NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 25 July 2019 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

AGENDA

No.	Item	Lead	Recommendation
1	Apologies for absence	Chair	
2	Declarations of interest	Chair	
3	Minutes of the Meeting held on 23 May 2019	Chair	Approval
4	Matters Arising	Chair	Discussion
Standing Items and Update Reports			
5 **5.1.**	Public Questions Patient Story (*Integration Accelerated Pilot).*	Chair Rebecca Barrow	Information Discussion
6	Clinical Chair's Update Report	Andy Seymour	Information
7	Accountable Officer's Update Report	Mark Walkingshaw	Information
8	Cinapsis Presentation	Christian Hamilton	Discussion/Verbal
9	Cancer Care in Gloucestershire	Kathryn Hall	Discussion
10	Performance Report	Cath Leech	Discussion
11	ICS Update Report	Ellen Rule	Discussion
12	Quality Report	Julie Symonds	Discussion
13	R4G Vision	Becky Parish	Discussion

14	Long Term Plan –outcome of engagement *(presentation)*	Becky Parish	Discussion
15.	Risk Management report Governing Body Assurance Framework	Cath Leech	Discussion
Items to Note:			
16	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
17	Governance and Quality Committee Minutes	Julie Clatworthy	Information
18	Audit & Risk Committee Minutes – 12 March 2019	Colin Greaves	Information
19	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 26 September 2019 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.

Gloucestershire Clinical Commissioning Group

Governing Body

Minutes of the meeting held at 2:00pm on 23 May 2019

Board Room, Sanger House

Members Present:		
Dr Andy Seymour	AS	Clinical Chair
Mary Hutton	MH	Accountable Officer
Mark Walkingshaw	MW	Deputy Accountable Officer
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Dr Caroline Bennett	CB	GP Liaison Lead – North Cotswold
Dr Alan Gwynn	AG	GP Liaison Lead – South Cotswold Locality
Colin Greaves	CG	Lay Member, Governance
Alan Elkin	AE	Lay Member, Patient and Public Experience
Cath Leech	CL	Chief Finance Officer
Peter Marriner	PM	Lay Member, Business
Julie Clatworthy	JC	Registered Nurse
Dr Lesley Jordan	LJ	Secondary Care Doctor
Teresa Middleton (*Deputising for Dr Marion Andrews-Evans*)	TM	Deputy Director of Quality
Dr Sheena Yerburgh	SY	GP Liaison Lead – Shroud and Berkeley Vale
Dr Will Miles	WM	GP Liaison Lead – Cheltenham Locality
Ellen Rule	ER	Director of Transformation and Service Redesign

Dr Will Haynes	WH	GP Liaison Lead – Gloucester Locality
Kim Forey	KF	Director of Integration
In Attendance:		
Gerald Nyamhondoro	GN	Governance Officer (taking minutes)
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Annette Blackstock *(Agenda Item 14)*	ABs	Nurse, Safeguarding Children
Andy Dempsey *(Agenda Item 14)*	AD	Director of Strategy and Partnerships, GCC
Two members of the public attended the meeting		

1.	**Apologies**
1.1	Apologies were noted from Helen Goodey, Dr Jeremy Welch, Sarah Scott, Dr Marion Andrews-Evans, Margaret Willcox, Helen Goodey and Jo Davies.
1.2	The meeting was confirmed as quorate.
2.	**Declarations of Interest**
2.1	No interests were declared.
3.	**Minutes of the Governing Body meeting held on 28 March 2019**
3.1	The minutes of the meeting held on Thursday 28 March 2019 were approved as an accurate record, subject to the following amendments: Paragraph 5.8 of the minutes should read 'WH emphasised that there was a need to further explore the '*Patient Story*' and the points raised by HS so as to derive more benefits and a wider range of outcomes for Gloucestershire. AS concurred that there was need for follow-up and the revisiting of the matter'. Paragraph 8.1 of the minutes should read 'MH presented the

	Accountable Officer's report and stated that there was an improvement in the way that local health and care services were shaping dementia services. She added that HLR had been driving the improvement of dementia services. HM further commented that Gloucestershire had a dementia diagnosis rate of 67.4% (above the national target set by NHS England)'.
4.	**Matters Arising**
4.1	**26/07/18, Item 15.1**: SS described a new Children and Families Partnership Framework that would go out to consultation and would be brought back to future Governing Body Business Session . **Item closed**.
5.	**Final Accounts 2018/19**
5.1	CL presented for approval to the Governing Body the set of accounts which were recommended on 21 May 2019 by the Audit & Risk Committee. CL stated that the accounts were now complete. Grant Thornton had undertaken an additional review of the accounts and this had led to further disclosure adjustments.
5.2	CL elaborated that Grant Thornton had rigorous internal review processes for larger organisations whereby further tests were carried out. The auditors selected a sample of some organisations' accounts for "hot review". This review was carried out by another central team within Grant Thornton who conducted a more in-depth review of the accounts. CL emphasised that the key financial numbers had not changed as a result of the review. CL explained to members that the external auditors were currently finalising their testing.
5.3	**<u>RESOLUTION</u>: The Governing Body approved the 2018/19 Final Accounts subject to the finalisation of the audit testing.**
5.4	<u>Letter of Representation</u>

5.4.1	CL delivered the Letter of Representation to the Governing Body. The Letter of Representation was provided by Grant Thornton in connection with the audit of the financial statements of the CCG for the year ending 31 March 2019. This was for the purpose of expressing an opinion as to whether the financial statements gave a true and fair view in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2018-19.
5.4.2	**<u>RESOLUTION</u>: The Governing Body approved the Letter of Representation.**
6.	**External Audit – Assurances from Management and those charged with Governance**
6.1	CL and CG presented and confirmed assurance on behalf of management and those charged with governance, in relation to the system of governance and internal control processes in place, which were operated by the CCG.
6.2	**<u>RESOLUTION:</u> The Governing Body noted the assurance from management and those charged with governance in relation to the governance and internal control processes operated by the CCG.**
7.	**Annual Report 2018/19**
7.1	MH presented the report and stated that the CCG had been established in April 2013 to commission services on behalf of the population of Gloucestershire. MH added that the CCG commissioned a wide range of hospital, community, mental health, learning disability and primary care based services.
7.2	MH outlined the CCG's main service providers as Gloucestershire Care Services (GCS), 2Gether NHS Foundation Trust (2g), South Western Ambulance Service NHS Foundation Trust (SWASFT),

	general practices, independent care homes, hospitals and third sector organisations.
7.3	MH summarised the report as follows: • The CCG was a clinically led organisation with 74 GP member practices working across 14 Primary Care Networks (PCNs). The CCG's membership covered seven localities namely Cheltenham, Forest of Dean, Gloucester City, North Cotswolds, South Cotswolds, Stroud & Berkeley Vale; and Tewkesbury, Newent and Staunton. • The CCG was committed to supporting the active communities programmes and it had pledged £1,200,000 to help get 30,000 inactive people to participate in daily exercises through the 'Gloucestershire Moves' programme. • The CCG and its partners ran programmes encouraging children and young people to exercise and more than 22,500 school children benefited from the programmes. • The CCG had been very active in promoting mental health in the county's young population. This included 900 children and young people who received on-line and face to face counselling through the 'Teens in Crisis' programme. • The CCG was strategically moving toward an Integrated Care System (ICS) and focusing on enhancing collaboration across health and care systems.
7.4	**<u>RESOLUTION</u>: The Governing Body approved the 2018/19 Annual Report subject to final opinion from the auditors.**
8.	**Public Question**
8.1	AS informed the meeting that one question had been submitted by Mr Bren McInerney. Bren McInerney's question was 'Since the introduction of the NHS Workforce Race Equality System (WRES) what approach/approaches has NHS Gloucestershire Clinical Commissioning Group undertaken to achieve visible ethnic minority

	representation at a senior leadership level, executive level, and at the NHS Gloucestershire Clinical Commissioning Group board/Accountable Body. What has been the significant impact of this approach/approaches?'
8.2	AS answered as follows: 'The CCG annually reviewed the outcome of our NHS Workforce Race Equality Standard and had consequently adapted our staff survey to try to improve the quality and range of data available in order to complete these reports. Our latest report in 2018 showed that whilst we no longer have BME representation at an executive level, our senior managers were more diverse, particularly those in a clinical role (14.3% Bands 8 & above). Overall, BME representation in our workforce was slightly higher than the Gloucestershire population – 5.5% compared to 4.6% (Source: 2011 Census – Population profile 2019 https://inform.gloucestershire.gov.uk/media/2087689/equality-profile-2019-final.pdf), with 5.9% of our Band 8,9 and VSM staff being from a BME background. However, we the CCG was not complacent and continued to look for opportunities to promote and recognise diversity in our workforce. In 2018, we were the first CCG in England to take part in the Insight programme: this aimed to increase the pool of high quality candidates for non-executive/lay member roles from under-represented communities, (i.e. BME background, female and disabled) by: • identifying and selecting potential non-executive candidates; • providing a central induction event to introduce the NHS; • giving participants the opportunity to experience 'life as a non- executive director' in a mix of NHS Trusts/Clinical Commissioning Groups by shadowing an existing NED/Lay Member; • mentoring and developing participants' skills with the

	support of experienced NEDs/Lay Members and Chairs; • arming participants with guidance, networks and testimonials that support future applications. It was reported that having completed a placement at the Royal United Hospitals Bath NHSFT, Razi Ahmed joined us during 2018, "shadowing" one of our Governing Body Lay Members at meetings of the Governing Body and a number of CCG committees. It was reported that in terms of the future, the CCG was currently exploring opportunities for further placements with the insight programme. It was also noted that the Equalities and Health Inequalities Working Group (which reports to the CCG Quality and Governance Committee) would review the WRES data for 2019 and develop an action plan to address any issues identified'.
9.	**Chairman's Report**
9.1	<u>Primary Care Strategy Progress and Improved Access</u>
9.1.1	AS presented the report and explained that there were now 14 Primary Care Networks (PCNs) established across the county. Clinical Directors were being nominated within each PCN and part of these individuals' role would be that of managing the interfacing between the CCG and the Integrated Care System (ICS).
9.1.2	AS stated that as part of the effort to deliver place based care in Gloucestershire, the CCG introduced Integrated Locality Partnerships (ILPs) had been established across the county. AS explained that the CCG Governing Body and its partners had approved the rollout of 6 ILPs.
9.1.3	AS further stated that the CCG was working with Chief Executives of District Councils to develop a deeper understanding of current partnership structures and how ILPs could help drive the integration programme.

9.1.4	AS explained that the Key Performance Indicators (KPIs) for primary care showed a positive trend in improving access to GP appointments. AS announced that 11,183 appointments were offered to patients across the county with an utilisation rate of 85%, in March 2019.
9.2	<u>Workforce</u>
9.2.1	AS informed members that the CCG and the Primary Care Training Hub were working together to inspire the new generation of GPs and he added that approximately 35 early career GPs were taking part in the 'Next Generation GP' scheme. A number of inspirational national speakers had been invited to speak to the group – these included Dr Robert Varnam, Dr Nick Harding, and Professor Simon Gregory. Participants reported that the event had been highly interactive and enjoyable, as early career GPs were empowered to explore and talk through opportunities available to them. There was also discussion on how to tackle challenges which they may face as leaders. Three out of the five sessions had taken place, with future sessions booked for the evenings of the 12 of June and the 9 of July.
	Teresa Middleton joined the meeting at 14:25pm
9.3	<u>Digital First Primary Care</u>
9.3.1	AS described the digital platform called 'FootFall' (supplied by Silicon Practice Ltd) as a platform that encouraged and supported care navigation. AS added that the platform offered self-help and allowed secure electronic communication between patients and the practice.
9.3.2	AS stated that the CCG was implementing a small scale pilot scheme to monitor and evaluate the benefits to general practice of an online symptom checking and triage system. The 'Doctorlink' system from Medvivo Group Ltd had been procured for the

	Gloucestershire pilot.
9.4	Phoenix and Romney House
9.4.1.	AS announced that Phoenix and Romney House contractually merged their practices with effect from 1 April 2019 thus bringing the total number of General Practices in Gloucestershire to 74.
9.5	**RESOLUTION: The Governing Body noted the contents of the Chairman's report.**
10.	**Accountable Officer's Report**
10.1	MH provided an update on some of the key programmes and initiatives within the CCG during April and May 2019.
10.2	Living Well with Pain Programme
10.2.1	MH stated that long term pain was disabling and there were no truly effective treatments available to reduce long term chronic pain. Many people suffering long term pain experienced frustration and isolation.
10.2.2	MH asserted that some of the commonly used medicines for pain management could be harmful to patients and there was little evidence to support their use in successfully treating the symptoms of pain.
10.2.3	MH explained that the 'Living Well with Pain Programme' aimed to protect patients from the harms of pain treatments. MH further explained that it was imperative to drive a shared understanding of pain to ensure that people with pain did not have the additional burden of harms from treatments that were not helping their symptoms and condition.
10.3	ESCAPE-Pain

10.3.1	MH described a rehabilitation programme for people with chronic joint pain called 'ESCAPE Pain' (Enabling Self-management and Coping with Arthritic Pain using Exercise). The programme integrated educational self-management and coping strategies with an exercise regime that was individualised for each participant. MH explained that ESCAPE-Pain training was accredited by the Chartered Institute for the Management of Sport and Physical Activity and the programme was also recognised by the NHS Long Term Plan (LTP).
10.4	<u>National Diabetes Prevention Programme (NDPP)</u>
10.4.1	MH stated that the NDPP was now fully operating in Gloucester, Cheltenham, Forest of Dean and nearly all of Stroud and Berkley Vale practices. Tewkesbury and the Cotswold districts were to follow shortly. MH further explained that at the time of presenting the report there had been 3,074 referrals to the NDPP with 57% of patients taking up the offer to go onto the programme.
10.4.2	MH stated that as part of the 10 Year NHS LTP, the NDPP would now be funded for an additional 3 years up to August 2022. Due to this service extension, the CCG had selected ICS Health & Wellbeing to be Gloucestershire's new NDPP service provider taking over from Living Well Taking Control (LWTC) LLP in August 2019.
10.5	<u>Dermatology</u>
10.5.1	MH asked AG if he wanted to comment on the dermatology work the CCG was pioneering. AG explained that the CCG in conjunction with Gloucestershire Hospitals NHS Foundation Trust (GHFT) were working together to move towards a 'virtual model' for dermatology. A platform had been created allowing clinicians in primary and secondary care to work together towards a virtual model of rapid diagnosis of skin conditions, particularly skin lesions, and deliver the

	most appropriate treatment. MH added that the Dermatology model was well received and it would be a good idea to extend the model to other areas of health delivery.
10.6	<u>Improving Outpatient Services</u>
10.6.1	MH advised that NHSE had allocated Gloucestershire ICS additional funding to help develop outpatient plans and share learning with other Integrated Care Systems across the country.
10.7	<u>Adult Carers Support Services</u>
10.7.1	MH explained that in April 2019 PeoplePlus became the provider of the adult carers' support service called the 'Gloucestershire Carers Hub' based in Gloucester City centre. The information, advice and guidance support service operated from the Carers Hub, but the rest of the support would be delivered in the community through key workers responsible for specific local areas.
10.8	<u>Young Carers Contract</u>
10.8.1	MH stated that support for young carers and young adult carers aged 8 to 24 years would continue to be provided by Gloucestershire Young Carers (GYC). The GYC would work in partnership with the statutory and voluntary agencies across the county to identify young carers.
10.9	<u>South West Ambulance Service</u>
10.9.1	MH explained that the CCG worked with South West Ambulance Service to introduce a pick-up service for people who had fallen, but not sustained serious injury. The pilot was producing positive outcomes for patients.
	<u>RESOLUTION</u>: The Governing Body noted the contents of the Accountable Officer's report.

11.	**Performance & Finance Report**
11.1	<u>Performance</u>
11.1.1	MW delivered the executive summary and the first part of the performance overview. MW explained that the overall CCG performance in areas of Leadership, Better Health and Sustainability remained good, but Better Care performance required some further improvement. MW summarised as follows: • Despite many challenges system performance against the 4 hour standard continued to put the Gloucestershire system into the top 33% nationally. • Progress was observed in the performance of community and mental health services. • The CCG failed to achieve the 92% target for patients on Referral to Treatment (RTT) pathways to be seen within 18 weeks; only 80.9% was achieved. However it was recognised that the focus for 2019/20 was upon stabilising performance and on making a small improvement in performance over the course of the year. • The Category 1 ambulance services performance standard had been delivered. It was noted that performance remained below target for the Category 2 standard
	Annette Blackstock joined the meeting at 14:45pm
11.2	<u>Cancer Performance Overview</u>
11.2.1	ER presented the cancer performance update and summarised as follows: • The 62-day cancer target to commence treatment on diagnosed patients was 85% and the CCG achieved 74.5% performance in 2018/19. It was reported that performance challenges within urology had significantly contributed to this.

	It was reported that if urology was excluded from the overall 62-day performance, the average performance would be much closer to the 85% target. • The cancer target for patients to be seen within 2 weeks of referral was 93% and the CCG achieved 90.1% in 2018/19. This was an improvement from 82.7% in 2017/18 but remained below target.
11.3	<u>Continuing Health Care (CHC) and Improving Access to Psychological Therapies (IATP)</u>
11.4	KF presented the CHC and IAPT performance updates and summarised as follows: • While IAPT performance appeared good throughout 2018/19, the change in recording methodology and reclassification had impacted negatively. The CCG continued to invest in IAPT with the aim to increase the number of people accessing treatment. • The CHC target was 80% of patients receiving full assessment within 28 days of referral and the CCG achieved 35% performance in 2018/19. However, the CCG achieved 100% against a standard target of 85% regarding assessments taking place outside of acute hospital settings. • Regarding performance at GCS, bed occupancy had been maintained at a more sustainable level throughout the year 2018/19. The average number of delayed patients in any month had not risen above 3; in the previous year of 2017/18 the average delay was 11. • Care provision at home had been supported throughout the year by the Rapid Response and Complex Care at Home services.
11.5	JC suggested that members could benefit from the availability of more data and information relating to factors affecting the 62-day cancer performance as this would facilitate more informed decisions.
11.6	The Chair asked MW/ER to provide more detailed data on the 62

	day cancer performance to the Quality & Governance Committee at a future date. **Action: MW/ER**
11.7	AE commented that it was worrying that the CCG had low CHC performance figures when there was evidence of Sheffield CCG showing performance as high as 96% assessments within 28 days.
11.8	CG advised that some of the problems contained in the report required a long term approach and may be difficult to remedy in the short term. He gave an example of pressures faced in the radiology department at GHFT.
11.9	MW emphasised that the problems identified in the report and the discussion demonstrated the need to revisit and re-design some pathways.
11. 10	<u>Finance Performance</u>
11.10.1	CL delivered the finance part of the report and summarised as follows: • The CCG confirmed the allocation of £891,700,000 as at 31st March 2019. The CCG operated within its resource limit and achieved a 2018/19 surplus of £5,000 and a cumulative surplus of £21,470,000 • The CCG had an over-performance in acute contracts in 2018/19, and in the case of the GHFT contract, the CCG agreed an outturn of £1m over-performance relating to elective activity and drug expenditure. • The CCG experienced an overspend on CHC. There was a high volume of assessment requests from nursing homes which required CHC funding. • The February 2019 statistics showed an under spend of £2,500,000 and an overall saving of £5,000,000 on prescriptions. • Estates budgets continued to show an under spend.

