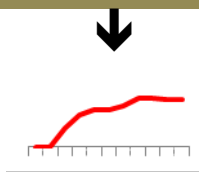
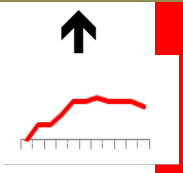
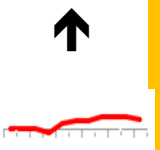
The financial summary as at 31st March 2017 shows a surplus of £17.551m; which is in line with the plan, after the release of the system risk reserve. Further detail is shown at Appendix 3. Key budget areas with either a significant financial risk or forecast outturn variance are highlighted below:

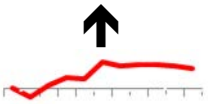
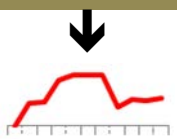
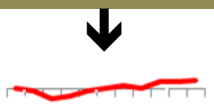
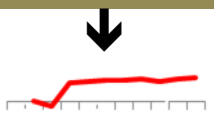
Key		**Trend**	**Forecast Over/ (Under) Spend £'000**
↑	Indicates a favourable movement in the month		
↓	Indicates an adverse movement in the month		

Gloucestershire Hospitals NHSFT

The CCG and GHFT agreed an outturn financial settlement for 2016/17 of £305m; this is equal to the contract value.

£0

Winfield Hospital		
The forecast overspend includes: – Elective activity: up by 279 spells in general surgery, T&O and spinal surgery – Outpatient attendances are over by 3,359 in spinal, urology and T&O specialties. The increased activity reflects transfers of patients to help manage the referral to treat waiting times.		£1,288
Great Western Hospital NHST		
The CCG and Trust agreed a financial outturn for 16/17 at £906k over performance against the contracted value. Over-performance in all areas of the contract: – Elective surgery over performance due to general surgery and T&O – Non elective activity within geriatric medicine, obstetrics, paediatrics and general medicine.		£906
Oxford University Hospital NHSFT		
Performance has improved from last month the main areas of over performance remain: – Elective activity, within spinal surgery and T&O – Day cases within clinical haematology – Non elective activity within ENT, nephrology, general surgery and general medicine specialties. – Non PbR in Drugs, predominantly Adalimumab, Vedolizumab and Idelalisib.		£390
Wye Valley NHS Trust		
Activity is showing overspends in the following areas: – Day cases – major oculoplastic – Non elective activity – therapeutic endovascular procedures – Non PbR – community nursing stroke rehab, ITU but underspent within Drugs There are offsetting underspends in the following areas: – Elective activity – major hip procedures – Outpatients attendances – urology, ophthalmology & clinical neurophysiology – Community contract day cases in podiatric surgery		£123
Non Contracted Activity (NCA)		
Invoices received to date are in line with the previously forecast position.		£1,146

Planned Care – Any Qualified Provider		
The overspend against this budget line is predominantly within the following contracts: - **GP Care (Urology)** continues to operate at full capacity and is anticipated to continue until September 2017 with an estimated 200 patients. This will enable patients on the GHFT backlog waiting list to be seen in a more timely manner. - **Cobalt** – This reflects a decision by GHNHSFT to suspend access by GPs to the MRI service, which has resulted in this being undertaken at the Cobalt facility. Currently no end date has been agreed but is anticipated to continue until April 2018.		£254
Mental Health Non Contract Activity		
There has been a marginal increase from the previously reported position due, primarily, to the CCG receiving invoices for final Q3 activity which where activity was higher than anticipated.		£384
Learning Difficulties		
The slight adverse movement this month is due to 1 new joint funded patient being slightly offset by 1 patient passing away. There continues to be 4 patients under Transforming Care which are included within the position. The CCG is discussing with NHSE the availability of funding in respect of any future transfers.		£403
Continuing Healthcare		
The significant overspend against this budget relates to the national fee increase announced in July for funded nursing care. A national review took place in January 2017; this review has recommended a small decrease in the rate for 2017/18. Domiciliary care packages are increasing this pressure, however it is marginally offset by underspends within physical disabilities and adult joint funded continuing health care positions.		£3,036
Prescribing		
When comparing February 2017 against February 2016, there has been a decrease in growth this month of -7.15% for the month itself. This has the effect of		(£1,440)

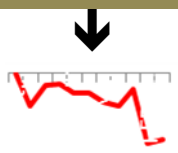
decreasing the year to date growth in cost terms to -1.70% (from -1.19% in January). However, an analysis of the detail indicates that the scripts may not be fully complete and this therefore may be artificially depressing the growth rate for this month

The accrual for the year end is based on the BSA forecast. The BSA significantly lowered its year end forecast by £500k between January and February data being received early in April. Due to the slight uncertainty around February's large decrease the CCG accrued to a level between the two forecasts which equates to an increase of the final prescribing underspend of £250k.

Clinical pharmacists are now in post in a number of areas and the roll out of the Optimise Rx system is progressing, both these initiatives are starting to show an impact in expenditure within the relevant practices.

Running costs

The previously reported underspend has decreased slightly due to additional legal fees received in the month.



(£438)

6.4 **QIPP**

Based on the information available the forecast is showing slippage of £1.79m against the plan, this includes additional schemes that have been identified totalling £1.198m; these include some transactional savings. Reporting from Gloucestershire Hospitals NHSFT is currently in arrears due to the implementation of their new patient administration system, the forecast is therefore based on the latest validated information from the Trust extrapolated forward and information from other sources. The urgent care reset schemes, including the GP in ED and rapid response at the front door, have been included within this position.

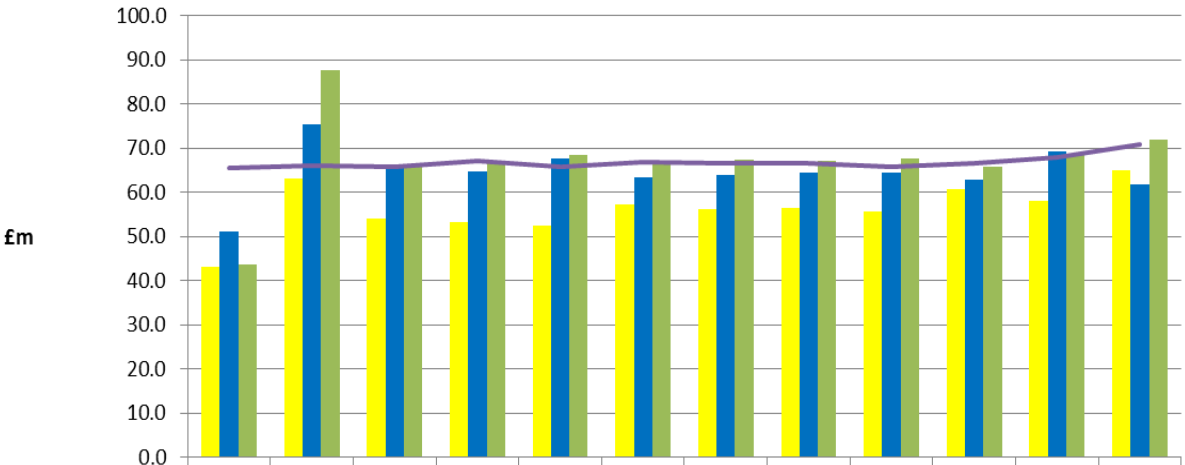
6.5 **Surplus Position**

The CCG set an initial budget with a planned surplus positon of £9.456m. The budget included a 1% system risk reserve (Headroom) to be set aside to manage overall financial risk within the NHS system in line with the NHS England planning guidance. This reserve remained unspent in this year and NHS England wrote to CCGs requiring them to release this reserve into their year-end positions; this means that the CCG's financial surplus position pending any audit adjustments is £17.551m in this financial year.

The aggregate impact of the release of this reserve across the whole of the commissioning sector should improve the overall financial position for the NHS as a

whole.

6.6 Run Rate



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
14/15 Actual	43.2	63.2	54.1	53.4	52.4	57.3	56.2	56.4	55.7	60.8	58.1	64.9
15/16 Actual	51.2	75.5	66.2	64.7	67.7	63.5	63.9	64.5	64.5	62.9	69.2	61.9
16/17 Actual	43.7	87.7	66.2	66.9	68.5	67.0	67.4	67.2	67.6	65.9	68.4	72.1
16/17 Plan	65.5	66.0	65.8	67.1	65.8	66.8	66.6	66.5	65.8	66.7	67.9	70.9
Variance	-21.8	21.7	0.4	-0.2	2.7	0.2	0.8	0.7	1.8	-0.8	0.5	1.2

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 March shows that programme spend is above anticipated levels by £1.2m. Cumulatively the CCG is still above estimated spend for Programme by £7.0m - this has been offset by a reduction in the commitments in reserves (which have now come to fruition).

6.7 Cash

At the end of March, the CCG has drawn down 100% of the total cash limit and the cash balance at the end of March totalled £17k.

6.8 Better Payment Practice Code

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 98.82% invoices paid by value and 97.78% by volume; both being on target.

6.9 Statement of Financial Position

The position shown includes the audited opening balances from the 15/16 Annual Accounts.

6.10 Financial Risk

The following risks have been taken into account in the reported financial position:

- Contract Performance
- Prescribing
- Better Care Fund performance
- QIPP slippage
- Continuing Healthcare
- Specialised Commissioning
- National position

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
Unscheduled Care																	
Accident & Emergency																	
E.B.5	**4-hour A&E target -** Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		GRH Attendances		6,926	7,621	7,355	7,638	7,232	7,136	7,471	7,090	6,965	6,878	6,267	7,379	85,958	85,958
		GRH Breaches		1,113	1,320	1,186	1,379	948	1,086	1,266	1,251	2,223	2,217	1,843	2,074	17,906	17,906
		GRH %	5	83.9%	82.7%	83.9%	81.9%	86.9%	84.8%	83.1%	82.4%	68.1%	67.8%	70.60%	71.90%	79.2%	79.2%
		CGH Attendances		3,851	4,233	3,988	4,331	4,103	4,167	4,226	3,951	3,867	3,735	3,505	4,124	48,081	48,081
		CGH Breaches		463	172	282	297	111	164	367	223	607	469	406	473	4,034	4,034
		CGH %	0	88.0%	95.9%	92.9%	93.1%	97.3%	96.1%	91.3%	94.4%	84.3%	87.4%	88.40%	88.50%	91.6%	91.6%
		GHNHSFT Attendances		10,777	11,854	11,343	11,969	11,335	11,303	11,697	11,041	10,832	10,613	9,772	11,503	134,039	134,039
		GHNHSFT Breaches		1,576	1,492	1,468	1,676	1,059	1,250	1,633	1,474	2,830	2,686	2,249	2,547	21,940	21,940
		GHNHSFT %	5	85.4%	87.4%	87.1%	86.0%	90.7%	88.9%	86.0%	86.6%	73.9%	74.7%	77%	77.90%	83.6%	83.6%
		GCS - MIU Atts		5,771	6,774	6,473	7,377	6,882	6,396	6,070	5,422	5,575	5,306	4,920	6,053	73,019	73,019
		GCS - MIU Breaches		25	17	22	30	31	27	22	18	24	42	11	23	292	292
		GCS - MIU %	0	99.6%	99.7%	99.7%	99.6%	99.5%	99.6%	99.6%	99.7%	99.6%	99.2%	99.80%	99.60%	99.6%	99.6%
		PC in ED Attendances		244	345	268	279	326	349	295	390	316				2,812	2,812
		PC in ED Breaches		0	0	0	0	0	0	0	0	0				0	0
		PC in ED %		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%
		Overall ED Attendances		16,792	18,973	18,084	19,625	18,543	18,048	18,062	16,853	16,723	15,919			177,622	177,622
		Overall ED Breaches		1,601	1,509	1,490	1,706	1,090	1,277	1,655	1,492	2,854	2,728			17,402	17,402
		Overall ED %		90.5%	92.0%	91.8%	91.3%	94.1%	92.9%	90.8%	91.1%	82.9%	82.9%			90.2%	90.2%
E.B.S.5	**12 hour trolley waits** (no A&E attender should wait more than 12 hours from the decicision to admit to admission)	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		GRH		0	0	0	0	0	1	0	0	1	0	0	0	1	3
		CGH		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		GHNHSFT total		0	0	0	0	0	0	0	0	1	0	0	0	1	2
		GCS - MIU		0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	13.6	23	12	16	35	22	36	45	47	36	31			30	30
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	Acute only	0	0	0	0	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	5	8	7	15	21	16					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%	91.3%	95.8%	96.0%	98.2%	98.0%	91.8%	92.3%	95.3%			
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%	2.0%	0.6%	0.9%	0.3%	0.5%	2.2%	0.7%				
Local	Calls triaged	Target		60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%
		Actual	84%	81.7%	81.3%	80.7%	79.2%	80.9%	82.5%	80.9%	82.4%	80.6%					
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%	6.6%	6.5%	7.0%	7.0%	7.3%	5.8%					
Local	Calls warm transferred	Target		26.0%	30.2%	33.3%	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%	28.8%	46.3%	39.2%	44.9%	44.4%	37.3%	40.6%				
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	00:08:47	00:12:46	00:06:40	00:05:08	00:06:07						
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	00:05:03	00:09:06	00:06:01	00:08:09	00:06:33						
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%	78.7%	80.0%	79.9%	78.7%	78.6%	78.7%					81.3%	81.3%
E.B.S.4	Number of completed admitted non adjusted pathways greater than 52 weeks	Target		-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Actual	-	3	5	6	5	6	7	10	8						
E.B.2	Percentage of non - admitted pathways treated within 18 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
		Actual		91.4%	91.5%	91.4%	89.8%	89.3%	86.4%	85.5%	87.4%					91.0%	91.0%
E.B.S.4	Number of completed non-admitted pathways greater than 52	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	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
E.B.S.4	weeks	Actual	-	2	3	10	13	10	7	15	18						0
Local	Number of specialties where non-admitted standard was not delivered	Actual	-	14	14	14	14	17	15	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%	92.8%	92.0%	92.1%	91.5%	91.0%	88.3%					92.6%	92.6%
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	9	13	8	10	11	8	4	11	10	10		
Local	Number of specialties where incomplete standard was not delivered	Actual	-	9	7	7	6	7	8	8	11						
Cancelled Operations																	
E.B.S.2	**Cancelled operations** - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		Actual	-	20	7	8	4	4	2	3							
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	-	*currently not receiving data from GHFT*													
Diagnostics																	
E.B.4	Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests	Target		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
		Actual breaches		414	119	126	52	65	203	146	78		104	136		1,443	1,443
		Actual Perf		4.5%	1.3%	1.4%	0.6%	0.8%	2.5%	1.9%	1.0%		1.5%	1.9%	3.1%	1.9%	1.9%
Cancer Waits																	
E.B.6	Percentage of patients seen within 2 weeks of an urgent GP or GDP referral for suspected cancer	Target		93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
		Actual breaches		353	226	151	165	244	190	184	116	109	200	84	106	2,128	2,128
		Actual Perf		78.0%	86.6%	90.6%	90.1%	85.8%	88.4%	89.1%	93.5%	92.6%	85.4%	94.4%	94.3%	86.3%	86.3%
E.B.7	Percentage of patients seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Target		93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
		Actual breaches		11	11	19	14	13	6	8	15	23	20	12	11	163	163
		Actual Perf		95.0%	94.7%	90.9%	91.5%	92.7%	96.3%	95.6%	92.1%	89.3%	88.6%	93.1%	94.8%	93.1%	93.1%
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	3	2	1	3	6	14	12	25	16	6	93	93
		Actual Perf		98.4%	99.6%	98.9%	99.1%	99.6%	99.0%	97.7%	95.4%	94.7%	90.4%	93.2%	97.9%	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	0	0	0	0	0	4	5	9	1	6	26	26
		Actual Perf		98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.8%	88.9%	83.0%	97.6%	88.5%	99.6%	99.6%
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	0	0	0	0	0	0	0	0	0	2%	1	1
		Actual Perf		98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	99.6%	99.6%
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	1	0	0	2	0	0	2	1	0	2	8	8
		Actual Perf		100.0%	100.0%	98.1%	100.0%	100.0%	94.7%	100.0%	100.0%	95.7%	98.0%	100.0%	96.5%	99.5%	99.5%
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	27	32	27	32	34	34	35	49	39	50%	370	370
		Actual Perf		80.1%	76.1%	81.8%	74.8%	79.5%	78.1%	73.6%	79.8%	71.5%	63.4%	70.5%	70.6%	78.3%	78.3%
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	1	0	3	0	3	0	0	5	1	2	20	20
		Actual Perf		91.7%	83.3%	95.0%	100.0%	90.9%	100.0%	85.7%	100.0%	100.0%	82.8%	92.3%	93.9%	92.6%	92.6%
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	2	0	0	1	0	0	0	0	0	3	3
		Actual Perf		100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.2%	88.2%
Long Term conditions																	
Local	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit (GHT Only)	Target		80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
		Glos		84.6%	89.0%	83.8%	86.2%	96.2%	84.0%	85.7%							
E.A.S.1	Dementia diagnosis rate	Target		66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%
		Numerator		5,633	5,636	5,616	5,650	5,686	5,750	5,767	5,820	5,825	5,758				
		Denominator		8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530	8,530		
		Glos		66.0%	66.1%	65.8%	66.2%	66.7%	67.4%	67.6%	68.2%	68.3%	67.5%			55.82%	
Community Care Referral to Treatment (GLOUCESTERSHIRE only)																	
Paediatric																	
Local	Percentage of patients referred to the Paediatric Speech and	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%

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	Language Therapy Service who are treated within 8 Weeks	Actual		95.9%	92.8%	99.5%	98.7%	97.1%	99.1%	99.3%	98.8%	99.4%	98.1%		94.7%	97.6%	97.6%
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%	96.9%	96.7%	100.0%	95.2%	96.2%	96.9%	97.2%	96.3%		96.3%	96.9%	96.9%
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%	99.1%	97.2%	98.2%	94.0%	92.3%	87.9%	93.0%	95.3%		95.1%	95.3%	95.3%
Adult																	
Local	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
		Actual		84.8%	88.6%	94.1%	100.0%	97.1%	98.9%	98.1%	98.7%	100.0%	98.4%		9.3.8%	95.9%	95.9%
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%	97.6%	92.6%	95.0%	96.0%	97.0%	96.6%	96.0%	87.0%		87.4%	94.9%	94.9%
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%	89.9%	92.8%	94.9%	94.6%	92.4%	91.8%	91.3%	86.1%		90.0%	91.4%	91.4%
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%	92.7%	92.5%	90.3%	88.3%	88.6%	91.9%	94.8%	89.3%		91.0%	91.5%	91.5%
Specialist Nurses																	
Local	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
		Actual		100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	99.1%	99.1%
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%	100.0%	95.9%	100.0%	96.0%	100.0%	100.0%	100.0%	98.0%		98.0%	98.1%	98.1%
Mental Health and Learning Disabilities																	
Adults of Working Age																	
E.B.S.3	Proportion of those patients on a Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	Target				95.0%			95.0%			95.0%			95.0%	95.0%	95.0%
		Glos				98.2%			97.2%			96.0%			100.0%	98.0%	98.0%
Improving Access to Psychological Therapies (IAPT)																	
E.A.3	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Glos target				3.75%			7.5%			11.25%			15.0%	3.75%	3.8%
		Glos actual				2.1%			3.7%			5.5%				2.1%	8.2%
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				53.0%			44.0%			47.0%			46.0%	47.0%	47.0%
E.H.1_B1	The proportion of people that wait **6 weeks** or less from referral to their 1st IAPT treatment appointment against the no. of people who enter treatment in the reporting period.	Glos target				75.1%			75.1%			75.1%			75.1%	75.1%	75.1%
		Glos actual	-			35.0%			31.0%			30.0%			44.0%	35.0%	35.0%
E.H.1_B2	The proportion of people that wait **18 weeks** or less from referral to their 1st IAPT treatment appointment against the no. of people who enter treatment in the reporting period.	Glos target				95.1%			95.1%			95.1%			95.1%	95.1%	95.1%
		Glos actual	-			90.0%			82.0%			83.0%			94.0%	90.0%	90.0%
Quality																	
Quality Indicators																	
E.B.S.1	Eliminate mixed-sexed accommodation breaches at all providers sites (patients)	CCG		60	0	26	19	17	0	0	24	18	15				
		GHFT		69	0	30	23	18	0	0	31	18	15				
		Care Services		0	0	0	0	0	0	0	0	0	0				
		2gether		0	0	0	0	0	0	0	0	0	0				
	Number of Never Events	GHT		0	0	0	1	0	0	1	0	0	0				
		Care Services		0	0	0	0	0	0	0	0	0	0				
		2gether		0	0	0	0	0	0	0	0	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%	90.0%	90.0%
		GHNHSFT		94.0%	92.5%	94.0%	93.2%	93.2%	93.9%	93.1%							
		GCS		95.4%	96.0%	91.5%	96.7%	97.9%	96.8%	97.2%	98.2%						
Cleanliness and HCAIs																	
Methicillin Resistant Staphylococcus Aureus (MRSA)																	
E.A.S.4	Number of MRSA infections (Health Community)	Glos HC target		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		Glos HC actual		1	1	0	1	1	0	0	0	1				5	5
	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		GHNHSFT actual		1	0	0	0	0	0	0	0	0				1	1
Clostridium Difficile (C.Diff)																	
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	142	157
		Glos HC actual		14	17	17	11	15	20	9	10	11				124	124