12.	**ICS Update**
12.1	MH presented the ICS update. MH articulated the key priorities for 2019/20 which included the Health & Wellbeing Strategy and was split across the 4 main work streams namely supporting pathways, supporting people, supporting communities and supporting the workforce.
12.2	MH further explained as follows: • The CCG was increasing the focus upon its patient centred approach. • The CCG was promoting a model of empowering communities to take greater control of their own health through the 'Enabling Active Communities' programme which focused on building an enhanced sense of personal responsibility and support for community capacity through working with the voluntary and community sectors. • The CCG's Long Term Plan (LTP) involved reducing inequality by increasing investment in human resources. One of the ways to achieve this was by increasing investment in the recruitment and training of midwives. • The CCG had enhanced its tools that helped identify the health needs of the community.
12.3	**<u>RESOLUTION</u>: The Governing Body noted the contents of the ICS update.**
13.	**Quality Report**
13.1	TM delivered the report and explained that the report provided assurance on the quality monitoring undertaken by the CCG and the work undertaken to improve the quality of services by providers.
13.2	TM gave a breakdown of Patient Advice and Liaison Service (PALS) figures to the members and described themes identified from PALS as follows:

	• Telephone systems. • Length of time on hold & position in queue. • Getting close to being answered only to be cut off. • Prescriptions not been sent to pharmacy. • Receptionists. • Queuing at the desk. • Getting an appointment - some patients stated that it would be quicker to drive to the practice and make appointments rather than use the telephone.
13.3	TM provided an update on infection control as follows: • NHS Improvement (NHSI) had set a countywide threshold target of 6 Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections for 2018/19, but instead the county suffered 14 incidents during that period with 6 of those cases being community acquired. A review group led by a GCC Public Health Protection Consultant was set up to analyse these cases. • During year 2018/19, 128 Methicillin-sensitive Staphylococcus aureus **(**MSSA) bacteraemia infections cases were reported. There was no threshold target for MSSA at the time of presenting the report. • The threshold set by NHS Improvement (NHSI) for Clostridium Difficile Infections (CDI), countywide, was 156 cases in 2018/19, but 184 CDI cases occurred during the period. 32% of those cases were hospital acquired and 68% were community acquired. A panel was set up to review the outcome and provide lessons from Post Infection Reviews (PIR). • In year 2017/18 Escherichia coli (E.coli) infections exceeded the set threshold by 17 incidents and in year 2018/19 E.coli infections exceeded the threshold by 29 incidents. • A countywide Urinary Tract Infection (UTI) reduction plan had been produced and cases were reviewed quarterly.

13.4	TM also stated that the CCG and GCC had been working collaboratively to improve flu vaccination uptake and reduce flu incidents, and the provisional outcome was encouraging.
13.5	CB commented on the Never Event that involved wrong site surgery which had been previously reported to the Governing Body. She explained that the problem had been reviewed and addressed.
13.6	AS queried what appeared to be the lack of correlation between resources invested and the outcomes in flu containment programmes. TM stated that flu vaccines were 60% effective. The Governing Body asked for further updates on the flu vaccination programme. **Action: TM**.
13.7	**RESOLUTION: The Governing Body noted the contents of the Quality report.**
14.	**Working Together**
14.1	ABs and AD gave a presentation on safeguarding children. ABs described the key links between child safeguarding arrangements and the wider governance network for the county.
14.2	AD added that the 'Working Together' programme linked well with other efforts supporting schools and other institutions of learning. AD also stated that the processes designed to support the programme were reliable and there were no immediate pressures to overhaul them.
14.3	AG sought assurance on the reliability of the data sets and dashboard presented by ABs and AD. AD gave reassurance that the data sets and dashboard were reliable and benefited from the employment of 'Big Data' tools.
14.4	WH requested assurance as to how the progress of the Working

	Together programme would be measured. AD responded that the CCG would be able to monitor performance and progress as the dashboard held a matrix that supported measuring performances and pressures for partnerships and also supported the measuring of other collective outcomes.
14.5	MH stated that sharing responsibilities had increased people's appreciation of the benefits of integrated service delivery, and there was room for continual improvement of the data collected and the dashboard. .
14.6	**<u>RESOLUTION</u>: The Governing Body noted the contents of the Quality report.**
15.	**2019/20 CCG Annual Budget**
15.1	CL presented the budget which supported the CCG's and Gloucestershire Shadow ICS's operational plan. The proposed budget was predicated on a savings programme of £17,300,000 and a range of non-recurrent measures. CL added that the savings plan had been discussed with the ICS Board.
15.2	CL cautioned that achieving such an outcome was challenging. Therefore strong financial control and monitoring systems needed to be maintained during the year across all budget areas in order to deliver the planned outcomes.
15.3	CL outlined key risks within the plan as the under delivery of savings plans, including contract over performance, prescribing costs being higher than that planned, the potential for increasing CHC cases, primary care expenditure exceeding the budget set and the impact of Brexit.
15.4	CL stated that the CCG was carefully studying areas in which it and its ICS partners would increase savings. CL emphasised that this year there were clear financial challenges, improved communication

	was required between the finance team and budget holders in order to find ways of containing costs.
15.5	**<u>RESOLUTION</u>: The Governing Body approved the proposed 2019/20 budget and noted the inherent risks within the plan.**
16.	**Audit & Risk Committee Annual Report**
16.1	CG presented the report and explained that the role of the Audit & Risk Committee was to critically review financial reporting and internal control systems, and to ensure that an appropriate relationship was maintained with internal and external auditors.
16.2	CG described the membership of the committee and assured the Governing Body that the committee maintained its independence and objectivity. He confirmed on behalf of the Audit & Risk Committee that: • The risk management systems in the CCG were adequate and allowed the committee to understand the level of existing risks. • There were no areas of significant duplication or omission in the systems of governance that came to the committee's attention. • The draft Annual Governance Statement for 2018/19 was consistent with the committee's views on the CCG's system of internal controls. • The committee supported the Governing Body's acceptance of the report.
16.3	**<u>RESOLUTION</u>: The Governing Body accepted the Audit & Risk Committee Annual report.**
17.	**<u>Primary Care Commissioning Committee Minutes, 31 January 2019</u>**
17.1	AE presented before the Governing Body the Primary Care Commissioning Committee (PCCC) minutes.

17.2	**<u>RESOLUTION</u>: The Governing Body noted the contents of the PCCC minutes.**
18	**<u>Quality & Governance Committee Minutes, 14 February 2019</u>**
18.1	JC presented before the Governing Body the Quality & Governance Committee minutes.
18.2	**<u>RESOLUTION</u> The Governing Body noted the contents of the Quality & Governance Committee minutes.**
19.	**<u>Audit & Risk Committee Minutes, 11 December 2018</u>**
19.1	CG presented before the Governing Body the Audit & Risk Committee minutes.
19.2	**<u>RESOLUTION</u>: The Governing Body noted the contents of the Audit & Risk Committee minutes.**
20.	**Any Other Business**
20.1	There was no other business to conduct.
	The meeting was closed at 16:06 pm
	Date and time of the next meeting: **The next meeting would be held at 2:00pm on Thursday 25 July 2019, in the Board Room, Sanger House.**

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair):_____ Date:_____

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 4

Governing Body
Matters Arising – July 2019

Item	Description	Response	Action with	Due Date	Status
23/05/19, Item 11.6	Performance and Finance report – Cancer Overview: JC suggested that members could benefit from the availability of more data and information relating to factors affecting the 62-day cancer performance as this would facilitate more informed decisions. The Chair asked MW/ER to provide more detailed data on the 62 day cancer performance to the Quality & Governance Committee at a future date.	Additional information to be included in the report to the Quality & Governance Committee in September 2019.	MW/ER	September 2019	Open

23/05/19, Item 13.6	Quality report: AS queried what appeared to be the lack of correlation between resources invested and the outcomes in flu containment programmes. TM stated that flu vaccines were 60% effective. The Governing Body asked for further updates on the flu vaccination programme.	Seasonal Flu: The CCG is working on actions to improve our flu vaccination uptake particularly to “at risk” groups as well as care home workers and carers/visitors. Promotional material for carers and visitors is planned to encourage these groups of people to protect residents by having a flu vaccination and not visiting when they have respiratory infections.	TM/PF	July 2019	Open

Case examples for the Integrated Accelerator Project

Case Study 1

M is 24 years old woman. She has cerebral palsy and emotionally unstable personality disorder .For the last 8 years, M has received multiple interventions from health and social care services' including a high number of inpatient stays in our psychiatric and specialist hospitals. M presented with significant self-harm which frequently required medical attention in A&E.

Given the volume of previous interventions M was a person who was perceived by some professionals as having exhausted all existing services. M's personal mental health recovery journey had stalled and her needs were not being adequately met through her current care plan.

M was identified as someone who would potentially benefit from a more personalised assessment process being developed as part of Gloucestershire Integrated Accelerator Pilot

M was provided with information about the Pilot and was happy to consent and engage in a new narrative based assessment leading to a co-produced care plan. She along with her family and other significant people in her life were supported and empowered to write and complete an integrated assessment around her health and social care needs. M felt able to tell her own story and be explicit and candid in her views and experiences in previous interventions that she felt had not facilitated her recovery.

- From this M was able to articulate a care that that she felt would work for her and one that she would be able to manage in the way she wanted and suited her life style
- M saw herself not as a set of mental and physical health needs but as a young woman trying to succeed with in university degree and explicitly expressed she wished to have the student experience.
- As such M advised she would like to visit her own health and fitness goals. She was aware she had gained some weight recently which was affecting her mobility more, but wanted to address this on her own terms and in a way that she determined.
- M expressed she wished to direct her care around her Cerebral Palsy, when the carer attends and what support is required.

Rebecca Barrow
Personalisation and Development Manager

- M advised this was the first time she had ever properly been asked what was important to her and what she thought would support her mental and physical wellbeing.
- M felt that having her narrative written by her with input from her family really demonstrated the important points about her life and focused more on what she could do than what she couldn't do.
- M has co-produced a package of care to support her with her physical health needs around the home. M manages this through a direct payment and employees a personal assistant which she manages herself with support around book keeping.
- M receives a personal health budget to facilitate specialist neurological exercise training with a specialist trainer which she identified and now attends weekly. It is reported that movement is improving and M has lost some weight.
- M has also purchased a weighted blanket to help support her anxiety.
- M currently has not had a hospital admission since receiving the joint assessment and is directing her care.
- M has expressed to her worker that she now has a very busy social and personal life and is finding it difficult to see professionals as frequently as she was before.
- M has significantly reduced herself harm and has adopted some other coping strategies when she becomes anxious such as using her weighted blanket.
- M is actively involved in the accelerator project and wants to advise workers and senior colleagues about how this process worked for her and what we as professionals needs to do differently.
- The staff member who undertook this assessment said she felt empowered by being able to listen to M and hear her narrative rather than be confined to tick boxes about what the person is unable to do rather than strengths based.
- The worker said that they really felt they got to know who M was rather than the diagnosis and label of "patient".
- The worker advised that it was more beneficial to spend time with the person than writing an assessment in a tool that was not formatted to meet the needs of M.
- The worker enjoyed the freedom to think in a holistic way

Update

M has only made appropriate required contacts with mental health services since her personalised budget commenced. M is directing her own care and regularly attending the Gym. M has lost some weight. M was asked if she would like to participate in feedback for this to which she responded that she was "a bit busy currently". M has not been admitted to psychiatric hospital /A& E or the Maxwell Suite (s136) since her personalised budget started. M started she wishes she had received this opportunity years ago.

Rebecca Barrow
Personalisation and Development Manager

Case Study 2

V is a 34 year old woman with a diagnosis of ARFID, avoidant restrictive food intake disorder. This is a rare eating disorder that only recently became a classified mental illness. There is a poor prognosis for recovery from ARFID and there are no specialist inpatient treatment units and no NICE guidance to give an evidence base for treatment. V has extreme aversions to any food other than potatoes. V has almost gone completely blind because of the lack of nutrients in her diet and recently broke her ankle by simply standing up out of bed due to brittle bones and muscle wastage. V also suffers with OCD.

V has been informed that the consequences for her now of not eating the correct nutrients is a significantly reduced life expectancy. However this information in itself is unlikely to empower V to make the necessary changes to her diet.

V is supported by secondary mental health services. She has a package of care to support her physical health needs but local services fell they are not equipped to meet this need. Admission to hospital and force feeding have been considered but are not the preferred way forward for her or mental health services. Clearly a new approach was required and potentially fitted very well with the aims and objectives of the Integrated Accelerator Pilot.

V has expressed a clear wish to live, she is aware of the effects on her body but feels powerless to help herself. Her self-expressed goal is to eat a balanced diet but feel the support available to date has not helped her achieve this. This has had a negative impact on the mental health and wellbeing and significantly impacted on her family.

V has a young daughter who acts as her main carer. V has expressed more than anything that she would like to see her daughter grow up and to be less dependent on her. V has a partner and expressed her wish to have a normal relationship with him. V advised her hair is falling out in clumps but she would like to have it washed and styled at the hair dresses, she is currently unable to leave the house.

- V has benefitted from a joint health and social care assessment with a worker who she has invested a lot of time in building a very good relationship with.
- V, her partner and her daughter have all played an active role in co-producing the assessment and talked about what they felt would help.
- V would like to have a mother daughter relationship
- V advised she would like help for her to live a more independent life and rely less on services.

Rebecca Barrow
Personalisation and Development Manager

- V advised the assessment empowered her, she felt she had control when she sat with the worker.
- V said the assessment is in her own words and is not in language that she couldn't always understand.
- V was happy to make suggestions about what might be helpful without being told it's not possible or there is are no local services available.
- V will now attend specialist counselling sessions in London for ARFID with the use of a PHB. This Counselling has helped 2 other cases which although is few is pioneering.
- V will have a package of care to support her physical needs, she will look to direct this care more when she has made some recovery.
- V's daughter has been referred to young carers for support
- V has been referred to the charity modern eyes, help for people with sight impairment to live as independently as possible.
- The worker expressed that this type of narrative assessment allowed for them to deliver a more holistic and acceptable approach going forward one based on informed choices and full of hope.
- The worker advised it allowed them to think beyond the boundaries of what services are there and how we could make V fit into them but rather where can we find a service that would fit around V.
- The worker was clear that without being offered this service. It is likely that options would have only been for admission to hospital, this PHB and different support gives hope.
- V feels with this counselling, it may give her the opportunity to move on with an independent life and prevent any further physical deterioration.

Update

V has received 3/6 sessions of hypnotherapy from the ARFID specialist. V has started to eat food, fruit, meat, fish. V has been able to take the food from another person's hand without being fearful of contamination. V is building her strength to mobilise fully again and plans to leave the house. V and her daughter have written a list of activities they want to do together when she regains her strength. The worker thanked management for the PHB and advised without the freedom of the money she would have never had this service commissioned. V thanked all for the opportunity at another chance at life.

The remaining hypnotherapy sessions will recommence when food becomes the norm again rather than experimental. It will aim to get V into the community.

Case Study 3

Rebecca Barrow
Personalisation and Development Manager

N is a 24 year old woman who has a diagnosis of Emotionally Unstable Personality Disorder, she also has a diagnosis of Autism. N has spent a significant period of time in psychiatric hospital and has had repeated contact with the police, mental health services and A&E.

N's twin sister took her own life whilst inpatient in a psychiatric hospital which had a significant impact on N and her family. N and her sister were very close and N has expressed a clear wish to be with her sister since her death.

Multiple services both health and social care have been offered and tried for N but all with poor outcomes so far. Her frequent admissions to hospital have been focused on preventing her significantly harming herself but in themselves have done little to encourage or empower a more progress recovery orientated way forward.

Whilst N was in hospital, the Accelerator Pilot afforded an opportunity for a worker in the project to build a relationship with her in order to undertake a more personised joint health and social care assessment.

N says she has trust issues around professionals due to past events and so relationship building is difficult. Spending time with her and valuing her assessment of the situation and past experiences of psychiatric care was vital to developing a co-produced assessment and care plan

- N advised that her dog is very important to her and she finds animals very soothing.
- N advised she enjoys peace and quiet. When she was younger she would follow her sister who would also take the lead on her behalf so she never really had to speak out or socialise.
- N loves to climb, she advised she feels free from her "stigma" when she climbs away from all of her concerns and issues.
- N expressed a wish to live. She advised she has some days, where she doesn't wish to be here but having trust in a professional and being listened to, makes her feels she might be able to cope.
- N advised that building a relationship and being listened to rather than being told what will happen was something she had not experienced before.
- N advised she would like to try and get on with her life if she could feel she has more control over her care. Expressing this was very difficult but the personalised and empowering approach adopted, to completing an assessment and care plan had a huge impact on her perspective of moving on with her life.
- By supporting the development of a co-produced care plan driven by her understanding of presenting mental health needs, it allowed for a truly different and for her, rewarding support package
- N is using a PHB to attend regular climbing lessons at the warehouse in Gloucester. N started these when she was still inpatient in the psychiatric

Rebecca Barrow
Personalisation and Development Manager

hospital. It is documented that there is a clear elevation in mood when she attended these and N herself advised she would “eat more” on these days as she wanted her strength to get better at climbing.

- The aspiration will be that N completes a climbing course and can go on climbing retreats and perhaps teach climbing herself.
- N is attending equine therapy to reduce anxiety. N will also attend RDA to help others with therapy through horses.
- N will attend a wood work class once a week
- N will attend an autism support group with peers.

Update

N has completed her initial sessions of learning to climb safely. She now hopes to pursue a train the trainer course to teach others. N is eating regularly to keep her strength up for climbing. N also attends the autism support group and equine therapy. N has only made appropriate required contacts with mental health services. N has not come to the attention of emergency services since receiving a personalised budget. N has not been admitted to psychiatric hospital since receiving a personalised budget. N and her family advised how grateful they were for this opportunity and feel it has given N a chance to start afresh. The worker said she felt empowered to support N .

Rebecca Barrow
Personalisation and Development Manager

Case Study CD

History

CD is a 35 year old gentleman with a long history of mental illness which has led to him spending the majority of his life in hospital, being initially admitted in 2000 right up until 2018 with only a few short periods of time in the community.

CD has a history of poor compliance with his medication and difficulties in engaging with the support that has been offered previously. He has experienced very difficult times in hospital and has needed to spend time in specialist units both medium and high secure.

CD's mother has said that he has never returned to 'himself' following his first admission to hospital and has subsequently found sustaining meaningful relationships challenging. CD only has a few friends, and they are mostly known to be multiple substance users. Prior to his first admission, CD was described as a confident and funny person who liked to look after and protect others. He was said to have many friends prior to becoming unwell.