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
	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target		3	3	3	4	4	2	3	2	2	4	3	4	33	37
		GHNHSFT actual		5	3	1	4	1	4	1	4	2				25	25
Local Priorities																	
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														

```
select          COUNTER

from       [Warehouse_14_15].[GHTActivity].[Episodes_Daily]

where      start_date_episode between '20140401' and '20150331'
and          age_on_admission >= 65
and          admission_method_hospital_provider_spell like '2%'
and          organisation_code_of_commissioner = '11m00'
and          organisation_code_of_provider = 'RTE00'
and          episode_number = '01'

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and          SUBSTRING(primary_diagnosis_icd_1,2,2) between '00' and '98')

and          (((secondary_diagnosis_icd_2 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_2,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_3 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_3,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_4 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_4,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_5 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_5,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_6 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_6,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_7 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_7,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_8 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_8,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_9 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_9,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_10 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_10,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_11 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_11,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_12 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_12,2,2) between '00' and '19')

or           ((secondary_diagnosis_icd_13 like 'W%' )
and          SUBSTRING(secondary_diagnosis_icd_13,2,2) between '00' and '19')
))

union all

select          COUNTER
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select      COUNTER

from      [SUS].[final].[Full_APC_finished_final]

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and         age_on_admission >= 65
and         admission_method_hospital_provider_spell like '2%'
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and         organisation_code_of_provider <> 'RTE'
and         episode_number = '1'

and         (((primary_diagnosis_icd_1 like 'S%' or primary_diagnosis_icd_1 like 'T%')
and         SUBSTRING(primary_diagnosis_icd_1,2,2) between '00' and '98')

and         (((secondary_diagnosis_icd_2 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_2,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_3 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_3,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_4 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_4,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_5 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_5,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_6 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_6,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_7 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_7,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_8 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_8,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_9 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_9,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_10 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_10,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_11 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_11,2,2) between '00' and '19')

or          ((secondary_diagnosis_icd_12 like 'W%' )
and         SUBSTRING(secondary_diagnosis_icd_12,2,2) between '00' and '19')
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Agenda Item 13

Governing Body

Meeting Date	**Thursday 25 May 2017**
Report Title	**Sustainability and Transformation Plan (STP): Update Paper**
Executive Summary	This paper provides an update on progress for Gloucestershire's STP including an update on governance arrangements.
Key Issues	• Programme Updates • Governance Arrangements
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	The main risks currently inherent in the development of the STP are still present. This consists of the capacity and capability of programme and project teams to deliver and the challenge of developing a shared resources plan for Gloucestershire.
Management of Conflicts of Interest	None identified
Financial Impact	The STP sets out a system wide resources plan for Gloucestershire until 2020.
Legal Issues (including NHS Constitution)	The STP includes a commitment to ensure compliance with NHS Constitution Standards and meet the requirements set out in the national planning frameworks.
Impact on Health Inequalities	The STP includes a clear commitment to reduce health inequalities.
Impact on Equality and Diversity	The STP includes a commitment to ensure equality, 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.

Impact on Sustainable Development	The STP supports sustainable development.
Patient and Public Involvement	Patients and the public were involved in developing the STP through the work done on Joining Up Your Care. Patient and public representatives are engaged through various stakeholder events.
Recommendation	The Governing Body is asked to note: • Programme Updates • Governance Arrangements
Author	Beth Gibbons
Designation	STP Project Manager
Sponsoring Director (if not author)	Ellen Rule – STP Programme Director

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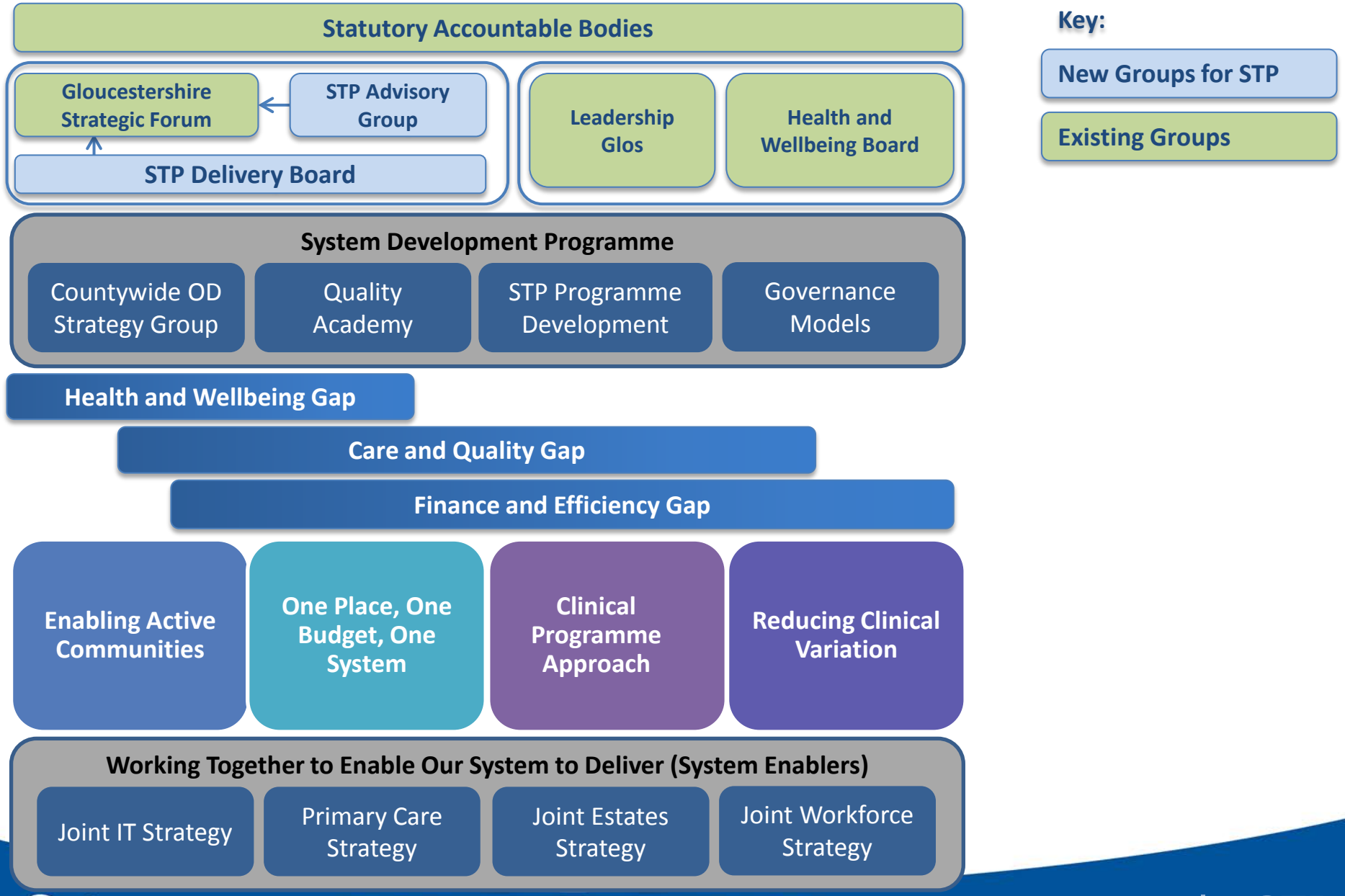
Agenda Item 13

STP
Governing Body Update

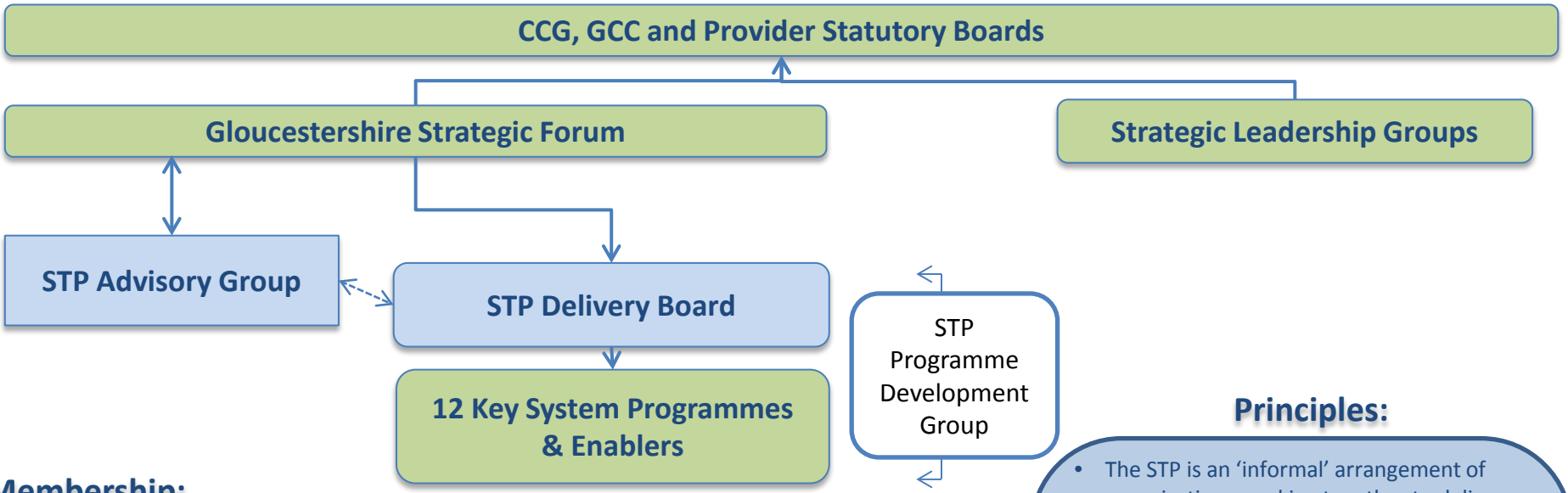
Thursday 25th May 2017

#glosSTP

STP Governance Structure



STP Governance Structure



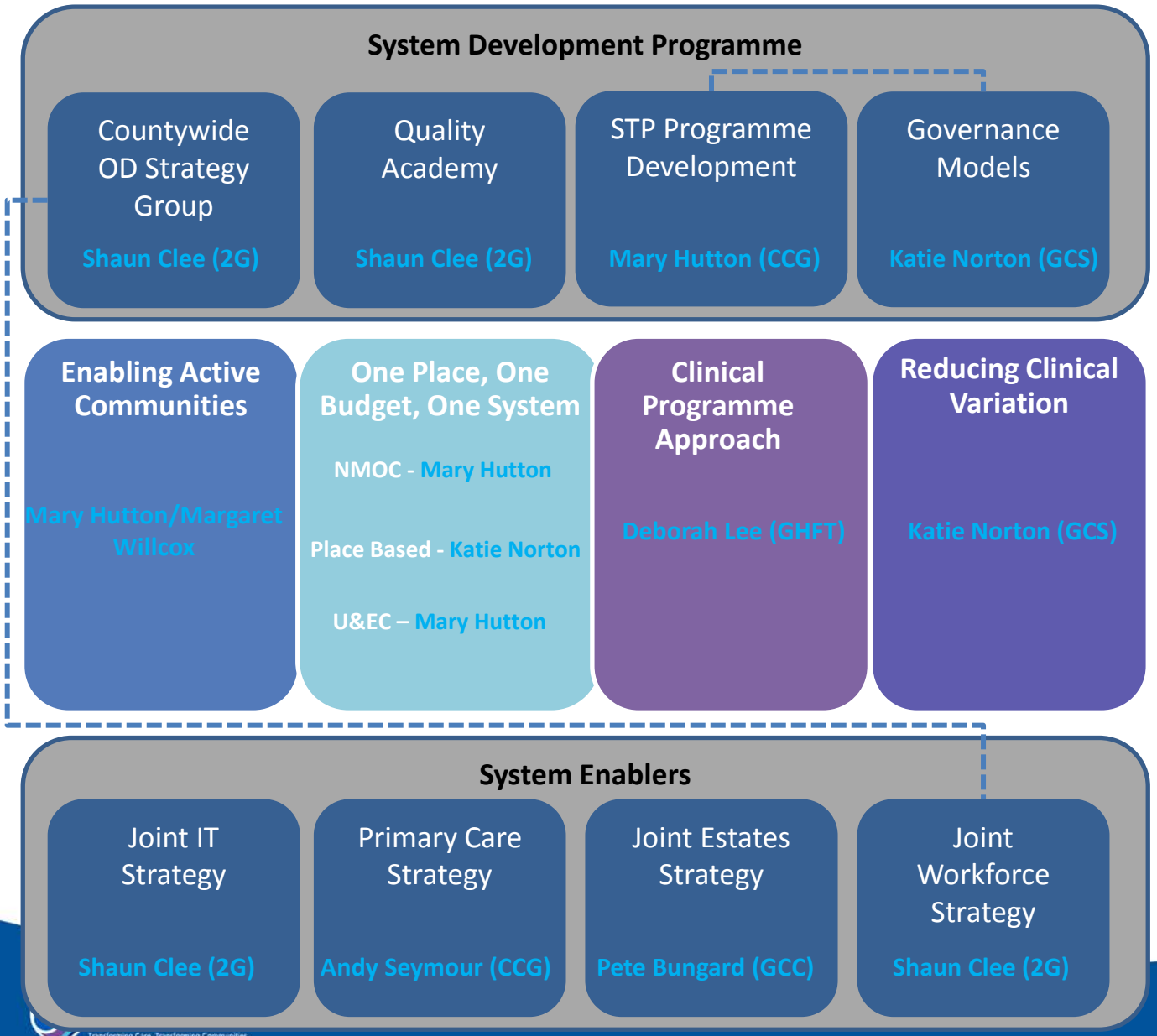
Membership:

Gloucestershire Strategic Forum	Chairs and Executive health and local authority commissioner and provider representation to enable decision making ,Independent Chair
STP Delivery Board	Representation from Provider & County Council CEO's, DASS, DPH, NHSE,PC, Independent Chair
STP Advisory Group	Delivery Board Members, Chairs and Council Leaders County and District Councils, NHSE, NHSI ,AHSN, Voluntary Sector, Healthwatch Gloucestershire to ensure wide partner engagement in STP programme
Key Programmes	Appropriate representation from system partners in each programme with agreed leadership supported by an MOU to achieve transformational change at scale. Terms of Reference established to support collaborative working.
STP Programme Office	Representation from all STP partner PMO's to ensure a standardised approach is adopted to provide assurance, information and support delivery of change across all programmes.

Principles:

- The STP is an 'informal' arrangement of organisations working together to deliver sustainable transformation. It does not have statutory status and cannot replace the existing statutory accountabilities of organisations
- Joint working arrangements and approach to decision making is set out in the MOU and reflected through terms of reference of working groups
- The Governance approach for the STP will be managed through the STP Programme Development Group, and supported by the STP programme office
- The Governance approach for the STP will make use of existing groups where possible, minimising the burden of additional meetings
- Lay representation will be included throughout the governance structure
- The Governance structure will be reviewed 6 monthly, and any recommended changes would be subject to same approval process

Chief Executive Sponsors for STP Programmes



Key:

CEO Sponsor

Combined

Governance – Gloucestershire Strategic Forum (GSF)

- GSF is the forum to which the STP Delivery Board is accountable.
- The role of the GSF is to ensure ownership of the strategic direction for health and care delivery in Gloucestershire.
- The forum will act as a steering group to provide collective and coincident direction for the delivery of the STP objectives.

Membership
Chief Executives of GCC, CCG, 2G, GHFT, GCS, SWASFT
Chairs of CCG, 2G, GHFT, GCS, SWASFT
Councillor, GCC
Director of Adult Social Care, GCC
Director of Public Health, GCC
Head of Operations, SWASFT
Finance Director from Gloucestershire system nominated by RSG
Strategy Director from Gloucestershire system nominated by Programme Development Group
STP Programme Director

- The GSF is responsible for receiving and formally signing off STP documents and plans as escalated by the STP Delivery Board.
- GSF provides a clear link between the STP and STP partner organisational boards

Governance – The STP Delivery Board

- The role of the STP Delivery Board is to oversee the progress of the STP and to drive consensus on change to be delivered and make recommendations to decision-makers.
- The Primary objective of the STP Delivery Board is to ensure Chief Executive Ownership and take responsibility for addressing system issues and aligning resources to successfully delivery Gloucestershire's STP

Name	Title & Organisation
Mark Outhwaite	Independent Chair
Mary Hutton	Accountable Officer, GCCG Gloucestershire STP Lead
Shaun Clee	CEO, 2G
Katie Norton	CEO, GCS
Pete Bungard	CEO, GCC
Margaret Willcox	Director of Adult Social Care, GCC
Deborah Lee	CEO, GHFT
Emma Wood	Executive Director HR & OD, SWASFT
Andy Seymour	Clinical Chair, GCCG
Sarah Scott	Director of Public Health, GCC
Ellen Rule	STP Programme Director
Debra Elliott	Director of Commissioning, NHSE SC
Rachael Bunnett	GP Provider Representative, RCGP STP lead for Gloucestershire

- The STP Delivery Board will manage and ensure shared ownership between partners of delivery against the STP Plan. The Board currently receives monthly highlight reports for all 12 priorities and will soon review a monthly performance report alongside this.

Governance – The Advisory Group

- The STP Advisory Group brings together the STP Delivery Board members along with a range of key stakeholders from partner organisations representing a range of organisations from across the Footprint.
- The role of the group is to oversee the progress of delivery, ensuring that key partners are engaged in supporting delivery of the Gloucestershire STP.

Membership
STP Delivery Board Membership
Chairs of STP Organisations
Chair of Health and Wellbeing Board
District Council Representation and link to Leadership Gloucestershire
NHS England and NHS Improvement Assurance Leads
NHS England Specialist Commissioning
Healthwatch Gloucestershire
Gloucestershire CCG Lay Member
Finance Director from system nominated by RSG
Strategy Director nominated by Programme Development
Chair of Urgent and Emergency Care network
Director of Children's Services, GCC
RCGP Representative for Gloucestershire STP

- The primary objective of the Board is to provide a forum where key stakeholders can meet with STP delivery board members to provide advice, share learning, drive development, identify programme synergies with wider system work programmes and support proposed mitigations for programme delivery risks and issues.

Top Line Messages:

- Measurement approaches developed for project, programme and system-wide levels to ensure progress towards delivery.
- Gloucestershire's STP facilitated a visit from National Director, Matthew Swindells, on the 5th May 2017 to showcase ongoing work and progress to date. Feedback suggests he was impressed with Gloucestershire's initiatives particularly in Primary Care and recognised the good deal of collaborative working across the county.
- STP Clinical Away Day planned for 13th June 2017 has had positive uptake so far with planning underway.
- Consultation Business Case priorities agreed and under development by July 2017 (subject to assurance).
- System Delivery Plans mapped against NHSE 5YFV Next Steps requirements in development to be submitted to regional teams

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STP Priority Programme Updates

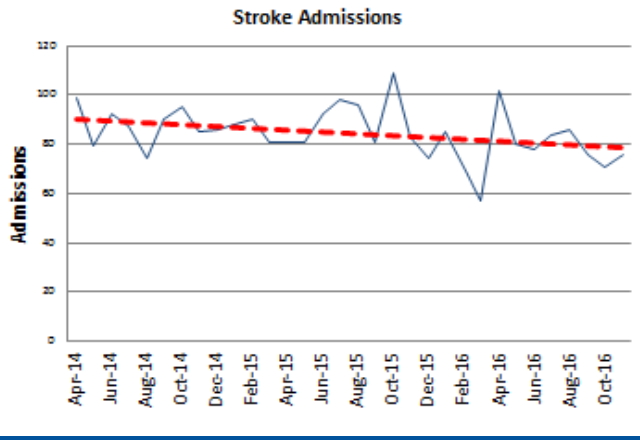
#glosSTP

Enabling Active Communities Update:

- Gloucestershire is one of 40 (out of 730) applications to be shortlisted for Sport England's **Active Ageing Fund** with the final outcome expected in late spring.
- 10,000 pupils from 43 primary schools (including 2 special schools) have signed up to walk, jog or run a mile every day as part of the **Daily Mile** initiative.
- Our target of 40 businesses having signed up to the **workplace wellbeing charter** has been achieved.
- The **National Diabetes Prevention Programme (NDPP**) is due to be rolled out across practices from May/June 2017.
- 7 Double Decker buses of weight has been lost so far by Slimming World weight management programme
- Cultural Commissioning, an innovative part of our Social Prescribing Programme, is piloting a range of projects, recognised at a national level as transformative, and early feedback is very positive with formal evaluation underway.
- Self Care & Prevention Board have proposed funding for the following projects from the **£1.9m Prevention Fund**, this includes:
  - Remodelled Self-Management / Expert Patient Programme – £120k
  - Early Identification of Domestic Abuse - £160k
  - Postpartum contraception £200k (Inc. £100k contribution from GCC)
  - Breastfeeding social marketing project - £50k

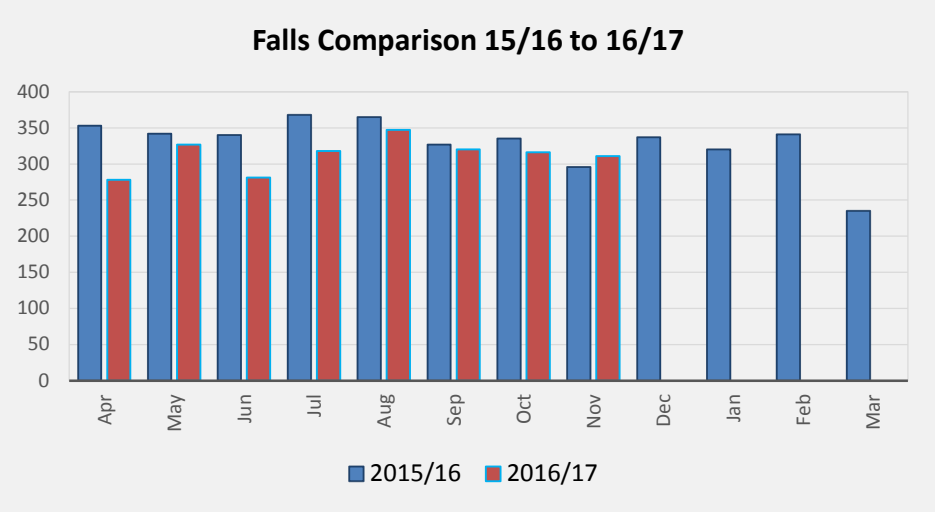
Clinical Programme Approach:

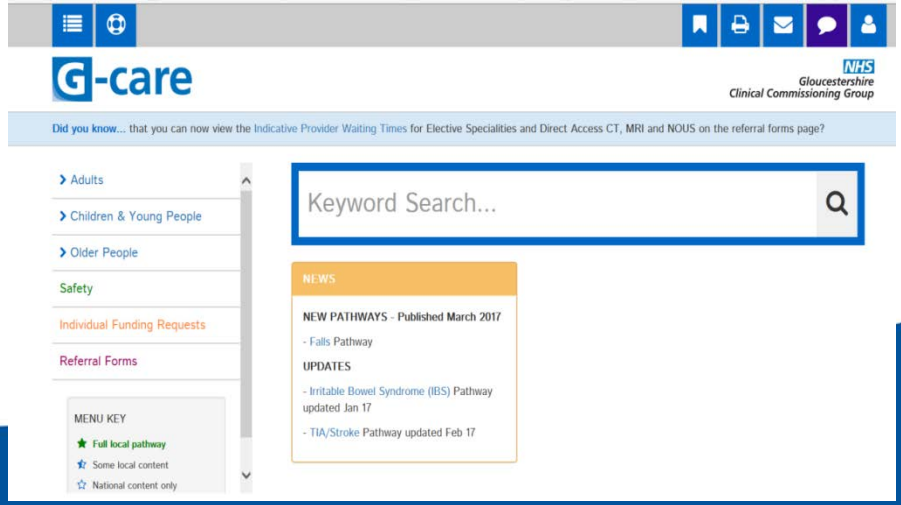
- **Cancer Programme:**
  - Macmillan investment of over £4m
  - Delivery of a successful early diagnosis programme & Community Based 'living with and beyond'
  - Holistic Needs Assessments being undertaken in all 3 cancer site clinics
  - One of the top 20 CCG's to improve one-year cancer survival rates from the All-Party Parliamentary Group on Cancer (APPGC).
- **Respiratory CPG:**
  - Four revised pathways for COPD being implemented
- **Dementia Programme:**
  - Four priority work programmes identified and diagnosis rates continue to increase from 0.81% in January 2015 to 0.93% in January 2017.
- **Eye Health:**
  - Delivery of a new community eye care service in 2016/17 with a staged roll out of community pathways, Cataract pre-operative assessments -1,342 patients seen to date, Minor Eye Conditions (MECs) - 422 new appointments and 28 follow up episodes, Children's School Vision Screening uptake increased from 66.3% to 90%, audit shows significant sight loss prevented in 50 children
- **Circulatory Programme:**
  - Troponin-T pilot for chest pain increased rate of patients going straight home from ED from 32% to over 50%.
  - New technology has moved 468 devices to remote monitoring over the last 5 months. (from repeat follow-ups)
  - 51 practices have completed the Don't Wait to Anticoagulate project which has led to substantial reduction in strokes



Clinical Programme Approach:

- **MSK CPG**
  - Orthopaedic elective procedures reduced by around 4% per year for the last two years (449 by 15/16 and 661 by 2016/17), and pathways have been published on G-Care to support delivery
  - 8.4% reduction in falls related admissions compared to 15/16 across our system supported by a wide range of initiatives such as working with the fire service doing home safety checks to spot falls hazards
- **Mental Health CPG**
  - Improved access to services for Children & Young People (CYP) by 5%, (419 students seen by Primary Mental Health Workers in school (January – June 2016), of which 271 (65%) had their case closed in school with no onward referral required)
  - Attendance at The Cavern has steadily increased since it opened in July 2016 and in the last month 529 visits were made to the service resulting in a significant impact on A&E admissions which are currently being evaluated.

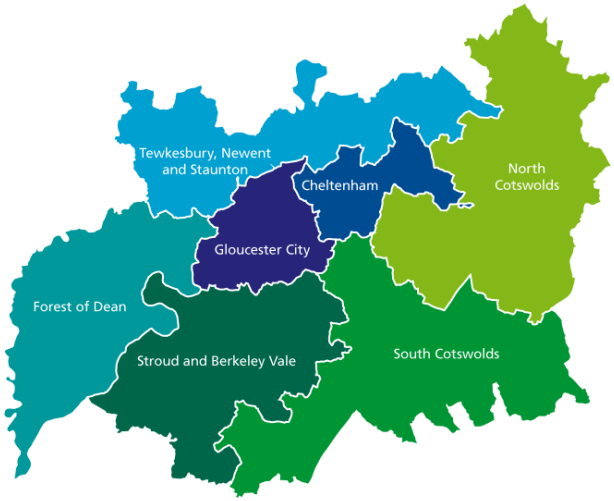




Reducing Clinical Variation:

- Ongoing medicines optimisation programme is focussed on reducing waste and prescribing the most cost effective medicines with savings of £3.5m in 16/17.
- De-commissioning of Gluten Free food on NHS prescription and reduced Sip Feeds prescribing (83% reduction in gluten free prescribing to date with an associated saving that will be reinvested in other higher priority medicines for our population.)
- Reduction of variation in follow-ups and roll-out of new models of follow up care including negotiated and telephone follow ups. Early pilots have included work in Rheumatology where an open follow up model reduced follow ups by around 80%.
- Living Well With Pain Programme is developing a new model of MDT care using cultural commissioning. A new Joint Formulary is being rolled out to support prescribers and patients to make the best choices of medicines for pain.

One Place – New Models of Care



Locality led New Models of Care – 81 independent GP practices have come together as 16 GP Clusters, supporting populations of circa. 30,000-50,000 population to work with other providers to design and implement new models of care based upon the needs of local population focussed on 'Place'.

GPFYFV

Building resilience and introducing extended access in primary care.

Primary Mental Health service

A six month pilot in one inner city cluster. GP Practices will identify patients who could be seen by full time mental health practitioners working in the cluster, instead of a GP.

Integrated Respiratory Services

Pilots in two Clusters. GP practices to identify respiratory patients with complex needs for joined up winter reviews, involving primary, community and hospital healthcare professionals.

Stroud rural Frailty and Dementia Pilot

Case Review

Community Dementia Nurses based in practice with access to the clinical system

Reduced duplication of Dementia reviews and care plans

Links with Dementia Advisors

Practice MDT
- For high risk patients
- Prices Mill pilot site

Stonehouse and Frampton Extended Hours Triage

Monday - Thursday
18:30-20:00

Urgent GP Advice

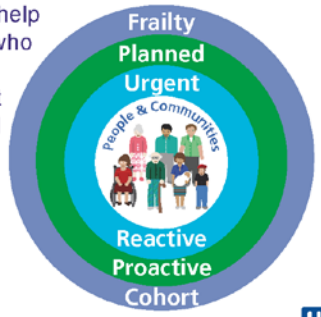
Urgent advice and signposting for patients

Ability to book into Choice+ or OOH appointments

Ability to book into GP appointments the following day (where appropriate)

South Cotswold Frailty Model

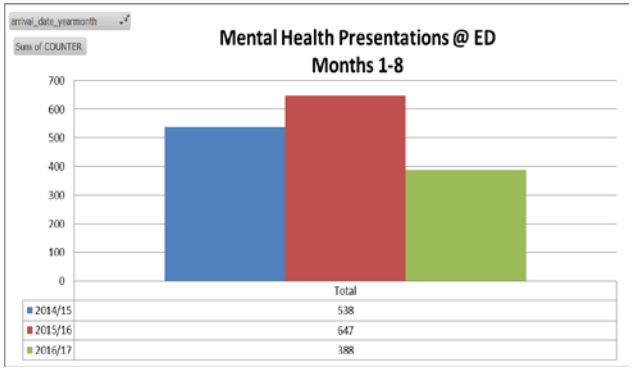
How do we help individuals who have been identified "at risk" to build resilience?



How do we support individuals to keep a condition stable to limit impact on family and carers?

How do we support individuals when they become unwell?

One Place: Urgent & Emergency Care



Significant delivery issues:

- Access standards consistently not met
- Confusing for users and staff
- Fragmentation with lots of “hand offs”
- Poor access to urgent diagnostics in the community
- No easy access to an urgent specialist
- Ineffective streaming Model with all people potentially requiring admission channelled through A&E departments
- A&E departments too small and struggling to respond to surges , risk that treatment for really sick patients is delayed

Comprehensive Plan:

- Resilience investment of circa £4.5m in 16/17 to support 4 hrs delivery
- A series of ‘Breaking the Cycle together weeks have been delivered with all key partners in our STP contributing to the learning
- Investment in out of Hospital Services in 17/18 eg. Rapid Response, Leg Ulcer Service, Frailty, Increase in Double Crew Ambulances)

Early Impacts:

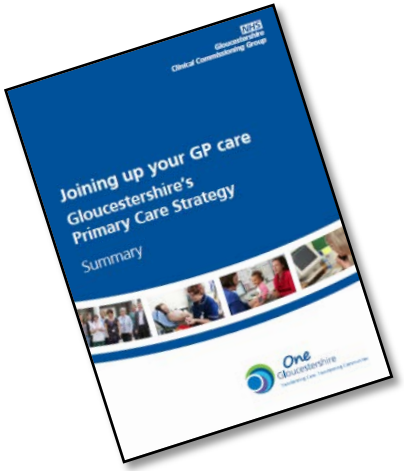
- Reduce demand - There has been a significant reduction in 999 demand by 4.7% YTD, Ambulance conveyance levels have stabilised throughout this year at 44.9%
- Avoidable emergency admissions across our system are showing signs of reducing - For the first 7 weeks of 2016/17 activity above 2015/16 levels, then reduced relative to 15/16 and flat until week 29, weeks 29-34 (to end Nov.) admissions reduced below levels seen last year (data issues mean latest not available)

Next Steps:

- A&E Delivery Board Overseeing Performance Recovery
- NMOC Group overseeing Strategic Delivery
- Comprehensive planning for Urgent Care Centres completed in partnership with clinical representation from localities, model covers urban and rural centres

System Enablers:

- The **Workforce & OD Strategy** is focusing on: Capacity, Capability & Culture with an Information Sharing Gateway in development to allow information to be shared under appropriate governance arrangements.
- **IT Strategy** group have worked extensively on JUYI and Local Digital Roadmap. The Estates and Technology Transformation Fund (ETTF) was received for GP Wifi and Mobile Working and Primary Care Redesign.
- The **Estates Strategy** group have developed the 'One Gloucestershire' Strategic Asset and Delivery Plan (SADP) which was submitted in December 2016.
- The **Improvement Academy** has agreed a joined up approach and has delivered a programme of QSIR courses to over 140 staff members to date. The Improvement Project Team is coaching and networking in collaboration with the Health Foundation Q Programme.
- Our **Primary Care Strategy** has been developed with a revised GP Five Year Forward View Plan. The Primary Care Offer includes activity such as:
  - Participation in Cancer Management Programme
  - Practice Based Clinical Audit
  - 'Not Yet Approved' Amber Drugs and Post-Operative wound care
  - Participation in annual practice visit by CCG
  - National Diabetes Prevention Programme (NDPP)
  - Sign up to Safety (SU2S)
  - Prescribing Savings – off formulary adherence
  - Frailty (Meds Optimisation, Training & Education, Communication, Primary Care Team Meetings for Frail Patients, Carers, Prevention, Existing Services, Coding)



- A cross-organisational virtual STP PMO approach has been agreed and the **Programme Development Group** have worked extensively on STP Solutions and ensuring alignment to contract agreements. A Strategic Networking Away Day was successfully held on 2nd February 2017 for Programme Areas with a further Clinical Away Day arranged for 13th June 2017

Agenda Item 14

Governing Body

Meeting Date	**Thursday 25 May 2017**
Report Title	**2017/18 CCG Annual Budget - Update**
Executive Summary	This paper provides an update to the budget approved by the Governing Body in March 2017. The CCG delivered an increased surplus in 2016/17 which will be returned in 2017/18 and the 2017/18 surplus therefore needs to reflect this increase. In order to ensure that the planned surplus is delivered and that the CCG has a recurrently balanced financial position, careful financial control and monitoring will need to be maintained throughout the year in order to deliver planned whole system service changes.
Key Issues	Contracts with the CCG's main providers have been signed and this impact is included within CCG budget plans. The CCG's savings requirement now stands at £25m, following recent discussions with NHS England (NHSE). The CCG's target retained surplus assumes that it will achieve £17,243k (increased from £9,456k in the last report). This is predicated on the receipt by the CCG of the 2016/17 surplus, together with associated drawdown of £302k.
Risk Issues:	The key risk within the plan remains the non-achievement of the planned surplus through a lack of available reserves to manage the impact of the following: • The impact of the Trakcare implementation

Original Risk (CxL) **Residual Risk (CxL)**	at Gloucestershire Hospitals NHS Foundation Trust (GHFT), including RTT delivery • In-year contract over-performance within acute contracts; this is mitigated to some extent by the block contract arrangement for emergency care with GHFT • Under delivery of savings plans, particularly those reliant on a whole systems solutions • Prescribing costs being higher than that planned, either due to the introduction of new drugs, increased growth or price increases on Category M items • The potential for increasing continuing health care (CHC) cases • The impact of LD transfers under the Transforming Care agenda • Primary Care expenditure exceeding the budget set • System risk relating to potential non-availability of Sustainability and Transformation funding (STF) should providers fail to meet control totals 4 x 5 = 20 4 x 5 = 20
Management of Conflicts of Interest	No specific conflicts of interest other than those declared at the meeting.
Financial Impact	The CCG has a statutory duty to achieve financial balance. The CCG is planning for a surplus of £17.243m.
Legal Issues (including NHS Constitution)	Not Applicable
Impact on Health Inequalities	There are no direct health and equality implications contained within this report. The assessed impact on health inequalities is

	contained within individual programmes for the year.
Impact on Equality and Diversity	Not Applicable
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is asked to: • approve the proposed 2017/18 budgets and; • note the inherent risks within the plan.
Author & Designation	Andrew Beard, Deputy Chief Finance Officer
Sponsoring Director (if not author)	Cath Leech, Chief Finance Officer

Agenda Item 14

Governing Body

Gloucestershire CCG - 2017/18 Budget Update

1. Introduction

This paper presents an update on the 2017/18 budget from the report approved at the March Governing Body.

2. 2017/18 Budgets

Updated budgets for the CCG are shown in Appendix 1. These budgets show a revised planned surplus of £17.243m for the year and are presented after allocating planned savings to the relevant budget line (as highlighted in Appendix 2 and 3).

Although the majority of contracts have been agreed, further budget changes will need to be made to reflect changes to the final timing of investment decisions. Such budget changes and amendments will be reflected in the budgets, and future finance reports to the Governing Body.

Savings plans and risk sharing against delivery of savings plans have been allocated across headings within the plan and these are currently the subject of discussions with providers. The schemes have been risk assessed, although there remains some further work to finalise some of the detail around milestones on some schemes.

3. Resources

The CCG's initial allocation for 2017/18 is £851.9m which includes:

- Programme funding of £744.9m;
- Delegated Primary Care allocations of £80.0m;
- Running costs of £13.6m;

- Returned 2016/17 surplus of £17.5m.

Since the March paper, the returned surplus has increased in line with that reported within the 2016/17 Annual Accounts (which included the release of 1% system risk reserve). However, this has not given the CCG any further flexibility as the target surplus for 2017/18 has also increased accordingly with an amendment for allowable drawdown of £0.3m.

Although the 2017/18 surplus is in excess of the 1% national requirement, the CCG will not have access to further drawdown funding in 2017/18.

Recurrent transfer of resources have been included within allocations for the following items:

- To NHS England (reduction to the CCG of £6.0m): a national assessment of the impact of the implementation of HRG4+.

- From NHS England (increase to the CCG of £1.9m): represents the nationally assessed impact of a change in commissioning responsibilities regarding specialist commissioning.

The Department of Health and the Welsh Assembly Government have confirmed that there will be no changes in financial flows during 2017/18 for the impact of cross border movements.

4. Expenditure Budgets

The CCG is planning to spend £821.1m on commissioning healthcare services in 2017/18 including primary care; this accounts for over 98% of our expenditure as a Clinical Commissioning Group.

It should be noted that the CCG holds a minimal level of uncommitted reserves and that, in line with national policy, 50%

of headroom funding on non-primary care budgets (£3.7m) has been ring-fenced at the start of the financial year. This contributes to the local system risk reserve, together with 0.5% of provider CQUIN.

4.1 Primary Care Budgets

The allocation for Gloucestershire's delegated primary care budgets under the co-commissioning initiative is £80.0m (including 0.5% contingency and 1% headroom). This funding is fully committed and the budget proposals have been reviewed and agreed by the CCG's Primary Care Commissioning Committee (PCCC).

5. Risk Management

To enable the management of risks during the year and in line with national guidance, a small contingency reserve has been built into the CCG's budgets.

Key risks and mitigating actions are shown in Appendix 4.

6. Capital

The CCG has bid for capital funding which is being reviewed by NHS England (confirmation date awaited). These bids are shown below:

Category	**2017/18 (£000)**	**2018/19 (£000)**
Local Digital Roadmap	4,300	3,000
Practice Network/Hardware Refresh	2,500	1,000
CCG Network/Hardware Refresh	70	70
Practice Minor Improvement Grants	342	250
CCG IT Infrastructure	290	TBC

The above schemes exclude any bids made against the Estates and Technology Transformation Fund and Transforming Care Partnerships (relating to Learning Disabilities).

7. Recommendation

The Governing Body is asked to:

- approve the revised 2017/18 budgets and;
- note the risks inherent within the plan

8. Appendices

- Appendix 1 – 2017/18 Budget proposals
- Appendix 2 – 2017/18 Allocation of savings
- Appendix 3 – 2017/18 Savings Plans
- Appendix 4 – Risk Management

2017/18 Budget Proposals

		Admin/Prog (net of Savings)	Primary Care Co-Commissioning	TOTAL CCG
Resources				
Programme Allocation (after IR/HRG4+)		740,820		740,820
Primary Care Co-Commissioning			79,968	79,968
Running Costs Allocation		13,558		13,558
2016/17 Surplus returned		17,545		17,545
		771,923	**79,968**	**851,891**
Expenditure				
Programme				
Acute		379,728		379,728
Community		83,172		83,172
Mental Health		88,029		88,029
Primary Care		112,906	78,768	191,674
CHC		33,909		33,909
Other		35,930		35,930
Reserves	Headroom	3,724	800	4,524
	Local Risk Reserve			
	National Contingency	3,724	400	4,124
Corporate (Running Costs)		13,558		13,558
Total Expenditure		**754,680**	**79,968**	**834,648**
SURPLUS		**17,243**	**0**	**17,243**

Gloucestershire CCG

2017/18 Allocation of Savings (Programme Budgets only)

		Gross Budget Excl savings £000	Transformational Savings Applied to Budgets £000	Transactional Savings Applied to budgets £000	Net Expenditure £000
Programme					
Acute		391,440	(11,712)		379,728
Community		83,172			83,172
Mental Health		88,553	(524)		88,029
Primary Care including prescribing		118,906	(5,000)	(1,000)	112,906
CHC		35,909		(2,000)	33,909
Other		40,848		(4,918)	35,930
Reserves	Headroom	3,724			3,724
	Contingency	3,724			3,724
	Savings	(25,154)	17,236	7,918	0
Corporate		13,558			13,558
					0
Total Expenditure		**754,680**	**0**	**0**	**754,680**

Gloucestershire CCG

2017/18 Savings Plans

Transformational schemes		
Category	Scheme Description	**2017/18 Total £'000**
Urgent Care	♦ AEC, OPAL, High Impact Improvement Standards, Urgent Care Reset Plan, FHC, Cardiology, 30k Cluster Model, MSK & Falls, Respiratory Admissions, IDT	**4,474**
	♦ CPA Pathways for inpatient care - MSK, Eye Health, Pain, Circulatory ♦ CPA pathways for outpatient care - MSK, Skin, Pain, Respiratory, Circulatory & Cancer	**6,835**
Medicines Optimisation		**5,000**
Continuing Health Care (CHC)		
Other		**926**
Total		**17,236**

Transactional schemes		
Category	Scheme Description	**2017/18 Total £'000**
Urgent Care		
Planned Care		
Medicines Optimisation		**1,000**
Continuing Health Care (CHC)		**2,000**
Other		**4,918**
Total		**7,918**

GRAND TOTAL	**25,154**

Gloucestershire CCG

2017/18 Risk Management

Risk	Mitigating Action
Further changes to the CCG's allocation as a result of transfers between commissioning organisations may not be cost neutral	Work with the Area Team and local providers to ensure that adjustments are cost neutral and transacted on the correct basis including correction of IR/HRG4+ adjustments where appropriate.
Assumed allocations may not materialise	Ongoing liaison with NHSE and other relevant parties to ensure that all issues are known together with a phased approach to the release of expenditure commitments to mitigate the risk of a reduced allocation.
Expenditure on Primary Care Co-commissioning may not be contained within the budget due to pressures within primary care and also external pressures such as NHS PS charging	Close monitoring and forecasting to enable early warning of financial issues arising. Regular contact with NHSE and other relevant parties.
Non achievement of the required level of savings through slippage in implementation or benefits not being realised as anticipated or through lack of engagement by partners:	Close review of resources allocated to each project to ensure sufficient to ensure robust implementation and delivery, enhanced monitoring of the project to ensure timely warning of slippage or benefit realisation differing to the forecast project. Development of robust exit strategies for projects to ensure that these can be stopped at short notice if they do not deliver against agreed objectives
Overperformance on acute contracts	Strengthening the contract management & monitoring processes, including that in relation to out of county contracts Plans to improve practice engagement to ensure that pathways followed are the most appropriate for the presenting condition.

Potential loss of control over service priorities or cost changes where the CCG is an associate commissioner to a contract	Establish stronger working relationships with other commissioners to ensure early warning of pressures within other contracts
Increased growth in prescribing	Monthly enhanced monitoring in place. Prescribing working group set up to implement savings plans.
Increases in continuing health care and placements	Monthly monitoring of trends. Joint plan to manage process improvement in year including further utilisation of Caretrack software.
Costs of nationally approved NICE developments in excess of that provided for (both in cost and take-up)	Increased profile of NICE horizon scanning and close liaison with contract management.
Population growth above planning assumptions	Continuing work to benchmark services to identify areas to review to ensure value for money from all services

Mitigating Actions Covering all risks:

Non release of development funds unless key to delivering service change or contactually committed, until planned financial targets are forecast to be delivered with a reasonable degree of confidence.

Utilisation of contingency and activity reserves

Increased financial management awareness throughout the organisation and member practices

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 15

Governing Body

Meeting Date	**Thursday 25 May 2017**
Title	**Gloucestershire CCG Organisational Development Strategy**
Executive Summary	The Gloucestershire CCG Organisational Development (OD) Strategy and Plan sets out an approach to OD for the Gloucestershire Clinical Commissioning Group in what will be a pivotal two years for the 'One Gloucestershire' Health and Care system. The approach is framed in the context of the One Gloucestershire OD strategy and focusses on development across three key areas, Capability, Capacity and Culture.
Key Issues	The strategy is supported by an ambitious action plan that will require sufficient resources to deliver.
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	None
Legal Issues (including NHS Constitution)	Not Applicable
Impact on Equality and Diversity	The OD strategy will act positively on our approach to equality & diversity across the CCG as it will focus on staff development across our organisation.
Impact on Health Inequalities	None
Impact on Sustainable Development	There are no direct sustainability implications contained within this document.
Patient and Public Involvement	Not applicable.

Recommendation	The Governing Body is requested to support the proposed Organisational Development strategy and plan for the CCG, noting the fit with the wider One Gloucestershire OD strategy.
Author and Designation	Ellen Rule, Director of Transformation Joanna Davies, Lay Member - Patient and Public Engagement
Sponsoring Director (if not author)	Ellen Rule, Director of Transformation

Annex 1: Gloucestershire CCG Organisational Development Strategy

Gloucestershire CCG Organisational Development Strategy

Version Control:

Version	Author
1.0	Developed by ER, 10th August 2016, based on previous OD strategy of CCG and system OD work plan developed through STP
1.1	Review at OD Strategy Group for feedback (August)
1.2	MAE updates to action plan following review at core directors discussion
1.3	ER revisions to create updated version for final sign off
2.0	MH approved version
3.0	ER and JD edits for Governing Body version based on feedback from development session

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3. Scope 5
4. Capability 5
5. Capacity 7
6. Culture 7
7. Governance 9
8. Summary 9
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1. Introduction

This Organisational Development (OD) Strategy and Plan sets out an approach to OD for Gloucestershire Clinical Commissioning Group (GCCG) in what will be a pivotal two years for the 'One Gloucestershire' Health and Care system. We have been working over the last year to develop a shared vision for improvement, which we have published as our Gloucestershire Sustainability and Transformation Plan (STP). Our challenge now is to turn our vision into delivery of real and tangible improvements in health and care for people in Gloucestershire.

Whilst we have agreed as a system to have a shared OD plan to support our system development, it remains important for our CCG to have a strategy and plan to develop our own organisation and staff to ensure we remain fit for purpose to deliver, change and grow in the new strategic context presented by our STP and any subsequent developments. To ensure alignment to the system plan, our delivery plan has been presented in the context of the OD plan proposed for the system and accepted by the STP Delivery Board.

It is important to note at the outset that OD can embody a range of activities and be understood through a variety of definitions. The NHS Leadership Academy describes OD as being "about leading change, service improvement initiatives, engaging and motivating staff, developing their talents and improving potential of staff. Great OD is about understanding context and culture, taking a systems approach and enabling NHS staff to design and deliver great patient care". This will broadly be the working definition assumed for this strategy and plan, although greater detail of the components of our approach will be set out through this document.

2. Context:

The Five Year Forward View outlines three critical gaps (Health and Wellbeing Gap, Care and Quality Gap and Finance and Efficiency Gap) facing the NHS, that need to be tackled across the health system by driving improvements in health and care provision, restoring and maintaining financial balance and delivering core standards. In Gloucestershire our system is facing a number of challenges:

- A growing population with more complex needs – it is estimated 47,500 people over the age of 65 are living with long term conditions, which is projected to rise to 77,000 by 2030.
- Increasing demand for services and rising public expectations, coupled with low levels of personal responsibility in some areas over personal health and care and lack of ownership over personal health planning,

- Innovation in new medical technology and medicines, which has the potential to improve lives for many people but needs funding for implementation
- Considerable pressure on NHS and social care finances – the health and care community is facing a gap of circa £226m over the next four years unless we make radical changes to the way we deliver services.
- Strengthening Mental Health Care and Support
- Significant pressures on our NHS and Social Care workforce capacity, with the potential for gaps to arise in key roles unless action is taken to develop new roles and ways of working.

Our long term ambitions are to have a Gloucestershire population, which is:

- Healthy and Well – taking personal responsibility for their health and care, reaping the personal benefits that this can bring. A consequence will be less dependence on health and social care services for support.
- 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

To successfully achieve these ambitions, the culture, capability and capacity of the CCG needs to develop, change and grow to deliver in the STP context. Significant changes in thinking are needed to take a systems approach, including (but not limited to):

- Working beyond traditional organisational boundaries in new collaborative working arrangements and virtual teams
- Taking innovative approaches to solving long term difficult service delivery issues, including putting organisational self-interests to one side in the interests of system sustainability
- Putting patients at the centre of service redesign and delivery, embracing the principles of co-production and patient led care
- Taking systematic and evidence based approaches to delivering change and service improvement, that are common across our system and valued by all partners

The STP OD group have proposed that the approach to system wide organisational development and workforce planning should be based around the following principles, which are based on the Kings Fund principles for Integrated Systems:

- Workforce and organisational development should be at the heart of all of our transformational programmes. The OD and Workforce Group will focus on owning delivery of the big ticket cross cutting issues and will work with other STP groups and our clinical programmes to support them to build these approaches into their practice.
- We will develop a common language across all the key STP partners to enable us to deliver consistent and sustainable change

- We need to consider the workforce in its widest sense and we recognise that this is underpinned by strong carers, communities and the voluntary and independent sector. Supporting vibrant communities is the key focus of our Enabling Active Communities programme and we will work with the Enabling Active Communities programme on key joint initiatives such as coaching and personalised care planning to support patient activation.
- We need to role model the values and leadership behaviours that we agree by the wider STP within this programme. Leaders of the programme will adopt these and using a model of distributed leadership will take accountability for delivery across the system.
- Our approach to workforce and organisational development needs to support the delivery of our financial context. Working with the Resource Group, the OD and Workforce Strategy Group will take the lead role in shaping and overseeing the workforce resource plan for the system.
- We will work collaboratively to support system goals and our organisations will align their work with this. The OD and Workforce programme does not seek to replace the ongoing work within organisations to support their organisational OD and workforce strategies – it will facilitate sharing of good practice, consistency in approach to achieve system goals, removing duplication and the creation of efficiencies of scale in key areas.

To start this work the CCG began a staff and Governing Body engagement process in late 2015 to refresh its Vision and Values. This included workshops exploring how people felt about working for the CCG and identification of key words that reflected what they felt the CCG stood for. The subsequent report showed very strong themes and a number of recurring words and phrases that informed and shaped a suggested reframing of the CCG Vision and Values.

Vision (Draft): Improved health and wellbeing through joined up care and communities.

Values (Draft):

Caring - Meeting your needs with compassion and respect
Integrity - Acting with professionalism, fairness, honesty and openness
Quality - Working positively with you for the best quality of life and safe, effective care
Collaborative - Supporting healthy, active communities and joined up care through strong partnerships
Innovative - Being forward thinking and creative to transform care and to make best use of limited resources

In May 2016, the CCG held interactive sessions exploring how we 'live these Values' in our day to day work. The action plan that has been developed through the STP is based around three key domains, Capability, Capacity and Culture. The CCG plan therefore follows this approach to support alignment.

3. Scope

As indicated in the introduction, the scope of an OD strategy is to a large extent determined by the perspective taken on OD. The schematic below sets out the scope included within this strategy. Each of the areas described are then included and expanded in the proposed CCG action plan set out below, grouped through the overarching headings of capability, culture and capacity.

4. Capability

To support our STP programme and organisational CCG objectives developing the capability of our staff is essential for success. This development will include, as well as be driven by, our leadership team. Our capability development programme will focus on the following:

- **Leaders,** by supporting the development through the STP OD working group of a shared model for distributed leadership across Gloucestershire
- **Governing Body,** by ensuring an ongoing programme of Governing Body development, including regular board to board opportunities with system partners

- **CCG staff** – who will need to be enabled to deliver systematic large scale transformational change, often working flexibly across organisational boundaries and outside of traditional team structures
- **Primary Care workforce** development, including developing Clinical Leadership and primary care education and development
- **Front Line delivery staff**, by Investing in development of key skills needed by 'front line' staff to deliver against the objectives of transformation programmes, such as co-production capability to support the wider self-care and prevention agenda and the skills needed to work within the new models of care

The capability approach will also consider the organisational capability of the CCG. More details of the delivery plan for capability are set out at Annex 1, the Delivery Plan. A summary of the 'offer' for each of the staff groups and the wider organisational capability approach is set out in brief below:

CCG Staff: Staff will be **enabled in key skills** for delivery with a particular focus on **improvement capability**. Supported by the principles set out in the STP MOU the system will offer training support in common across the health and care economy, with a training 'passport' developed for use across all organisations.

Primary Care Workforce: The CCG will support **clinical leadership, education and development** and in line with the plans set out in the Primary care strategy will deliver a **Primary care workforce development strategy** to ensure sustainability of the primary care workforce.

Front Line Delivery Staff: will be **enabled in key skills** in line with CCG staff including **improvement capability,** and access to a range of training options accessible through the single training passport. Offers for clinical staff will include additional focus on IT skills, Co-Production skills and Making Every Contact Count (MECC) in support of our STP programmes, in particular the Enabling Active Communities and One Place, One Budget, One System Programmes.

Leaders: Future leaders will need to be confident working in a **model for distributed leadership** that is recognised across the health and care system. Once this model has been described, current and future leaders will be supported to develop their capabilities. Of particular focus for leaders employed by the CCG is the skills needed to deliver the CCG's responsibility for **System Development and Service transformation**, which has been expressed over the last year through the work to develop and deliver the GSF workshops and build consensus for the STP.

Organisational Capability: the capability of the CCG in the wider sense will be captured through the **CCG Assurance Framework** and supported by the **CCG Framework of Excellence**. The new OD tool developed by the NHS Leadership Academy will be used to assess organisational capability with regards to OD.

5. Capacity

As described in section 4, capability of staff is critical for ensuring success. However, having sufficient staff capacity to deliver what is needed can be a significant challenge as the health and care system has to compete for talented staff in the wider job market and the training lead in times for skilled staff can be long. For some staff groups, the situation with recruitment and retention has reached a critical point, meaning that the system will need to contemplate some radical new ways of working and new opportunities for skill mixing if sustainability is to be achieved. Our approach to ensuring sufficient capacity in our system is based on the following core objectives:

Capacity and Structure for Delivery: Our organisation will have capacity in place for the responsibilities we need to deliver, and will set an organisational structure that supports and enables staff. Roles will be defined and supported with proper inductions and training made available (see capability section) and there will be a sense of progression available through our organisational structure.

Workforce Strategy: Through our system role we will work with our STP partners to develop a workforce strategy, of which the CCG will be a part. Organisationally, we will focus on developing a workforce strategy for the CCG, and lead on delivery of a workforce strategy for primary care. The wider system workforce plan will both model the **current system workforce profile** and develop the **future workforce profile (including skill mix opportunities)** to support new models of care. Examples already in hand include work to develop opportunities for new roles such as apprenticeships and nursing associates.

Workforce Sustainability: Our approach to sustainability will involve a range of actions to support recruitment and retention which are described in detail at Annex 1. For CCG staff, this will include having clear recruitment approach including bringing people into the workforce through apprenticeships, and supporting work experience placements. To support the health and wellbeing of our staff, we will adopt and sponsor the Workplace Wellbeing Charter along with our STP partners.

6. Culture

Organisational culture is typically described as the values and behaviours that contribute to the unique social and psychological environment of an organisation, or the 'way we do things round here'. The culture of an organisation can be expressed through many means, but typically includes self-image, rules (both written and un-written), shared attitudes and beliefs. The culture of an organisation also impacts on the freedom allowed in decision

making, the approach to developing new ideas, and how power and information flow through the hierarchy and decision making structures of the organisation.

Through our STP we have committed to working on the concept of a shared system culture, but this does not preclude the need to continue to develop our organisational culture within the CCG. It should be acknowledged that any approach to deliver cultural change requires a significant investment of time and effort, and the understanding that culture develops organically in response to a range of internal and external factors, alongside any systematic efforts to move culture in line with any particular agenda. The impact of wider system change and the national context of the NHS will all have an effect on staff and systems. The areas of focus are described below with more details of actions set out in the plan at Annex 1.

Vision, Values and Behaviours: the CCG has held a series of workshops to develop a new set of vision and values statements, that has included all staff in the development process

Positive and Supportive Culture: The OD group have led a number of actions to support growing a positive and supportive culture, including the introduction of a staff awards and recognition programme and offering Mindfulness training to all staff.

Organisational Strategy and Objectives: The CCG has clear organisational strategy and operational plan that is accessible to all staff and stakeholders. Staff in our organisation will be supported to understand how their work aligns to the overarching direction of travel, and know how to influence future organisational strategies

Operational Policies and Procedures: The CCG has clear operational policies and procedures to ensure staff are clear on 'how we do things round here'. Recent examples of new policies being developed include the amended flexible working policy.

Patient and Public Engagement: Having a clear and positive approach to patient and public engagement is central to the organisational culture of our CCG and aligned to our philosophy of ensuring the patient voice informs all we do. Our approach is described in our PPE strategy.

Staff and Membership, Engagement and Communication: To support development of a shared and inclusive culture, the CCG delivers a range of engagement and communication offers for the staff and the membership. These include events such as the Annual clinical commissioning conference for all staff and membership colleagues, the in house Staff Events that include an 'ask the exec' panel, monthly staff meetings and communications through a range of e bulletins such as "Team Brief" and "What's new this week".

7. Governance

The Organisational Development working group will own and provide oversight to delivery of the action plan. The JSCC will act as a reference group with regards to the contents of the action plan as it develops. Further work is needed to agree the governance structure that will best enable the delivery of the action plan including how full accountability to the Governing Body will be achieved. The plan has been reviewed and approved through the Core Executive Group and regular updates will be provided to the CCG Governing body. Consideration is being given to leadership arrangements for the delivery of the plan within the CCG staffing structure.

8. Summary

This OD strategy sets out an approach for our CCG anchored in a wider STP OD approach, based around three key aspects –Capability, Capacity and Culture. In summary the plan will focus on ensuring the CCG:

- Can deliver organisational change as part of a programme of system wide organisational and cultural development
- Has an approach which is driven by the leadership team with the full support of the Governing Body
- Maintains an approach to ensure its' staff feel supported and empowered to deliver in their roles

The attached Annex sets out an action plan to deliver against each of these areas.

Annex 1: Detailed Action Plan:

The action plan is evolving as work progresses and will be managed by the OD strategy group. The actions set out in the STP OD and Workforce plan are included shaded in blue to highlight collective system actions alongside the CCG specific action plans.

Work streams	Change Activity Required	How?	Outcomes	Lead	Delivery Date
CAPABILITY - CCG Leads – Dr Andy Seymour/Helen Goodey / Marion Andrews-Evans / Ellen Rule (System thematic lead: Carol Sparks, Director of Organisational Development, 2Gether NHS Foundation Trust)					
Clinical Leadership, Education and Development	CCG will support Clinical Leadership development and deliver a Programme of GP Education and Development, Primary care workforce development strategy	The CCG in partnership with local provider organisations and universities leads the contracting process for provision of service transformation post-graduate training funded by HEE. The training is for non-medical clinical professional staff.	Clinical leaders will be better supported in our system to support ongoing STP delivery objectives	HG / AS MAE	Ongoing
System development and Service Transformation	Establish system OD group with programme leadership from GSF Work with partners to develop system approach to service transformation, links to quality academy work	The CCG will work with partners to develop a system wide organisational development programme as part of the GSF work programme	System OD group set up. Agreement to progress quality academy through STP	ER / MH	Ongoing
System Leadership	Programme of GSF workshops to develop system wide work programme Lead development of Sustainability and Transformation plan	The CCG has a key role in the development and support of the GSF Work Programme	Workshops delivered, STP developed, now moving into delivery phase. Need to consider STP resourcing especially PMO	MH / ER	Ongoing

CCG Assurance Framework / Framework of Excellence (Organisational Capability)	CCG performance report reviewed by Board and core monthly / Completing assessment against new CCG assurance framework Developing approach to benefits management and alignment to key CCG objectives / CCG reviewed itself against FOE framework and undertook a number of actions in response	The CCG will measure it's performance against relevant national and local measures and will ensure the requirements of the CCG assurance framework are met The CCG will review itself against the framework of excellence for clinical commissioning	CCG is delivering excellence in commissioned services to ensure high quality and timely services delivered for people in Gloucestershire	CL / ER	Ongoing
Embed improvement capability	Shared approach to improvement capability and training delivered to staff across system to support transformational change Develop Joint commissioning skills & resources building on existing arrangements and experience where joint commissioning roles already exist across health and social care	Ensuring embedded improvement capability e.g. through QSIR programme, and new service transformation education arrangements funded by HEE– including transformation master classes, specialist skills education and higher-level qualifications.	People have the skills we need to deliver the goals of the STP and feel confident in their ability	MAE	Ongoing
Model for distributed leadership	Develop and describe a shared model for distributed leadership across health and care system, roll out to embed key capabilities	Building on previous work of leadership network will pool thinking on leadership models, including drawing on work with 'top leaders' programmes. Develop model, agree and then roll out across system	Leaders will feel supported to lead for and across the system. Organisations will collaborate with and support leaders who are assuming these roles	FP	October 2016 for model, roll out ongoing
Build co-production capability with	Developing shared approach to building co-production capability to ensure patients are motivated to self-	Embedding a culture of co-production Health e.g. through coaching to mobilise healthy	Improved patient experience and satisfaction.	HG / MP	June 2017

clinicians and carers	care and feel supported to make healthy choices.	behaviours and person led care Supporting self-care and prevention agenda - MECC, common e-learning module across Gloucestershire for healthy lifestyles	Increased patient activation Staff provide brief interventions to patients and individuals that lead to healthy living		
Enable the workforce in key skills	Define training needs analysis and address gaps taking account of new models of care	Support development of an IT enabled workforce –use of technology to support remote monitoring across health and care (telehealth and telecare training in domiciliary care/ care homes/ practices/ community nursing). PDA devices to enable carers and other workers to maximise time with patients.	Patients feel confident in using technology to help manage their conditions Staff feel equipped to use technology and integrate this into their working practice		December 2018
	Provide Mutual support and learning opportunities using opportunities in our system	Offering training support within the health and social care community. Develop a training passport for the county	We adopt best practice within the economy and reduce the cost of outsourcing training		October 2017
	Creating one system	DBS clearance to follow individual, Assess other elements of HR/recruitment practice that can be shared. Develop integrated health and social care pathways – including leadership pathways	Staff are able to rotate and take up new roles across our organisations without delay		January 2018

CAPACITY – LEAD: CCG Lead: Marion Andrews-Evans (System thematic lead - Tina Ricketts, Director of Human Resources, Gloucestershire Care Services NHS Trust)					
Structure and Skills for Delivery	CCG Structure agreed, regularly reviewed to ensure relevant and displayed clearly with photos Skills assessment in teams and training plan for staff Definition of skills required in different roles and support to develop these	The CCG will agree a staff structure that will ensure successful delivery The CCG will appoint and train staff to ensure that we have the skills to deliver against our objectives, Staff will be supported to develop their skills and experiences in their roles	The CCG will have staff in place who are qualified to deliver against agreed organisational objectives	MH	Ongoing
CCG Workforce Strategy	Develop workforce strategy for system, with a specific focus on primary care workforce Campaign support for primary care recruitment	Support the development of a workforce strategy for Gloucestershire, develop specific actions to support development of the CCG workforce	Workforce is in place to do required roles as needed	ER / HG	Ongoing
Model Current system workforce profile	Workforce Profiling	Sharing information on workforce, developing a common language, adopting workforce profiling tools, , improving data capture, looking at how we compare to elsewhere, using this to inform our actions, look at how this supports our system plans, keep information under review	We have a system-wide understanding of our workforce issues, we agree priorities for action based on what is best for the system	TR	June 2016 with 6monthly refresh

Develop future workforce profile (skill mix) **Supporting New Models of Care**	Develop 5 year strategic workforce plan	Future - What does future workforce profile need to be to support new models of care (review skill mix and integration opportunities) Now - What are the opportunities for new roles including Apprenticeships – health and social care roles – how can we further harness the capacity and capability of the private, voluntary and independent sector to support health and social care professionals – Can we build career pathways across all health and care economy workforce groups? - Take the opportunity to develop the role of the Nursing Associates across the system by the county being one of the 'Fast Follower' sites funded by HEE. Working in partnership with UoG implement NA training at apprentice level throughout the county.	We have a robust plan for our future workforce and we are developing the workforce in a timely fashion to underpin the roll out of our models of care	MAE/ SF/M A /MC	November 2017
	Learn from best practice	Participate in wider networks – e.g. HESW and bring back	We adopt an evidence based approach to our	MAE	Ongoing and as

		learning Learn from Vanguards and other national initiatives that have had workforce development at their core. Ensure that we are linked into national workforce development work in LGA, ADASS, PPMA.	work and we avoid re-inventing the wheel		identified
	Supporting access to care	Identify how 7 day working will impact on future workforce profiles	We have an agreed resource plan to support 7 day working		November 2017
Sustainable workforce **Recruitment - Encouraging People to Join the Workforce** **Retention - Encouraging people to stay in the Workforce**	Recruitment - Career Pathways – Schools	Promoting health and care careers as a package to schools, careers advisors, Skillsfest, work experience, business breakfasts	Pupils and career advisors have a better understanding of the range of career opportunities in health and care. Young people are encouraged to think about health and care careers from an earlier age and we see an increase in uptake of these career pathways.	MAE	June 2017
	Recruitment - Careers Pathways – 14+	Exploring local pathways into nursing linked to local education providers and development of a University Technical College	Young people are supported to take up routes into health and care professions	TR/SP / MAE	September 2017
	Recruitment - Career Pathways – those not in employment	Work with LEP on application advice	The statutory sector plays its part in		Ongoing

		Support Building Better Opportunities initiative and LEP driven DWP programme to support employability	improving employability in Gloucestershire and contributes to a reduction in people not in employment.		
	Recruitment - Marketing Gloucestershire	Use community wide branding on advertisements and promote the county – build on work within primary care workforce strategy. Learn from Health and Social Care recruitment event at end June and plan and deliver additional event in September 2016 and onwards	People are attracted to come to work in Gloucestershire. They can see that are a cohesive system offering a wealth of opportunities.		October 2017
	Recruitment – Local source of trained registered nurses.	Plan to open a new degree nurse training college at UoG for initially 120 students / year from September 2017.	To enable recruitment to nursing programmes from the local community with a greater chance that they will remain in county following graduation.	MAE/ MC/S F /MA	September 2017
	Retention - Career pathways – those currently working in the NHS	Apprenticeships, nurse practitioner role, other social care roles Support the development of a Community Education Provider Network for Gloucestershire	People stay in Gloucestershire and take up training opportunities to pursue new roles		June 2017
	Retention - Health and Wellbeing of staff	Adopt and sponsor Workplace Wellbeing Charter within STP	Our organisations promote the wellbeing		June 2017

		partners and in the local economy	of staff which keeps them motivated to work here. We increase productivity and reduce staff absenteeism.		
CULTURE: CCG Lead: Mary Hutton, Ellen Rule (System thematic lead - David Smith, Director of Human Resources & Organisational Development, GHNHSFT)					
Vision, Values and Behaviours	Programme of workshops – outputs to update previous values (shown below)	The CCG Vision Statement and Values are defined, next steps is to review the CCG behaviours	Vision and Values workshops held and new set proposed	KF / AD	June 2017
Organisational Culture	Introduction of staff awards and recognition programme Mindfulness training Improve physical environment of CCG	We look after and value our staff - The CCG will celebrate staff success, The CCG will follow the NICE guidelines regarding healthy workplaces and think about what can be done to support the health and wellbeing of staff	Staff recognition programme in place, environment refresh complete. Mindfulness training sessions held	MH / BP / SH / LH	January 2017
Organisational Strategy and Objectives	Ensure that organisational strategy is well understood and that individuals in our organisation understand how their work aligns to the overarching direction	The CCG will have a clear organisational strategy and objectives that are accessible to staff and well communicated. The CCG will consult widely as it develops and shapes future strategy	Alignment of individual objectives to organisational objectives completed in Transformation? Need to check how clear elsewhere?	MH / ER	June 2017
Operational Policies and Procedures	The CCG will have clear operational policies and procedures, such as Flexible working policy development Risk registers, Business continuity	The CCG will ensure that there are appropriate operational policies and procedures in place, avoiding over bureaucracy	Flexible working policy updated. JSCC established and up and running. 5 C's exercise	MAE / AP / LH	Ongoing

Patient and Public Engagement	Delivery of PPE strategy, engagement approaches Planning round consultation events	The CCG has a PPE strategy and has held a programme of engagement events to support planning	Patients and public are engaged and feedback is taken into account.	BP	Ongoing
Staff and Membership, Engagement and Communication	All Staff Event delivered and now planned every six months Membership and staff communication through range of e bulletins like WNTW and CCG bulletin	The CCG will improve staff and membership engagement and communication		AD / ER / LH	Ongoing
Develop and embed vision, values and behaviours to support the STP agenda	Develop and embed vision and values and align organisational strategies where appropriate	Alignment of organisational OD and workforce strategies to support STP goals	People working in Gloucestershire recognise the culture, values and behaviours agreed by the system and adopt these as their ways of working and this is evidenced through staff surveys		December 2016
Actively promote working across boundaries to create enabling culture	Learn from each other by Supporting a network and culture of learning from each other – sharing of strategies, approaches to common problems.	Explore development of a staff ideas network – so that we can have a rapid assessment of improvements so we can get them implemented quickly. Develop mechanisms to improve people's understanding of what different partners across our STP do	Learning culture means lessons learned are collected and shared widely		Ongoing

Agenda Item 16

Governing Body

Meeting Date	**Thursday 25 May 2017**
Report Title	**General Practice Forward View: Gloucestershire's updated plan**
Executive Summary	The General Practice Forward View (GPFV) was published in April 2016 with the explicit aim of addressing the pressures being felt by GPs and their teams, such as reduced funding, increased workload and insufficient workforce. CCGs were asked to submit a plan by 23 December 2016 to NHS England, setting out their approach to delivery of the GPFV. This was approved by the Governing Body pre-submission. Since then, a further update was requested by NHS England by 10 March, which was seen and approved by the Primary Care Commissioning Committee (PCCC). Following this submission, GCCG received a letter from the Director of Commissioning, NHS England South (South Central) assuring our plan. The ratings were as follows:

GP Access	Care Redesign & development	Investment in Primary Care	Workforce	Practice Infrastructure	DCO Assessment