CD currently has lost the ability to have hope for the future due to his experiences through his teens and early adult life making it hard for him to now build relationships. He is used to institutional settings but wants to 'be free'. CD needs the opportunity to build relationships that will help him in the long run engage in connecting with the wider community as well as rebuild the confident sociable character he once was.

On CD's most recent discharge from hospital. CD invited a friend into his home. The friend then used CD's property to take his own life successfully. Professionals were concerned this would cause CD to relapse.

Involvement

The worker completed an assessment using our new conversation based joint health and social care tool. CD advised he felt able to talk about what is really important to him and what he would like to achieve in the future. CD felt that he did need some practical support through care hours but also identified he would like to be part of the community again.

CD advised he used to enjoy playing golf as a child. He advised it allowed him to have important time to himself but he also could make friends at the golf club that were not linked to substance misuse or crime. CD advised he would like to first build his confidence and then perhaps apply for jobs that may come up at the club.

Rebecca Barrow
Personalisation and Development Manager

CD's worker requested a personal health budget for a Golf membership. She advised this would allow him to engage in something outside of his flat. She added that he says he feels happy and doesn't think about substances or illness she went on to say it adds considerable therapeutic value to his health and wellbeing' when playing golf. His worker has also engaged CD in the "men's shed" a voluntary service exclusively for men to meet weekly and build things in a workshop or socialise.

Cost of hospital care 2018	Cost of golf membership+ package of care	Total cost difference
£182,500 aprox.	**Golf - £399 per annum+ care package £14,913.60**	**£167,187.40**

Outcome

CD is subject to a community treatment order but has remained in the community without incident to date. The golf package has not yet started but CD has already showed keen motivation with his self-care, compliance with treatment and engagement with staff which has seen a reduction in care hours required. CD advised he feels hope for his recovery this time because he has been listened to and is receiving a service which he feels will aid his recovery and wellbeing. He advised it will allow him to get his life "back on track".

Case study DW

History

DW has a diagnosis of recurrent depressive disorder and has been in psychiatric services for over 3 decades. DW experiences general low mood which he attributes to his low appetite, poor motivation and desire to sleep for long periods of time. This has an impact on DW's ability to maintain his basic needs and to maintain his environment and safety. DW has been admitted to hospital informally on 3 occasions, and has been evicted from previous care settings. Currently, he has been resident for 12 years in a care home situated in the middle of town.

Involvement

During the integrated assessment process Dw was able to establish that he would like to be able to have access to a garden which he is not able to do in his current care setting. He used to be a gardener and would like the opportunity to be able to

Rebecca Barrow
Personalisation and Development Manager

go outside and enjoy the fresh air. He also felt that he needed to have access to an en-suite for Diverticulitis.

With DW'S permission, his sisters were involved in the assessment and would like him to live in a home that will support his physical and mental health needs, whilst also enabling him to access the outdoors and enjoy gardening.

DW is aware that maintaining routine has a positive effect on his mental state. He would like to build his confidence and motivation with accessing the community and would eventually like to be able to get a bus to visit his sister's home which is now significantly closer than the previous care setting.

Outcome

The worker along with DW and family identified a care home in a rural location that was significantly closer to the family home. There is a small saving of around £15 per week . DW advised he feels positive about the future and because he can access the outdoors freely, he believes it will significantly improve his mental state. The worker reflected that, if it was not for a narrative based assessment she would likely have not known that DW had these interests and would have continued to appropriately identify need but not fully consider the persons thoughts around what would help promote their wellbeing.

Rebecca Barrow
Personalisation and Development Manager

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 6

Governing Body meeting

Meeting date	**25 July 2019**
Title	**Clinical Chair's Report**
Executive Summary	This report provides a summary of key issues and updates arising during June and July 2019 for the Clinical Chair.
Key Issues	Key topics for this report: • Primary Care Strategy progress including Primary Care Networks and Integrated Locality Partnerships • Improved Access • Workforce • Digital First Primary Care • Care Quality Commission Inspections and mergers • Meetings June and July 2019
Conflicts of Interest	None.
Risk Issues: Original Risk	None.
Financial Impact	None.
Legal Issues (including NHS Constitution)	None.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	
Impact on Sustainable Development	None.
Patient and Public Involvement	None.
Recommendation	This report is presented for information and Governing Body members are requested to note the contents.
Author	Andy Seymour
Designation	Clinical Chair

Agenda Item 7

Governing Body

25 July 2019

Clinical Chair's Report

1. Primary Care Strategy progress

1.1 As anticipated Gloucestershire CCG received GP Network DES (Directed Enhanced Service) registrations from the fourteen Primary Care Networks (PCNs) in the county. The Gloucestershire PCNs cover all of our 74 practices. This means that we have full coverage of our patient population. The PCNs comprise between one and eleven practices and between around 30,000 and 63,000 patients. Twenty Clinical Directors were nominated to lead the 14 PCNs; a demonstration of the level and maturity of GP leadership in our county.

1.2 By the deadline of 28 June all fourteen PCNs had confirmed how they will work together under a Mandated Network Agreement (with over 100 clauses and seven associated schedules) to deliver the new Network Contract DES.

1.3 Each PCN is finalising their initial workforce requirements. NHS England confirmed that Gloucestershire demonstrated that it already had access to a full complement of social prescribers. As this function was included within our Community Wellbeing Service commissioned by the CCG and County Council. This means our PCNs have greater freedom to recruit clinical pharmacists or social prescribing link workers, to meet the needs of their populations.

1.4 This year is one of development; with Clinical Directors leading the work with health and care staff from across our Integrated Care System, to ensure that community and mental health staff are integrated well with

PCNs.

1.5 One way for primary care and community staff to build relationships is through their Integrated Locality Partnership (ILP). The ILPs are as follows:

- Cheltenham ILP- comprising 3 PCNs.
- Cotswolds ILP- comprising 2 PCNs.
- Forest of Dean ILP- comprising 1 PCN.
- Gloucester City ILP- comprising 4 PCNs.
- Stroud and Berkeley Vale ILP– comprising 3 PCNs.
- Tewkesbury ILP – comprising 1 PCN (Tewkesbury town centre practices, Newent, Staunton and West Cheltenham Practice). With communication links to practice populations in Gloucester, Forest and Cheltenham.

1.6 A pragmatic approach is being taken to areas where populations of PCNs are not coterminous with Place and District council boundaries.

1.7 Commissioners and providers including Gloucestershire County Council and the 6 District Councils have identified and assigned senior leads to each of the 6 ILPs. In some cases these individuals will attend both the monthly operational and quarterly strategic meetings of their respective ILP, and in other cases just the strategic meeting. Each Place is supported by a CCG Locality Manager who will provide dedicated project, development and delivery support.

1.8 To support development of Place in this county, the CCG and Public Health are jointly hosting a Place Development Session of the afternoon of Tuesday 9th July for ILP members and other interested individuals. The session will have three key purposes

- spending time together with other local leaders in ILP areas and building relationships;
- hearing about work programmes already taking place in local health and wellbeing partnerships and
- beginning to understand the needs of the place, priorities, and plans and understanding local population health data and how it can better support local people and patients.

2. Improved Access

2.1 Gloucestershire's Improved Access continues to deliver a significant number of routine and same day appointments across the county. From April 2018 until the end of May 2019, over 123,000 (123,587) additional appointments were available for patients. During the coming months, PCNs will begin to consider how to deliver both Improved Access and Extended Hours collectively.

3. Workforce

3.1 The Next Generation GP Gloucestershire project featured Dr Raj Patel, NHS England Interim Deputy Director for Primary Care and Gloucestershire's own Artic Explorer, Dr Ian Davis on the 12 of June. Inspiring GP's will complete a 'Strengths Finder' diagnostic session this month to understand more about their skills and strengths and how to build on them for the future. The CCG and Primary Care Training Hub are jointly funding a GP career promotion lead for one session a week. Dr Laura Halden will focus on work to develop and retain early career GPs, including follow ups for the attendees of the Next Generation GP Gloucestershire project.

3.2 All PCNs in county have been part of a workforce baseline data survey submission to NHS England to declare roles, which will form the basis of claims for the Additional Roles Reimbursement Schemes as part of the GP PCN DES contract. The baseline includes Clinical Pharmacists, Physiotherapists, Specialist Paramedics, Specialist Pharmacy Technicians and Social Prescribing workers.

3.3 The CCG and Primary Care Training Hub have been working on a Health Inequalities Fellowship, which has been recognised as a regional champion for The NHS Parliamentary Awards 2019 and received a visit from MP Richard Graham to celebrate this. The Fellowship is now through to the national shortlist in the Health Equalities Award Category the awards will be announced on the 10 of July.

3.4 From the 19 to 21 of June Gloucestershire CCG supported a regional International GP Recruitment event which took place at Marsh Farm in

Swindon. The three day event enabled engagement with four GPs and their families who also attended an interview and skills assessment session. The event also hosted a jobs fair for all regional GPs on Friday 21 June, where all Gloucestershire vacancies and schemes were promoted.

4 Digital First Primary Care

4.1 We are now in the process of mobilising new websites (FootFall product) across the county. It is anticipated the new websites will ease the administrative burden for practices, by supporting care navigation and signposting, offering self-help and allowing secure electronic communication between patients and the practice. Currently 49 practices have expressed interest in adopting the new website, with 8 having already upgraded.

4.2 The CCG is currently running a small scale pilot to monitor and evaluate the benefits to general practice of an online symptom checking and triage system. The Doctorlink system from Medvivo Group Ltd was procured for the Gloucestershire pilot. The system is currently live in 5 practices and we are working to improve patient adoption to gain the necessary information to conduct a thorough assessment of the system.

4.3 We recently secured additional funding to expand the pilot into an additional five practices for 12 months only, specifically to test working across a wider demographic and gain further intelligence to inform our future commissioning intentions.

4.4 The NHS App has been available to Gloucestershire Practices from March. NHS Digital has planned a national promotion campaign for September 2019.

5. Care Quality Commission (CQC) Inspections and mergers

5.1 Only one CQC report has been published since my last update. In total 68 Gloucestershire Practices are currently rated “good”, 4 are rated “outstanding” and 2 “require improvement”.

5.2 There have been no new contractual mergers to report since my last report.

6. Work starts on a new Health Centre in Cinderford

6.1 Building work commenced on a brand new £5 million health centre in Cinderford, with a turf cutting ceremony which marked the start of the construction. The purpose-built new facility will be built on Valley Road, replacing the town's existing health centre, which houses both Dockham Road Surgery and Forest Health Care.

6.2 The turf was cut on the site at a small gathering with representatives from the two practices, NHS Gloucestershire Clinical Commissioning Group, specialist development company Assura and construction company Speller Metcalfe.

6.3 The new building will take around 12 months to complete. It will be built to modern, environmentally friendly, state-of-the-art specifications, which include 20 multi-purpose consulting rooms, nurse treatment areas and spacious facilities for reception and administration staff.

7. Meetings

- Thursday 30 May - Visit to Charlie's cancer Support and Therapy Centre
- Monday 3 June - Practice visit to Meeting with Healthwatch Gloucestershire
- Thursday 6 June - ICS Executive, Sanger House
- Monday 10 June - Buddy Training, NHSCC, London
- Wednesday 12 June- Next Generation GP Scheme, Sanger House
- Monday 17 June - Practice Visit to Gloucester Health Access Centre and Matson Lane Surgery
- Tuesday 18 June - PCN Clinical Directors Meeting, Aspen Centre
- 18- 20 June - NHS Confed, Manchester
- Monday 1July - JCPB Meeting, Sanger House
- Thursday 4 July - NMOC Meeting, Sanger House
- Thursday 4 July - GP/Consultant Meeting, Sanger House
- Monday 8 July- ICS Executive, Sanger House
- Monday 8 July - Practice visit to Rendcomb Surgery
- Tuesday 9 July - Place Development Session, Hatherley Manor Hotel
- Wednesday 10July - PCN Development Group, Sanger House
- Thursday 11 July- PCN Clinical Directors, Aspen Centre
- Thursday 11 July - LMC Main Meeting, Farmers Club, Gloucester
- Monday 15 July - Practice Visit to Walnut Tree and Acorn Practices, Dursley
- Tuesday 16 July - ICS Primary Care Leads Meeting, London
- Wednesday 17 July - Meeting with Simon Stevens, Taunton

- Thursday 18 July - ICS CEO's Meeting, sanger House
- Monday 22 July - Practice Visit at Holts Health Centre, Newent
- Tuesday 23 July - Health and Wellbeing Board, Shire Hall, Gloucester
- Tuesday 23 July - A&E Delivery Board, Sanger House
- Thursday 25 July - Leadership Gloucestershire, Shire Hall, Gloucester

7. Recommendation

The Governing Body is asked to note the contents of this report.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 7

Governing Body

Governing Body Meeting Date	**Thursday 25 July 2019**
Title	**Accountable Officer's Report**
Executive Summary	This report provides an update on some of the key programmes and initiatives within the CCG during June and July 2019. To note for this report items about quality issues appear in a dedicated report included in each Governing Body meeting and will no longer feature in the AO's report.
Key Issues	Key topics for this report: • **New ENT service** • **Outpatient services** • **NHS Parliamentary Awards** • **Mental Health Trailblazer** • **Maternity Transformation – Better Births** • **Mindsong – singing to improve health** **Meetings attended in June and July.**
Conflicts of Interest	None.
Risk Issues: Original 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	None.

Involvement	
Recommendation	This report is presented for information and Governing Body members are requested to note the contents.
Author	Mary Hutton
Designation	Accountable Officer

Accountable Officer's Report

25 July 2019

The following report provides an update on some of the key areas of the CCG's work during the last two months, since the last report on 23 May 2019.

1. New Community Ears, Nose and Throat (ENT) Service

1.1 On the 1 July 2019 the CCG launched a new community ENT service as an 18 month pilot. The service, which is provided by G-Doc, will initially provide treatment for a small range of ENT conditions such as removal of ear wax via microsuction, treatment for otitis externa, and treatment for nose bleeds.

1.2 There is also the intention to expand the service further during the pilot period, to cover a wider range of ENT conditions. The service will allow patients to be treated quickly within community settings, rather than attend an acute hospital outpatient appointment. This will provide much needed alternative ENT capacity to help reduce waiting times for appointments at Gloucestershire Hospitals Foundation Trust (GHFT).

2. Redesigning Outpatient Services

2.1 In April this year the CCG and GHFT appointed Attain to support the outpatient re- design programme. Attain is currently working with health partners to develop a refreshed outpatients plan that builds on the gains we have made with re-organising outpatient services. Our refreshed plan describes how outpatient services will be made more efficient and effective, developing new alternatives in order to reduce at least a third of face to face outpatient visits over the next 5 years (in line with the national target).

2.2 Attain started work at the end of April to deliver a 12 week rapid review process, in order to identify opportunities to improve outpatients in 4 target specialties (dermatology, diabetes, neurology, and rheumatology). Working with health professionals they have identified opportunities to improve booking processes and services. Attain is working with us to draft our Integrated Care System outpatient strategy. Good progress has been made with developing new processes and procedures that will improve the efficiency of outpatient services that will also improve patient

experience of the service. Work is now commencing on a detailed and clear action plans for delivering the service over the medium to longer term.

3. Gloucestershire celebrates regional successes at NHS Parliamentary Awards

3.1 Primary Care Workforce Team

3.2 Two health initiatives in Gloucestershire have been chosen as regional winners at the NHS Parliamentary Awards for making a real difference to how the NHS provides care for patients.

3.3 The two innovative schemes that have been developed are Gloucestershire Primary Care Workforce Team in The Health Equalities Award category (see Clinical Chair's report); and Kingfisher Treasure Seekers in The Excellence in Mental Health Care category. Both initiatives are now on the shortlist for the national award in their respective categories.

3.4 Both these schemes were shortlisted against 600 nominations for this national award. The Primary Care Workforce Team impressed the judges with identifying new ways to support people who have traditionally found it difficult to access health services. The Health Inequalities Fellowship is designed to tackle GP recruitment issues in Gloucester's deprived inner city areas. The GPs recruited to this scheme connect with local health, care and voluntary services, to obtain specialist knowledge and expertise of inner city Gloucester populations. The expertise they develop including a greater understanding of how to engage with people who experience increased health and social challenges, allows the GP Fellows to build relationships with their patients that helps to improve their health.

3.5 GP Fellows have developed a specialist asylum seeker and refugee service. They also work with people who frequently access NHS services and need dedicated support such as those with mental health problems and obesity. The GP Fellows work for five sessions each week in general practice and complete a project, as well as a Postgraduate Certificate in Public Health. Although the Primary Care Team did not win the award, they came within the top three nominations for that category and were thrilled with the recognition they received for their innovative work.

3.6 Kingfisher Treasure Seekers

3.6.1 Kingfishers Treasure Seekers, an organisation that supports vulnerable and disadvantaged people won its award, for helping the hardest to reach groups to become the best versions of themselves, as fully engaged and contributing members of their communities.

3.6.2 Kingfishers Treasure Seekers has run The Cavern Café in Gloucester since 2015, providing non-clinical mental health support to people in the evenings. As a voluntary organisation it has a long history of supporting people who have mental health problems, as well as providing support to people with physical health needs such as diabetes. Additionally they run a community café with food training courses for disadvantaged and vulnerable people, which give new opportunities to people to engage with healthy food choices.

3.6.3 The café evening opening times are hugely beneficial, by offering support to people often at a time they may need it most helping to combat loneliness and isolation. The café is run by trained staff and volunteers who offer a listening ear and low-level interventions such as board games, adult colouring and more inclusive activities such as quiz nights. The Café also provides an inclusive and supportive environment, with a ‘snug’ and quiet space upstairs when privacy is needed.

3.6.4 The Café is funded by contributions made by the CCG, Gloucester District Council, the Police and Crime Commissioner and other partners.

4. Mental Health Updates

4.1 Mental Health Trailblazer

4.1.1 The Mental Health Trailblazer Programme started in April 2019. Four new Mental Health Support Teams were created to serve Trailblazer schools in the Forest of Dean, Cheltenham and Gloucester City localities. The teams will cover a total of 32,000 students aged 5-18 years across 72 schools.

4.1.2 As part of the programme a new workforce of ‘Education Mental Health Workers’ has been developed. The EMHW are currently training at Exeter University and will be on placement in Gloucestershire alongside more

experienced practitioners, team managers, the charity TiC+ and other voluntary and community organisations.

4.1.3 Ten schools have signed up as our 'Early Adopter Trailblazer schools', which gives us a great opportunity to introduce our Education Mental Health Practitioners. It also means that we are in a 'Test and Learn' phase, where we test out how we will work together with schools, parents and young people. Currently we are working with young people, parents and schools to look at referral pathways into mental health services. Over the autumn term the number of schools we are working with will increase. In January 2020 the programme will be rolled out to all 72 Trailblazer schools, with a combination of secondary, primary and special schools across three localities.