This strong rating across our plan recognises the significant progress we have made in Gloucestershire in planning and implementing the General Practice Forward View, much of which is integral to the ambitions set out in our Primary Care Strategy. While 'Workforce' has been given an 'amber' rating, we have been informed this is consistent with NHSE's approach across South (South Central) given workforce pressures across the region.

While the plan has been rated 'Green', we have been

	asked for some supplementary information across these areas and for the plan to then be resubmitted to NHSE by the end of May, following sign off by our Governing Body. This paper therefore presents this updated, final, version for approval by the Governing Body. The changes in this update to the previously submitted document can be summarised as follows: • **Workforce section** – This has been updated to respond to NHSE's request on how GCCG are investing in GP Leadership and plans for Multi-Disciplinary Team development. International Recruitment plans have also been added to the document. • **Access section** – Further detail has been added on how GCCG are currently approaching this scheme. The criteria by which GCCG will assess expressions of interest have also been added. • **Infrastructure section** – This section has been updated with regards to estates and technology. This includes GCCG progress on the Primary Care Infrastructure Plan along with further information on Joining Up Your Information (JUYI) and the Wi-Fi rollout in General Practice. • **Workload section** – The latest update on the Releasing Time for Care Programme plans and progress made has been added. • **Organisational Form section** – This has been updated to provide details on how the General Practice Resilience programme has been locally implemented. • **Engagement section** – Further detail has been added regarding the patient engagement carried out through the Patient Participation Group (PPG) Network events, the patient-friendly Primary Care Strategy developed with Healthwatch and the GPFV meetings which have been established.

Key Issues	The General Practice Forward View addresses the sustainability and resilience of Primary Care nationally. This plan sets out how GCCG are implementing this locally in Gloucestershire, with significant progress already made and plans in place to continue this work.
Risk Issues	None identified regarding this particular paper. Risks regarding delivery of the General Practice Forward View plan are stated within the document.
Management of Conflicts of Interest	None identified regarding this particular paper. Conflicts of Interest with regards to any GPFV programmes are being handled in accordance with the latest policy, with the PCCC being responsible for decision making under the GCCG delegated commissioning arrangements.
Financial Impact	None identified regarding this particular paper. The financial impact for the GPFV is included within the plan submitted.
Legal Issues (including NHS Constitution)	We are ensuring adherence to the NHS Operational Planning and Contracting Guidance 2017-2019 while also acting within the terms of the Delegated Agreement between NHS England and GCCG dated 26 March 2015.
Impact on Health Inequalities	Not applicable
Impact on Equality and Diversity	Not applicable
Impact on Sustainable Development	Not applicable
Patient and Public Involvement	GCCG Primary Care Strategy, which included the implementation plans for the GPFV, was informed by two rounds of engagement and feedback. For patients, this was focused through representative bodies, in particular Patient Participation Groups and

	Healthwatch Gloucestershire.
Recommendation	The Governing Body is asked to approve the GPFV Plan for submission to NHS England, further to the recommendation made by the PCCC (this will be verbal following earlier meeting).
Author	Stephen Rudd
Designation	Head of Locality & Primary Care Development
Sponsoring Director **(if not author)**	Helen Goodey, Director Locality Development and Primary Care

NHS Gloucestershire CCG: GPFV – Transformation Plan

Agenda Item 16

Area of plan	Description
Vision A clear narrative on the vision for and delivery of sustainable general practice that reflects the ambition set out in the General Practice Forward View	**Background and Vision** NHS Gloucestershire Clinical Commissioning Group (GCCG), in conjunction with its member practices and partners, has developed an ambitious 5-year strategy for the future of Primary Care in Gloucestershire as part of our 'One Gloucestershire' Sustainability and Transformation Plan, reflecting the national ambitions of the General Practice Forward View, alongside those generated by our member practices. This Strategy was formally agreed by our CCG Governing Body in September 2016 with the following vision: **Our Gloucestershire Primary Care Vision**  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 primary care 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 six components of our Strategy are set out below: 

NHS Gloucestershire CCG: GPFV – Transformation Plan

Area of plan	Description
	1. Access  This section of our Strategy sets out our commitment to provide patients with improved access to primary care, including extended evening and weekend access that is joined up, easy to navigate and provided locally. Our approach will be informed by evaluation of our local GP Access Fund (GPAF) 'Choice Plus' pilot that has been in place across our localities and other local services and we will work with practices, patients and providers to design our long-term models of care in the context of the access requirements set out within the General Practice Forward View (GPFV). We will also further develop our approach to Community Connector Service (Social Prescribing). These initiatives, in all our localities, are helping practices to manage demand and support people with broader, non-medical needs to improve their well-being and access sources of community and social support. Finally, we will also utilise the funding provided for care navigation and handling clinical correspondence joined-up with the wider GPFV workstreams, particularly sustainability and transformation of primary care. **2. Primary Care at Scale**  There is an increasing trend towards delivery of 'Primary Care at Scale', with the traditional small GP partnership model often recognised as being too small to respond to the demographic and financial challenges facing the NHS. This should result in a number of benefits including access to a wider range of local services for patients within the local community, increased staff resilience, improved staff satisfaction, work life balance and learning opportunities, and improved financial sustainability. **3. Integration**  Through our localities, we will support GP practices to work as part of an integrated (joined-up) team of multi-disciplinary professionals (including community, voluntary and hospital services) for the benefit of a defined population of approximately 30,000 patients. This is likely to involve an extended team of GPs, nurses, allied health professionals and specialists offering easy access to a wide range of health and care close to people's homes. Our Strategy also sets out plans for developing a joined up, seven-day urgent care system, with centres and services to meet the needs of local communities. **4. Greater use of technology**  Through implementation of our IM&T Strategy and local 'digital roadmap', we will work to provide secure access to patient records

Area of plan	Description
	for clinicians and care workers, where and when they are needed and provide access for patients and their carers to their digital health records. We will also empower patients and their carers to take greater responsibility for their health through increased use of technology-based support tools and other on-line resources, including information on local services and support. We will also look to extend the role of technology to support direct patient care, including on-line video consultations and e-consultation, accelerated by the national funding from 2017/18. **5. Estates**  Our Strategy describes how we will implement our five year Primary Care Infrastructure Plan. The Plan sets out where investment is anticipated to be made in either new or extended buildings to enhance the practice team and patient environment and to support modern healthcare. The Plan is informed by evidence of future population growth and need as well as considering current provision, condition of buildings and existing schemes in various stages of development. In some cases, it may be beneficial for practices to look at shared premises to meet the needs of their local populations, but not in every case – it is very much dependent on a range of local circumstances. Buildings will need to be developed in a flexible way to take into account future demand, new technology, and the bringing together of other community, care or leisure services. **6. Developing the workforce**  This component is critical to the sustainability of primary care in Gloucestershire. Our Strategy describes our approach to recruitment, retention and return of the GP workforce, the education and training of the practice nurse workforce and development of the 'skill mix' in primary care, including new roles to support current professionals in providing care, such as clinical pharmacists. We have already made significant early progress across these components and in implementing the GPFV, details of which can be found in the sections below.
Investment in primary care The investment plan (revenue and capital) in primary	GCCG has already demonstrated a clear investment in general practice. Our CCG was in the first wave to take delegated commissioning arrangements for Primary Care, with the direct intention of increasing the resourcing of general practice and to commission across pathways so we can shift activity from secondary to primary care. For example, we invested £1m recurrently to

<table>
<tr><th>Area of plan</th><th>Description</th></tr>
<tr><td>care to deliver all aspects of the General Practice Forward View, locally.</td><td>
support the Unplanned Admissions DES which has subsequently been re-invested in our ‘Primary Care Offer’ for all our practices that has improved the quality of general practice provision with investment of c.£3 per patient (c.£2m) in addition to the £1m recurrent funding.

We have also invested in the leadership development of seven new GP Provider Leads to represent their localities with regards to the GPFV and who are all members of our New Models of Care Board (NMOCB), which reports to the STP Delivery Board. They are each funded at 3 sessions per month recurrently, demonstrating the early additional investment we are making in local delivery of the GPFV and the voice of Primary Care in the future of our Gloucestershire STP and organisational structure.

Furthermore, the GPFV sets out that CCGs must invest £1.50/head in 17/18 and 18/19 non-recurrently to fund transformation. GCCG is committed, in addition to proposals on delegated budgets, to invest at least £3 per head (over £1.9m) into practices across 2017/18 and 2018/19 as part of a transformational support package. To ensure this is transformative we have asked practices to coalesce in units of c.30,000 registered populations, in accordance with our Primary Care Strategy, to develop transformative ideas that support the sustainability of both primary care and the wider system; equating to over £1.2m recurrent funding each year.

The innovative projects that the practice transformation fund is supporting are as follows:

<table>
<tr><th>Scheme</th><th>Progress update</th></tr>
<tr><td>Clinical Pharmacists</td><td>Eleven clusters have opted to employ clinical pharmacists as part of their practice teams. The practices within the clusters are working together to do this, with the resource being shared equitably between them in order to work differently through diversifying the skill mix in general practice.

GCCG have been working with all eleven clusters to determine employment models and support recruitment, with clusters having now either employed or in the final process of recruiting.</td></tr>
<tr><td>Repeat Prescribing</td><td>One cluster is setting-up a back-office repeat prescribing hub for all their practices. This is based on evidence from models established in Swindon and Coventry & Rugby. GCCG Medicines Management Team has supported the set-up which is now rolling out across the cluster.</td></tr>
<tr><td>Urgent Care</td><td>Urgent visiting service: a shared urgent visiting paramedic service to relieve pressure on the practices within the cluster, working with SWAST.</td></tr>
<tr><td>Frailty service</td><td>Three clusters are developing elderly care services to support frail patients, enabling them to be cared for in their own home through improved local care provision. The corollary is also reduced pressure on general practice. One cluster has</td></tr>
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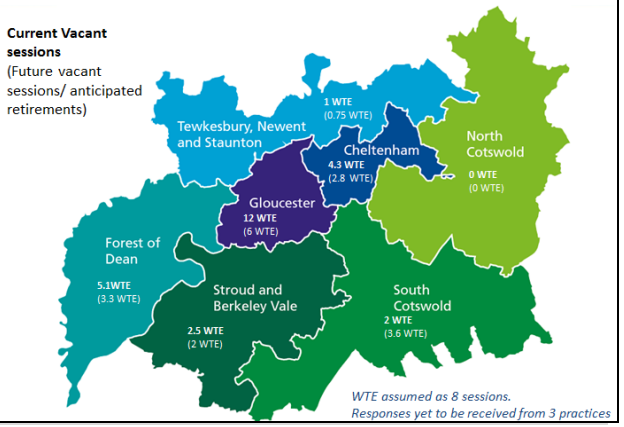
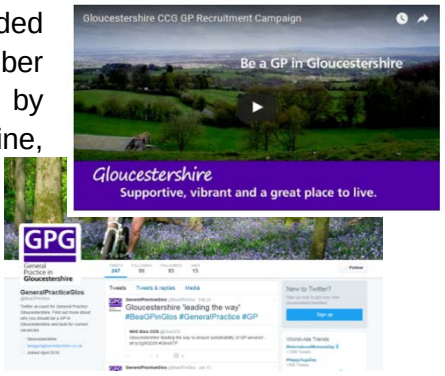
Area of plan	Description
	already recruited, one is in the process of doing so, while the other is finalising the scope of the service. Furthermore, we are ensuring all funding set out for Primary Care within the GPFV reaches general practice. For example, with regards to the funding allocation for care navigation and clinical correspondence, GCCG received £55k in 16/17 and anticipate £110k in 17/18 through to 20/21. We made this a focus of one of the breakout sessions at our Gloucestershire GPFV event on 24 January 2017. Clusters have been encouraged to utilise either a training provider listed within the NHS England Directory of Providers, or to assure themselves of the provider's training based on NHS England's 'Essential Features', and to ensure the training provider meets the needs of their cluster. At the time of writing, nearly all clusters have either booked or commenced the start of that training programme and we confirm that every practice and every cluster will receive this training, with support from GCCG to enable them to organise their chosen training provider. The Primary Care allocation for delegated commissioning has increased by 1.8% in 2017/18 from the previous year. The allocation is forecast to increase by a further 1.9% in 2018/19; both increases being predicated on an annual population growth of 0.7%. With additional investment by GCCG for Practice Transformation under the GPFV, along with GPAF investment, the primary care uplift is as follows, which compares favourably to the GCCG core allocation increase of 2% in each year:

Item	2016/17	2017/18	2018/19
Delegated baseline	78,523	79,968	81,511
Practice Transformation (GPFV)		1,000	1,240
GPAF	2,910	3,658	3,706
Revised total for year	**81,433**	**84,626**	**86,457**
Revised %age uplift with slippage		**3.92%**	**2.16%**

Support and grow the primary care workforce A baseline assessment of workload, demand and supply side numbers. A plan to: - develop initiatives to attract and retain GPs and	In order to better understand the workforce and recruitment needs of our practices, we undertook a survey in February 2017. Practices were asked to confirm whether they have any GP vacancies, the number of partner and salaried vacant sessions and whether they are aware of any planned or anticipated GP retirements. 78 of our 81 practices responded, demonstrating a stark comparison in GP vacancies between our localities, particularly in Gloucester City where a significant number of vacancies are being carried (12 WTE with 

Area of plan	Description
other practice staff - develop expanded multi-disciplinary primary care teams	a further 6 anticipated in the near future) and Forest of Dean (5.1 WTE, a further 3.3 WTE anticipated). We are utilising this information to continue to inform the CCG's support of our member practices including adaptations to existing schemes to meet new requirements. In addition to this survey, we also have used the Health Education England survey data to provide a baseline assessment of our workforce numbers, which was then utilised within our STP forecasting. Our baseline (establishment) therefore at 2015/16 was: • GPs: 341 WTE • GP support staff: 939 WTE • Commissioner Administration Staff: 218 WTE Forecasts within the STP show the growth of these figures in accordance with baselining against national trend alongside our local plans for recruitment of clinical pharmacists, health visitors for the elderly, mental health workers in primary care and a recruitment drive for GPs (both to fill vacancies and also for growth). The employment model for the pharmacists was assumed to be on basis of GCCG employment but three employment models have since emerged across our clusters. The forecast (establishment) employment by end of 2020/21 as a result of these actions is as follows: • GPs: 381 WTE • GP support staff: 984 WTE • Commissioner Administration Staff: 254 WTE Our approach to supporting the workforce of our 81 member practices has been focused around the recruitment, retention and return of the general practice workforce, following the NHS England, Health Education England (HEE), the General Practitioners Committee (GPC) and the Royal College of General Practitioners (RCGP) produced GP workforce 10 point plan. The work programme has been developed with our GP-led Primary Care Workforce and Education Workstream Group. Going forward, our plans for developing the general practice workforce will also be supported by our newly-established Gloucestershire Community Education Provider Network (CEPN or training hub) and the workforce development needs identified by our clusters of general practices. **Recruit:**

NHS Gloucestershire CCG: GPFV – Transformation Plan

Area of plan	Description
	Countywide Recruitment Events GCCG, alongside the other main Gloucestershire Health and Social Care providers, held a recruitment event to support promotion of the health and social care job opportunities in the county in November 2016. General Practice shared their clinical and non-clinical vacancies and this showed the breadth of opportunities available to those looking to move to Gloucestershire. The event was a good opportunity for all providers to work together and we plan to hold another in the future to support Gloucestershire providers including General Practice, in the spirit of the STP. Be a GP in Gloucestershire: Promoting local Primary Care campaign  To support recruitment costs, GCCG has provided significant investment to support member practices to recruit general practitioners, by producing a multi-media campaign (print, online, social media) and provision of campaign branded recruitment advertisements and materials for practices with the British Medical Journal (BMJ) during 2016/17. The aim is to produce a campaign to support the short-term recruitment pressures on our member practices as well as the longer term requirement for a primary care workforce that works in a more collaborative and sustainable way. The campaign promotes Gloucestershire as a place to be a general practitioner, but also highlights the benefits of the county's healthcare system alongside benefit to residents such as recreational, sporting and cultural activities[1]. At the time of writing: o 47 GP recruitment packages have been utilised. o The 2016/17 campaign resulted in around 13 GPs being recruited to roles in Gloucestershire. o The CCG and Primary Care workforce group plan to continue with an integrated branded microsite to support practice recruitment with the BMJ, which features a live link to current Gloucestershire roles advertised in the journal and is supported by social media activity. International Recruitment We will be working with NHSE to explore international recruitment opportunities. We have received 13 expressions of interest from our GP practices for employing International GPs as part of our recent workforce survey. We have engaged with the LMC, our PCCC, HEE and the GPFV Project Group, who are all supportive of this approach and we therefore intend to develop a proposal for Phase 2 of the International GP Recruitment Programme.

[1] https://jobs.bmj.com/minisites/beagpinglos/

Area of plan	Description
	Retain: Newly Qualified GP Scheme The workforce group identified a need to support GPs that have trained in Gloucestershire to practice in the county once qualified. Currently it is likely a proportion will either return to practice nearer to home (e.g. Bristol) whilst some of those who will practice in Gloucestershire will choose to do so as a locum, at least to begin with. It is known from engagement with ST3s that there is some demand for an offer that bridges the gap between a salaried or partnership position and the flexible but sometimes less supported locum option. Working with current ST3s and other stakeholders we are developing the offer to support this retention scheme which will most likely include: • Flexible rotations of between 4 and 12 months per practice, with a minimum commitment to work in two different practices over the term to be defined with the individual. • CCG facilitation between newly qualified GPs and general practices based on reasonable requirements such as geographical location, with employment by the individual practices. • Allocated funding per Newly Qualified GP to cover postgraduate study or medical indemnity for Out Of Hours work. • Mentorship and support expectation of practices for the newly qualified GP alongside additional CCG-arranged development and networking opportunities. We believe the gain for the GPs on the scheme, which could enhance the potential for them to take up local employment, would be to begin their careers with the benefits and stability of working in a practice for an extended period of time, without a full partnership commitment but with additional benefits. These include the opportunity to try a small number of different practices, mentor support, and the opportunity to continue to study and develop new skills for use in general practice or be supported with MDU costs. The mentor support in particular may be attractive as newly qualified GPs may find they miss the support mechanisms they had as a trainee. GCCG has engaged with the Gloucestershire ST3s and have found that there is a good level of interest in the proposed scheme. We expanded it to include GPs in their first five years post CCT and also promoted nationally in the BMJ to increase take up. The trainees present felt the scheme would provide the flexibility and stability they are looking for, and would bridge the gap between the opportunity to work as a locum and working as a salaried GP. We are therefore supporting the 8 ST3s to join the scheme. GP Retainer Scheme GCCG continues to work closely with stakeholders to promote the

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	Gloucestershire GP retainer scheme, for example via the LMC newsletter, to raise the profile of relaunching this opportunity in county. This advertising has led to a number of enquiries from GPs who have expressed an interest in becoming retainers due to their personal circumstances. The workforce group will continue to support GPs to join the retainer scheme as appropriate in order to enable them to continue to practice. <u>Portfolio career offer for those considering leaving general practice</u> The workforce group have developing methods to encourage GPs considering leaving general practice or retiring early to work in a different way in order to retain their skills and experience within primary care in Gloucestershire. GCCG held an engagement event in 2016 to assess the requirements of the GPs that expressed an interest in the scheme. We continue to work closely with identified individuals looking for support to continue to practice, albeit in a different way, in order to retain their expertise in the Gloucestershire workforce. National developments to the GP Retainer Scheme to include GPs looking to retire but maintaining a small number of clinical sessions, has further enabled us to support this group. <u>Setting up a Community Education Provider Network</u> GCCG, of behalf of all practices in Gloucestershire, submitted an expression of interest in obtaining support to set up a Community Education Provider Network (CEPN) to improve provision of education and training for all roles in primary and community care. Following submission of a formal bid GCCG was successfully approved to set up the CEPN. HEE SW has a contract with the West of England Academic Health Science Network (AHSN) to host and deliver the CEPNs, and as such Gloucestershire is benefitting from the cross-regional experience of the AHSN. The funding available for the CEPN is at this stage only short term, with a view to developing a sustainable structure following the pilot period. The Gloucestershire CEPN was set up in 2016 and includes various stakeholders with an interest in supporting and developing the workforce. The CEPN is aligned to our local plans to join-up services, bring care closer to home and support our member practices by promoting working in primary care and community-based roles. GCCG sees value in the CEPN supporting our 81 member practices to work in a more collaborative way, for example in practices providing training for groups of primary care professionals. The CEPN will support our pre-existing structures and plans to empower our primary care colleagues to play a role in developing provision of local services for their patients, in this case by enhancing the short, medium and long term sustainability of the primary care workforce. Identified early priorities of the CEPN include: • Piloting the integration of Mental Health practitioners into primary care,

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	bridging the gap between primary and secondary mental health services, improving access for patients and supporting the sustainability of general practice. • Broaden membership and expand education and training provision across both clinical and non-clinical roles. • Establish a CEPN Education Lead role for a senior clinician to provide leadership to this area of the CEPN. Recruitment commenced in March with a view to having the CEPN Education Lead in post as soon as possible on a part time contractual basis. <u>Practice Nurse Education and Training</u> This group, with practice nurse representation from all seven localities, is held bi-monthly. The purpose of the group is to provide informed, expert advice and strategic direction to support the development of nurses in General Practice and facilitate the implementation and development of an educational/career framework for nurses in General Practice. A number of schemes have already been agreed following the work of this group, notably; • Practice Nurse Facilitators across all seven localities • Advanced Nurse Practitioners – Funding for course and backfill in each locality agreed February 2016 to complete by 2021. • Consistent approach to mandatory training for Practice Nurses. • Practice Nurse Development Forums. • Health Care Assistant Development Forums. • Practice Nurse Education and training needs analysis and increasing the number of practice nurses with LTC courses. • Practice nurse placements. • Nursing Associates: CCG in collaboration with provider organisations started this new course in April 2017. 1 student employed by the CCG. • BSc Nursing: University of Gloucestershire have approval to commence this course. We are working with them to encourage student placements in General Practice. • UWE Contract 17/18: reduced amount of funding. Will concentrate on clinical examination course. <u>New skill mixes in Primary Care</u> The CCG has been supportive of working with its constituent practices and stakeholders to develop new roles and skill mixes in primary care. Examples include: • Clinical pharmacists in general practice to alleviate some of the pressures on GP time, both as part of supporting practices in the

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	national scheme (we had successful bids in both Wave 1 and Wave 2) and developing their ideas for the transformation funding we are making available (which is, for example, resulting in c.15 additional WTE clinical pharmacists being available to general practice). • Mental Health practitioners working within General Practice as part of a broader MDT, working closely with 2gether to design, develop and implement the pilots; • Paramedics working both in practice and as support to urgent visiting services across a cluster; • PAs are being considered as part of the future General Practice workforce in Gloucestershire, with one cluster in Gloucester City currently providing a placement for a PA from the University of Worcester to better understand the potential for the role. Feedback from this will be shared and will inform future plans to introduce PAs. • A number of clusters have identified the potential for physiotherapists in general practice to alleviate the current demand on GP time for patients who may be best supported by this professional group. Pilot clusters will be determined during 2017/18 to progress this new skill mix. We will continue to work with our CEPN, HEE and the West of England Academic Health Science Network to further support new skill mixes and benefit from national best practice. This will be vital to the successful implementation of new models of care as part of the Gloucestershire STP, and to alleviate the workforce pressures felt by Gloucestershire practices currently carrying GP and other vacancies or anticipating vacancies in the future as a result of planned retirements. **Developing Clinical Leadership to support at-scale provision** As mentioned earlier within this Plan, we have also invested in the leadership development of seven new GP Provider Leads. In addition, for those localities with clusters, we are also funding GP Cluster Leads too, meaning that all 16 clusters have funded Clinical Leadership to support at-scale provision. Through this funding being made available by GCCG, all clusters are making significant progress in delivering the national ambitions of the GPFV, along with our local ambitions set out in this plan and our Primary Care Strategy. These identified local clinical leaders have been undertaking development opportunities such as the General Practice Improvement Leaders Programme, visits to Vanguard sites, the GP Provider Leads are all members of the NMOCB, networking meetings and so on. We intend to do more for these local leaders by working with NHSE's Sustainability and Improvement Team to host a two-day Gloucestershire General Practice Improvement Leaders programme in early Summer. **Multi-disciplinary Team Development**

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	As described earlier, and throughout this Plan, we are diversifying the workforce within Primary Care as well as supporting our clusters to form closer relationships with their provider colleagues in the 'place-based' approach. Learning from the Dudley MCP Vanguard, we are designing an MDT process bringing together primary and community care, social care, the new roles in practice such as clinical pharmacists, social prescribing and mental health. A phased test and learn approach to embed cluster based MDTs into Gloucestershire clusters is envisaged and will be based on national best practice. MDTs have therefore been added this year to the Primary Care Offer.
Improve access to general practice in and out of hours A baseline assessment covering local variation in access, in-hours and out of hours plus an assessment of current extended hours practices A plan to implement enhanced primary care in evenings and weekends – with a clear trajectory for delivery by 2020 A description of how the plan for access to general practice is linked into the wider integrated urgent care system including 111.	The Gloucestershire GP practices are open from 8am to 6.30pm and 85% are currently providing extended hours through the Extended Hours DES. A number of practices are working at a cluster level to review integrated primary and community urgent care to provide better links and reduce duplication between providers across in hours and out of hours. GCCG is a GPAF Wave 2 pilot; offering "Choice Plus" appointments across weekdays, evenings and weekends, which are available to patients registered at all our practices across the seven localities. This pilot is averaging over 30 minutes per 1000 patients as per the national core requirements and has been extended to March 2017 with the objective of developing a plan towards achieving 45 minutes per 1000 patients. There is also a focus on ensuring the appointments are provided based on population need and demand and to increase utilisation of the appointments offered. As a GPAF site, we will receive £6/head of funding (weighted) to continue to commission extended access in accordance with national guidance. We are therefore working with all our 16 clusters to determine their interest in piloting alternative, innovative, models to commence in October 2017. Expressions of interest are to be made by 15 May to GCCG and the PCCC will determine the pilots to be taken forward in-year. Evaluation will focus on time of appointments, utilisation, patient experience, location, access criteria, skill mix, clinical effectiveness, capacity, innovation and impact on the system. We are taking a pragmatic approach to non-core hours that integrate extended access with extended hours provision, and we will look to increase to 45 minutes where demand dictates it. In the meantime, we are working with GDoc to continue the existing Choice+ project to ensure patient access to these extended appointments continues. As we look to our future model from April 2018 and beyond, we will be considering: • How the service fits with system wide plans (STP), the GPFV and the local work on the integrated primary and community based/led urgent care services. • Maximising appointment utilisation against population need/patient demand and reducing any inequalities in access across geographical

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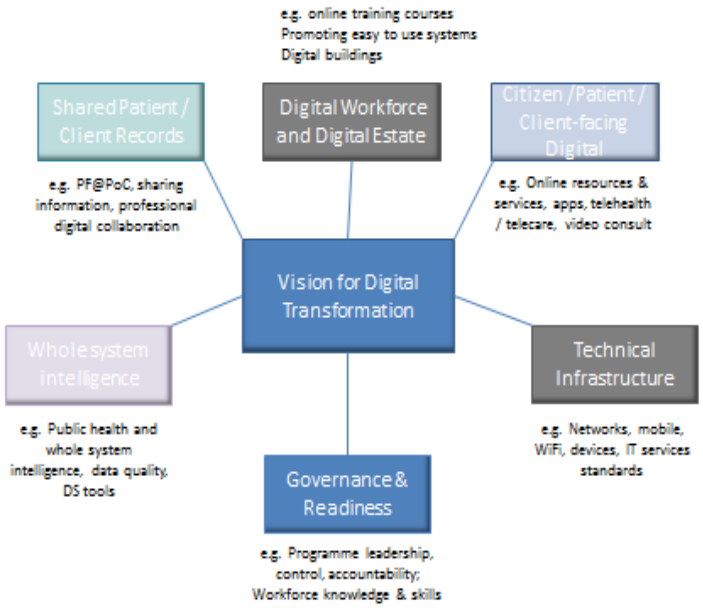
	locations. • The cluster workforce model, potential skill mix and training and how this can be done in a sustainable way for primary care and the wider system. • Appropriate performance measures and outcomes. We have good provision of dentists, optometrist and community pharmacists across Gloucestershire and access to urgent provision is widely shared. We will work with NHS England, as the commissioners of these contractor groups, to bring wider primary care into the delivery of our strategy to support enhanced access arrangements and as part of placed-based working. Choice Plus appointments can already be accessed by Out of Hours at weekends to support surges in demand. For bank holiday periods in and out of hours, opening hours and capacity is reviewed and shared with all providers. In conjunction with the recommissioning of OOH and 111, GCCG is undertaking a review of primary and community urgent care which is considering how these services fit together to ensure patients are seen by the right professional at the right time to reduce duplication and better manage urgent, same day, demand within an integrated urgent care system for Gloucestershire. As requested, this update should be read in conjunction with the UNIFY submission on 27 February.
Transform the way technology is deployed and infrastructure utilised A map of current estates and technology initiatives. A plan to deliver the requirements set out in the GP IT Operating Model 2016/18 A clear primary care estates and infrastructure strategy linked to the wider strategy	Our Primary Care Strategy has estates and technology as two distinct components reflecting their importance to the successful future of primary care.  **<u>Technology</u>** The Gloucestershire IM&T plan on a page sets out how we will ensure delivery against the National Information Board (NIB) "Personalised Health and Care 2020" framework to action and how we will transform health and care services through data and technology: • Enable me to make the right health and care choices; • Transforming general practice; • Out of hospital care and integration with social care; • Acute and hospital services; • Paper-free healthcare and system transactions;

Area of plan	Description
for integrated out of hospital care. Confirmation that primary care requirements have been included in Local Digital Roadmaps	• Data for outcomes and research. GCCG commission and oversee the delivery of high quality core and mandated GP IT services. In addition, as part of the Sustainability and Transformation Plan (STP), steps are taking place to deliver a fully interoperable health and care system by 2020 that is paper free at the point of care. Enhanced and transformational primary care IT services will complement core and mandated GP IT services and will align with and support the delivery of CCG strategic objectives, service improvement initiatives, Local Digital Roadmap (LDR) and the STP. In the implementation of our LDR and as part of our IM&T Strategy, we will improve clinical effectiveness, decision making and the health and wellbeing of the population through: o Moving towards a fully interoperable health and care system, connecting primary care providers with each other and all other providers. o 'Paper-free' at the point of care and available to all providers 7 days a week, with mobile working solutions for clinicians to access securely. o Access for patients (and their carers) to their digital health records. o Extending our online offering to patients, taking learning from our development of our innovative "ASAP" app to bring more services to fingertips. o Utilising remote monitoring technology, building on the Telehealth, Telecare and health alerting systems already in place. The Universal capability plan within the LDR outlines plans to provide access to, share and electronically transfer information for patients and providers, this includes the implementation of all national digital systems such as the Summary Care Record additional information, Patient Online, GP2GP, e-referrals and electronic prescriptions. It is recognised locally and nationally that the kinds of transformative change required to meet the challenges outlined in the STP and LDR cannot be achieved without the use and extensive deployment of digital technology. This includes delivering primary care at scale, securing seven day services, supporting new care models and transforming care in line with key clinical priorities along with the promotion of self-care.

Area of plan	Description



One Place, One Budget, One System (STP) – Place based services will require several different digital enablers for example: the ability to share primary care data and to write back into the record, mobile working, e-consultations and decision support tools. The CCG bid for funds from the Estates and Technology Transformation Fund (ETTF) for the redesign of primary care IT seeks to ensure that these services are provided as close to home as possible, support seven day working and help patients to take more responsibility for actively managing their own health. The proposal has three core objectives:

- Clustering of GP practices to support urgent, on the day appointments and extended hours appointments.
- Greater patient self-care- sources of information and apps to manage and record data relating to long term conditions. Improving patient access to their electronic health record both in primary care and other secondary and community care providers.
- Improved capacity and efficiency in primary care.

The proposal requires not only new ways of working (clustering/remote triage) but also flexible, intuitive and adaptive technology to provide new methods of interacting with primary care: apps, web-based authoritative and evidence-based service information, e-consultation requests and access to extended hours via a variety of interfaces, e.g. direct appointment request (either directly to practice or via a digital HUB), telephone triage or email directly to the GP via completion of a symptom based questionnaire. With regards to e-consultations, an evaluation is being undertaken on the existing pilot that has taken place as part of the original PMCF, while other solutions are being appraised for when the online consultations guidance is released by NHS England.

A second ETTF bid was also submitted to deliver a common Wi-Fi platform for mobility, interoperability and to work in conjunction with other projects such as Server Upgrade/Single GP AD Domain which will facilitate integrated team working. The project's core objectives are:

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- Improving access to information from any location by implementing Wi-Fi in practices – for both staff and the public
- Migrating and upgrading the 81 practices to new servers, while replacing any redundant server hardware.
- Giving clinicians the mobile tools that they need to be able to work out of any location e.g. tablets, laptops, VPN.
- To ensure clinicians can access the clinical system in care homes and hospices.

Details of the funding lines by EFFT scheme are below:

Gloucestershire NHSE ETTF	Budget 2016/ 2017	Budget 2017 / 2018
	£	£
ETTF Glos GP WIFI and Mobile Working 51714	93,000	463,000
ETTF Glos GP WIFI and Mobile Working 51714 Slippage	400,000	
ETTF New Ways of Working Revenue 51715	93,000	185,000
ETTF new Ways of Working Revenue 51715 slippage	400,000	
Grand Total IM&T	986,000	648,000

- The ITT for the Wi-Fi solution for the GP Practices was issued and orders placed in March. The procurement for the WI-FI solution has now taken place and the contract has been awarded to EE.
- Surveys will now be completed at each of the Practices followed by an install of the infrastructure, with the first practices going live in July 2017.
- We have a number of schemes within the second funding stream, including Vision Outcome Manager, upgrade of Docman to version 10 for GP Practices, development of a BI strategy and JUYI (see below) interfaces.

Joining Up Your Information

The Joining Up Your Information (JUYI) project will help securely share important patient healthcare information across primary, community and secondary care, as well as mental health and social care teams on a read-only basis. This will include:

- Medication and any changes to it made by a clinician
- Medical conditions
- Operations/treatment received
- Contact details for next-of-kin and others involved in care
- Tests that GPs or hospital clinicians have requested or carried out
- Appointments (past and planned) and recent visits to out-of-hours GPs and minor injury and illness units
- Documents, such as care plans and letters about treatment (for example “discharge summaries” following a hospital stay).

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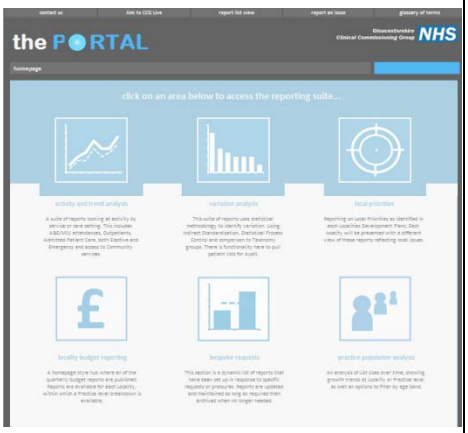
	Patient, carer and voluntary sector representatives have been involved in the project from the start, providing valuable insight into the best way to communicate JUYI to local residents. The project piloted sharing primary care information in a small number of practices and community teams in 2015/16 ahead of a wider rollout. A procurement process has been undertaken for the first phase of implementation with the contract being awarded to KANOS and phase 1 go live expected late summer 2017. The intention is that a future phase of JUYI will enable patients to access their shared records. More information can be found at: http://www.gloucestershireccg.nhs.uk/joiningupyourinformation/index.php. The JUYI project, along the successful ETTF bid award to integrate secondary care data with Primary Care data to provide clinicians with a view of a single patient record via the JUYI solution, will support: • domiciliary outpatient appointments within multi-disciplinary teams; • new ways of working; • 7 day access; • increased capacity for services out of hospital in locality hubs. **GP Portal**  GCCG has invested in a talented Primary Care and Localities Information Team to improve information flow and provide GP practices with easily accessible activity information that enables them to examine and audit areas of variation which are material and unwarranted. In April 2016, 'the Portal' was launched, providing activity, trend and variation analysis that can be aggregated and disaggregated as required, with access for practices to their own patient data. This is being continually developed, with recent releases including interactive budgetary spend analysis, in-depth prescribing reporting and reporting available by practice, locality, or by the new cluster groups, in addition to taxonomy group (similar practice groupings) views. This tool is therefore supporting clusters to identify the priorities for their practices and patients at a place-based level. **Online Consultations** With regards to online consultations, we are awaiting details from NHS England (was expected Autumn 2016) on the expected requirements in order to be able to plan our approach. However, we can confirm we fully intend to ring-fence 100% of this funding for the purpose of online consultations. In terms of the pilots undertaken of online consultations through the GPAF, we have the following learning to use when the details are provided by NHSE on the rollout

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	of this element of the GPFV scheme funding: • 18 Gloucestershire practices signed up to use an e-consultation system. 12 practices actually used the system and the feedback suggests that practices found it difficult to implement themselves. In terms of utilisation, as at Oct 2016 (latest information) 935 e-consultations had been carried out of which 609 were medical. While doctors felt it had not saved them time, patient feedback has been positive. The CSCSU are undertaking a more in-depth evaluation for us to utilise for online consultation rollout (once details known). • 4 practices signed up to use video consultations, although only one found it to be a viable option on a frequent basis. • We are working with our 'at scale' GP Federation Gloucestershire Doctors (GDoc), to ensure we build on the experience and learning from these pilots – both the best practice from those that have made these schemes work, and from the learning of those that struggled. **Estates** Recognising the importance of our Primary Care estate to our ambitions, we have a specific workstream covering the following core areas: 1) Ensuring the delivery of the committed premises developments to practical completion. 2) Progressing the priorities identified in the Primary Care Infrastructure Plan (PCIP), including proactively working to kick start development opportunities and supporting business case development. 3) Ensuring local practices take full advantage of national funding initiatives such as the Estates and Technology Transformation Fund (ETTF). 4) Working with other key delivery partners particularly NHS Propco where joint responsibility for business case development exists. 5) Managing local improvement grant processes. 6) Ensuring the CCG operates within Premises Directions and uses these regulations appropriately. 7) Ensuring delivery of the committed premises developments to practical completion. 8) Ensure good patient and public involvement takes place within this field of work.  These will ensure we are well set to deliver the ambitions of

Area of plan	Description
	the GPFV. Most importantly, we have a clear five-year prioritised Primary Care Infrastructure Plan (PCIP – approved in March 2016) that forms an integral part of our overall Primary Care Strategy. The PCIP sets out where investment is anticipated to be made in either new or extended buildings, subject to business case approval and available funding. The Plan reflects our strategic intent to deliver primary care at scale, where there is an opportunity to do so.  Primary care infrastructure Plan 20 Progress and future plans are set out against each of the core areas below: **1. Ensuring the delivery of the committed premises developments to practical completion** o The CCG has an agreed Primary Care Infrastructure Plan that supports model of care requirements, meets demographic need, supports / delivers NHS constitution and other relevant standards and the Plan is reviewed annually. o Plan approved March 2016 by the PCCC and Governing Body. Progress & review reported to the PCCC 3 times per year. **2. Progressing the priorities identified in the Primary Care Infrastructure Plan (PCIP), including proactively working to kick start development opportunities and supporting business case development** o Working with all 12 identified priorities on business case development. o Currently a number of business cases are being progressed and expected to be completed during 2017/2018, including Cheltenham Town Centre's 5 practice development; Beeches Green 3 practice development, Minchinhampton and Cinderford Health Centre. o Business cases in early stage of development that that could be completed in 2017/2018, but more likely during 2018/2019, includes Romney House, Tetbury; Phoenix Surgery, Cirencester; Avenue & St Peters Surgery, Cirencester and Coleford Health Centre. o Business cases not expected until 2018/2019 as follows: Gloucester City Health, Brockworth & Hucclecote joint development; Regent Street Surgery; North West Cheltenham (the Elms) new surgery provision for new centre of population. **3. Ensuring local practices take full advantage of national funding initiatives such as the Estates and Technology Transformation Fund (ETTF)** o Developed local process for support to all practices seeking applications. o Worked closely with core priorities. o Invested £30k in professional to support applications.

Area of plan	Description
	o Four successful applications and almost £5m allocated: Cheltenham Town Centre, Culverhay Surgery, Lydney and Springbank (these last two being managed as improvement grants). o Close liaison with NHS England during process and will remain involved as oversight as NHS England manage the process direct with successful practices (albeit Lydney and Springbank surgeries being managed by CCG as now improvement grants). **4. Working with other key delivery partners particularly NHS Propco where joint responsibility for business case development exists** o Additional support commissioned with business case input funded by CCG for Beeches Green proposal. **5. Managing local improvement grant processes** o 2016/2017 improvement grant priorities agreed for 2016/2017 and a number of priorities funded and currently being delivered. o 2017/2018 improvement grant process now in progress. **6. Ensuring the CCG operates within premises Directions and uses the regulations appropriately** o Clear governance structure in place. o Consistent processes. o Rent review processes enacted. o Fees policy. o Effective use of district valuations. **7. Ensuring the delivery of the committed premises developments to practical completion** o New Churchdown Surgery (additional financial support from CCG, practical support with land purchase and planning) – construction now commenced and expected to be open Spring of 2018. o New Kingsway Surgery, Gloucester (additional financial support with extra £200k for fees). Planning permission granted in April 2017. Construction due to start in summer of 2017 and new building open summer/autumn of 2018. o Glevum Surgery refurbishment and extension, Gloucester (additional CCG support with revenue costs and enabling works) – work commenced at the start of 2017. o Tewkesbury Primary Care Centre – opened in March 2017. o Stow Surgery (additional financial support from CCG with fees and practical support). Planning permission and current developer reviewing delivery approach. It is anticipated that construction will not commence before Autumn of 2017 at the earliest. o Longlevens Surgery extension (support from CCG on rent reimbursement) – now completed and open from December 2016.

Area of plan	Description
	o Stoke Road Surgery refurbishment and extension (additional practical CCG support to speed up delivery of requirements). Due to be completed by end of May 2017. o Sevenposts Surgery new surgery (practical CCG support to confirm financial envelope and negotiation of shared benefits). Planning permission granted and construction due to start in the summer of 2017. **8. Ensure good patient and public involvement takes place within this field of work** o Formal arrangements set out in the CCG's PCIP on Practice requirements for patient and public involvement in new proposals. Fully aligned with NHS England policy. o PCIP fully discussed at CCG sponsored PPG Countywide network event. Premises proposals continue to be discussed at these events. o Locality proposals frequently discussed at various local stakeholder forums (e.g. Gloucester City Locality Stakeholder Forums, which includes representatives from City's PPG groups, voluntary sector representation, Healthwatch, Gloucester City Council and Tewkesbury Borough Council). o CCG teams provide practical support to patient and public events relating to premises developments and programme of engagement work being coordinated as and when appropriate.

NHS Gloucestershire CCG: GPFV – Transformation Plan

Area of plan	Description
Better manage workload and redesign how care is provided A plan to improve the capacity in general practice through redesign (e.g. LEAN / Releasing Time to Care) and collaboration (such as shared clinical services and back-office functions)	When consulting our members on the future of primary care in the development of our Primary Care Strategy, reducing workload was a common request. In order to tackle this we have developed several approaches, leveraging the strength of the GPFV: • With the support of our GP Provider Leads, Locality Chairs and the Local Medical Committee (LMC), we submitted a 'Releasing Time for Care' bid for our 81 practices to have a CCG-wide (and therefore STP-wide) programme in 2017. We have now been accepted on to the programme and are working with the NHS England Sustainability and Improvement Team to develop a Time for Care programme that focuses on the specific high impact actions that are important to our practices, that improves capacity and collaboration and delivers against our Primary Care Strategy. Having met with the Development Advisers allocated to Gloucestershire, we have developed an outline programme which we will now form in more detail with our GP Provider and GP Cluster Leads and the GPFV Project Team. • We held an all-day Gloucestershire GPFV event in January 2017 for all practices to attend, focusing on the "Ten High Impact Actions", with Robert Varnam as our key note speaker and breakout sessions with national and local speakers. We had over 200 attendees and received excellent feedback, with practices telling us that they now understand the GPFV and feel positive about the future and new models of care.  General Practice Forward View EVENT #GlosGPFV Tuesday 24 January 2017 – 9.15am to 4.00pm at Gloucester Rugby Club, Kingsholm Road, Gloucester, GL1 3AX AGENDA 9.15am Registration – Tea/Coffee (Abbey Lounge) 10.00am Welcome and format of the day (1873 Suite) — Dr Andy Seymour – GCCG GP Chair 10.15am Gloucestershire's Sustainability and Transformation Plan — Mary Hutton – Accountable Officer, GCCG 10.25am General Practice Forward View – national picture Future Gaze – where is general practice heading? — Dr Robert Varnam – NHS England, Head of General Practice Development 11.00am The Ten High Impact Actions 12.00pm Developing Quality Improvement Expertise 12.30pm Questions from morning Plan for the afternoon session 12.45pm LUNCH (Abbey Lounge) First session 1.30-2.20pm: Breakout sessions Active Signposting & Productive Workflows (clinical correspondence and care navigation) (1873 Suite (front)) — Lewis Smith & Kerry Few, Dr Sam Kuok, Wyndham Parry, Katie Stovall and Karen Rearle Second session 2.25-3.15pm: Develop the Team (1873 Suite (back)) — Dr Robert Varnam & Ravi Sharma, Ziad Suleiman and Dr Liza Pickett, Dr Sanjay Shyamalgund Partnership Working (Legends Lounge) — Dr Vish Ratnasuriya, Dr Andrew Sampson, Colin Merker 3.15pm Tea and Coffee – pick up from Abbey Lounge and take to Q&A in 1873 Suite 3.30pm Panel Q&A: Hosted by Dr Robert Varnam (1873 Suite) — Dr Robert Varnam, Dr Andy Seymour, Dr Vish Ratnasuriya, Ravi Sharma, Mark Jennings, Helen Goodey 4.00pm Next Steps and Close — Dr Andy Seymour 4.10-6.00pm Informal Cluster Meetings — For those clusters choosing to use opportunity to meet • Through the transformation funding we have enabled our emerging clusters of practices to work together to employ shared additional clinical and back-office staff. For example, through this process alone we are anticipating an additional c.15 clinical pharmacists working in general practice. One cluster is also re-organising how repeat prescriptions are ordered, with a shared back-office function. Others are looking at utilising paramedics in a home-visiting service. This has also triggered discussions between practices and the 2gether Trust on bringing mental health workers into primary care in the inner-city areas where this will significantly support the workload of GPs and support patients better with their needs. • Building on the successful GPAF pilot whereby, working with our 'at scale' GP Federation Gloucestershire Doctors (GDoc), we implemented: o 'Choice Plus' for urgent on the day appointments; o Social prescribing rollout to all seven localities and 81 practices; o E-consultations;

<table>
<tr><th>Area of plan</th><th>Description</th></tr>
<tr><td></td><td>

o Remote consultations.

Enforcing the new NHS Standard Contract with our local acute trust that reduces workload on our practices, such as preventing the hospital from re-referring patients back to their GP following an outpatient non-attendance.
Rolling out ‘Pharmacy First’ minor-ailment scheme, so that patients can be supported by their local community pharmacist in the first instance.

</td></tr>
<tr><td>Organisational Form

A description of the current organisational form of general practice within the CCG

The ambition for primary care at scale underpinned by a delivery plan</td><td>
Our Primary Care Strategy is a key system enabler within our One Gloucestershire STP Governance Structure.

We have 81 practices in Gloucestershire, which has reduced slightly over the last couple of years with one practice closure and a small number of mergers. Up until the summer of 2016, these practices have worked within a locality commissioning infrastructure of seven localities, aligned with our GCCG constitution:

Cheltenham
Forest of Dean
Gloucester City
North Cotswold
South Cotswold
Stroud & Berkeley Vale
Tewkesbury, Newent & Staunton

While that structure still exists, as mentioned in the previous section, we have supported the development of ‘grass-root’ initiated clusters to start the delivery of our ambition of ‘primary care at scale’ set out within our Primary Care Strategy. The 16 clusters that have now formed are as follows:
<table>
<tr><th>Locality</th><th>Cluster collaborations</th></tr>
<tr><td>Cheltenham
(three clusters, c.50,000 patients each)</td><td>St Pauls - Corinthian, Portland, Royal Well, St.Catherine’s, St.George’s
Central - Berkeley Place, Crescent Bakery, Overton Park, Royal Crescent, Springbank, Underwood, Yorkleigh
Peripheral - Leckhampton, Sixways, Seven Posts, Stoke Rd, Winchcombe</td></tr>
<tr><td>Forest of Dean (c.60,000)</td><td>All eleven practices in one cluster: Blakeney, Brunston, Coleford, Dockham, Drybrook, Forest Health Care, Lydney, Mitcheldean, Newnham, Severnbank, Yorkley</td></tr>
<tr><td>Gloucester City
(five clusters, c.18,000-41,000)</td><td>• Rosebank, Hadwen and Quedgeley
• Bartongate, Gloucester City Health Centre, Partners in Health, Kingsholm
• Brockworth, Hucclecote, Gloucester Health Access Centre
• Cheltenham Road, Churchdown, College Yard, Longlevens
• Barnwood, London, Heathville, Saintbridge</td></tr>
<tr><td>North Cotswolds (c.29,000)</td><td>All five practices in one cluster: Chipping Campden, Cotswold Medical, Mann Cottage, Stow, White House</td></tr>
<tr><td>South Cotswolds (c.58,000)</td><td>All eight practices in one cluster: Avenue, Hilary, Lechlade, Park, Phoenix, Rendcomb, Romney, St Peters</td></tr>
<tr><td>Stroud and Berkeley Vale
(four clusters, c.18,000-39,000)</td><td>Cluster 1: Acorn, Cam & Uley, Chipping, Culverhay, Marybrook, Walnut Tree
Cluster 2: Beeches Green, Locking Hill, Rowcroft, Stroud Valleys
Cluster 3: Frampton, High Street, Regent Street, Stonehouse
Cluster 4: Frithwood, Michinhampton, Painswick, Prices Mill</td></tr>
<tr><td>Tewkesbury, Newent and Staunton (c.43,000)</td><td>All four practices in one cluster: Church Street, Mythe, Newent, Staunton & Corse</td></tr>
</table>
As described throughout this Plan, we are supporting clusters with the next
</td></tr>
</table>

Area of plan	Description
	stages of their development and funding GP Provider and Cluster Leads to lead these conversations locally. Our support to the development of these c.30,000 cluster provider models extends to appropriate managerial (change and project management), informatics and finance support. We are utilising this 'at scale' approach across the GPFV, i.e. care navigation and clinical correspondence training, transformation funding, resilience funding, online consultations and extended access. The General Practice Resilience Programme is a good example of how we have implemented this approach. For Resilience, we developed a process with our RCGP GP Ambassador and the LMC that has encouraged practices to work together in their clusters. The purpose of this work has been building longer-term resilience and maintaining an open process for clusters to self-nominate for the coming years, thereby providing an equitable solution for the whole county. This process is supported by our CCG Locality Development and Primary Care Directorate, with nominated leads for each cluster to provide additional support. For 16/17, those clusters who have self-nominated for resilience have been supported in developing their plans and funds allocated accordingly – this was across 12 clusters covering over 60 practices. All funding has now been paid to these clusters. The four remaining clusters are now being supported to develop their resilience bids during Q1 17/18; thereby ensuring equity. Predominantly, resilience bids have been for progressing ideas for working at greater scale, such as: • Merger • Federation • Change management advice for collaboration ideas • Merging back-office functions • Sharing staff In terms of further developing our wider organisation form, we have developed a Memorandum of Understanding with our providers that enables us to commence 'working without walls' across the previous organisational boundaries. We have termed this the 'place-based' approach and are trialling this with the Stroud & Berkeley Vale cluster and the Gloucester City cluster, reporting to the New Models of Care Board described earlier. We intend to then rollout this programme in 2017/18 across all clusters, commencing with the Forest of Dean. These 'Integrated Locality Boards' will form the infrastructure for providers working closer together in an 'alliance' structure as we develop new models of care for the future.
Engagement A description of how the CCG is engaging local primary care professionals and the local population	In the development of our Primary Care Strategy, the overall plan that sits within the Gloucestershire STP and describes our implementation of the intentions and ambitions of the GPFV, we commenced with a countywide general practice event with over 100 attendees from across our practices. This set the priorities that were important for them within the context of the original Five Year Forward View and commenced the early discussions of how they could consider working together to bring about transformation in future.

<table>
<tr><th>Area of plan</th><th>Description</th></tr>
<tr><td>and patients in the development and delivery of the Transformation Plan.</td><td>Through the development of the Strategy, we held two almost month long engagement exercises; the first around the early draft agreed by our Primary Care Commissioning Committee; the second around an updated version inclusive of all feedback from the first round of engagement. Both rounds of engagement included our GP practices, our Gloucestershire Patient Participation Group Network, County, District and Parish Councils, Gloucestershire Hospitals, Gloucestershire Care Services, 2gether Trust, South West Ambulance Service, the West of England Academic Health Science Network, VCS Alliance, Healthwatch Gloucestershire, Gloucestershire Police and Crime Commissioner and the Local Medical Committee.

Since this, as mentioned earlier, we have also had an all-day Gloucestershire GPFV event on 24 January 2017, with over 200 attendees from across our practices, with clusters staying in the evening to determine how they would implement the ideas and schemes from the day.

Furthermore, the Sustainability and Transformation Plan will be supported by the STP communications and engagement approach which will be delivered in two phases. In developing this format, we have drawn upon published national guidance, as well as our local experience of what works well in Gloucestershire. This builds upon our earlier Joining Up Your Care engagement, when over 2000 local people were involved in shaping our current thinking. Phase One ran from autumn 2016 to early spring 2017. Phase Two will support our legal duty to consult with the public regarding more detailed proposals for service change, which will commence during summer 2017.

In addition, we have also engaged with the PPG Network, presenting updates across our Primary Care Strategy and the General Practice Forward View, including facilitated tables to gain feedback from patients on our approach and describing the initiatives we are undertaking that are set out in this plan. We will continue to undertake this engagement at a countywide level, while also discussing plans locally with patients through Locality Reference Groups or similar. Working alongside Healthwatch Gloucestershire, we also have produced a patient-friendly version of the Primary Care Strategy, which was published in February 2017.

In terms of wider engagement, we have been working with the LMC, HEE and our local RCGP GP Ambassador in developing and implementing our GPFV plans and have now formalised this by establishing a GPFV Project Team, to which the NHSE GPFV Transformation Lead for Gloucestershire is also invited.</td></tr>
<tr><td>Risks and Mitigation
A description of the key risks and mitigations.</td><td>
<table>
<tr><th>Risks</th><th>Mitigation</th></tr>
<tr><td>Practices will not grasp the importance of acting now to work with their cluster colleagues in delivering transformation and primary care at scale, thereby risking their future sustainability and furthermore the resilience of</td><td>• Established the 7 GP Provider Leads to lead this locally
• Hosted an event in January 2017 for all practices countywide
• Successfully applied to the national NHSE ‘Releasing Time</td></tr>
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<tr><th>Area of plan</th><th colspan="2">Description</th></tr>
<tr><td></td><td>neighbouring practices</td><td>for Care' programme on behalf of the whole county, working with the LMC and RCGP Ambassador
• Investing resource in the cluster development of their 'at scale' models</td></tr>
<tr><td></td><td>The resource available within the CCG is insufficient to support the cluster's emerging ambitions of how they want to deliver the GPFV</td><td>GCCG are utilising existing resource through re-prioritisation and re-alignment of work programmes in order to release sufficient capacity. For example, we are currently restructuring our locality commissioning infrastructure for 2017/18 to align this with the clusters, thereby reducing duplication of functions and investment by both CCG staff and GPs.

Clusters have also recognised their need for specialist support and have bid for General Practice Resilience Programme Funding, which we are supporting as a delegated CCG.</td></tr>
<tr><td></td><td>Key agreed estates developments are not supported by the local people, patients and key stakeholders, which hinder implementation.</td><td>Key strategic priorities were supported by the development and implementation of an engagement framework and communications strategy.</td></tr>
<tr><td></td><td>There is insufficient financial resource to fund the development of necessary premises requirements, which means that practices are unable to provide the right level of service to patients leading to less effective care</td><td>• Financial framework developed
• Use of ETTF to offset some costs
• Development of larger centres, wherever possible to maximise estate efficiency
• Prioritising and scheduling of developments</td></tr>
<tr><td>Governance
A description of the governance arrangements to provide the CCG with assurance that the plan is being delivered fully and on time.</td><td colspan="2">As described throughout this document, our Primary Care Strategy is the plan which describes our ambitions and intentions for Primary Care in Gloucestershire.

The CCG is committed to establishing effective governance procedures to ensure that it discharges its duties effectively and with due regard to mandatory regulations and voluntary guidance. This also applies to the risk of real, or perceived, conflicts of interest.

The Primary Care governance structure below demonstrates how we achieve this. It is in accordance with the Delegated Agreement between NHS England and GCCG dated 26 March 2015. The structure minimises the risk of conflicts of interest occurring while maintaining important clinical input to the design and delivery of our primary care commissioning responsibilities.</td></tr>
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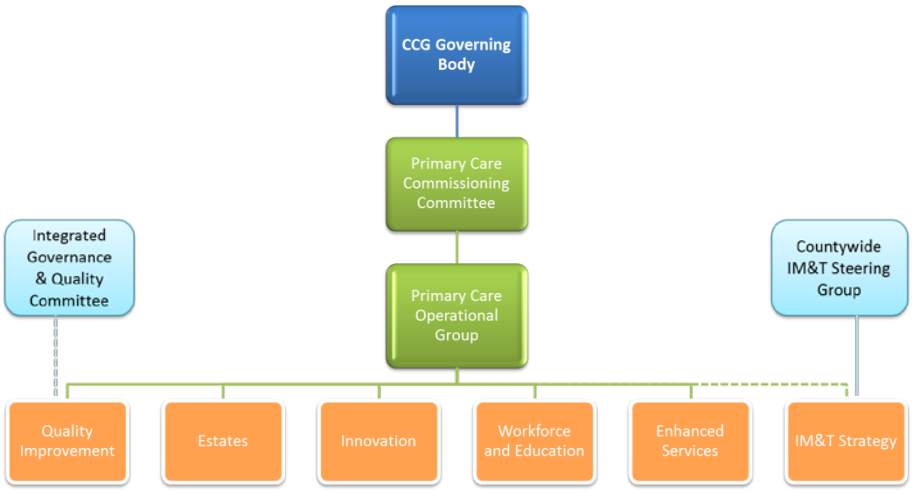
Area of plan	Description



Primary Care Commissioning Committee

The purpose of the Primary Care Commissioning Committee (PCCC), as a committee of the GCCG Governing Body, is to manage the delivery of those elements of the primary care healthcare services delegated by NHS England to the GCCG. The Committee have delegated responsibility for primary medical care decisions relating to:

- The award, design and monitoring of GMS, PMS and APMS contracts;
- Locally defined and designed enhanced services;
- Local incentive schemes;
- Procurement of new practice provision;
- Discretionary payments (e.g. returner/retainer schemes);
- Practice mergers;
- Contractual action such as issuing branch/remedial notices and removing a contract.

The Committee – which meets in public and is made up of CCG Executives, lay representatives, and representatives from Healthwatch/the Health and Wellbeing Board/NHS England – also report on, and make recommendations to, the Governing Body on the following:

- Primary Care Strategy;