4.2.1 **The Four Week Wait for Mental Health Services**

We are working with NHS England on waiting times for mental health services; aiming to transform our current system of specialist mental health support to ensure minimum waiting times for patients. We are working with NHS Improvement, clinical teams, young people and parents looking at our demand and capacity modelling and the whole pathway, to see what changes can be made to improve efficiency and the experience of young people. Additionally we are looking to recruit more specialist mental health staff to provide more capacity and reduce waiting times. In order to promote choice, a pilot of online specialist therapeutic support is being launched in September.

4.3.1 **Maternity Transformation – Better Births**

4.3.2 The Better Births transformation programme commenced three years previously and has another two years to run. We are continuing to progress our large programme of work. Our vision in Gloucestershire is

4.3.3 *"Working together in Gloucestershire so that every woman and their family has access to safe, high quality and personalised maternity care; giving babies the best possible start in life."*

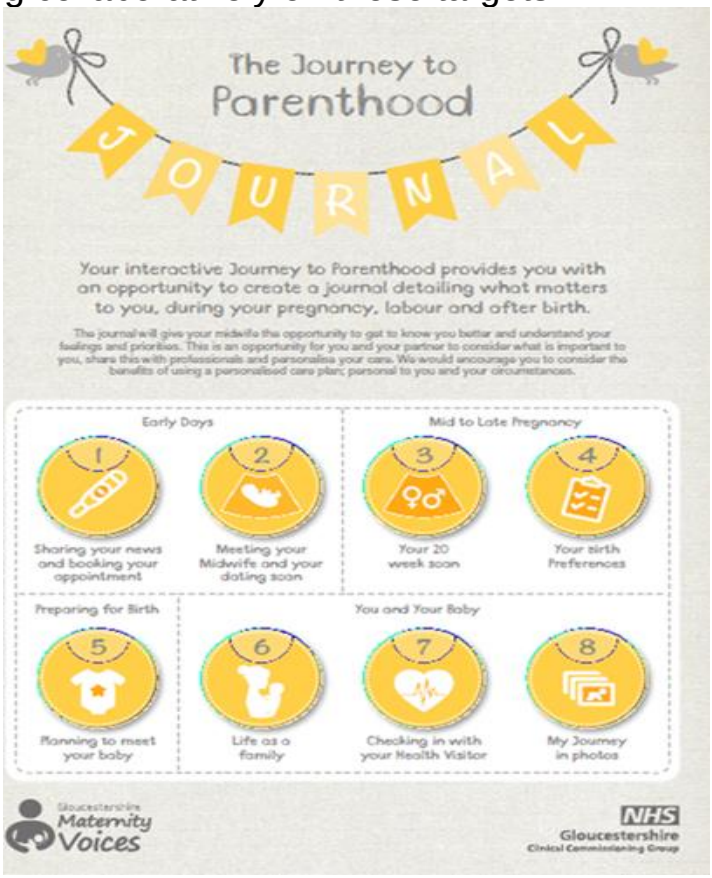
4.3.4 The voice of women and families in making continual improvements to services is a central part of our programme. We have recruited Emma Rawlinson as our Chair and launched a Maternity Voices Website last week. The website provides a trusted source of information, a forum for feedback and sharing events. Emma will be recruiting volunteers to work

with her from a variety of diverse backgrounds. A link to the website can be found here. https://www.glosmaternityvoices.nhs.uk/

4.3.5 We have developed personalised care plans with women and clinicians as part of our target to ensure that 100% of women have access to a personalised care plan. The plans are designed for woman so that they can say what is important to them in their care journey. The plans will be available on the Maternity Voices Website to download onto the woman's phone. All maternity staff are being trained in personalised care planning to support the roll out of this scheme.

4.3.6 A key part of our programme is developing small teams of midwives to care for women, providing support all the way through the pregnancy and birth journey, by a team of midwives that women know. This has been shown to improve safety and outcomes. Our target for March 2019 was 20% of women accessing care in this way, and currently we are achieving just over 10% of women who are being cared for in this way.

4.3.7 For 2020/21 NHS England will increase the target to 35% of women being looked after by a small team of midwives. The CCG along with GHFT is working collaboratively on these targets.



4.4 **Can singing improve our health?**

4.4.1 ***Whilst singing can lift our spirits, research evidence suggests it could also improve breathing for people with lung conditions and help us cope with dementia.***

4.4.2 The health benefits of singing was the topic of discussion between behavioural research and clinical experts at this year's Science Festival in Cheltenham held on 4 June, when they met with local singers from Mindsong. This new health-focussed approach to supporting people in Gloucestershire with persistent respiratory conditions is funded by the CCG.

4.4.3 Bespoke 'Breathe In Sing Out' singing groups have been set up to help participants to gain more control over their breathing, learning how to manage their condition better, meet people and improve their overall wellbeing. Trained vocal leaders teach appropriate breathing techniques through singing during the 12 week courses, which are now available across the county. This new scheme has recruited around 50 people who have been referred to the programme. Feedback from participants has been really positive, indicating that they feel more positive and less stressed or anxious, both during the singing session and afterwards. Being part of a group also helps them to gain confidence and a sense of achievement, and feel more like choir members, rather than patients.

4.4.4 Clinical trials have shown that in addition to breathing improvements and increased lung volume, singing can also help people with depression and anxiety and improve voice quality and power for people living with Parkinson's disease. It can also improve the behaviour and wellbeing of people living with dementia."

4.4.5 Breathe in Sing Out groups are run by Mindsong, a Gloucestershire charity that works with people who have dementia as well as respiratory conditions.

5. **Meetings**

A summary of meetings I have attended over the past couple of months

03 Jun Practice Visit – Stoke Road Surgery

03 Jun	Meeting with Lydney League of Friends
05 Jun	West of England AHSN Board
05 Jun	Joint Commissioning Partnership Executive Meeting (JCPE)
06 Jun	ICS Board
07 Jun	MPs and ICS NHS Chief Execs Meeting
10 Jun	Integrated Accelerator Pilot cross-site workshop
10 Jun	Health & Wellbeing Board Strategy Steering Group
18 Jun	Opening of Specialist Stroke Rehabilitation Unit
19 Jun	NHS Confed 2019, Manchester
24 Jun	Extraordinary ICS Executive Meeting
24 Jun	Practice Visit - Corinthian Surgery
25 Jun	Better Births 3 Years on Celebration Event
25 Jun	ICS Executive Board
26 Jun	Local Workforce Action Board (LWAB)
27 Jun	Primary Care Commissioning Committee (PCCC)
04 Jul	New Models of Care Board (NMOC)
05 Jul	2018 Leadership Development Programme alumni event, Gloucester
08 Jul	ICS Executive Board
08 Jul	Practice Visit - Rendcomb Surgery
08 Jul	Health & Wellbeing Board Strategy Steering Group
09 Jul	One Place Development Session
10 Jul	Parliamentary Awards, London

15 Jul	Visit from The Department of Health & Social Care, Gloucester
15 Jul	Practice Visit - Walnut Tree & Acorn Practices
16 Jul	Health & Care Scrutiny Committee
17 Jul	NHSE/I Meeting, Taunton
18 Jul	STP & ICS Leaders' Development Day, London

7. Recommendation

The Governing Body is asked to note the contents of this report.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 9

Governing Body

Meeting Date	Thursday 25th July 2019
Title	**Improving the Quality of Cancer Care in Gloucestershire Thematic Review.**
Executive Summary	Improving cancer care is a key priority for Gloucestershire CCG. This report, originally presented to the NHS England Quality Surveillance Group in May 2019, provides a broad overview of the work undertaken by the Cancer Clinical Programme Group with ICS Partner Organisation including third sector partners, patients and carers.
Key Issues	• Improving health outcomes through early diagnosis. • Delivering high quality best practice and timely treatment. • Improving the longer term health and wellbeing of people living with and beyond cancer.
Risk Issues: **Original Risk** **Residual Risk**	n/a - currently escalated through appropriate programme channels.
Financial Impact	n/a
Legal Issues (including NHS Constitution)	Gloucestershire is not currently meeting the 62 day cancer waiting time standard. Focussed improvement with close overview from system partners remains a top priority for 2019/20.
Impact on Health Inequalities	Many of the initiatives noted in the report act to reduce health inequalities from the point of diagnosis through to rehabilitation.
Impact on Equality and Diversity	Not detailed in this report.
Impact on Sustainable Development	Not detailed in this report.

Patient and Public Involvement	Active involvement is shown in the development and redesign of services, and new initiatives have been led by the Cancer Patient Reference Group.
Recommendation	To note the programme of work currently in delivery with the Cancer CPG. To receive a further update on the next stage of the cancer programme's development to meet the objectives of the NHS Long Term Plan at a future date.
Author	Kathryn Hall
Designation	Associate Director Service Improvement and Redesign
Sponsoring Director (if not author)	Ellen Rule Director of Transformation and Service Redesign.

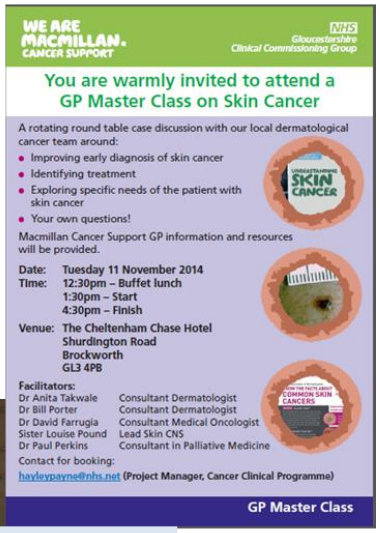
NHS
Gloucestershire
Clinical Commissioning Group

Improving the Quality of Cancer Care in Gloucestershire Thematic Review

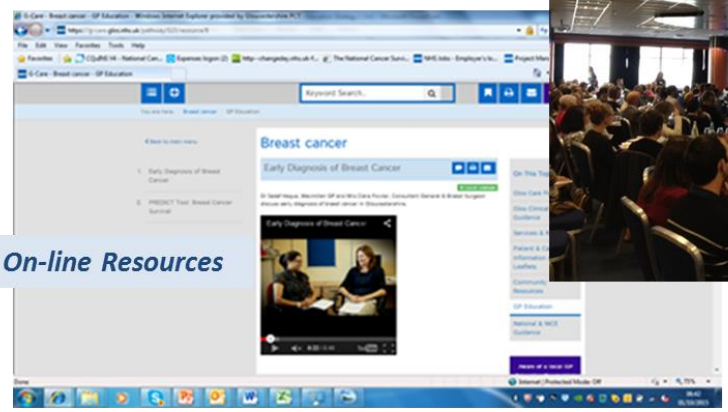
Presented to NHS England Quality Surveillance Group May 2019

Public engagement

Macmillan Next Steps: Cancer Rehab Exercise Class



GP Education



On-line Resources

1. Introduction

This report provides an overview of some of the quality priorities in the delivery of cancer care in Gloucestershire. We highlight the joined-up quality improvement approach we take as both an ICS partnership and an active member of the Somerset Wiltshire Avon and Gloucestershire (SWAG) Cancer Alliance and describe some of our key projects.

2. Background and Working Approach

Cancer is a significant and increasing health burden for the population of Gloucestershire and is responsible for approximately 960 deaths in our county every year. The incidence of cancer is increasing due to factors such as our aging population, rising obesity, continued smoking and physical inactivity. However improvements in early diagnosis and treatment mean that more people are living beyond cancer. Therefore one of the most significant changes will be that the number of cancer survivors is likely to double by 2030.

Cancer care is therefore a significant programme for Gloucestershire and the assurance of high quality services and a focus on continuous quality improvement is paramount to our approach.To set our strategy and drive change we have formed the Gloucestershire Cancer Clinical Programme Group with representative from across our STP including third section and patient representative partners.

The vision of the Cancer CPG is as follows:-

> *To save lives and reduce the impact of cancer on the health and wellbeing of people in Gloucestershire. Some cancers are preventable and we will support our population to make the healthy life choices that reduce their risk factors. However for everyone that does develop the disease we are committed to ensuring the best possible health outcomes and compassionate care. We will do this through early diagnosis, excellent treatment and joined-up support for people Living With & Beyond Cancer.*

The Cancer CPG has a published strategy that underpins our programme of service development and quality improvement projects. The programme group regularly reviews its Outcomes Report, to ensure we remain focussed on work to address key issues. Our programme plan is summarised as a Driver Diagram shown in Appendix 1.

Since 2017 One Gloucestershire has been an active member of the SWAG Cancer Alliance and this has been an important development in supporting region-wide cancer service improvement and the sharing of best practice to improve the quality of patient care.

One Gloucestershire and SWAG Cancer Alliance plans are now developing the next significant challenges of the NHS Long Term Plan including the transformational early diagnosis objective of 75% of cancers being diagnosed at Stage 1 or 2, the introduction of faster diagnosis pathways to deliver the and new 28 days from referral to diagnosis standard and the delivery of personalised care to support the increasing number of people that are living with and beyond a cancer diagnosis.

As commissioners our wider quality assurance for the cancer care is collaboration between CCG clinical programme staff, quality leads, patient and public engagement and contracting and performance leads.

3. Key Quality Management Themes and Current Status

Theme and Issues	Quality Improvement Approach
Improving Early Diagnosis Ensuring cancer is picked up as early as possible is critical to patients health outcomes. It is therefore essential to ensure GPs have high level professional skills to recognise early symptoms and that practices adopt best practice for monitoring and safety netting patients. Also the patient and public awareness is key in ensuring people respond to screening requests and seek advice if they have worrying symptoms.	We have run an active early diagnosis programme for 5-years, key highlights so far:- • Supported primary care quality improvement through a 3-year Primary Care offer, with all 76 practices participating. • Worked in collaboration with Macmillan and secondary care colleagues on a county-wide GP education programme which has held 20 masterclasses with over 1100 GPs attending the events. • Used our on-line clinical platform, G-Care to provide GPs with educational materials, including pod-casts, presentations from masterclasses and top tips for each cancer site. • Undertaken over 600 Significant Event Audits across all GP practices, to reinforce clinician and practice based learning. In-depth qualitative analysis has been progressed to • Worked with practices on increasing uptake of bowel and cervical screening. • In 2016 we received an All Party Parliamentary Group Award for achieving one of the most improved one-year cancer survival rates in the country. • From 2018 GP Practices in Gloucestershire have been participating in the SWAG Cancer Alliance project to introduce a new in-practice diagnostic test based on a single stool sample for people with some symptoms but an otherwise low risk. • In 2019 we are collaborating with the Bowel Screening programme on a joint project to improve health inequalities for bowel cancer in Gloucestershire.
NICE Guidance Implementation Commissioners and providers recognise the critical importance of NICE guidance in ensuring delivery of high quality cancer care. Both have frameworks in place to review and horizon key guidance, with assurance and review processes.	As a health system, the implementation of NICE Guidance NG12 on the referral of suspected cancer has been a priority since its publication in 2015, and have progressively revised referral forms, extended GP direct access diagnostics and provided education sessions to support full compliance. As at May 2019 final deviations are being removed as we have a good availability in the county for GP Direct Access Diagnostics and we are finalising the updating of our advice for children with suspected cancers and people presenting with vague symptoms. The Cancer CPG ensures a regular oversight of new NICE guidance, and for example this year we will be assessing the impact of the new Prostate Cancer guidance due for publication in May 2019.
Outcome Benchmarking, Clinical Audits and Responding to Alerts.	The cancer clinical programme group regularly reviews a number of key indicators.

These provide a critical part of our quality review as a system and at the level of individual pathways and services.	For example this included analysis from the Rightcare comparing Gloucestershire outcomes to similar health communities from across the country. Some areas where Gloucestershire performs well were noted. For preventative measures this included effectiveness of quit smoking programmes. It was also good to note that the county to continuing to perform well for >75 mortality, which was especially highlighted for breast and colorectal cancers. However we have used this benchmarking to identify need to reduce the proportion of cancers presenting via emergency routes for colorectal and lung cancers. This has been used to inform some of our programme planning such as our focus on addressing public awareness with more deprived communities, and we are now co-designing campaigns with NHS cancer screening colleagues and community partners. Gloucestershire has robust process for ensuring clinicians can raise quality concerns and that as a CCG we investigate issues and take appropriate actions. For example during 2019 a couple of quality issues have been raised about the clarity of our out of area coordination for patients with suspected sarcoma. As a result we are now collaborating with regional colleagues to ensure full clarity and agreement on these patients following more complex pathways.
Quality Surveillance Programme for CCG Commissioned Services	From September 2018 the Gloucestershire CPG team became active contributors of the Quality Surveillance Programme for CCG commissioned services. The contribution of the team has enhanced the Annual Assessment process by providing a good local perspective and review on the services self-assessments. In line with the national process surveillance levels have been set e.g. routine or enhanced. Progress against the action plans will continue to be reviewed during the year with an updates to the Cancer CPG and CCG Quality and Governance Group with any issues escalated accordingly.
Cancer Waiting Time Performance Achievement of 2ww, 31 day and 62 day waiting times is a key measure of quality in ensuring timely cancer care and patient experience. During 2018/19 Gloucestershire has shown improvements in the delivery of the 2ww standard and this is currently performing above standard at 94.8% for March 2019 However the 62 day standard has remained a challenge, and although many specialities have now shown	Performance continues closely scrutinised at regular performance meetings, especially with an in-depth focus with Gloucestershire Hospitals NHS Foundation Trust which provides care for the vast majority of Gloucestershire cancer cases. Overview is maintained by CCG through joint system approach with NHS England/NHS Improvement and with expert support from the Cancer Alliance. The CQC report for GHNHSFT also made the key recommendation for a focus on the recovery of the 62 day standard as priority for improving quality, whilst specifically acknowledging the issues in Urology services and the need to rebuild clinical capacity. Service Recovery Plan has been defined by each cancer site specific team with associated recovery trajectories. To support a joint visibility of the improvement plans a Cancer Improvement Workshop was held

improvements over the last 12 months, urology pathway continued to be under pressure whilst new pathways and backlog clearing initiatives fully impact. However for progress is being made and performance at 79.0% for March 2019. Good delivery against the 32 day target continues.	in October 2018 with a full representation of system colleagues. During 2019/20 a Gloucestershire Cancer Quality and Standards Group will be meeting to maintain a joined up focus. The Implementation of the National Timed Pathways has been a key improvement programme to streamline patient care and reduce waiting times:- • Colorectal: we have introduced a Straight to Test pathway which now means that 65% are now able to proceed to a colonoscopy supported by nurse telephone preassessment. This has reduced breaches and released consultant capacity. • Lung: we have introduced a Straight to Test CT pathway when required following X-ray, meaning patients have necessary diagnostics completed rapidly and in advance of seeing a respiratory consultant. • Prostate: Gloucestershire has implemented the recommended pathway of undertaking MRI diagnostics prior to biopsy, and will be further optimising the pathway with the support of new pathway co-ordinators. Changes have been enabled by both grant allocations from the National Cancer Support Fund that has supported the fundamental pathway redesign and from the Turnbull Fry fund to support immediate reduction in waiting times through additional interim capacity. Also during 2018/19 we have run a successful Cancer Referral Improvement project that has ensured full compliance with new referral approaches and supported providing patients with better information at the point of referral, making a significant contribution to 2ww capacity utilisation as people understand the importance of attending their appointment.
Improving Health Outcomes for People Living With & Beyond Cancer The National Cancer Survivorship Initiative published key evidence in 2013 highlighting deficit in care for people following cancer treatment.	Following a period of stakeholder consultation the One Gloucestershire Living With & Beyond Cancer Programme was formally launched in December 2014. Our aim is to create a sustainable and joined up model of care to ensure the best outcomes for our population and to enable people to live well with and beyond cancer. Gloucestershire CCG supported the initiation of the quality improvement with GHNHSFT through the use of a 2-year local CQUIN. We have also benefitted from generous Macmillan funding to support our work. From 2017 the SWAG Cancer Alliance's regional programme has enabled delivery at scale and pace of the key components of the Cancer Recovery Package. From the outset the programme has been a system-wide collaborative programme, which is now supported with the framework of the One Gloucestershire STP plan. Our programme supports people towards radical self-care and adopting healthy lifestyles. Physical activity in many cases is the single most effective intervention in preventing the recurrence of cancer and other health risks.