- Premises improvement grants and capital developments.

Primary Care Operational Group

The Primary Care Operational Group (PCOG) has been established to implement and monitor the progress of the operational functions that delegated commissioning responsibilities provide, while making recommendations to the PCCC where decisions are required. In addition, the Group also has responsibility, on behalf of the PCCC, for oversight and delivery of the workstreams.

Area of plan	Description

Governance of the Primary Care Strategy

Approving the Primary Care Strategy

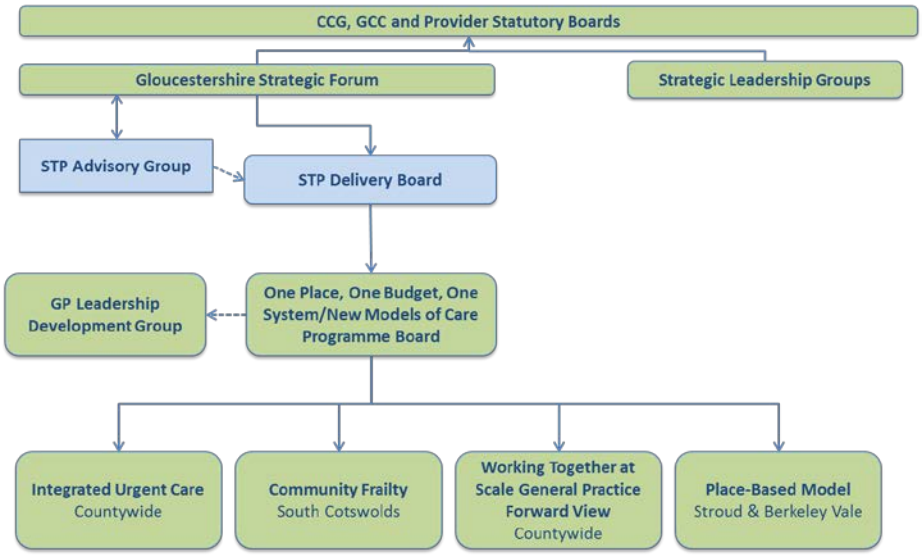
In accordance with the above, the approval process for the Strategy was via our CCG Governing Body, with progress reported through the Primary Care Commissioning Committee, which is held to account for delivery by the Governing Body. Operational delivery of the Commitments set out against the six components is managed by the Primary Care Operational Group.

Oversight of GCCGs Sustainability and Transformation Plan and New Models of Care

Overseeing delivery of GCCG's Sustainability and Transformation Plan, of which the Primary Care Strategy is an enabler, is the Gloucestershire Strategic Forum along with a separate STP Delivery Board for oversight of implementation. The Primary Care Strategy delivery is therefore reported to the STP Delivery Board.

As a key element of our Sustainability and Transformation Plan is the design and delivery of new models of care, a 'New Models of Care Programme Board' has been established to drive and oversee these models across our County.

This New Models of Care Programme Board, reporting to the STP Delivery Board, has Executive membership from across our Providers, with Primary Care represented by our GP Provider Leads as described earlier. The GPFV delivery is therefore reported to the NMOCB too.



In this governance structure, we therefore have statutory accountability for delivery through our CCG Primary Care Commissioning Committee, while we also recognise the importance to the whole system through reporting to the STP governance framework.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 17

Governing Body

Meeting Date	**Thursday 25 May 2017**
Title	**Assurance Framework 2016/17**
Executive Summary	The attached final update of the Assurance Framework for 2016/17 provides details of the assurances provided to the Governing Body regarding the achievement of the CCG's objectives. The Assurance Framework identifies gaps in assurances and controls regarding the objectives along with details of the principal high-level risks that have been identified by lead managers.
Key Issues	A number of risks have been identified which could adversely affect achievement of the objectives. Action plans have, however, been devised and are being implemented to minimise the effect of these risks.
Management of Conflicts of Interest	None identified
Risk Issues: **Original Risk** **Residual Risk**	The absence of a fit for purpose Assurance Framework could result in gaps in control or assurances not being identified and addressed. 8 (2x4) 4 (1x4)
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality	None

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

Agenda Item 17

Governing Body

Thursday 25 May 2017

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 principal 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 is based on the document considered at the April 2017 meeting of the Integrated Governance and Quality Committee (IGQC).

2.5 An Assurance Framework for the year 2017/18 is being prepared and will be presented to the meetings of the IGQC in June and the Governing Body in July.

3. Recommendation

3.1 The Governing Body is requested 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**
Objective 1: Develop strong, high quality, clinically effective and innovative services.									
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 2017. Furthermore - NHS Property Services are notifying practices occupying health centres of significant increases in facility costs in 2017/18.	Helen Goodey Helen Edwards Stephen Rudd Jeanette Giles	12 (3x4)	12 (3x4)	Primary Care Strategy & General Practice Forward View - robust implementation. General Practice Resilience Programme & Vulnerable Practice Programme. Exercising Delegated Commissioning Responsibilities. Close working with member practices.		Primary Care Commissioning Committee, Primary Care Operational Group, Risk and Issues log.		GPFV & PCS in implementation. 16 clusters established. Vulnerable practice funding reaching those practices most at risk. Resilience will support every practice through cluster based resilience work in 16/17 and 17/18, with additional change management support to those that need it. Practice transformation funding made recurrent and every cluster has transformation schemes. Care navigation and clinical correspondence training being arranged in every cluster.
T12	Insufficient clinical capacity and leadership across the system to deliver changes required within the CPG.	Kelly Matthews/ Kathryn Hall	12 (3x4)	12 (3x4)	Clinical programme approach, locality structure and meetings. Terms of reference for CPG, Use of CPG Board.		Performance reports to Governing Body		Implementation of the Clinical Programme Development Plan 2016/17. Monitor clinician participation with Clinical Programme Groups. Clinical Programme Board to be established for 2016/17.
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, Helen Ford, 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) - jointly with the council and other partners.
T14	Ensuring there is sufficient project management resource and skills to deliver the transformation programme/QIPP across all organisations.	Kelly Matthews/Kathryn Hall	12 (3x4)	12 (3x4)	Project Resource identified, documented and agreed across all CPGs. Clinical Programme Approach understood. Provider Representatives appointed to CPGs along with TOR. STP agreed across health community. Clinical Programme Board developed for governance and assurance.		Performance reports to Governing Body		1. PID, detailing Project workstreams, leads and deliverables, to be developed and agreed by relevant CPG, including providers, for each project. 2. Project Board and Project Team Terms of reference agreed by relevant CPG, CCG and providers. 3. Resource Plan in place and monitored for Clinical Programme Team and relevant CPG provider representatives as appropriate.
Objective 2: Work with patients, carers and the public to inform decision making.									
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.									
C3	Increased risk of CCG receiving legal challenge as a result of competitive tendering following the introduction of the EU Remedies Act, the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 1 April 2013 and the Public Procurement (The Public Contracts Regulations 2015).	David Porter	12 (3x4)	12 (3x4)	Ensure that EU procurement process is followed for all procurement exercises (above and below) the EU threshold in accordance with DoH, Cabinet Office and Government Procurement Service Guidelines.		Project reports to Core Executive Team and Governing Body		Continual adherence to European Union Public Contracts Regulations 2015 and the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013

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**
C27	Risk to KPI delivery and Patient experience due to variance in predicted daily activity levels, operational issues and financial sustainability regarding the Non-Emergency Patient Transport contract	Gill Bridgland	12 (3x4)	12 (3x4)	Risk to be managed consistently across Gloucestershire, Swindon, Wiltshire and BaNES CCGs.		Performance reports to Governing Body.		Commissioners to identify potential service gaps and work with provider to ensure continuity and quality of service. Continuing strong focus on contract and quality management. Work underway with GHFT to reduce on the day bookings.
C5	(Discharge) Risk that system partners will be unable to effectively deliver a timely and coordinated approach to patient flow and discharge ensuring a reduction of patients who remain in the acute trust when medically stable and with a LOS greater than 14 days.	Maria Metherall	16 (4x4)	12 (3x4)	A&EDB, Onward Care Task & Finish Group, Urgent Care Strategy Group		Performance Reports and dashboards, critical milestones reviewed, regular programme stocktake.		Continual monitoring and review via the A&EDB 4-hour Improvement Plan. Monitoring and review to be undertaken through the Onward Care Task & Finish Group and A&E Delivery Board throughout 2017/18. System currently focussing upon Breaking the Cycle Together initiatives alongside key focus being delivered via the Onward Care Task and Finish Group.
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)	A&EDB, Admission & Attendance Avoidance Task & Finish Group, Urgent Care Strategy Group		Performance Reports to Governing Body, weekly situation report, project status updates.		Continual monitoring and review via the A&EDB 4-hour Improvement Plan. Monitoring and review to be undertaken through the Admission & Attendance Avoidance Task & Finish Group and A&E Delivery Board throughout 2017/18. Focussed work within the Emergency Departments in line with GHFT Urgent Care Programme approach. Enhanced support to ED from acute consultants who are available to support via hot advice. Agreement to extend GP in ED back door to March 2017 with review underway.
C8 (inc C28)	(Signposting & Admission Avoidance) Risk of failure to reduce demand and prevent unnecessary acute attendances and emergency admissions.	Maria Metherall	12 (3x4)	12 (3x4)	A&EDB, Admission & Attendance Avoidance Task & Finish Group, Urgent Care Strategy Group		Performance Reports to Governing Body, weekly situation report, project status updates.		Continual monitoring and review via the A&EDB 4-hour Improvement Plan. Monitoring and review to be undertaken through the Admission & Attendance Avoidance Task & Finish Group and A&E Delivery Board throughout 2017/18. Right Care 2 within SWAST continues with focussed on falls, rota review, specialist paramedics and working closely with care homes.
T10 (inc F12)	Delayed implementation of QIPP Projects and/or failure of projects to deliver anticipated benefits could result in under-delivery on planned care QIPP savings target. Transformation projects may not deliver the expected outcomes.	Ian Goodall	12 (3x4)	12 (3x4)	Robust project management planning and reporting to the PMO.		Performance reports to Governing Body.		All projects to have clear baseline monitoring with agreed KPIs. Monthly project monitoring with focus on schemes at risk of non-delivery, with agreement on remedial action. Planned care QIPP manager recruit to Trust. Monthly QIPP Review meetings for Planned Care and Urgent Care.

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**
C15	Failure to comply with the NHS Constitution 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. The IST will begin working with Urology at GHFT in relation to their capacity and demand modelling. GCCG have met with Urology, Gastroenterology, Orthopaedics and Gynaecology to continue with IMAS modelling A number of targets regularly not being met, including 62 day cancer target, 2WW, 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 and access and performance meetings. 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. (Sept 2017)
K2	Impact on discharges due to delays sourcing independent sector domiciliary care.	Donna Miles	12 (3x4)	12 (3x4)	GCC CPAC / Brokerage for LA funded service users		Performance Reports to Governing Body		Maintain regular monitoring of performance/progress at quality groups. Daily updates for the System Call. Demand and capacity being mapped to try and understand underlying issues and monitored as part of the implementation of dom care new contracting arrangements. Extension to Hospital Rapid Discharge service supporting the new 'Hospital to Home' to run concurrently.
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). The delivery of 2016/17 financial performance targets are dependent upon QIPP performance in the last six months of the financial year. Work on Sustainability and Transformation plan within the Health Community is being refined with a final submission due in October leading to two year contracts. All major contracts for 2017/18 now agreed with principles agreed for 2018/19
					Robust contract management including activity monitoring and validation (particularly at GHFT), additional monitoring of volatile budget lines such as prescribing & CHC		Monthly performance dashboard for larger contracts with robust out of county contract monitoring reflected within performance reports. Monthly prescribing & CHC information including trends		Monthly performance meeting which reviews all contracts (including out of county) together with Contract Boards and Performance, Finance & Information Groups for larger contracts.
					Internal audit of financial procedures undertaken on an annual basis		Internal audit reports and recommendations to be reported to Audit Committee.		Internal audit considered to be a low risk but procedures will be regularly reviewed (next due by Q3 2017/18)
F18	Lack of alignment of IM & T strategy with partner and provider organisations.	Cath Leech	12 (3x4)	12 (3x4)	ICT Programme Group		Governing Body reports		Local Digital Roadmap signed off by all STP partners. Countywide Steering Group now jointly chaired and sub-groups in place with ToR and membership from all partners.

Risk					Controls		Assurances		Actions / Status
Risk ID	**Principal Risks to achieving strategic objectives**	**Risk Owner(s)**	**Original Risk Ratings (LxC)**	**Current Risk Ratings (LxC)**	**Key Controls**	**Gaps in Controls**	**Sources of Assurance**	**Gaps in Assurances**	**Actions**
F24	Implementation of Trakcare within acute provider has led to reporting issues for clinical correspondence, national performance reporting and contractual management. This increases clinical risk.	Cath Leech/Mark Walkingshaw	16 (4x4)	16 (4x4)	Remedial action plan supported by CCG/CSU staff		Regular reporting to CCG Governing Body		1. Remedial action plan in place for performance reporting, fortnightly assurance calls in place to manage progress with NHSI/NHSE/GHFT/GCCG. Update reports provided. 2. Ongoing communication with regular face to face meetings GHFT/GCCG 3. CCG staff assisting the Trust in backlog data and RTT validation and some workload has transferred to the CCG on a temporary basis. 4. CCG seeking additional CSU support for outpatient clinic rebuilt. 5. Confirmation of arrangements in place for management of operational and clinical risks – including operational risk review process.
C36	Inability to report on constitutional targets and provide information to operational staff relating to their service.	Natasha Swinscoe	12 (3x4)	12 (3x4)	Fortnightly provider, commissioner and regulator update call in place.		Regular reporting to CCG Governing Body		1. Weekly monitoring 2. Recovery actions agreed with specialist and CCG resource secured.
F25	Local Digital Roadmap - Agreement of programme may not be reached by all providers causing projects not to be delivered and may impact on the delivery of benefits identified in the STP.	Sarah Hammond	12 (3x4)	12 (3x4)	County Wide IM&T Steering Group and associated sub groups, STP delivery Board		Regular reporting to CCG Governing Body		1. Key LDR workstreams groups being established with appropriate governance. 2. A criteria-based matrix tool to be used to score and prioritise key LDR projects to deliver the greatest benefits across all organisations. 3. Agreement on plan signed off by Countywide group
F26	Local Digital Roadmap - Resources may not be available to deliver the programme or projects within the STP which will result in an impact on delivery and benefits.	Sarah Hammond	12 (3x4)	12 (3x4)	County Wide IM&T Steering Group and associated sub groups, STP delivery Board		Regular reporting to CCG Governing Body		1. Resourcing requirements to be identified by organisations 2. Potential risks to programme /project delivery to be escalated to the Countywide IM&T Group with options to mitigate the risk.
Objective 4: Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.									
F20	Shared Record Project - It will not be possible to get data from SystmOne practices in the short-term. This requires having EDSM (intra-SystmOne sharing) switched on which makes the entire patient record available to all other SystmOne users (i.e. national) which may put patients off and is a different model to that agreed for JUYI. The only current way to share with the JUYI solution would be via the MIG.	Cath Leech	12 (3x4)	12 (3x4)			Governing Body reports		Escalation to HSCIC. Meet with TPP (supplier for SystmOne). Seek alternative method of sharing TPP data. Regular calls with other shared care record programmes (Birmingham/Surrey/Nottingham/Leeds). Review options.
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.									

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**
Q19	The CCG has a statutory duty to ensure that the health needs of Children in Care (CiC) are met and this includes the provision of RHAs whilst a child remains in care – every 12 months for those over 5 and every 6 months for those under 5. The number of CiC has grown significantly, meaning that the services providing RHAs are struggling to manage the increased demand. The main service that provides RHAs (public health nursing) is the responsibility of the county council, making the situation and its resolution more complicated. There is therefore a risk that children and young people do not get a review of their health needs, or that the healthcare plan is not implemented effectively. This is known to have a negative impact on subsequent longer term health and wellbeing outcomes later in life.	Simon Billous	12 (3x4)	12 (3x4)	Analysis of the impact of the increased numbers and the effectiveness of the current service arrangements has been undertaken, with proposals developed for a new model of provision. This is being overseen by the CiC Health Coordination Group, and decision making on next steps will be made by JCPE due to the multi-agency nature of the issue.		Governing Body performance reports		Joint Commissioner leading the finalising of potential new service model, including the need for investment in additional staff and the split of funding between CCG and council. Decision by JCPE followed by implementation of the new arrangements (including recruitment) to follow.
K7	The implementation of Trakcare within GHNHSFT means that there is no reportable data for maternity services. We are therefore not able to be satisfied about the quality of care provided other than through the risk management processes.	Helen Ford	12 (3x4)	12 (3x4)	Ongoing monitoring of data.		Regular reporting to CCG Governing Body		GHNHSFT are working to minimise the impact and record manual data where able. GHNHSFT are working to implement Trakcare fully.
C35	The change in the regulations around whether a role is classified as self employed or employed is impacting on the ability of the OOH service (SWASFT) to be able to fill GP OOH slots.	Felicity Taylor-Drewe	16 (4x4)	16 (4x4)	Situation being managed by SWAST with monitoring by the CCG urgent care team & Director level escalation. Daily OOH Status updates provided to CCG and Trust.		Regular reporting to CCG Governing Body		1.Correspondance from SWAST and individual GPs, including initial letter, email helpline and call helpline to support queries 2.CCG facilitating conversations between SWAST and other providers to look at contingency and support options, including peripheral OOH sites (e.g. Worcester) and additional Rapid Response; MIIU capacity. 3.SWAST reviewing options from Board meeting.
Q20	The HSMR (Hospital Standardised Mortality Ratio) and SMR (Standardised Mortality Ratio) are statistically significantly higher than expected within GHNHSFT overall and individually at both acute sites. This could be an indication that there are high mortality rates at the Trust.	Kay Haughton	12 (3x4)	12 (3x4)	Monthly mortality briefings provided by Dr Foster. Trustwide mortality strategy reviewed at CQRG.		Governing Body performance reports		Proposal to initiate a countywide mortality group to review deaths outside of the hospital
Objective 6: Develop strong leadership as commissioners at all levels of the organisation, including localities.									
F23	The proposed allocation change relating to the new tariff for 2017/18 may not be cost neutral for Gloucestershire.	Steve Lowson/Sarah Hammond	12 (3x4)	12 (3x4)	Due diligence being carried out through running information through the latest grouper.		Performance reports to Governing Body		Information behind the allocation change requested from NHSE but access denied. Comparison of grouper results between CCG & GHFT being undertaken

Agenda Item 18

Governing Body

Meeting Date	**Thursday 25 May 2017**
Report Title	**Audit Committee Annual Report 2016/17**
Executive Summary	The report outlines the work of the Audit Committee during the financial year 2016/17.
Key Issues	The role of the Audit Committee is to critically review financial reporting and internal control principles, and to ensure an appropriate relationship is maintained with internal and external auditors. The report outlines details of this activity over the six meetings held during 2016/17.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	The absence of an Audit Committee Annual Report could result in the Governing Body being insufficiently aware of the role and activities of the Committee. 6 (2x3) 3 (1x3)
Management of Conflicts of Interest	None identified.
Financial Impact	There is no financial impact associated with this paper.
Legal Issues (including NHS Constitution)	None to note
Impact on Health Inequalities	Not applicable
Impact on Equality and Diversity	Not applicable
Impact on Sustainable Development	Not applicable
Patient and Public Involvement	Not applicable

Recommendation	The Governing Body is asked to accept this report on the work of the Audit Committee as part of its overall governance and assurance programme for 2016/17.
Author	Colin Greaves
Designation	Audit Committee Chair
Sponsoring Director (if not author)	Not applicable

Appendices

- Appendix 1 – Auditor Panel
- Appendix 2 – Audit Committee attendance
- Appendix 3 – Auditor Panel attendance

Agenda Item 18

Thursday 25 May 2017

Audit Committee Annual Report 2016/17

1. Introduction

1.1 The Health and Social Care Act 2012 set out the requirement for Clinical Commissioning Groups (CCGs) to establish an Audit Committee. This report, the fourth to the Governing Body, covers the work of the Audit Committee (the Committee) for the financial year 2016/17.

2. Membership

2.1 The membership of the Audit Committee during the year was:

Colin Greaves Chair – Lay Member Governance;
Alan Elkin – Lay Member Patient Public Engagement;
Valerie Webb – Lay Member Business (resigned wef 31 May 16);
Peter Marriner – Lay Member Business (appointed wef 1 Jan 17);
Dr Hein Le Roux – Deputy Clinical Chair (formerly GP Stroud Locality);
Dr Will Haynes – GP Gloucester Locality.

3. The Function of the Audit Committee

3.1 The role of the Committee is to critically review the CCG's financial reporting and internal control principles whilst ensuring that an appropriate relationship is maintained with both internal and external auditors. It is important that the Committee maintains an independent and objective view.

3.2 The Audit Committee also fulfils the role of the Auditor Panel, as defined in the Local Audit and Accountability Act 2014. Details of the Auditor Panel are at Appendix 1.

4. Terms of reference

4.1 The Committee's terms of reference were updated by the Governing Body at the 24 November 2016 meeting as part of the revision to the Constitution.

4.2 The Committee's terms of reference were reviewed at the 13 December 2016 meeting.

5. Meetings

5.1 The Audit Committee met on the following dates:

10 May 2016;
24 May 2016;
12 July 2016;
20 September 2016;
13 December 2016;
14 March 2017.

5.2 The external auditors and the internal auditors attended all of the meetings to which they were invited. A Local Counter Fraud Service officer attended three of the four meetings to which he was invited. The Chief Finance Officer or her deputy attended all meetings. The Associate Director of Corporate Governance attended five out of the six meetings held. A breakdown of meeting attendance is at Appendix 2

5.3 The Accountable Officer had an open invitation to attend all meetings.

5.4 The confirmed minutes of all the Audit Committee meetings were considered at the Governing Body meetings.

5.5 The Committee had a private meeting with the internal auditors on 12 July 2016.

5.6 The Committee had a private meeting with the external auditors on 20 September 2016.

5.7 There was an open invitation to the internal and external auditors and the Local Counter Fraud officer to make contact with the Chair of the Committee if at any time they had any concerns.

6. Review of the Committee's Work

6.1 The Committee had an annual work plan, which was updated during the year as additional issues were identified.

6.2 The Committee completed a self-assessment on 20 September 2016. A similar exercise is planned for September 2017.

7. Internal Audit

7.1 PricewaterhouseCoopers provides the internal audit service for the CCG.

7.2 The Internal Audit Annual Report for 2015/16 was presented at the Audit Committee meeting on 24 May 2016. The Head of Internal Audit's annual opinion was that governance, risk management and control in relation to the CCG's business critical areas was generally satisfactory. However, there were some areas of weakness and non-compliance in the organisation's system of internal control which potentially put the achievement of objectives at risk. The CCG has either implemented or has action plans in place to implement the recommendations raised during the year.

7.3 The internal audit work plan for 2016/17, which was based on a risk assessment for the organisation, was presented and agreed at the Audit Committee meeting on 24 May 2016. The audits undertaken in 2016/17 with their associated assessments are:

- Core Financial Systems – low risk;
- Procurement – low risk;
- Human Resources – medium risk;
- QIPP – low risk;
- Risk Management – low risk;
- Corporate Governance – Conflicts of Interest – low risk;
- Compliance with Clinical Standards – Medicines Management – medium risk;

- Clinical Governance – low risk;
- Information Governance – low risk;
- Performance Management – low risk;
- Primary Care Co-commissioning – low risk;
- Continuing Health Care (CHC)/ Funded Nursing Care (FNC) follow up was rated as high risk overall. This included two high risks: non-compliance with CHC/FNC processes, which included issues with on-going case management, insufficient documentation and performance against 28 days target; and Domiciliary Care, where invoices did not match the documentation on CareTrack. An action plan is in place to address both these risks.

7.4 Comparing the risk findings with 2015/16: the number of high risks has reduced from 3 to 2 and the number of medium risks has reduced from 11 to 9; however, the number of low risk findings has increased significantly from 33 to 47. In addition, there were areas of good practice noted in all reports issued.

7.5 A risk-based work plan for internal audit for 2017/18 was considered at the Audit Committee meeting on 14 March 2017.

7.6 South, Central and West Commissioning Support Unit (CSU) provides services to a number of CCGs. NHS England, which hosts the CSU, engaged a reporting accountant to prepare a report on internal controls for 2016/17. The only area tested, which is applicable to Gloucestershire CCG, is payroll. There were two areas identified within the report where the controls were not found to be operating in the way described. The CSU has developed an action plan to remedy these issues. The CCG's internal auditors tested the payroll controls and found no evidence that incorrect payments had been made.

8. External Audit

8.1 The role of external audit is to give an opinion on the financial statements and issue a value for money conclusion. The external audit service is provided by Grant Thornton.

8.2 At the Audit Committee meeting on 24 May 16 Grant Thornton presented their audit conclusions for 2015/16:

- Financial statements opinion – an unqualified opinion was provided on the financial statements, which give a true and fair view of the CCG's financial position as at 31 March 2016 and of the CCG's expenditure and income for the year;

- Regularity opinion – an unqualified regularity opinion was provided;

- Value for money – that the CCG had proper arrangements in all significant respects to secure economy, efficiency and effectiveness in its use of resources.

8.3 Grant Thornton has provided update reports against the agreed work plan for 2016/17 and their draft assessments are due to be presented to the Committee at the meeting on 23 May 2017. Grant Thornton has also provided reports on emerging issues and developments; this has proved most helpful to both the Committee and the Executive.

9. Counter Fraud

9.1 The counter fraud service is provided by the Gloucestershire Hospitals NHS Foundation Trust and covers the following areas: preventing and detecting fraud; investigating fraud; and the creation of an anti-fraud culture. The annual plan for 2016/17 was agreed following a risk assessment of the CCG. The Committee has received reports on all of the above areas and progress on the plan was presented to the Audit Committee at the 14 March 2017 meeting. In addition, a risk-based draft work plan for 2017/18 was presented to the Audit Committee at the same meeting.

10. Other Assurance Functions

10.1 Through the receipt of regular reports the Audit Committee reviewed the management of the following:

- Procurement decisions;
- Procurement Waiver of Standing Orders;
- Aged Debts;

- Debts Proposed for Write-off;
- Losses and Special Payments.

The Committee is satisfied that these areas are being appropriately managed. Any concerns on individual items were raised at the time and appropriate responses have been received.

11. Governance

11.1 The Integrated Governance and Quality Committee ensures that the appropriate governance plans and mechanisms are in place for all areas other than financial governance, which is the responsibility of the Audit Committee.

12. Annual Governance Statement

12.1 The Draft Annual Governance Statement for 2015/16 was reviewed by the Audit Committee at the 10 May 2016 meeting. The Annual Governance Statement was approved by the Governing Body at the 26 May 2016 meeting.

12.2 The Draft Annual Governance Statement for 2016/17 was reviewed by the Audit Committee at the 14 March 2017 meeting.

13. Annual Accounts

13.1 The year-end reports and accounts for 2015/16 were considered by the Committee on 24 May 2016 and approved at the extraordinary Governing Body meeting on 26 May 2016.

13.2 International Accounting Standard requires management to assess, as part of the annual accounts preparation process, the CCG's ability to continue as a going concern. A paper on this issue was presented at the Audit Committee meeting on 10 May 2016 and the Committee confirmed that the CCG was a going concern.

13.3 The year-end reports and accounts for 2016/17 will be considered by the Committee on 23 May 2017 before being recommended for approval at the Governing Body meeting on 25 May 2017.

14. Co-operation

14.1 The Committee is grateful to the CCG staff, the CSU staff, Gloucestershire Local Counter Fraud Service, Grant Thornton; and PricewaterhouseCoopers for their positive and constructive approach in discussions and reporting.

15. Conclusion

15.1 The Audit Committee can confirm the following:

- The risk management systems in the CCG are adequate and allow the Governing Body to understand the appropriate management of those risks.

- There are no areas of significant duplication or omission in the systems of governance in the CCG that have come to the Committee's attention.

- The draft Annual Governance Statement for 2016/17 is consistent with the Committee's views on the CCG's system of internal control and that it supports the Governing Body's approval of the Statement.

The basis for the above opinion is drawn from evidence highlighted in paragraphs 5 to 13 and from discussion and debate in the Committee.

16. Recommendation

16.1 The Governing Body is asked to accept this report on the work of the Audit Committee as part of its overall governance and assurance programme for 2016/17.

Colin Greaves
Chair of Gloucestershire CCG Audit Committee

21 April 2017

NHS
Gloucestershire
Clinical Commissioning Group

Appendix 1

Auditor Panel

1. Introduction

1.1 The Local Audit and Accountability Act 2014 introduced significant changes to the local public audit regime in England by replacing centralised arrangements for appointing external auditors to CCGs with a system that allowed each body to make its own appointment.

1.2 From 2017/18, CCGs must have an auditor panel to advise the Governing Body on the appointment of their external auditors. As the 2017/18 appointment must be made by 31 December 2016, the auditor panel needed to be in place early in 2016. Audit Committees are able to fulfil the role of the auditor panel.

1.3 At the 26 November 2015 meeting the CCG Governing Body approved the Audit Committee to fulfil the role of the Auditor Panel (the Panel).

2. Membership

2.1 The membership of the Auditor Panel during the year was:

Colin Greaves Chair – Lay Member Governance;
Alan Elkin – Lay Member Patient Public Engagement;
Peter Marriner – Lay Member Business (appointed wef 1 Jan 17)
Dr Hein Le Roux – Deputy Clinical Chair (formerly GP Stroud Locality);
Dr Will Haynes – GP Gloucester Locality.

3. The Function of the Auditor Panel

3.1 The role of the Panel is to advise the Governing Body on:

- The selection, appointment and removal of the CCG's external auditors;

- The maintenance of an independent relationship with the appointed external auditor;
- The purchase of 'non-audit services' from the external auditor.

4. Terms of reference

4.1 The Panel's terms of reference were updated by the Governing Body at the 24 November 2016 meeting as part of the revision to the Constitution.

4.2 The Panel's terms of reference were reviewed at the 13 December 2016 meeting.

5. Meetings

5.1 The Auditor Panel met on the following dates:

21 June 2016;
20 September 2016;
13 December 2016;
14 March 2017.

A breakdown of meeting attendance is at Appendix 3.

6. Additional goods and services from the CCG's external audit provider

6.1 At the 21 June 2016 meeting the Auditor Panel approved the purchase of an online tool called Place Analytics Online from Grant Thornton UK LLP, the CCG's external auditor.

7. Procurement of external auditors

7.1 The major work for the Panel during the year was the procurement of external audit services. The Panel, at the meeting on 21 June 2016, agreed to a joint procurement process with Bath and North East Somerset, Swindon and Wiltshire CCGs, which was administered by the South, Central and West Commissioning Support Unit.

7.2 After a competitive process, which included a presentation day, the Panel at the 20 September 2016 meeting agreed to recommend to the Governing Body that Grant Thornton UK LLP was awarded the contract.