	In line with national guidance our programme focusses on the delivery of the Cancer Recovery Package, however in Gloucestershire we have had an added focus on improving the quality of patient health outcomes through community-based rehabilitation and primary care development. • **Holistic Needs Assessments & Care Plans**: successfully launched now to progress to high attainment via team development & eHNA approach. Over the last 18 months there has been significant success in the developing roll out of HNAs and Care Plans. Gloucestershire Hospitals now benchmarks as the 5th best trust in the country for the provision of HNAs. • **Treatment Summaries**: these enable better communications between secondary care with GPs and patients. During 2018 some delays had been caused due to major IT system pressures at GHNHSFT, Treatment Summaries have now completed live testing and are due for full implementation over the summer of 2019. • **Needs Follow Up Pathways/Risk Stratified Pathways: in implementation for Breast, Colorectal & Prostate in 2017-18** New protocols have been agreed with clinical teams and we introduced My Health Record as monitoring and communication tools, commending with the tracking of PSAs for men following prostate cancer. • **Patient Education:** Approximately 1000 patients have now participated in our education programmes to support people, including our well received Taking Control half day health and wellbeing workshop. The Taking Control workshop is now available for all people affected by breast, colorectal or prostate cancer. The workshop provides patient with a link to further rehabilitation support. • **Cancer Rehabilitation: Macmillan Next Steps** This has been a leading strategic development project for the Gloucestershire Living With and Beyond Cancer Programme in partnership with Macmillan Cancer Support and Gloucestershire Care Services. The service was launched in April 2016 following a design phase in co-production with providers, patients, carers and third sector partners, with the objective of making a whole system transformational shift towards radical self-care and integrated restorative and preventative cancer rehabilitation and support. The project offers a wide range of education and healthy lifestyle programmes, as well as targeted 1:1 support from cancer specialist AHPs. The ethos of the service is to holistically support and empower people affected by cancer to take an active role in their health and care. The project has had a highly positive independent evaluation and has been recognised in numerous national awards. • **Primary Care Development**: we have undertaken primary care education and quality improvement projects.

	○ All GPs practices have sent representatives to education events that support high quality care for people following their cancer treatment and each has completed a case study review. These have reinforced local awareness and confidence to signpost; the findings are being collated to share knowledge on best practice and identification of gaps. ○ Over the last 3 years we run practice nurse education programme in collaboration with Macmillan. Nurses covering all of Gloucestershire's localities have attended the programme which has improved confidence in supporting cancer patients, built cross system relationships with hospital based nursing staff and the community-based Macmillan Next Steps cancer rehabilitation team.
Patient Experience Patient experience is central component of high quality care. The current focus started in 2013 when the National Cancer Patient Survey indicated that although patients in Gloucestershire were generally satisfied with the care provided there was some real scope for improvement on some specific indicators relating to themes such communications and involvement in decisions. A range of cross system developments has supported a consistent improvement trend over a number of years.	Improving Patient Experience was set as a key priority for our health community. To address whole pathways and wider patient experience improvement the Cancer CPG supported the formation of the Gloucestershire Cancer Patient Reference Group, under the leadership of an experienced Lay Champion. The group's work has included the co-design of our Living With and Beyond Cancer programme, and they have helped us select a range of engagement activities including in-depth interview, focus groups and public meetings. Group member have been very active in supporting the development of service user information and the development of patient resources. Indeed some of the group members have now become lay facilitators for our patient education events. The following video was prepared near the start of the programme, and the good news is that some of the patients' aspirations and recommendations are now being delivered. http://youtu.be/ohIhvS8O-ic. During 2018 the group have initiated the launch of a Bowel Cancer Patient Support Group to address in a recognised gap in the county. GHNHSFT established a Patient Experience Group, with a broad representation of clinicians and patients representatives focussed on an action plan to address operational improvements within the Trust. The group has taken in depth stories and have prepared extremely powerful video teaching resources that have underpinned education in the trust for nursing and care assistant staff. The group have also overseen significant improvements to the provision of information to cancer patients and in 2018 we were delighted that a new Macmillan Information Pod has opened at Gloucester Royal Hospital. Our ambition is to achieve exemplary patient experience, so our efforts with our teams and patient groups will continue.

4. Conclusion

We trust that this report provides a useful overview of our approach to achieving high quality cancer care in Gloucestershire. We have only provided a snapshot of some areas of our work and would be pleased to share further information on request.

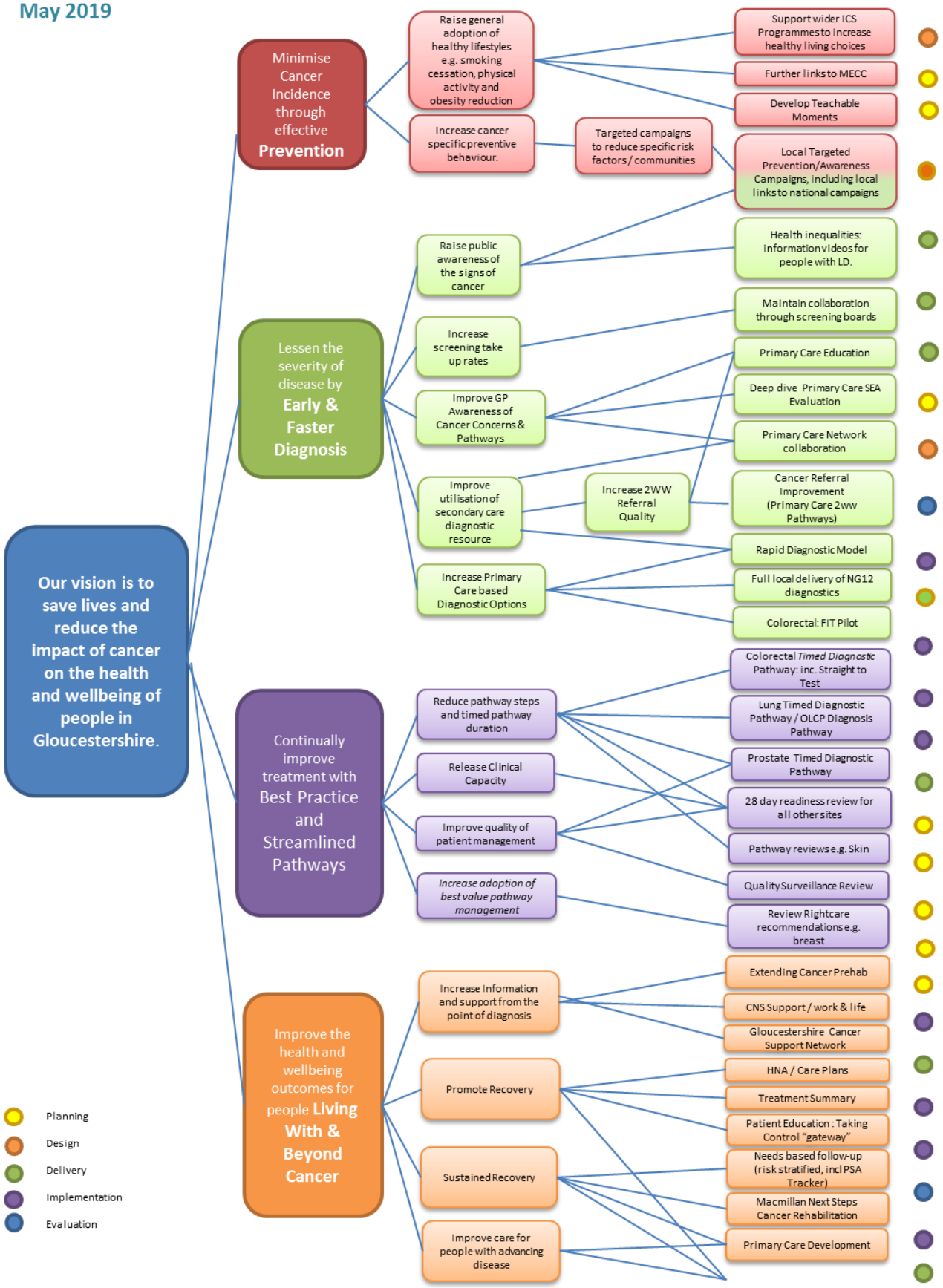
We would be grateful for any feedback and advice on:-

- **Additional quality themes that we may wish to include in our programme focus.**
- **Recommendation on how we could develop our quality improvement approach further.**

Author: Kathryn Hall, Associate Director Service Redesign and Improvement, Gloucestershire CCG

Appendix:

One Gloucestershire ICS - Cancer CPG Programme Summary Driver Diagram
May 2019



NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Governing Body

Governing Body Meeting Date	**24th July 2019**
Title	Finance and Performance Report
Executive Summary	The bi-monthly finance and performance report has been submitted to the Governing Body covering a review of performance to M3 (where available)
Key Issues	This report covers the following key elements: **1.0 Scorecard** **2.0 Executive Summary** 2.1 Leadership 2.2 Better Care 2.3 Sustainability 2.4 Better Health **3.0 Better Care** 3.1 Constitution updates reported by exception **4.0 Leadership** 4.1 Measurement **5.0 Sustainability** 5.1 Resource Limit 5.2 Acute Contracts 5.3 Community 5.4 Prescribing 5.5 Mental Health 5.6 Primary Care 5.7 CHC 5.8 Other 5.9 Savings Plan 5.10 Savings forecast delivery 5.11 Risks & Mitigations 5.12 Cash drawdown 5.13 BPPC performance 5.14 Income & Expenditure.

Risk Issues: **Original Risk** **Residual Risk**	The key risks are detailed within the report
Financial Impact	See slides 37-55
Legal Issues (including NHS Constitution)	N/a
Impact on Health Inequalities	N/a
Impact on Equality and Diversity	N/a
Impact on Sustainable Development	N/a
Patient and Public Involvement	N/a
Recommendation	The Governing Body is asked discuss and note the Finance and Performance Report
Author	Katharine Doherty
Designation	Performance Manager
Sponsoring Director (if not author)	Mark Walkingshaw – Deputy Accountable Officer Cath Leech - Chief Financial Officer

NHS
Gloucestershire
Clinical Commissioning Group

CCG Monthly Performance Report

July 2019

Contents

This document is a highlight report which is presented to give the CCG Governing Body an overview of current CCG and provider performance across a range of national priorities and local standards.

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.

1.0 Scorecard: CCG Performance Overview

CCG IAF assessments for 2018/19 were published 11th July 2019.
GCCG was rated "Good" overall.

2.1 Executive Summary – Leadership

Green

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.

2.1.1	**Staff engagement :** Robust culture and Leadership Sustainability (OD Plan)
2.1.2	**Probity and Corporate Governance:** Full governance compliance
2.1.3	**Effectiveness of working relationships in the local system:** Effectiveness of working relationships in the local system
2.1.4	**Quality of CCG leadership:** Review of the effectiveness of culture, leadership sustainability and an oversight of quality assurance.

2.2 Executive Summary – Better Care

Amber

This domain focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas.		Overall Rating
2.2.1	Planned Care	
2.2.2	Unscheduled Care	
2.2.23	Cancer	
2.2.4	Mental Health	
2.2.4	Learning disability	
2.2.5	Maternity	

2.3 Executive Summary - Sustainability

Green

This domain 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		Rating
2.3.1	Year to date surplus variance to plan (%)	
2.3.2	Forecast surplus to plan (%variance)	
2.3.3	Forecast running costs in comparison to running cost allocation (%)	
2.3.4	Forecast savings delivery in comparison to plan (%)	
2.3.5	Year to date BPPC performance in comparison to 95% target (%)	
2.3.6	Cash drawdown in line with planned profile (%)	
2.3.7	Forecast capital spend in comparison to plan (%)	

2.4 Executive Summary – Better Health *(1 of 2)*

These indicators show the latest known position from nationally available data

This section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve.	Current CCG Performance				
	Period	National	Glos CCG	What is good?	Trend
Smoking: Maternal smoking at delivery: The percentage of women who were smokers at the time of delivery, out of the number of maternities *Next publication 2nd July 2019*	Q3 18/19	10.5%	12.1%	Low %	*Up from last quarter (-)*
Child Obesity: Number of children in Year 6 (aged 10-11 years) classified as overweight or obese in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England as a proportion of all children measured. *Next publication January 2020*	2017/ 2018	34.3%	32.1%	Low %	*Up from last year (-)*
Diabetes: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children: The percentage of diabetes patients that have achieved all 3 of the NICE-recommended treatment targets – *New indicators being measured for 2017/18 – update to follow*	2016/ 2017	39.7%	36.4%	High %	*No change*
Personalisation and choice: Indicators relating to utilisation of NHS e-referral service to enable choice at first routine elective referral.	Dec 2018	80%	66%	High %	*Up from last month (+)*

2.4 Executive Summary – Better Health *(2 of 2)*

These indicators show the latest known position from nationally available data

This section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve.	Current CCG Performance				
	Period	National	Glos CCG	What is Good?	Local Trend
Personal health budgets Per 100k population *new*	Q3 18/19	59.9	144.6	High rate (National target 100-200 by 2021)	*Higher than Q2 2018/19*
Percentage of deaths which take place in hospital *new*	Q3 18/19	46.8%	40.4%	Low %	*Lower than national average. 1% Higher than 2017/18 (+)*
People with a long-term condition feeling supported to manage their condition(s). *Next publication Nov 2019*	2017/ 2018	59.6%	64.0%	High %	*Lower than 2016/17 (-)*
Health inequalities: Inequality in avoidable emergency admissions for chronic ambulatory care sensitive conditions – *indicator not updated*	Q3 17/18	1992.07	1889.33	Low rate	*Indicator not updated* – to be retired
Appropriate prescribing: Prescribing of broad spectrum antibiotics in primary care (co-amoxiclav, cephalosporins, and quinolones as a percentage of total antibiotics prescribed) *new*	12 months to March 2019	9.8%	8.7%	<10%	*Lower than July 2018*
Carers: Quality of life of carers *Indicator methodology has been updated – awaiting publication*	2018	Tbc	63.5%	High %	*No data*

3.0 Performance Dashboard

Amber

Unscheduled Care

4 Hour A&E June (System)	4 Hour A&E June (GHFT)	Category 1 Ambulance May 19 (Gloucestershire)	Category 1 Ambulance YEAR TO DATE (Gloucestershire)	Delayed Transfers of Care (DToC) May 19 (GHFT)
91.1%	86.8%	6.4 mins	6.6 mins	3.78%

Planned Care May 2019

RTT Incomplete <18 weeks Gloucestershire	RTT Incomplete <18 weeks GHFT	RTT 52 week breaches Gloucestershire	RTT 52 week breaches GHFT	Diagnostics >6 weeks (Gloucestershire)	Diagnostics >6 weeks (GHFT)	Diagnostics >6 weeks (YTD) (Gloucestershire)	Diagnostics >6 weeks (YTD) (GHFT)
81.5%	80.6%	84	83	1.2% (all)	0.64% (GHFT)	1.3% (all)	0.5% (GHFT)

Cancer Dashboard (May 2019)

	2 Week Waits	2 Week Waits Breast	31 Day 1st Treatment	31 Day Waits Surgery	31 Day Waits Drugs	31 Day Waits Radiotherapy	62 Day GP Referral	62 Day Screening	62 Day Upgrade
Performance (all Gloucestershire patients)	86.7%	96.5%	92.8%	97.8%	100%	100%	80.7%	100%	85.7%
GHFT Performance	86.5%	97.3%	92.3%	95.1%	96.2%	97.5%	79.7%	100%	44.4%

IAPT (YEAR TO DATE) May 2019

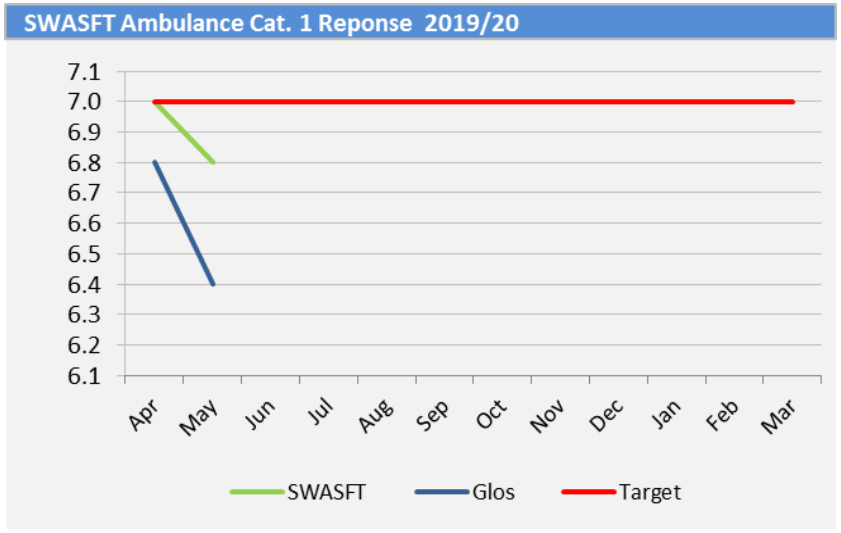
Access *(target 1.45%)*	Recovery *(target 50%)*
1.45%	50%

Dementia Diagnosis June 2019

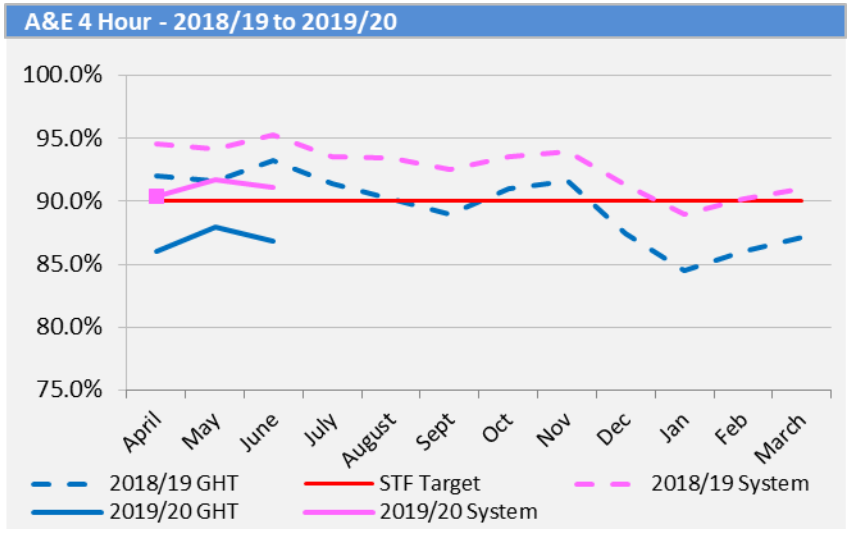
Estimated Diagnosis Rate (Target 66.7%)
67.8%