7.3 The Governing Body, at the meeting on 29 September 2016 meeting (confidential section), approved the Auditor Panel recommendation that Grant Thornton UK LLP was awarded the contract to deliver External Audit Services to Gloucestershire CCG for the period 1 April 2017 until 31 March 2020 (inclusive of a transition period at both ends of the contract to allow for the satisfactory completion of the 19/20 accounts).

Appendix 2

Audit Committee Attendance

		10th May	24th May	12th Jul	20th Sep	13th Dec	14th Mar
Colin Greaves	Lay Member	√	√	√	√	√	√
Alan Elkin	Lay Member	√	√	√	√	√	√
Valerie Webb	Lay Member	√	√				
Peter Marriner	Lay Member						√
Dr Hein Le Roux	Dep Clinical Chair	√	√	√	√		√
Dr Will Haynes	GP Glos Locality				√	√	√
Lyn Pamment	PwC		√	√	√	√	√
Natalie Tarr	PwC		√			√	
Liz Cave	Grant Thornton		√	√	√	√	√
Laura Hallez	Grant Thornton		√	√			
Michelle Burge	Grant Thornton				√		
David Johnson	Grant Thornton						√
Lee Sheridan	Counter Fraud Off				√	√	√
Mary Hutton	Accountable Officer	√					
Cath Leech	CFO	√	√	√		√	√
Andrew Beard	Dep CFO	√	√	√	√	√	√
Rupert Boex	Financial Accountant	√	√				
Alan Potter	Assoc Dir Corp Gov	√		√	√	√	√

In accordance with the Audit Committee's Terms of Reference other members of CCG staff attended on an as required basis.

Appendix 3

Auditor Panel Attendance

		21st Jun	20th Sep	13th Dec	14th Mar
Colin Greaves	Lay Member	√	√	√	√
Alan Elkin	Lay Member	√	√	√	√
Peter Marriner	Lay Member				√
Dr Hein Le Roux	Dep Clinical Chair	√	√		√
Dr Will Haynes	GP Glos Locality			√	√
Cath Leech	CFO	√	√	√	√
Andrew Beard	Dep CFO		√		
Alan Potter	Assoc Dir Corp Gov	√	√	√	√

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 19

Governing Body

Meeting Date	**Thursday 25 May 2017**
Title	**Integrated Governance and Quality Committee (IGQC) minutes**
Executive Summary	The attached minutes provide a record of the IGQC meeting held on the 16th February 2017.
Key Issues	The following principal issues were discussed at this meeting: • Experience and Engagement Report; • NHS England Bath, Gloucestershire, Swindon and Wiltshire Quality Surveillance Group Patient Experience Report • Quality Report and Dashboard; • Primary Care Quality Report; • Proposed Deviation from NICE guidance; • Risk Register; • Assurance Framework; • Policies for Approval; • Information Governance; • Complex Lower Limb Wound Care Service; • Suicide Briefing; • Care UK CQC Review; • GHFT CQC Review; • 360 Degree Survey; and • Current Mortality Review Processes in Gloucestershire.
Risk Issues: **Original Risk** **Residual Risk**	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable

Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
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Sponsoring Director (if not author)	Julie Clatworthy IGQC Chair and Registered Nurse

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 19

Integrated Governance and Quality Committee (IGQC)

Minutes of the meeting held on Thursday 16 February 2017, in the Board Room, Sanger House

Present:		
Julie Clatworthy (Chair)	JC	Registered Nurse
Dr Charles Buckley *(part meeting)*	CBu	GP Liaison Lead – Stroud and Berkeley Vale
Peter Marriner	PM	Lay Member – Business
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Colin Greaves	CG	Lay Member – Governance
Cath Leech	CL	Chief Finance Officer
Dr Tristan Lench	TL	GP Liaison Lead – Forest of Dean
Dr Andy Seymour (*part meeting)*	AS	Clinical Chair

In Attendance:		
Rob Mauler *(item 5)*	RM	Patient Experience and Safety Manager
Alan Potter	AP	Associate Director of Corporate Governance
Zoe Barnes	ZB	Corporate Governance Support Officer

JC welcomed PM as a new member of the Committee and briefly described the Committee's responsibilities.

1. Apologies for Absence

1.1 Apologies were received from Mary Hutton (MH), Sarah Scott (SS), Mark Walkingshaw (MW), Alan Elkin (AE) and Dr Caroline Bennett (CBe).

2. Declarations of Interest

2.1 TL and CBu declared a general interest in discussions regarding Primary Care.

3. Minutes of the meeting held on 15 December 2016

3.1 The minutes of the previous meeting were accepted as a true and

correct record.

4. Matters Arising

4.1 IGQC155 Quality Report

MAE confirmed that the definition of falls issue had been resolved with Gloucestershire Hospitals NHS Foundation Trust (GHFT). They had now reported two falls therefore this was showing a slight improvement but would be kept under review. CG noted that the summary explaining the definition and how these were reported was not included within the attached Quality Report therefore wondered if this matter had yet been resolved. MAE advised that she was waiting full assurance and more up to date data on falls would be presented at the next meeting. **Item closed.**

4.2 IGQC175 Transforming Care Workstream

An update was included within the quality report on the Transforming Care workstream. **Item closed.**

4.3 IGQC180 360° Survey

JC noted that the report was attached however queried where the action plan was as this was not included. AP advised that there was no action plan as there had been no recommendations brought forward from the report. CG suggested that this could be worked on for next year's survey. **Item to remain open.** AP

4.4 IGQC186 Quality Report

A comprehensive report was included within the agenda however the Committee accepted that Mortality would need continuous monitoring. **Item closed.**

4.5 IGQC192 Primary Care Quality Report

MAE advised that reporting of surgical site infections was not progressing well as it was difficult to collect the data. JC stressed the importance of effective follow ups and feedback to improve services. MAE noted she had spoken to the Head of Planned Care about this but would follow up further. **Item to remain open.** MAE

4.6 IGQC196 Stroke and TIA Progress Report

JC informed the Committee that she had received an update from Craig Robinson regarding the education of non-clinical navigators in general practice. This would be considered by the CVD CPG for future training programmes. JC thanked CBu for his help in this matter. **Item closed.**

4.7 IGQC206 Complex Lower Limb Wound Care Service

A report on the service was included within the agenda. **Item closed.**

4.8 IGQC207 Experience and Engagement Report

It was noted that the Sustainability and Transformation Plan (STP) communications and engagement highlight report information was included within the attached engagement report. **Item closed.**

4.9 IGQC208 Quality Report

The Technology Appraisals (TAs) were included as requested however further information on how many had been implemented to date was still outstanding. CBu added that this was done by exception however implementation plans were not received to show what was being done and this was important. MAE agreed to ensure this information was provided. **Item to remain open.** MAE

4.10 IGQC209 Quality Report

Feedback was still awaited from the Countywide research awareness and education event. **Item to remain open.**

4.11 IGQC210 Quality Report

"MAE advised that difficulties in relation to GHFT's lack of response regarding the emergency cascade system had been highlighted by 'Exercise Bugle". MAE added that since the last meeting, this had been formally raised with GHFT whose emergency lead had tested the system and advised that it had worked however, the CCG emergency planning lead had also tested the system finding that it did not work. MAE also raised concerns that an interim manager was leading on emergency planning currently within the Trust. MAE noted that she would now be cascading this issue to NHS England (NHSE) as the CCG was unassured. The Chief Executive of South West Ambulance Service Foundation Trust (SWASFT) had also been asked to formally raise the issue with the Chief Executive of GHFT as a serious concern for patient and staff safety. The Committee supported the decision to raise this matter further with NHSE. **Item to remain open.** MAE

4.12 IGQC211 Quality Report

The briefing report on suicides was included within the agenda. **Item closed.**

4.13 IGQC212 Quality Report

The matter of providers considering suicides was linked into the attached suicides report. **Item closed.**

4.14 IGQC213 Quality Report

It was confirmed that the impacts of the issues with the implementation of TrakCare (new clinical information system at GHFT) had been added to the CCG risk register as a high rated 'red' risk. The members discussed this further and TL advised that there was a backlog of discharge summaries being received late by Doctors. It was noted that there was now a lead in place with an IT background at GHFT who was managing the actions to rectify the issue. **Item closed, for review as part of the CCG risk management process.**

4.15 IGQC214 Quality Report Incidence of Pressure Ulcers

This was confirmed as complete as it was included within the Quality Report. **Item closed.**

4.16 IGQC215 Quality Report

The Care UK CQC report update was included within the agenda. **Item closed.**

4.17 IGQC216 Quality Report

The mental health support in a secondary care setting action plan was yet to be received by members. This was expected to include a breakdown of the expenditure to date. MAE to circulate. **Item to remain open.** MAE

4.18 IGQC217 Quality Report

MAE confirmed that Cirencester, Stroud General, Gloucester Royal and Cheltenham Hospitals had all now received accreditation for Endoscopy services on 1.02.2017. **Item closed.**

4.19 IGQC218 Quality Report

CBu advised that Radiology reporting was still an area of concern and provided an example of a case where a Chest X Ray report from November 16 had only been received last week. The Committee accepted that there was not an easy solution to this issue however it was advised that CBe had been involved and would have further information. TL added that patients were being told to ask their GP to download the information on the system however this was not feasible. JC requested a deep dive review at

the April meeting. **Item to remain open.**

4.20 IGQC219 Quality Report

GHFT Director of Improvement report on emergency care MAE performance to be circulated. **Item to remain open.**

4.21 IGQC220 Quality Report

It was noted that a mortality paper was included within the agenda and that information would be presented at each IGQC meeting moving forward. **Item closed.**

4.22 IGQC221 Quality Report

It was reported that no feedback had been received from the Countywide Health Protection Group. MAE informed the Committee that an update was included within the quality report however national thresholds were expected for E Coli. **Item Closed.**

4.23 IGQC222 IG Staff Handbook

Confirmation was received that the IG staff handbook was now available on CCG live. **Item closed.**

4.24 IGQC223 Career Break Policy

AP informed members that he had queried the five year allowance for career breaks with HR who had confirmed that this was as per agenda for change guidance however this was not an entitlement, and was subject to manager's discretion and was clear within the CCG policy. **Item closed.**

4.25 IGQC224 Registration Authority Policy

The updated Registration Authority policy had been added to the staff intranet. **Item closed.**

4.26 IGQCC225 NICE Guidance

It was confirmed that 'Non Site Specific Symptoms' had been incorporated into the GHFT contract agreement. **Item closed.**

4.27 IGQC226 Urology Report – Community Urology Service

MW had confirmed by email that arrangements were in place to monitor infection rates and pain levels, and it had also been confirmed that those arrangements were robust.

5. Experience and Engagement Report

5.1 RM presented the Experience and Engagement Report which provided information on engagement and experience activity. The report was taken as read.

5.2 RM gave a presentation, which covered the key data relating to:

- provider friends and family test (FFT);
- primary care friends and family test;
- staff friends and family;
- themes of the contacts received; and
- patient experience examples.

5.3 RM reported that the GHFT FFT was showing as above the national average for response rates for both inpatients and the Emergency Department. The new texting system had contributed to this improvement. JC noted that results for A&E were still low.

5.4 RM outlined the PLACE (patient led assessment of the care environment) survey results and explained that PLACE surveys collect information using local people to assess the quality of the patient environment, food, cleanliness and general building maintenance and analyses these against the national picture. The annual assessments apply to hospitals, hospices and day treatment centres funded by the NHS.

5.5 RM highlighted the results of the PLACE survey for each of the organisations and noted that GHFT were reported in the Lower Quartile within their peer group, however Stroud Maternity were showing as green. Results had been discussed at the Clinical Quality Review Group (CQRG) for GCS and would also be discussed at the next GHT CQRG.

5.6 RM noted the Contact information and advised that the increase in quarter 3 (49 contacts into the PALS team) which specifically related to Gluten Free prescribing. Without these, there would have been a normal amount of contacts.

5.7 The FFT data for GP Practices was discussed and RM raised concerns that 49 practices had not submitted information, which is a GMC contract requirement. RM advised that the Associate Director of Experience and Engagement was trying to encourage this through Patient Participation Group (PPG) meetings however the

lack of completion rate was a national issue, and was not limited to Gloucestershire.

5.8 RM discussed Primary Care complaints and noted that NHS England had a new complaints manager in post who was sending examples through to the CCG. The team had noticed that there were no posters from NHSE regarding complaints or raising concerns visible within Practices. JC queried if NHSE provide training for Practices in handling complaints. RM and MAE advised that they were not aware of any training being available at present.

5.9 The Committee discussed how the management of complaints could be audited or reviewed within GP surgeries. RM advised that the CQC would review complaints in practice. MAE added that ideally it would be more practical for the CCG to handle complaints internally. CBu noted that there was currently no learning processes for complaints within the system which was a concern.

5.10 RM gave an example of a service users experience using the PALS system regarding access to medication which had resulted in a positive outcome and response. CBu suggested that this was pertinent as problems with access to medications was likely to happen moving forward therefore recommended the development of a general response. MAE added that this had been discussed at the South West Clinical Senate regarding giving more responsibilities to CCGs in these types of issues. CBu noted that it was also raised with NHS Clinical Commissioners.

AS joined the meeting at this point.

5.11 PM recommended the encouragement of reporting complaints and concerns as this helps organisations to improve however, the way in which complaints are dealt with demonstrates how good the service is. AS advised that the difficulty is identifying and managing genuine concerns over vexatious complaints. JC raised concerns that the lack of training from NHSE and within the system as a whole does not help. RM informed members that the idea behind PALS was to resolve issues before they develop into complaints.

5.12 MAE discussed the national cancer patient survey results 2015. Specific with previous years comparisons were unable to be completed as the survey questions had changed. The key themes from 2015 were written information for patients, communications,

research, and advice about financial help. CBu noted that the benchmarking narrative was helpful and had highlighted the same themes. The Committee welcomed and noted the overall improvements.

5.13 CBu noted that Macmillan and Cancer Research UK provide good information however work was needed to signpost people to the right areas of support available to them. CBu raised concerns regarding the home care and support information. It was noted that the Cancer Clinical Programme Group (CPG) would pick this matter up.

5.14 MAE advised the Committee that Healthwatch had been out to tender and a contract awarded however the results from this were awaited.

5.15 <u>RECOMMENDATION:</u> The Committee noted the contents of this report.

6. <u>NHS England Bath, Gloucestershire, Swindon and Wiltshire Quality Surveillance Group Patient Experience Report (6 January 2017)</u>

6.1 MAE presented the report and noted that it provided helpful comparisons across the CCGs.

6.2 MAE advised that Gloucestershire was showing as above other Counties now in the completion of the FFT.

6.3 JC commended the GP Patient Survey results as these were good in all areas however queried how this information would be used in the CCG's internal processes. MAE advised that the results informed the CCG improvement plans.

6.4 <u>RECOMMENDATION:</u> The Committee noted the contents of this report which was provided for information.

7. <u>Quality Report and Dashboard</u>

7.1 MAE presented the Quality Report, the purpose of which was to provide assurance to the Committee that quality and patient safety issues were given the appropriate priority and that there were clear actions in place to address them. The report was taken as read.

7.2 MAE highlighted the NICE and Clinical Effectiveness overview as outlined within the report and noted the active Clinical Effectiveness Group.

7.3 JC queried if there was a list available of active research projects currently underway. CBu advised that the minutes from the Clinical Effectiveness Group would provide information on some of these and also within the RDSU report. JC requested that a list of research activity was presented to the Committee every 6 months to highlight the main themes of research underway. MAE

7.4 MAE discussed the areas of additional funding with regards to research and development and advised that the trial using a particular laser for prostatectomies that also required an overnight stay in hospital was not demonstrating definite delivery. MAE reported that concerns had been raised about this and JC noted concerns regarding trialling this outside of NICE guidance that recommends the use of a 'green laser' for clinically appropriate cases.

7.5 MAE presented the safeguarding section of the report and highlighted the ongoing cases, noting that she was happy to take questions from the Committee on any of these. It was advised that cases within Primary Care were specifically followed up by the GP Lead in place for safeguarding. AS queried how long the GP Lead commits to adult safeguarding and MAE confirmed that more time is taken on adults than children due to domestic abuse and that sessions had been increased.

7.6 MAE discussed the Incidents and Quality Alerts from Primary Care and noted that discharge was the biggest theme arising from these within quarter 3.

7.6.1 MAE highlighted the serious incident tables broken down by organisation at point 9.

7.6.2 It was advised that there had been one never event relating to the wrong strength intra-ocular lens being inserted in to an eye during a cataract removal procedure. There had been no harm to the patient as a result however this was still classed as a never event.

7.6.3 CG wondered if the reason for the discharge theme in incidents had

been influenced by transport issues. RM advised that late discharge summaries were the main contributory factor.

7.6.4 MAE informed the Committee that NHS England were taking an interest in the two ED incidents regarding patients deteriorating in corridors. MAE advised that there was assurance that full investigations had taken place and reports had been received by the CCG. The reports showed that both patients were regularly assessed and were not harmed as a result; however MAE stressed that corridor waiting was not condoned.

7.7 MAE advised that GHFT CQRG minutes had not been included within this report as they were yet to be approved and GCS CQRG were from October 2016. The December meeting had been cancelled. JC queried why the GHFT CQRG had been cancelled and if the frequency of meetings had changed. MAE confirmed that these were scheduled bi-monthly for GHFT and GCS and 2G were held quarterly. MAE noted that there were discussions underway regarding having one meeting to focus on quality and performance issues.

7.8 PM queried if the suicide data represented people who were under the care of 2G and MAE confirmed that these were not necessarily people within 2G sites or buildings and were predominantly community based patients.

7.9 The Improving Access to Psychological Therapies Service (IAPT) data was discussed and CBu raised concerns that information was not received on which patients were completing the full treatment after referral. MAE agreed to confirm this. MAE

7.10 MAE noted the Health Education England Dementia community master classes which were free for staff to attend.

7.11 JC queried the purpose of the 2G Quality and Clinical Risk (QCR) sub-committee and MAE advised there was a focus on governance and risk and that she felt confident that 2G had robust arrangements in place for these areas.

7.12 MAE highlighted the update from the GHT Quality Committee at point 11.2 of the report. JC requested assurance on the level of harm to patients as a result of the Trust not meeting the targets that were outlined. MAE advised that a clinical care protocol had been

received which she was pleased with. CBu queried when outcomes would be received as this was a big piece of work. JC noted that there was a standard operative procedure and a flag system which would need validation. MAE agreed to request that Kay Haughton picks this up. MAE

7.13 MAE informed the Committee that GHT now had three leads for Quality on the Executive team as a result of restructuring of responsibilities. MAE was concerned about this as there was not a clear route of accountability and responsibility for the leadership of quality at the Trust. It was agreed that MH should raise with the Trust's Chief Executive as part of regular 1:1s. MH

7.14 JC discussed Nursing students and noted that there had been a lot of interest in the Gloucestershire University programme however raised concerns that UWE students Community Hospital placements were offered at Tewkesbury.

7.15 MAE reported that there was now somebody in place within the Quality Team working on Care Home Quality specifically.

7.16 The Committee discussed the Infection Control section of the report. MAE advised that GHFT currently did not have a Senior Nurse lead for Infection Control which was a significant issue. There had been discussion around GHFT joining the Countywide HCAI Group however they felt that they did not want to join until they had appropriate microbiology resources in place for this work. The Committee noted that GHT were paid for infection control as part of the tariff therefore would be required to submit a business case for additional services. JC requested clarity on how this was being dealt with. CG noted that this issue was raised previously, and that the CCG should request formally that GHT deliver. It was advised that Deborah Lee, Chief Executive may not be aware of the issue therefore it was agreed that MH should raise this with her and await feedback. MH

7.17 The Committee noted the seasonal influenza information and MAE advised that she was hoping that the figures would increase as GHT were reported to be encouraging staff to take up the vaccine. It was noted that information on flu vaccine completion rates amongst Primary Care staff was needed and the Committee discussed how to address this.

7.18 **<u>RECOMMENDATION:</u> The Committee noted the contents of this report.**

8. Primary Care Quality Report

8.1 JC qualified the role of IGQC on assurance, as the detail of Primary Care quality improvement would be managed by the Primary Care Commissioning Committee. JC requested however that the data within the report remained up to date.

8.2 MAE presented the report and it was taken as read for the members to raise particular concerns.

8.3 JC queried if GPs had attended the GSCB Roadshow events. AS advised that there were quarterly meetings in place for GPs in each practice and that there was a focus on Serious Case reviews as part of these.

8.4 MAE highlighted the CQC inspection reports and noted that White House Surgery had now received an inspection; however the report was yet to be received. MAE advised that each Practice with a 'requires improvement' rating had developed an action plan to make the necessary improvements. The overall results of CQC inspections within practices was positive.

8.5 CBu informed members that the medicines optimisation dashboard would be added soon which would be useful. Prescribing performance and information would also be presented to Governing Body Development Sessions every month.

8.6 JC drew attention to appendix one of the report, the Quality Framework for General Practice and highlighted the use of assessment tools activity and queried if contract monitoring would pick this up. It was noted that this was high level performance information and the Quality Outcomes Framework (QOF) should be incorporated within the Primary Care report.

8.7 **<u>RECOMMENDATION:</u> The Committee noted the contents of the report.**

9. Proposed Deviation from NICE guidance

9.1 CBu introduced the paper which was brought forward to propose a

deviation from NICE guidance for Abdomino/Pelvic CT scans for Unprovoked Deep Vein Thrombosis (DVT) specifically covering investigations for cancer.

9.2 CBu advised that evidence suggested that pick up rates were low therefore the recommendation would be to advise Clinicians that they would not need to default to referring patients for Abdomino/Pelvic CT scans for Unprovoked DVT. The attached paper provided detailed evidence to support this recommendation.

9.3 CBu added that there were disadvantages for patients if the waiting list for CT scans was long, as this would delay their treatment further.

9.4 CBu stressed that the recommendation was not to advise Clinicians not to forward for CT scans but to suggest that it was not standard practice due to the lack of evidence and potential disadvantages associated.

9.5 JC raised concerns about the proposal as she felt that NICE would have reviewed the evidence for the guidance again in 2015 and update it if necessary. CBu advised that NICE would not necessarily update or change the guidance and that the reason for the proposal is that the evidence of success following CT Scan was low and also leads to extra diagnostic imaging and capacity issues for the Trust.

9.6 JC requested assurance that the proposal was not in response to demand and capacity pressures at GHFT that led to rejecting X Ray requests. CBu advised that there were capacity issues and further knock on effects as a result of the guidance and that the CCG should be advocating the standard. AS supported CBu and provided assurance that this was not as a response to pressure but supported clinical examination of patients on this pathway. AS added that the question would be how to disseminate the advice to GPs.

9.7 CBu reiterated that this would be advice only and was an opportunity to better manage CCG resources and reduce risks and costs associated with the current guidance.

9.8 JC noted that the CCG had the opportunity to call the Clinicians who produced the guidance in order to gain assurance of the

potential deviation. AS suggested that this was more about the patient in front of the GP in each case.

9.9 JC requested that assurance was gained before the approval of the proposal was given, however advised that this could be done outside of the meeting and did not have to wait until the April meeting. It was agreed that CBu would confirm there were no additional risks with deviating from the guidance and the Committee Chair would confirm approval after this information had been received. CBu

9.10 <u>RECOMMENDATION:</u> The Committee noted the request for approval to deviate from NICE recommendations, however agreed to approve this subject to the further assurance requested.

10. <u>Risk Register</u>

10.1 AP presented the Risk Register which provided details of those risks identified by the responsible managers that currently face the CCG and which could affect the achievement of the organisational objectives and included additional information regarding the red risks (x1) as requested at the previous Committee.

10.2 The Risk Register comprised a total of 39 risks, one of which was graded as 'red' as outlined at Appendix 1. In addition, the Committee were asked to consider the addition of the two new risks detailed at Appendix 2, and the closure of one risk at Appendix 3.

10.3 AP advised that risk C6 regarding the 4 hour wait in the emergency department had been increased as shown within appendix 1.

10.4 JC requested that it would be useful to look at feedback from the GHT breaking the cycle events. MW to provide a briefing note to the next IGQC. MW

10.5 CG noted that the GHFT ED rates had improved therefore queried why the risk had not decreased. MAE advised that the average had improved however the rates were still down below the 60% margin and that this had also been raised at the monthly assurance meeting. CL added that there was work ongoing with the Trust and that a consistent rise over time would be needed to trigger a reduction in the risk.

10.6 The Committee discussed the approval of the new risks as included at appendix 2. CBu queried if there was an issue between TrakCare and contract monitoring and wondered if this should be added as a risk. CL advised that there was no financial risk to the CCG as a result of the implementation issues of TrakCare. It was noted that two weekly calls were in place with the Chief Executive of the Trust to monitor progress.

10.6.1 PM queried if GHFT had indicated a timescale for a resolution (Risk F24 regarding TrakCare). CL confirmed that it was too early to tell however there was potential for closure in March/April as work was underway, and staff had been put in place to manage the backlog.

10.7 The Committee discussed the risk for closure (C36) regarding meeting A&E Delivery targets through winter, and agreed that this could be closed as winter was now over.

10.8 <u>RECOMMENDATION:</u> The Committee:

- **reviewed the paper and the attached Risk Register; and;**
- **approved the addition of two new risks detailed on Appendix 2 and;**
- **approved the closure of Risk C38 at Appendix 3 regarding A&E Delivery Priorities through winter.**

11. <u>Assurance Framework (AF)</u>

11.1 AP presented the Assurance Framework for 2016/17 which provided details of the risks to the CCG against the achievement of the strategic objectives. The AF was reviewed and included the two new risks as outlined above.

11.2 <u>RECOMMENDATION:</u> The Committee noted the updated AF.

12. <u>Policies for Approval</u>

12.1 Whistleblowing 'Freedom to Speak Up' Policy

12.1.1 AP introduced this policy which had been reviewed by ZB to incorporate the Freedom to Speak Up guidance released following a report published by Robert Francis in 2016.

12.1.2 JC queried who the Executive Lead for whistleblowing was as this was not clear within the policy. ZB advised that the Freedom to Speak Up Guardian role had been assigned to MAE as the Executive Nurse and Quality Lead however Core Team had felt that the role should be assigned to someone of a more middle level in order to ensure staff felt they could approach them with confidence.

12.1.3 MAE advised that a poster was being produced within the Quality Team to communicate information to staff on whistleblowing to accompany the policy.

12.1.4 MAE noted that separate guidance had been developed for Primary Care however a policy had not been produced as yet as the guidance had been released later and was currently under review.

12.1.5 JC suggested that clarification was given as to where cases would go for investigation and follow up. It was advised that this would be looked into further.

12.1.6 <u>RECOMMENDATION:</u> The Committee approved the Policy for implementation subject to minor amendments.

CBu left the meeting at this point, however before he left the Committee discussed agenda item 19 (see point 19).

12.2 Flexible Working Policy and Procedure

12.2.1 MAE introduced this policy which had been under review as the CCG want to support flexible working however it was agreed that rules were required to ensure a consistent process was in place across teams. The policy had been developed based upon Agenda for Change (AfC) guidance but with some areas altered to be more relevant to the way in which the CCG operates.

12.2.2 JC requested that the following was added to point 5.5 of the policy:

"Clinical staff should work sufficient hours to maintain professional registration and revalidation requirements."

12.2.3 The Joint Staff Consultative Committee (JSCC) had reviewed the policy and were comfortable with its content.

12.2.4 MAE advised that the major areas to address within the policy were Time Off In Lieu (TOIL) and compressed hours. AfC allows Band 7 and below staff to take TOIL up to one day per month however the CCG policy states 2 days a month in order to make this equivalent to those that complete a 9 day fortnight (Bands 8a to VSM only).

12.2.5 JC requested clarity regarding point 5.9 of the policy as this stated that the change would be permanent and that a trial period may be agreed. This comment was accepted.

12.2.6 <u>RECOMMENDATION:</u> The Committee approved the Flexible Working Policy subject to minor amendments.

12.3 Alcohol, Drugs and Substance Misuse Policy

12.3.1 The Alcohol, Drugs and Substance Misuse Policy was a new policy developed in order to provide CCG staff and managers with guidance on how to manage issues of this type in the unlikely but possible event that they should occur. This was also a requirement of the Workplace Wellbeing Charter accreditation process.

12.3.2 JC requested that reference was included within the policy to drink driving convictions as it is a requirement to advise the CCG of these. MAE agreed to add this.

12.3.3 <u>RECOMMENDATION:</u> The Committee approved the policy subject to the above alteration regarding drink drive convictions.

12.4 Physical Activity at Work Policy

12.4.1 MAE presented the Physical Activity at Work Policy and advised that this had been developed as part of the Workplace Wellbeing Charter and circulated to Core Team for approval.

12.4.2 CL had provided a suggestion regarding point 4.2 of the policy to adjust ‘Provide corporate memberships at local authority facilities’ to ‘any local authority’ which had been agreed following circulation outside of the meeting .

12.4.3 JC requested that the wording at 3.1.1 was adjusted to ‘CCG staff will ensure that they participate in any of the *appropriate* health at work activities’ as this needed to be inclusive of those with

disabilities.

12.4.4 The Committee queried how the CCG would ensure the policy would be supported by managers. CL confirmed that the Executive team would be encouraging managers to be flexible about hours.

12.4.5 <u>RECOMMENDATION:</u> The Committee approved the above Policy.

13. <u>Information Governance</u>

13.1 CL presented the Information Governance update report which was taken as read.

13.2 CL provided assurance that the CCG was on track to maintain level 2 for the IG Toolkit as in previous years.