3.1 System Overview Unscheduled Care

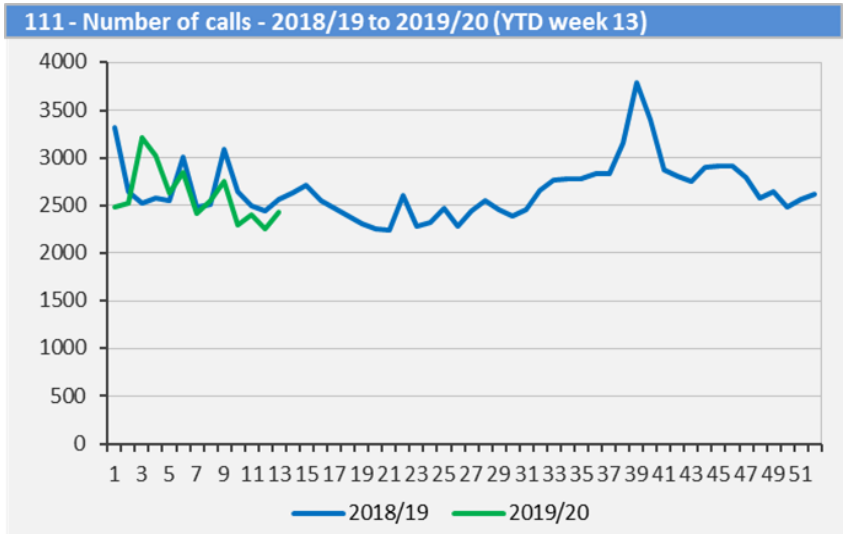
Ambulance – Category 1



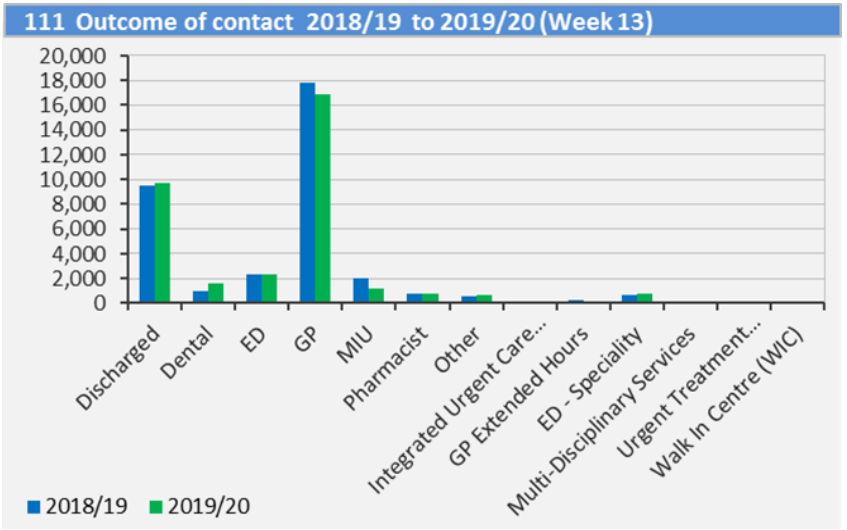
System A&E 4 hr Performance



111 Call Volume

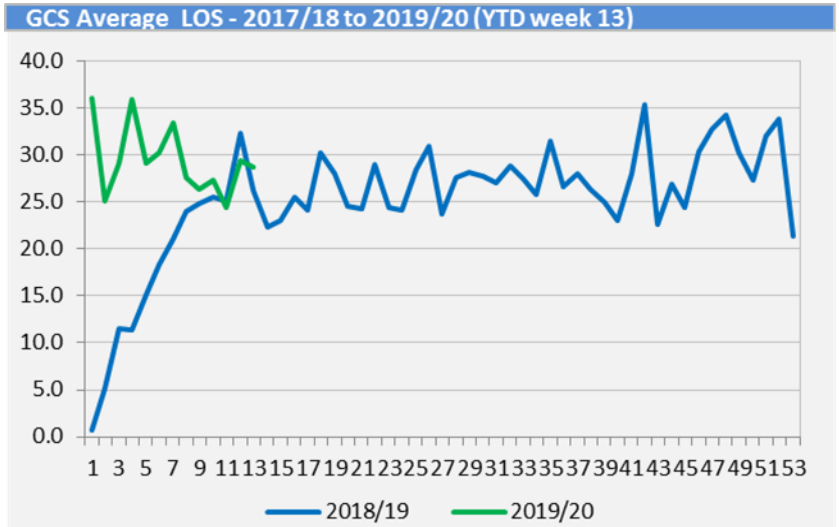


111 Disposition

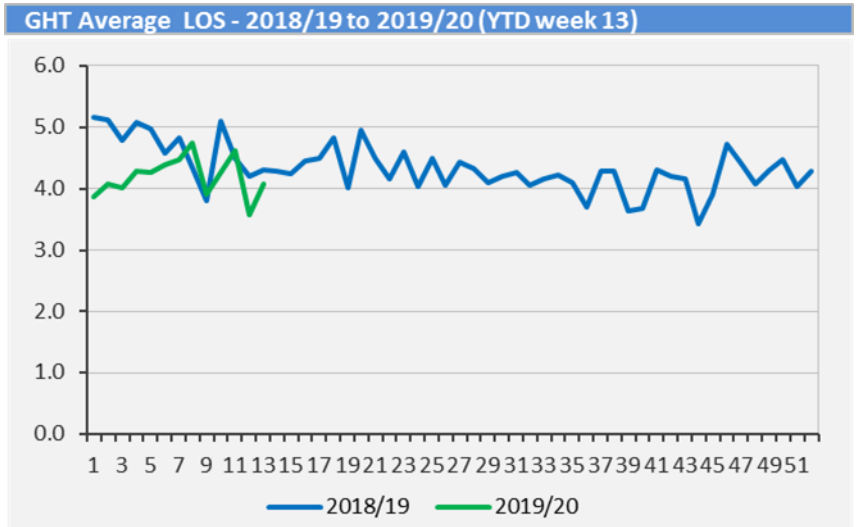


3.1 System Overview Unscheduled Care

GCS average Length of Stay

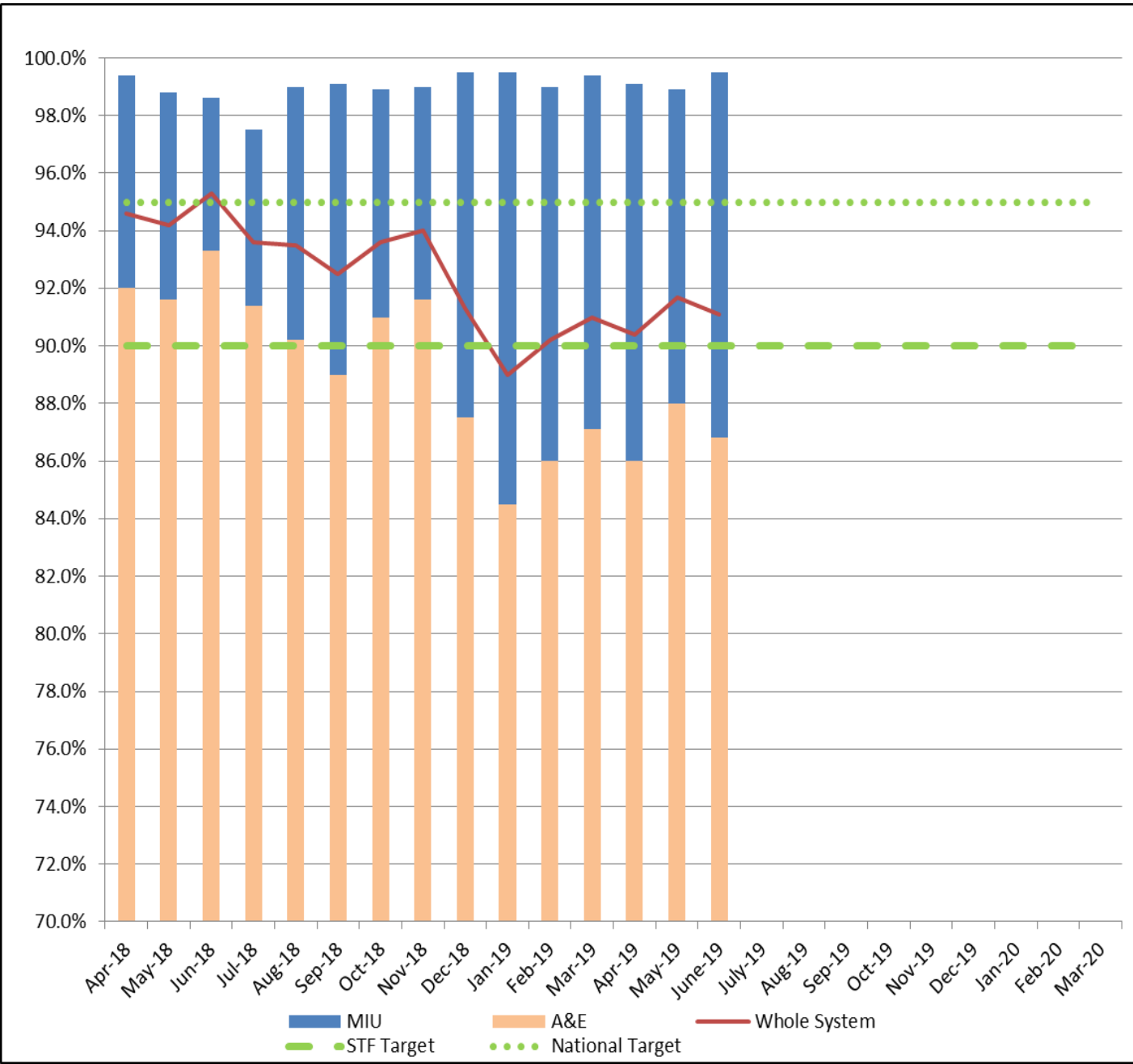


GHFT average Length of Stay



3.1 Unscheduled Care – 4 hour A&E

Green



Top Line Messages:

Gloucestershire whole system performance was 91.1% in June 2019, reflecting performance of 86.8% against the 4 hour target at GHFT and 99.5% across all MIIU sites. Average activity in June has been stable across the month (and from May 2019) but there have been days with particularly high attendances, including the highest ever number of attendances in a single day at GHFT on 24th June 2019 (546 in total).

Daily 4 hour performance across June has remained volatile, with a daily high of 95.7% (meeting the national target), and a low of 79.7%, with no significant improvement or deterioration across the month.

On an national level, Gloucestershire system (STP) ranks 7th out of 42 STPs for 4 hour performance in June 2019. GHFT performance was 27/119 acute trusts for Type 1 activity in June 2019.

3.1 Unscheduled Care

Updates/Actions:

Focus for unscheduled care remains the 3 outcomes of the Urgent Care summit:

- Theme 1: To identify opportunities to enhance positive “decision” making across Urgent and Emergency Care.
- Theme 2: Develop the “Home First” philosophy and pathways, reducing reliance on bed based pathways.
- Theme 3: Enhance streaming and signposting at Emergency Department “Front door”

GHFT deputy COO for Unscheduled Care is now in post and is working with the Head of Urgent Care to deliver the actions agreed at the summit.

Admissions and Assessments activity, as well as SWAST activity (leading to non-admitted conveyances, or short admissions), are an area of interest due to the above plan levels of activity year to date. These are due to be reviewed, with an action plan to be drafted by end of 15th July for both SWAST and Emergency admissions to help to manage growth.

OOH:

- Shift fill across the summer period is a known risk which the service is addressing through a number of initiatives. There has been improved performance in KPIs across the service – particularly timeliness of face to face contacts, however performance remains variable.
- Care UK are working well with the test and learn in Cheltenham for colocation of ED minors and OOH; further work on streaming will be progressed from these pilots.

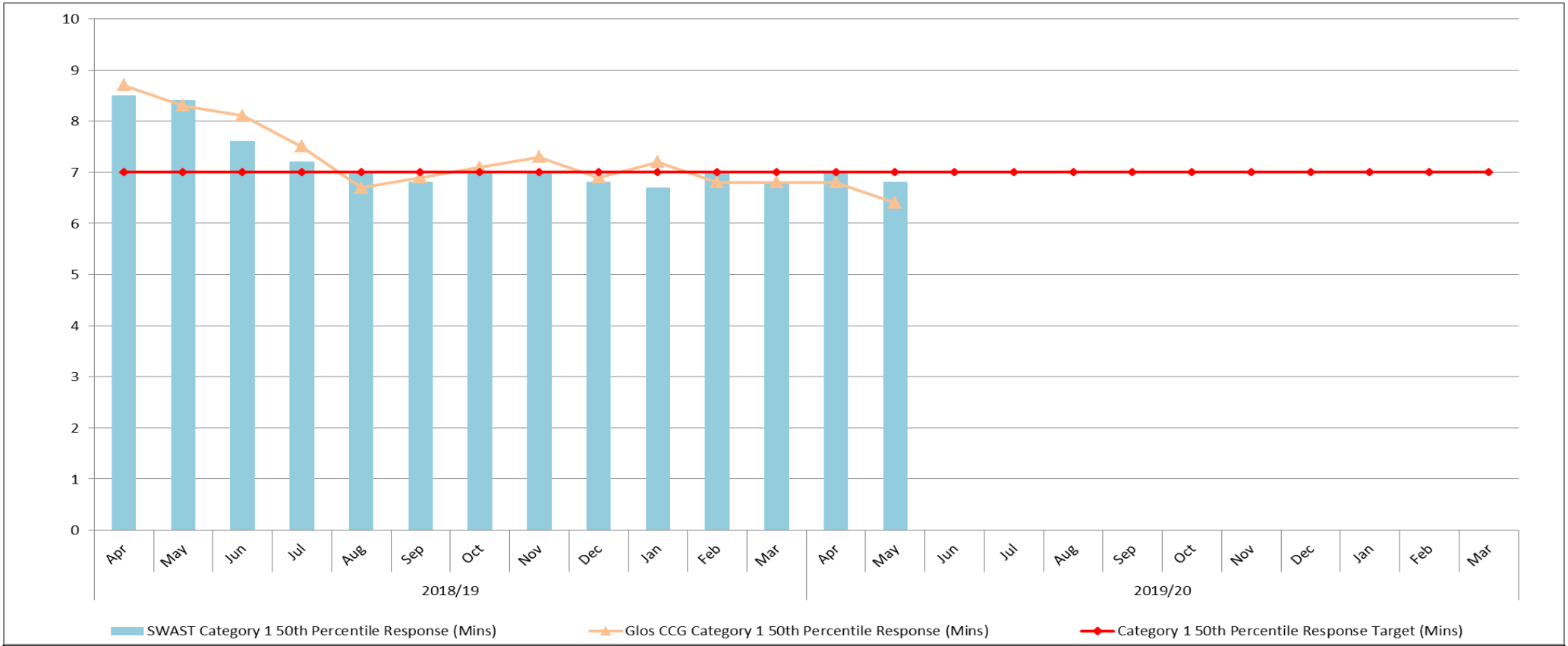
3.1 Unscheduled Care - NHS 111

NHS111 – Performance for calls to NHS111 service

- 60 second performance (target for call answering- 95% of calls to be answered within 60 seconds) continues to be an area of concern particularly over weekends and Mondays, with the CCG closely monitoring the Care UK “Back to Basics” plan.
- The 60 second performance is starting to impact abandonment rate, with poor performance against the 60 second target correlated with higher call abandonment.
- GCCG has weekly calls with Care UK to monitor the situation, with Care UK providing daily updates, as well as projected performance based on shift fill.
- To support performance, Care UK have reinstated overtime for targeted shifts for some weekends.
- Cat 3 and 4 call validation of NHS111 calls continues to ensure patients are treated in the appropriate setting, Cat 2 checking is being stepped down as this has shown dispositions generally remain consistent with the initial triage.
- From 18th July – GP in SPCA pilot will be launched for 2 months to support 111 calls (immediate triage of GP dispositions from 111 outcomes).

3.2 Unscheduled Care – Ambulance Category 1

Amber

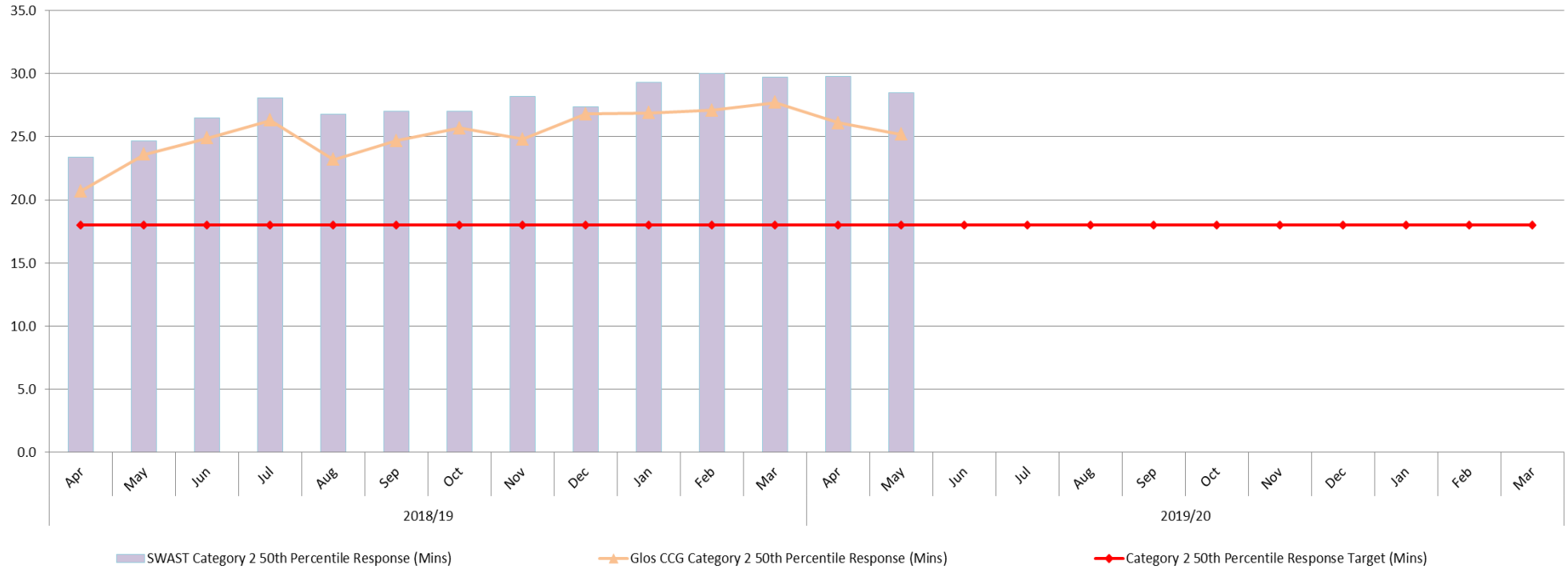


Gloucestershire performance in Category 1 for April 2019 has remained stable at 6.8 minutes on average. Performance has been relatively consistent around the 7 minute target since August 2018. SWAST Performance across all geographical areas (South West) was 7 minutes in April, achieving the national target.