13.3 CL advised that NHS Digital had withdrawn the e-learning modules as these were being replaced by a new training module. The CCG was currently using a workbook for all new staff to complete their IG training which was considered to be a good document following testing.

13.4 CL noted that the Joining Up Your Information project was progressing well and that the contract had been signed in December. A series of workshops had been held and Clinicians were involved. CL highlighted the workstreams to support the project.

13.5 CL advised that the Gloucestershire Information Governance Group was currently focusing on cluster working which was positive.

13.6 JC requested an update on the Nuffield Trust 'The Digital Patient: Transforming Patient Care' report in terms of the view of the IT Team and any key areas to pick up. CL confirmed that she would ask the team to pick out the key areas from the report.

13.10 JC highlighted that the IG Group Meeting notes made reference to two Lay members who did not have employment contracts and queried what this referred to. AP advised that these two contracts had been composed and were in draft awaiting completion.

13.11 It was noted that guidance would be forwarded to staff regarding

the use of personal IPhones to access NHS work emails as there were risks to highlight.

13.12 JC queried if the CCG were well represented at the Gloucestershire Information Group meeting as there was no attendance noted within the minutes of the November 16 meeting. CL advised that the CSU represent the CCG if a member cannot attend.

13.13 RECOMMENDATION: The Committee noted the contents of the Information Governance report.

14. Complex Lower Limb Wound Care Service

14.1 The paper was taken as read and the Committee accepted it as a good proposal.

14.2 MAE advised that the Complex Leg Wound Service (CLWS) had been well-received and the paper was to highlight where the service was heading moving forward.

14.3 MAE noted that GHFT deliver a CLWS in addition to GCS for vascular patients.

14.4 CG raised concerns regarding the financial issues associated with continuing to provide resources for the service and requested a further report on the proposal for these further resources necessary for consideration by Priorities Committee. CL advised that this would be subject to the CCG business case process.

14.5 JC requested further clarification on the quality impacts. MAE advised that the CPG led workshop taking place in March 2017 would help and would be agreeing the end to end pathway. It was noted that further information would be available on the 7th April. JC requested a further update at the April IGQC meeting and then again in June. MAE

14.6 RECOMMENDATION: The Committee noted the briefing paper which was provided for information.

15. Suicide Briefing

15.1 MAE presented the suicide update briefing paper which was taken as read. The Committee accepted that the paper was helpful

however requested more up to date data for April, than quarter 1 2016. MAE advised that more up to date data was available.

15.2 JC queried if the lessons from Scotland's fall in suicide rates would be considered locally noting the South West had a higher suicide rate. MAE provided assurance that the CCG were working with 2G and noted the CQRG notes which highlight the focus on suicides given at this group.

15.3 MAE provided further assurance that she felt sufficient focus was being given to suicide prevention of which further information could be provided from the quality dashboard.

15.4 CG noted that the report could be formatted slightly better to make it more readable. MAE agreed to ensure this was tightened for the next report. MAE

15.5 RECOMMENDATION: The Committee noted the contents of the briefing paper.

16. Care UK CQC Review – verbal update

16.1 MAE provided a verbal update on the Care UK CQC review which took place in the Autumn 2016 and advised that the review had been good overall with no actions required. MAE was not sure why Care UK did not receive and 'Outstanding' rating in light of this.

16.2 RECOMMENDATION: The Committee noted the verbal update.

17. GHFT CQC Review

17.1 MAE provided a verbal update with regards to the CQC inspection at GHFT which was very recently completed and noted that the general view was that there were no areas of serious concern or immediate action required outside of the financial issues at the Trust.

17.2 It was noted that the CQC may want to review end of life care at a later date however in general the verbal reports had been quite positive anecdotally.

17.3 MAE advised that the draft report was expected at the end of March 2017, and that the Trust were likely to receive a 'Requires

Improvement' rating due to the current financial pressures.

17.4 MAE informed members that there was a meeting arranged to review the new risk tool which NHSE would present to GHT.

17.5 RECOMMENDATION: The Committee noted the verbal update.

18. 360 Degree Survey Briefing

18.1 AP presented the briefing paper which was taken as read.

18.2 AP advised that statistics had been received since the time of writing the paper which were showing a 48% response rate which is positive.

18.3 The CCG had sent reminder letters to stakeholders to encourage completion and the Director of Primary Care had also encouraged those in general practice to complete the survey.

18.4 AP informed the Committee that an update on the outcome of the survey would be provided in due course following its completion on 24 February 2017. Final reports were expected on the 31 March 2017.

18.6 RECOMMENDATION: The Committee noted the report.

19. Current Mortality Review Processes in Gloucestershire

19.1 The mortality briefing paper was discussed. The focus on mortality is to assure the CCG regarding mortality rates their accuracy, impact on patient care, lessons learned, and service improvement. The need for a countywide mortality group was discussed.

20. Any Other Business

20.1 There were no items of any other business.

21. The meeting closed at 12.00pm.

Date and time of next meeting: Thursday 20th April 2017 in the Board Room at 9am.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 20

Governing Body

Meeting Date	**Thursday 25 May 2017**
Title	**Primary Care Commissioning Committee (PCCC) minutes**
Executive Summary	The attached minutes provide a record of the PCCC meeting held on the 26th January 2017.
Key Issues	The following principal issues were discussed at the meeting: • Cheltenham Town Centre Development; • General Practice Forward View; • GP Access Fund; • NHS England Commissioner guidelines for responding to requests from Practices to temporarily suspend patient registration; • Update on Primary Care Support England; • Delegated Primary Care Commissioning Financial Report; • Draft Outline Budget Update; • Primary Care Quality Report; and • Primary Care Commissioning Committee self-assessment.
Risk Issues: **Original Risk** **Residual Risk**	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable

Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Alan Elkin PCCC Chair and Lay Member

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 20

Primary Care Commissioning Committee

Minutes of the Meeting held on Thursday 26th January 2017 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Alan Elkin	AE	Lay Member – Patient and Public Engagement (Committee Chair)
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Andrew Beard	AB	Deputy Chief Finance Officer
Julie Clatworthy	JC	Registered Nurse
Joanna Davies	JD	Lay Member – Patient and Public Engagement
Colin Greaves	CG	Lay Member - Governance
Mary Hutton	MH	Accountable Officer
Dr Andy Seymour (Non-Voting)	AS	Clinical Chair
In attendance:		
Helen Goodey	HG	Director of Primary Care and Locality Development
Cllr Dorcas Binns	DB	Chair of the Health and Wellbeing Board
Andrew Hughes (Item 5)	AH	Locality Implementation Manager
Alistair Black (Item 5)	ABl	Monitoring Surveyor
Dr Sanjay Shyamapant (Item 5)	SS	GP
John Webb (Item 5)	JR	Senior Project Manager, Pick Everard
Claire Feehily	CF	Chair of Healthwatch Gloucestershire
Becky Parish	BP	Associate Director, Engagement and Experience
Jeanette Giles	JG	Head of Primary Care Contracting
Joanna White	JWh	Programme Director, Primary Care
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were no members of the public present.		

1 Apologies for Absence

1.1 There were no apologies received.

2 Declarations of Interest

2.1 CF declared an interest as a member of the Patient Participation Group (PPG) at Minchinhampton Surgery.

2.2 AS declared a general interest as a GP member and as a member of GDoc.

2.3 CG declared an interest in Agenda Item 5 as he was a registered patient at Crescent Bakery Surgery.

2.4 AE declared that the meeting was quorate and that he felt that AS should not be excluded from any discussions as he was a non-voting member.

3 Public Questions

3.1 AP advised that a question had been received regarding the Romney House Surgery in Tetbury which referred to issues contained within a petition signed by 880 of the practice's patients. The question sought clarification regarding the powers of the CCG in relation to a number of issues.

3.2 AP read the following response:

Firstly, in terms of the allegations, an independent investigation has been commissioned by NHS England and the CCG. This was being carried out by the legal firm, Capsticks, with an independent GP chair.

In order to ensure that there could be no conflicts of interest when the CCG took on responsibility for commissioning primary care services in April 2015, this Committee was established with an independent lay Chair. It was this committee that will oversee the independent investigation with NHS England.

In terms of the question of choice, patients are able to exercise choice in terms of which GP they see and also which surgery they are registered with.

It is increasingly important as we look to the future that a GP practice is resilient and is in a position to offer a full range of services and roles within the team, including highly skilled nurses and other staff to, for example, provide care support for people with long term health conditions.

Within that context and given the size of the population, the Primary Care Commissioning Committee is not in a position to consider the opening of an additional practice or related pilot GP scheme in Tetbury at this time.

We do however, take our responsibilities very seriously and want to ensure that patients in Tetbury and the surrounding area have access to the best possible provision moving forward. We are working closely with GP colleagues in the South Cotswolds to ensure that the necessary support – both in the short term and in the longer term - is in place at Romney House surgery. We will be happy to provide further information on specific plans in the near future.

In terms of the individual doctor you refer to, as I am sure you will appreciate, it would not be appropriate or possible for the Committee to comment on her future intentions or to comment on her decision to resign from the practice. The CCG has not received any correspondence from the individual in relation to these matters.

4 Minutes of the Meeting held on Thursday 24th November 2016

4.1 The minutes were approved subject to the amendment below:

- Section 8.8 to be amended to read: '*JC felt that the **self-assessment** was a good mechanism to act as a reflection and learning process.*'

5 Matters Arising

5.1 28.01.2016 Item 9.1 – Any Other Business - AE advised that he

had received responses to the self-assessment questionnaire from members although some were still outstanding. Further details regarding this would be discussed at Agenda Item 13.

5.2 26.05.2016 Item 3.2 – Minutes of the meeting held on Thursday 31st March 2016 – AH updated members regarding Stow Surgery and advised that the developer was working through the financial modelling although the scheme was ready to progress. It was noted that the architect was finalising the arrangements with the District Valuer.

5.3 28.07.2016 Item 8.13 - Sevenposts: Bishops Cleeve premises development – AH advised that planning permission was granted and it was anticipated that the developer would move as quickly as they could to progress to delivery. **Item Closed.**

5.4 24.11.2016 Item 5.6 - Premises Workstream Progress Report – AH advised that further clarity regarding the ETTF process from NHS England had not been received although the issues regarding funding had been resolved. The Committee remained concerned regarding the lack of transparency and was awaiting further details from NHS England.

5.5 24.11.2016 Item 5.22 - Premises Workstream Progress Report – AH advised that he had commissioned some support and they were working with NHS Property Services to develop a business case.

6 Cheltenham Town Centre Development

6.1 AH introduced a presentation relating to the Cheltenham town centre development and provided a background context to the development. AH advised that a number of bids were submitted for the national Estates and Technology Transformation Fund (ETTF) and approximately £4m funding to support the Cheltenham Town Centre development had been secured.

6.2 ABl made a presentation which covered:

- setting the scene;
- a real opportunity;

- not just a new building - making things better;
- working with our patients;
- plans for new development;
- draft building plans; and
- timetable – to commence site work by March 2018.

6.3 JC queried the opportunity for service innovation in particular to prepare for the next stage of primary care i.e. the surgical suite. ABl advised that there was a minor operation suite outlined within the schedule of accommodation and space was available although there was a likely impact on the building design and costs. However, the practices would need to decide on their requirements in collaboration with the CCG.

6.4 CF queried what the practical impacts were for the patients being served and if this could be anticipated in order to plan the engagement activity effectively i.e. travelling implications.

6.5 CF also queried the parking requirements imposed by the Local Authority on the site and asked if this had been considered as part of the overall access requirement. ABl acknowledged that parking was usually challenging when developing new projects and advised that the developer had confirmed that the Council had agreed that the 300 parking spaces would be exclusive of any spaces being created for the medical centre. It was noted that the practices were currently reviewing their essential parking requirements prior to negotiation with the Local Authority. The Committee also noted that three of the five practices had no provision for parking currently and that discussions with the local public transport providers would be undertaken.

6.6 HG highlighted that she had visited the current premises of the five practices and noted that the new development would be a significant improvement.

6.7 DB enquired of the process for the public consultation exercise and was advised that a series of engagement activities were being undertaken which included displaying posters within the practices and publishing notices on the practices' websites, etc. It was noted that this would also be undertaken in conjunction with the CCG Engagement Team.

6.8 **RESOLUTION: The Committee noted the presentation.**

7 General Practice Forward View update

7.1 HG provided a brief update on the progress of implementing the General Practice Forward View (GPFV). The report was taken as read.

7.2 HG advised that a GPFV project group had been established including representatives from the Royal College of General Practitioners (RCGP), Local Medical Committee and NHS England. It was noted that the inaugural meeting was held on the 17th January 2017 where the programme approach was reviewed.

7.3 HG advised that the paper outlined a number of key workstreams. These included the general practice resilience programme and the practice transformational support.

7.4 HG advised that a local GPFV event was held on the 24th January 2017 at the Gloucester Rugby Club with approximately 220 attendees and noted that this had been a success. HG advised that the feedback from this event had been positive. JC concurred that this was a successful event although raised concerns regarding capacity in term of supporting implementation. HG agreed that there was a challenge going forward.

7.5 JD enquired of the plans to maintain the dialogue and was advised that a further event was being organised. HG advised that her team were being allocated to the clusters and that she was meeting with the GPFV practice leads in order to understand the level of support required.

7.6 In response to a question from CG, HG confirmed that no representative from NHS England had attended the event. HG advised that invites would be issued promptly for future events.

7.7 CF queried the risk assessment process in particular ensuring that issues were prioritised effectively. HG concurred and advised that risks needed to be strategically reviewed.

7.8 <u>RESOLUTION:</u> The Committee noted the paper.

8 GP Access Fund

8.1 JW introduced this paper which provided background information regarding the GP Access Fund (GPAF) and outlined a proposal regarding the contract extension.

8.2 JW explained that, in line with national guidance and following a decision made by the Primary Care Committee in November 2016, the GPAF contract was further extended to March 2017 to continue the delivery of the Primary Care Access Fund pilot.

8.3 It was noted that the Choice Plus appointments had been positive at 30 minutes per 1000 and that work on improving the utilisation rate continued in particular for evenings and weekends.

8.4 JW advised that the national guidance stated that procurement advice should be sought by CCGs regarding the new 2017/18 GPAF contracts. JW advised that the initial procurement advice suggested that a contract extension was necessary from April 2017 to April 2018 whilst a procurement exercise was undertaken which also aligned with the Out of Hours and NHS 111 procurement timescales.

8.5 AE highlighted the issue relating to inequalities in patients' experience of accessing general practice identified by local evidence and queried what local evidence was being used. JW advised that regular reviews with the provider were held which included monitoring patient and practice feedback. HG advised that all access surveys were reviewed which measured patient satisfaction rates although recognising the importance of monitoring wider health inequalities.

8.6 JW discussed the options appraisal which included a review of the current service provision and what was working well elsewhere to understand if the current model was suitable going forward. JW advised that a questionnaire had been sent to the practices, cluster leads and GP locality commissioning leads in order to gain feedback.

8.7 It was noted that the options appraisal also included a review of the non-registered patient element of the Gloucestershire Health Access Centre (GHAC) to understand opportunities for alignment with extended access through the GPAF. JW advised that the options appraisal was scheduled for completion at the end of February 2017.

8.8 JC suggested that the measurement tool should also include any impact on ED attendances. JW advised that data was being reviewed which would support the provision of the evening/weekend service.

8.9 **RESOLUTION: The Committee noted the paper.**

9 NHS England Commissioner guidelines for responding to requests from Practices to temporarily suspend patient registration

9.1 JG outlined the guidance that had been published by NHS England in December 2016 to assist commissioners in responding to practices wanting to suspend patient registration on a temporary basis.

9.2 JG advised that the guidance should be read in the context of the General Practice Forward View with a commitment to supporting practices in difficulty.

9.3 The Committee were advised that the guidance had been drafted in recognition of the immediate pressures some practices would face, e.g. an immediate and unpredicted shortfall in the availability of staff, or an unexpected event affecting a practice's ability in the short term to provide a full range of services normally available, e.g. flood or a fire.

9.4 JG advised that guidance stated that the CCG should engage with the LMC and agree what action should take place by the practice and/or CCG in order for the list to be re-opened. The CCG should also consider support under the practice resilience programme or the use of the Section 96 funding.

9.5 JG advised that the CCG would need to respond quickly and proposed that the decision to approve any requests to temporarily suspend patient registration was delegated to the Chair of the PCCC and the Accountable Officer.

9.6 The Committee noted that if, despite the support to deliver an action plan over an agreed period, the practice continued to feel compromised, the CCG should consider an application from the practice for formal list closure in line with the GMS and PMS contracts.

9.7 CG requested that the new guidance was aligned within the Standard Operating Procedures (SOP). HG advised that the SOP dealt with formal requests although concurred that the new guidance should be embedded within the SOP. HG highlighted that generally most requests would be submitted for urgent issues.

9.8 JC requested that an email was circulated to PCCC members when these decisions were made.

9.9 <u>RESOLUTION:</u> The Committee:

- **noted the guidance; and**
- **agreed to delegate approval of requests from a practice to temporarily suspend patient registration to the Chair of the PCCC and the Accountable Officer.**

10 <u>Update on Primary Care Support England</u>

10.1 JG introduced this paper and provided background information regarding the role and responsibilities of Primary Care Support England (PCSE). JG outlined the problems that existed, particularly regarding records, and the action being taken by PCSE to resolve them. Members were advised that there remained a problem with the performers list and advised members that the problems being encountered were common nationally.

10.2 AE expressed concern regarding the situation and asked if practices were aware that the CCG could offer support. JG advised that practices were advised through the locality meetings, attended by CCG staff that support was available.

10.3 JC enquired about local safeguards, particularly in relation to the performers list. JG stated that for future applicants, checks would be undertaken by Health Education England as part of the recruitment process. However, at present, JG advised that any issues would be raised with NHS England. HG advised that all practices are required to undertake checks when employing locums or salaried staff.

10.4 RESOLUTION: The Committee noted the paper.

11 Delegated Primary Care Commissioning Financial Report

11.1 AB presented the report which outlined the financial position regarding delegated primary care co-commissioning budgets as at the end of December 2016 and drew members' attention to the year to date underspend of £60k. AB advised, however, that a year-end 'break-even' was forecast.

11.2 RESOLUTION: The Committee noted the report.

12 Draft Outline Budget Update

12.1 AB introduced this paper which provided an overview of the Gloucestershire Clinical Commissioning Group draft budget proposals for delegated co-commissioning in advance of the 2017/18 financial year.

12.2 AB advised that an increased allocation of £1.5m for the year was expected.

12.3 CG expressed concern that primary care had been disadvantaged since delegation, as NHS England did not have to allow for the headroom reserve that CCGs are required to provide, which reduces the amount of money available to practices. AB advised that this issue was being pursued with NHS England.

12.4 RESOLUTION: The Committee noted the paper.

13 Primary Care Quality Report

13.1 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. MAE reminded members that the report had previously been presented to the December meeting of the IGQC. The report was taken as read.

13.2 MAE expressed concern that the CCG was still not able to access details of Serious Incidents reported by general practices to NHS England.

13.3 MAE referred to the newly appointed Named GP for Safeguarding and provided an overview of the work that this individual had been involved with.

13.4 Members were advised by MAE that the CQC inspectors had now rated four practices as 'Requiring Improvement' although one of these had now been re-assessed and rated as 'Good'. MAE also advised that a total of three practices had been rated as outstanding. These were: Mythe in Tewkesbury, Minchinhampton and Winchcombe.

13.5 JC referred to the infection control concerns raised by the CQC and asked if the CCG was able to support practices to resolve these issues. MAE advised that, whilst the CCG had no dedicated resources in this area, the infection control nurses within the trusts would provide ad hoc advice if needed. HG stated that she would discuss priorities for next year with MAE and if this was considered to be significant, a training session could be provided by the nurse facilitators.

13.6 AE referred to the opening paragraph that referred to quality indicators from across primary care and requested that these should be included in future reports. MAE

13.7 CF referred to the lack of information regarding Serious Incidents and expressed concern that there may be a culture of low reporting resulting in a risk. MAE referred to the National Reporting and Learning System statistics which indicated low levels of primary care reporting of incidents nationally.

13.8 **RESOLUTION: The Committee noted the report.**

14 Primary Care Commissioning Committee self-assessment

14.1 AE advised the responses to this survey were still being gathered and agreed to bring a final report to the March Committee meeting. AE

15 Any Other Business

15.1 AE advised members that, following appointments to new positions, both CF and FT would not be attending future meetings of the PCCC. AE, on behalf of the PCCC, thanked both individuals for their valued contributions to the Committee since its inception.

16 The meeting closed at 12:50.

17 Date and Time of next meeting: Thursday 30th March 2017 in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Primary Care Commissioning Committee:

Signed (Chair):_____ Date:_____

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 21

Governing Body

Meeting Date	**Thursday 25 May 2017**
Title	**Joint Commissioning Partnership Board Minutes**
Executive Summary	The attached minutes provide a record of the Joint Commissioning Partnership Board meeting held on the 9th November 2016.
Key Issues	The following principal issues were discussed: • Joint Commissioning Partnership Finance Report; • Better Care Fund update and Risk Register; • Mental Health, Perinatal and IAPT; and • STP update.
Risk Issues: **Original Risk** **Residual Risk**	Not applicable
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director of Corporate Governance
Sponsoring Director (if not author)	Mary Hutton Accountable Officer

Agenda Item 21

Gloucestershire County Council & Gloucestershire Clinical Commissioning Group
Joint Commissioning Partnership Board (JCPB)
9th November, 2016 2:00pm – 3:00pm
Bartlett Room, Sanger House

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
Mary Hutton	MH
Cath Leech	CL
Kim Forey	KF
Margaret Willcox	MW
Linda Uren	LU
Sarah Scott	SS
Jo Walker	JW

In Attendance:

Angelique D'Boure (Minutes)	AD'B

Apologies:

Mark Walkingshaw	MWa
Dr Andrew Seymour	AS

1.0	**Apologies** Apologies were received from Mark Walkingshaw and Andrew Seymour.	
2.0	**Minutes from the last meeting and Matters Arising**	

	The minutes from the last meeting held on 7th June 2016 were agreed as a true record. **ACTION 001: KF to forward a copy of the document for circulation by AM -** KF advised that this action had been superseded. We have got the bid and that a copy of the poster had been circulated.	**KF**
3.0	**Joint Commissioning Partnership Finance Report**	
	JW went through the JCP Finance report 16/17 – Forecasts Month 5. There were no significant variances but attention was drawn to the demand on the community equipment service which had increased. **FNC** MW updated the Group regarding the FNC. Earlier this year a Court ruling instructed the NHS to raise FNC by 40% without any new funding. **STP Finance** JW and CL updated the group on the STP financial situation. JW advised that the STP financial return now reflects the known impact of the acute deficit position. **End to End Project** KF shared the project model and updated the group on the following points: KF to circulate to the group. • The project is developing how it would improve the support for patients coming out of hospital and having one	**KF**

	shared methodology. • The information would be for the ward staff, consultants, managers at GHT, social work team, community hospitals etc. • The aim is to have everyone sign it off and operate the model.	
4.0	**BCF Update & Risk Register – Margaret Willcox**	
	MW advised that there were no changes to the BCF from the last meeting and went through the Risk Register. • £1.327m – this is the money that could be reallocated as it was no longer required. • PBS = Positive Behaviour Support – It was agreed to fund this for a further year. The results from this service are significant and future years funding will be considered during 17/18. • Trusted Assessor Pilot – Has been agreed for 2 years.	
5.0	**Mental Health, Perinatal, IAPT – Mary Hutton/Kim Forey**	
	<u>Perinatal</u> • KF advised that Helen Ford and Simon Bilous have been working extensively with Karl Gluck in putting together a complicated business case which had to go back to the DoH following sign off by all of the system partners. • We have been allocated approximately £1.2m for 3 years to help to support the perinatal agenda. **ACTION: KF to find out when we can formally announce this.** **<u>Schools Pilot</u>** • LU asked whether we have got the money to rollout the schools pilot? KF advised that it was part of the Future in	**KF**

	Mind funding. • MH clarified that we need to understand how much of Future in Mind can be invested in 17/18. • MH advised that we are currently working on the improvement access to psychological therapies targets. The model in Gloucester was mainly nurse led but following the central intensive support team review of the service it was decided that they want to see greater levels of training and qualifications which resulted in staff having additional training during 16/17 and into 17/18 with an increase in staff required to deliver the improving access to psychological therapies. • Gloucestershire is now doing well on the recovery rate and achieving the 50% target. • We are not delivering on the level of access target that other communities are delivering. We are current delivering 12% and should be moving to 15% which will take a significant investment. • We have invested £675,000 in 16/17. The plan is to invest a further £525,000 in 17/18. • PMcL asked when the FIM funding will be allocated. • MH suggested that we should ask the team to produce a schedule of FIM future in mind proposals and look at what has been tested and piloted and what the outcome of those pilots are. Then we can decide how much can be allocated.	
6.	**STP Update – Mary Hutton** The presentation had been circulated to the Group prior to the meeting. MH gave a verbal update and answered any questions raised. The following was noted:	

- We have been working on a short guide over the last number of weeks
- The plan is to launch the STP on 11th November.
- The community have asked for more support to help them manage their own conditions and more community support.
- £226m challenge over the next 4 years if services are delivered in exactly the same way due to changing demand and requirement for investment in new services, drugs and technology.

The following were discussed:

- Background
- Plan on a Page
- Financial challenge:
  - Focussing on productivity, reducing waste, making services more efficient and streamlined.
  - Each CCG normally holds back 1% for contingency, for Glos CCG this is £8m a year. In addition Glos will be allocated £40m additional funding in 20/21.
  - MW asked about the capital allocation. MH advised that there is no capital allocation but capital may be identified for those areas which are top priority.
- EAC:
  - Prevention and self-care is included under this category.
  - There was concern about sending a lot of people into the voluntary sector as this may raise issues around capacity but there have been no significant problems. The voluntary sector is generating further capacity. There has been some investment in the voluntary sector in 2016/17.
  - We have agreed to pilot the Academic Health Science Network diabetes NHS Digital Test Bed programme. This programme is called Mapmydiabetes and it is

being rolled out to 12,000 people in the next two years in Gloucestershire.

- We have seen that people who have the Mapmydiabetes product are embracing it.

- SS advised the Group that we have been chosen to be in the next wave for the National Diabetes Prevention programme. It is not in the public domain until the end of the month. It is a nationally funded prevention programme.

- PMcL asked "what would happen if the devolution bid did not happen". MH advised that Leadership Gloucestershire would continue to work together regardless of the Devolution Bid.

- LU mentioned that we need to make sure we make a link with the community safety review.

- PMcL queried the controversy over the restriction of access to elective procedures due to factors such as BMI/smoking and obesity. SS advised that there are no such plans in the STP.

- Clinical programme approach:
  - The plan is to take the whole of the budget and get all parties working together, maximise the benefits which include using community hospitals more for some of the work and ensuring people get one stop shops where they need to and ensure access and performance are delivered.

  - The measurements for the cancer targets are reported with a significant time lag and we will not therefore see the impact as to whether we are improving early cancer diagnosis until data is released rationally.

  - Question asked will the Governments new approach to pharmacies have any impact on this as there could be less funding coming through to community pharmacies or the closure of community pharmacies.

	➢ MH replied that this poses a risk as we are prioritising more use of pharmacies. • 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. ➢ 7 day service across our urgent care systems by 2021. ➢ There are 16 Clusters agreed across Gloucestershire. ➢ DB informed the group that at a Stroud District Council meeting 2 weeks ago, Questions were raised on the clustering of GPs and other services. ➢ This is a four year plan; there will be some engagement between now and May and consultations after May. Engagement means public meetings. There will be specific engagement around urgent care starting in December. ➢ MH advised that they were confident they can answer all the questions around the place-based models, work in the community etc. The group had a detailed discussion around STP	
7.	**AOB**	
	Nothing to report.	
	Date of Next Meeting: 11th January 2017	