Outcomes to incidents remained fairly stable month-to-month throughout 2018/19, with conveyance to ED around 50%. April 2019 has seen a small increase to conveyance to ED for all incidents in Gloucestershire, and conveyance to ED from a care home setting remains higher in Gloucestershire than the SWAST average (for April, Gloucestershire conveyance to ED from a care setting was 61.4% compared to 56.7% for the whole region). This is being explored with Rapid Response to identify any areas where the service could support Care Homes in avoiding hospital conveyance and subsequent admission.

3.2 Unscheduled Care – Ambulance Category 2

Amber



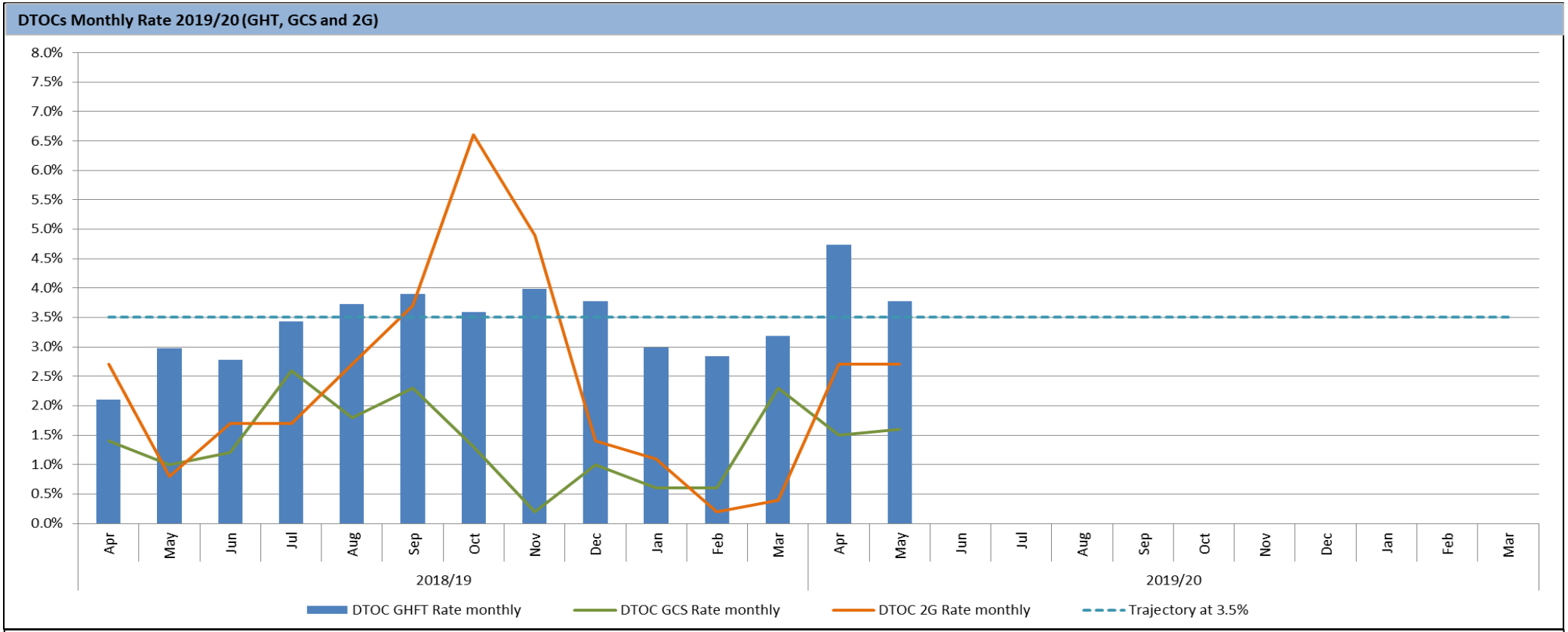
Category 2 performance remains more challenging, with the 18 minute target average response time missed throughout 2018/19 and remaining above target in May. Commissioners across the South West are aiming to focus on this target throughout 2019/20, in conjunction with overall demand management to reduce the pressure on the ambulance service, and mitigate the risk of over performance in ambulance activity (which would be a financial risk to the system).

SWAST activity is above contracted levels, with a significant financial risk associated with the over-performance.
A working group has been set up to assess demand management for SWAST incidents and define actions to reduce pressure focussing on:

- 111 demand (validation of Cat 3 and 4 calls)
- High Intensity Users
- Transfers between GRH and CGH
- Care home activity

3.21 Unscheduled Care – Delayed Transfers of Care

Amber



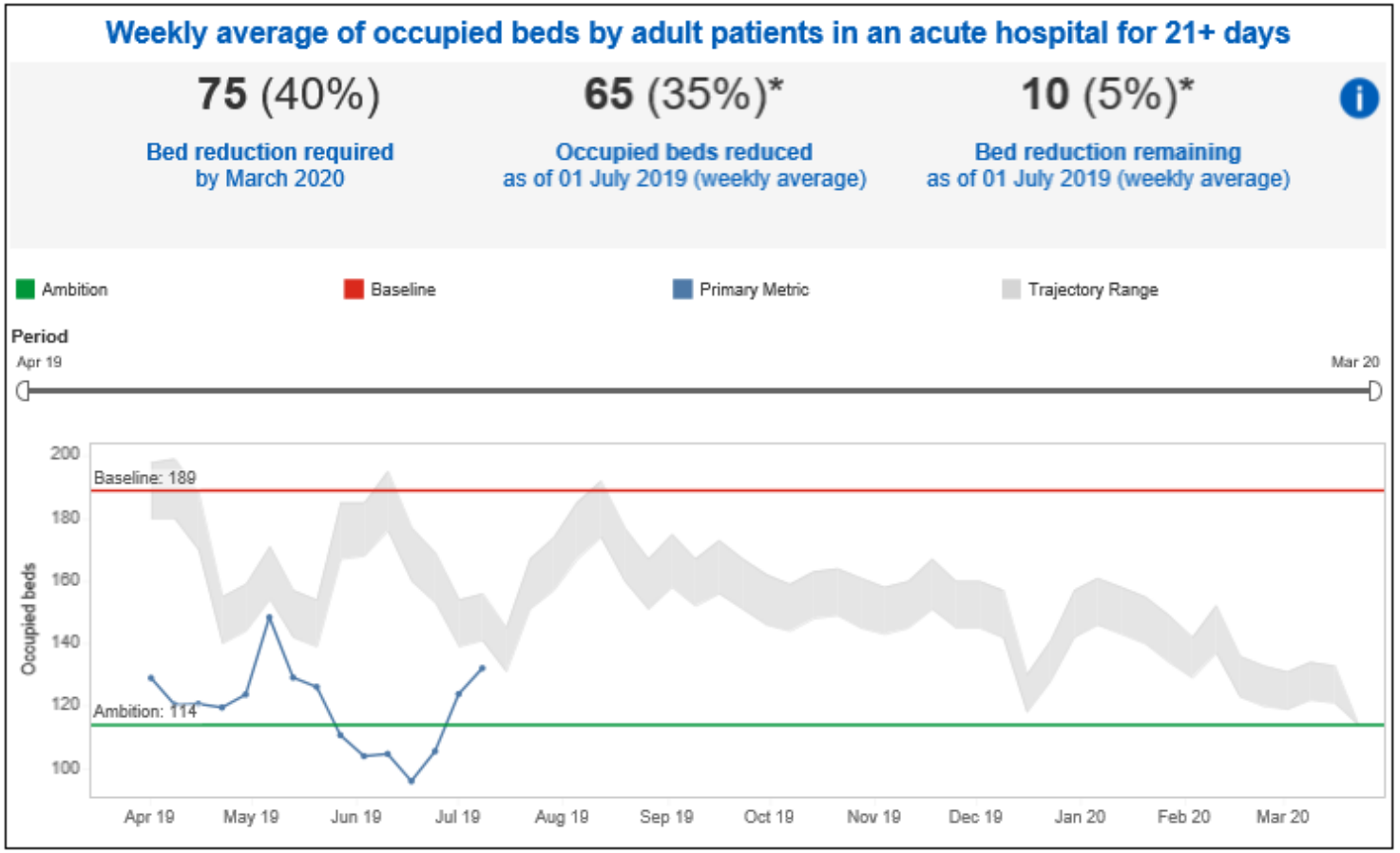
Following a jump in the DToC rate in April 2019, GHFT DToC performance has dropped back to 3.78%; this remains above the national target rate of 3.5%.

A plan to support the Urgent Care summit aim (Develop the "Home First" philosophy) has been developed, which will also aid the reduction of delays in transfers of care. Key actions include:

- Review of the Community Hospital Bed model to enable rehabilitation and maximise patients potential;
- Early discharge planning & MDT communication from admission;
- Improving communication with patients, especially around funding for care;
- Development of the positive risk taking programme at GHFT to support getting patients home and reducing long term care placements;
- Care Home support project.

3.21 Long Stay (>21 day LoS)

Green



The ambition for the Gloucestershire system is therefore to reach 114 beds occupied on average by long stay patients (patients in acute hospital beds for more than 21 days) by March 2020.

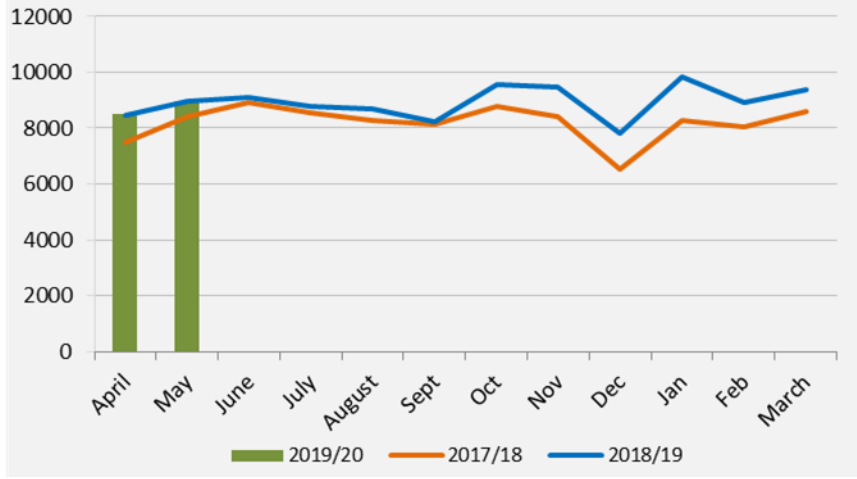
After a period of excellent performance against this target in June (where the average weekly number of long stay patients was 105), numbers have risen again at the start of July. For w/c 1st July, the average number of long stay patients in Gloucestershire is 124, 10 above the national ambition, but in line with the expected trajectory at this point in the year.

3.3 System Overview - Planned Care:

Amber

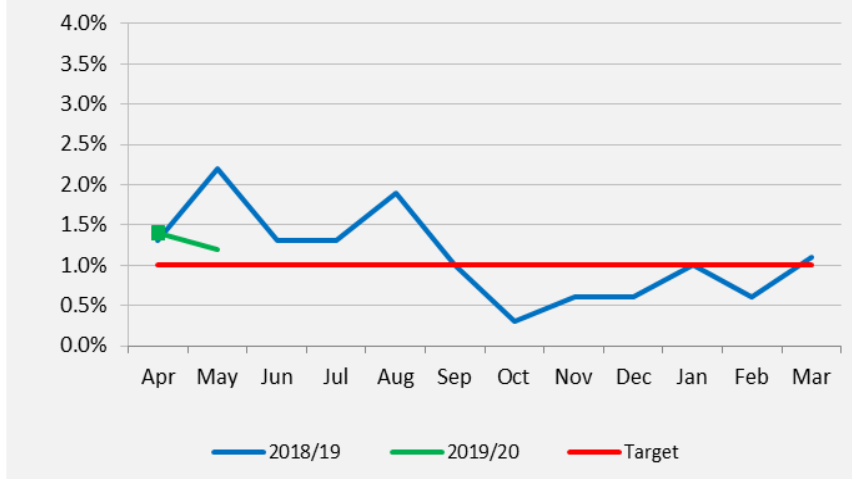
Referral Trends

E-referrals - GP Referred - 2017/18 to 2019/20 (YTD April 2019)



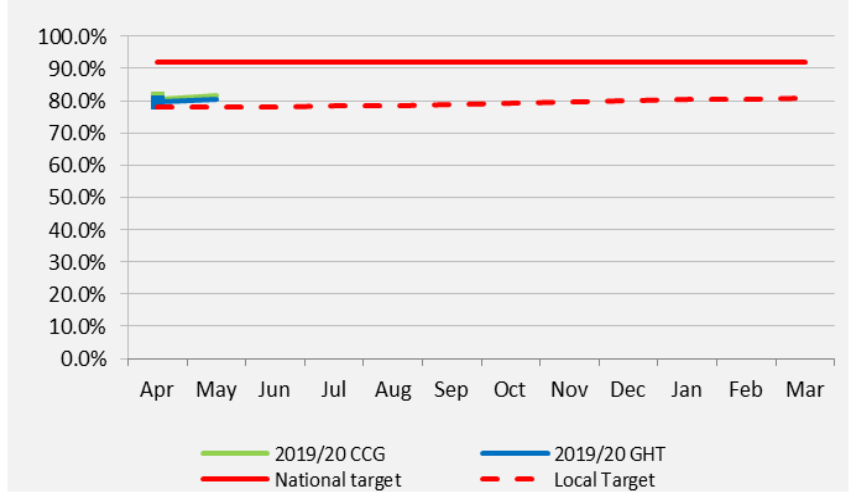
Diagnostics

CCG Diagnostic Tests - 2018/19 to 2019/20



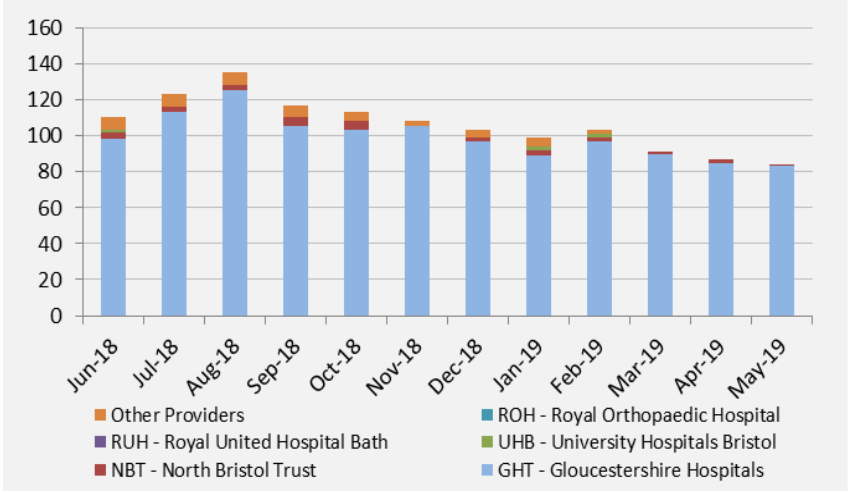
RTT >18 weeks

RTT Incomplete Pathways - Performance 2019/20



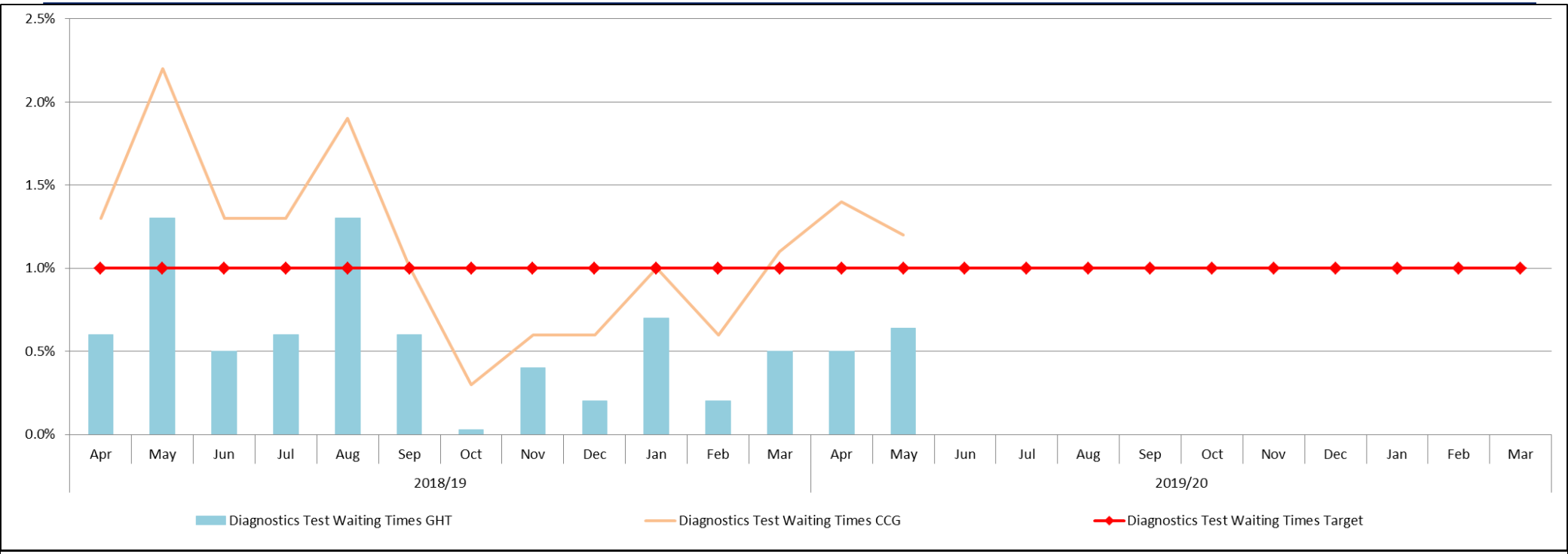
52 week waits (RTT)

RTT Incomplete Pathways - Number of Breaches ovr 52 Weeks



3.4 Planned Care – Diagnostics >6 weeks

Amber



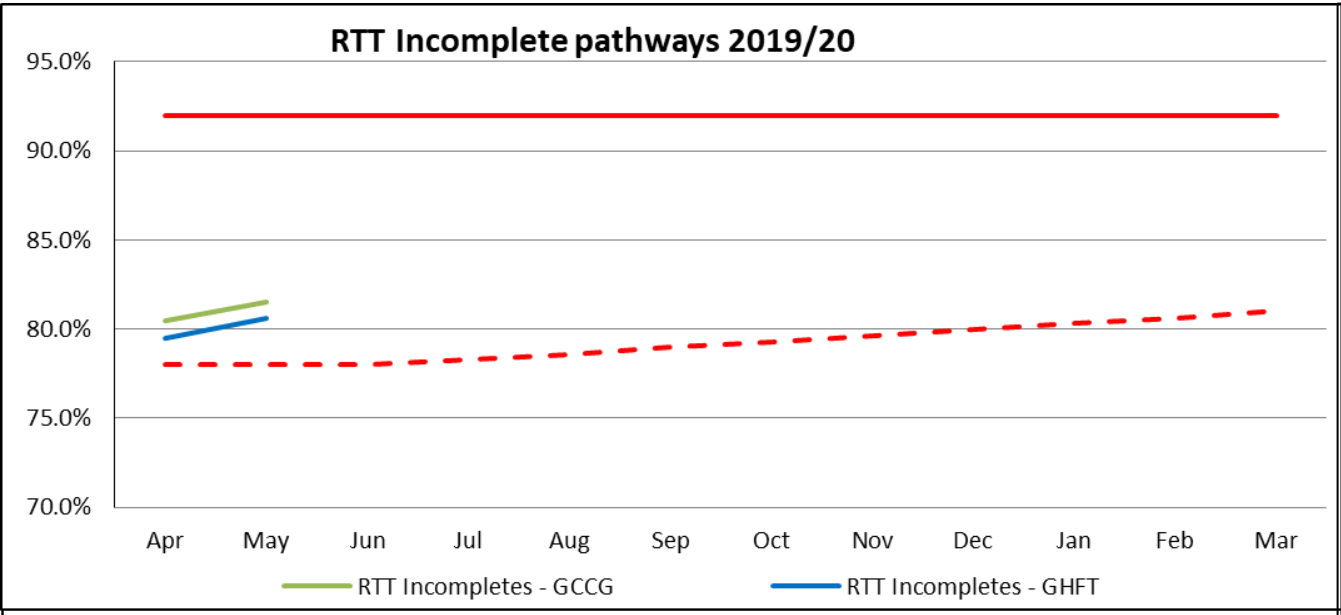
Top Line Messages:

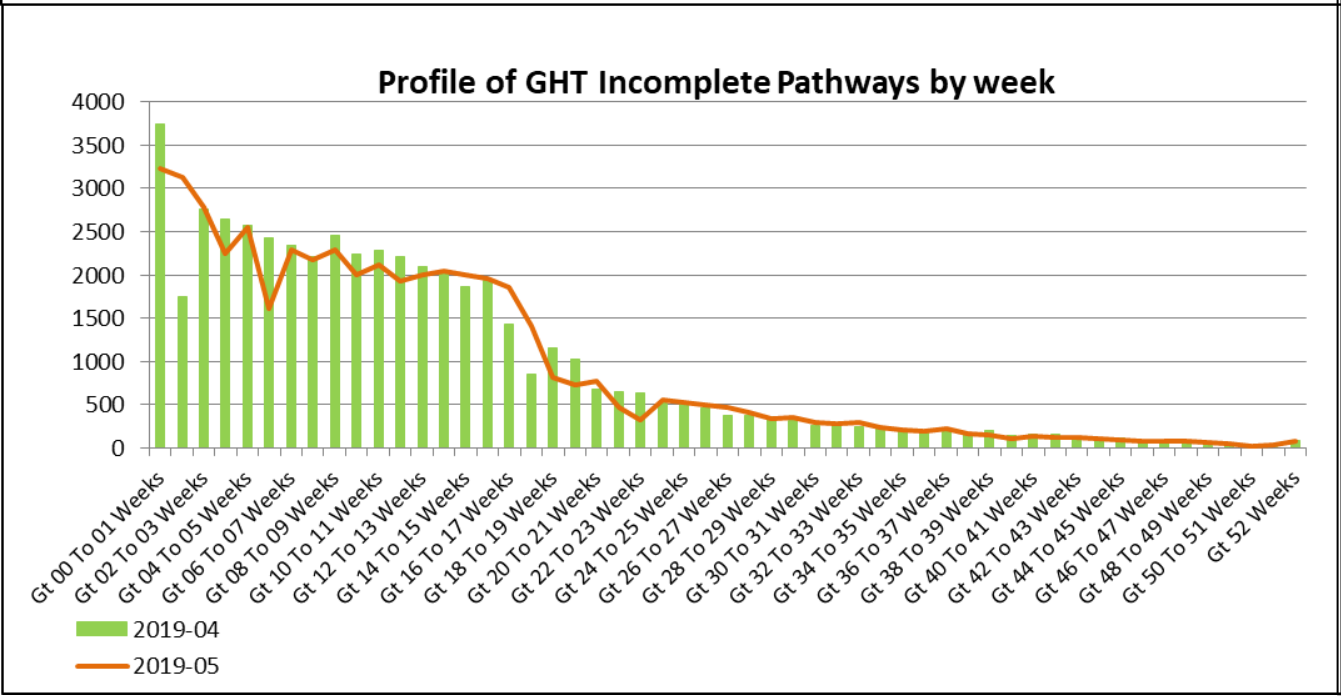
In May, GCCG performance was 1.2%, failing to meet the 1% target, primarily as a result of breaches at GP Care in non-obstetric ultrasound due to a combination of lack of capacity and patient choice in attending within 6 weeks, reflecting the lack of choice of clinics. In May there were 16 breaches at GP Care, which is an improvement on their performance in March and April and reflects additional capacity put in place by GP Care to address this ongoing issue.

The total number of breaches for the CCG was 115, with more than 1% of patients waiting over 6 weeks for the following tests: Cystoscopy (16.7% - 7 breaches – continuing their improvement from April at 20%, and March at 36.8%), Urodynamics (15.4% -2 breaches), Flexi Sigmoidoscopy (4.1% - 8 breaches), Gastroscopy (3.9% - 19 breaches), Sleep Studies (2.2% - 4 breaches) and Echocardiography (2.0% - 11 breaches).

GHFT performance in May 2019 was 0.64%, with 48 breaches over 6 weeks across all tests, and only 4 tests failing to meet the 1% standard. Gastroscopy (9 breaches), Flexi Sigmoidoscopy (4 breaches) and Sleep Studies (4 breaches) achieved performance of just above 2%; Cytoscopy performance was 13.8% however this comprised just 4 breaches due to low numbers waiting at GHFT for this test.

3.4 RTT





Top Line Messages:

May 2019 data shows that GCCG incomplete pathways (>18 weeks) stands at 81.5% - exceeding the locally agreed planning target (for May the trajectory was to achieve 78%. GHFT performance for May was 80.6%.

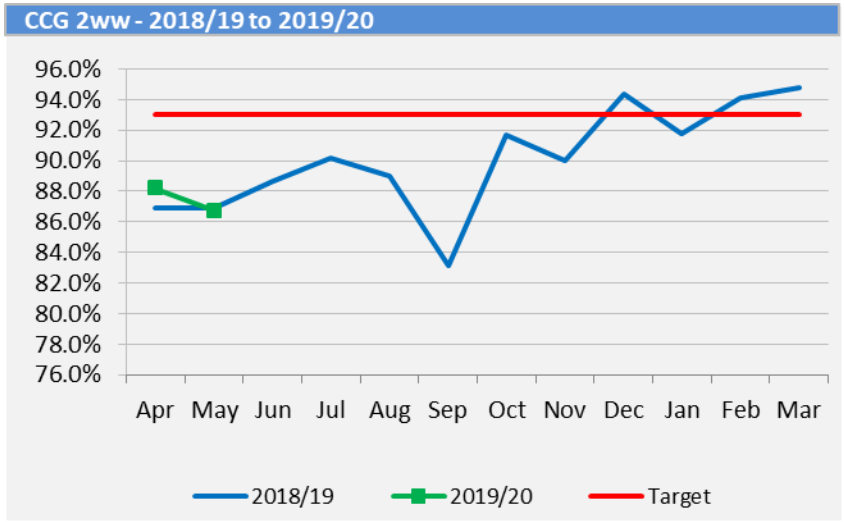
There were 84 fifty-two week incomplete waiters: 83 of these were at Gloucestershire Hospitals NHSFT in General Surgery (9), Trauma and Orthopaedics (1), ENT (7), Other (55), Gastroenterology (2) and Gynaecology (9), with 1 at North Bristol Trust, in Plastic Surgery. GHFT had a total of 91 52 week breaches in May (8 for non-11M commissioned patients).

From April 2019, the Department of Health have stipulated that all >52 week breaches will be subject to a £5000 mandatory fine, which will be split between commissioner and provider. The CCG are awaiting further technical guidance in how this will be administered and for information on how the fines levied will be reinvested into the system.

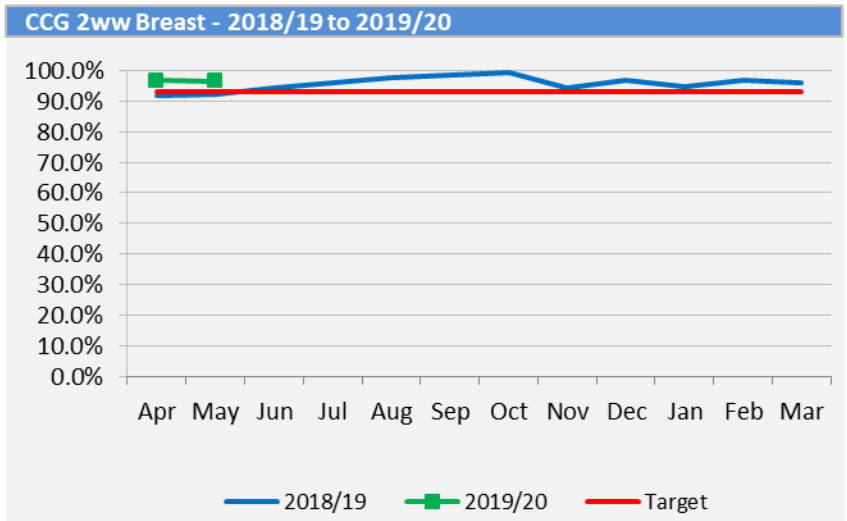
3.5 System Overview Cancer: May 2019

Amber

2WW (GP Ref'd)



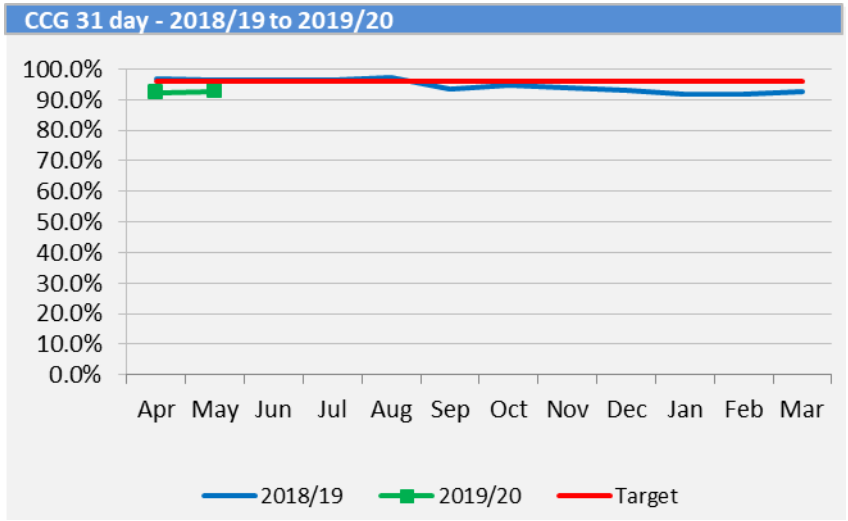
2WW (Breast)



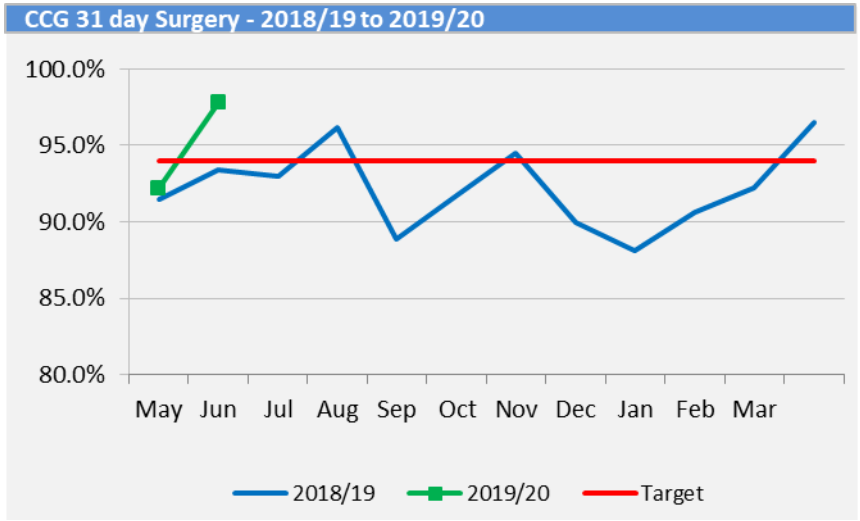
3.5 System Overview Cancer: May 2019

Green

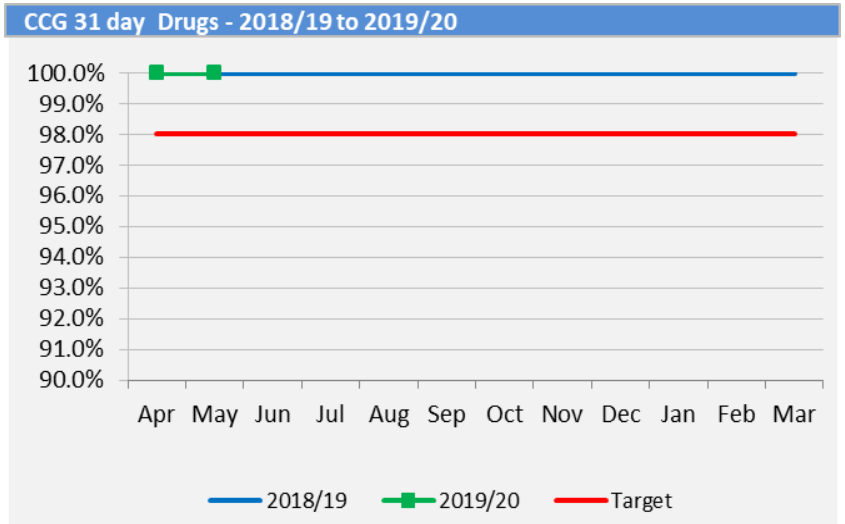
31 day



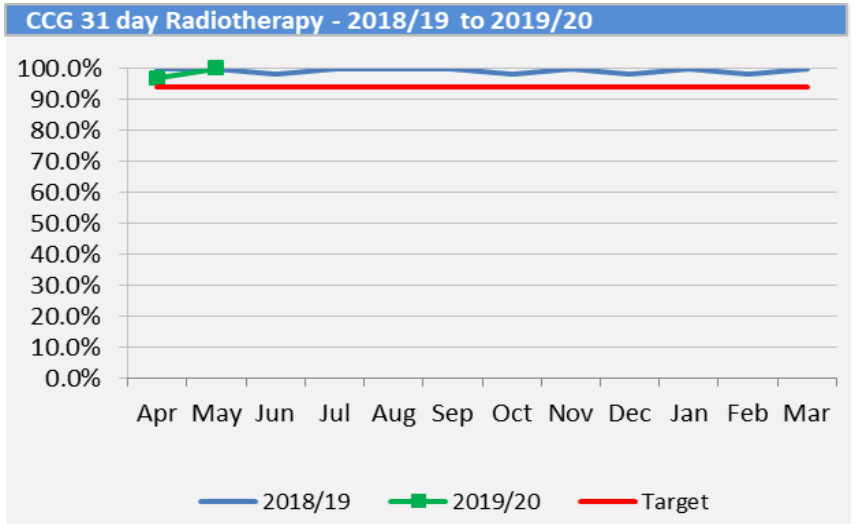
31 day subsequent treatm't: Surgery



31 day subsequent treatm't: Drugs



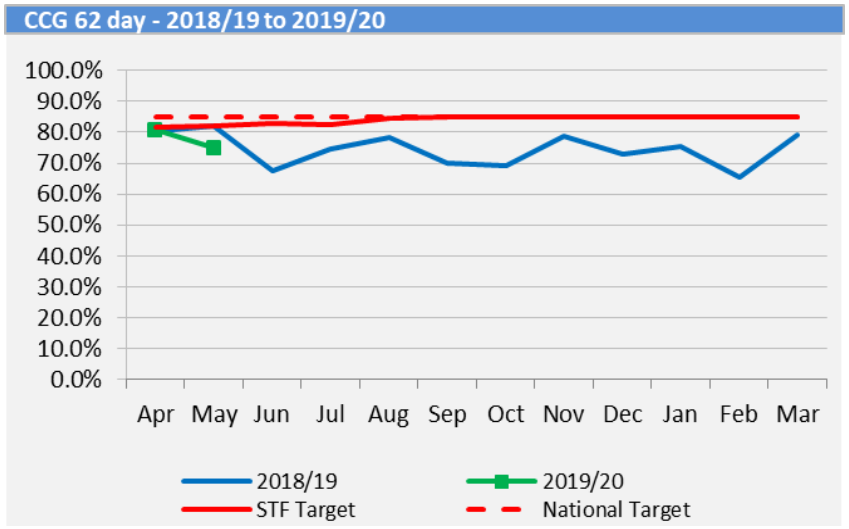
31 day subsequent treatm't: Radiotherapy



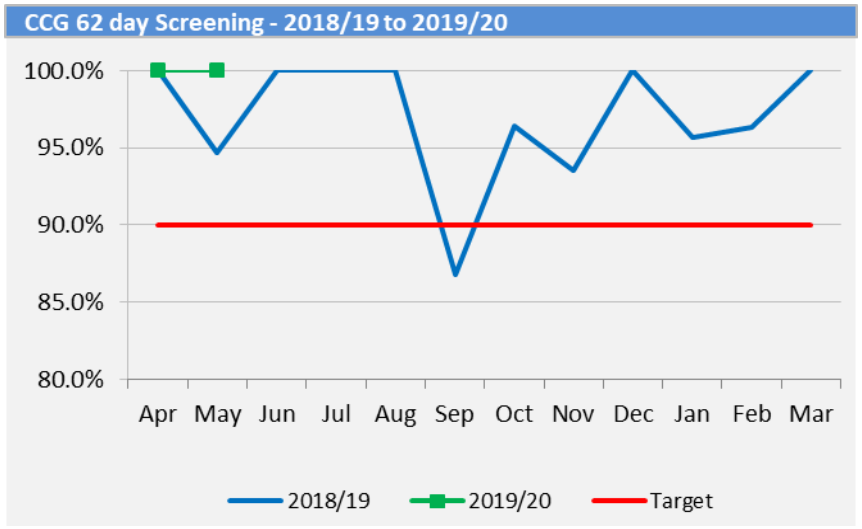
3.5 System Overview Cancer: May 2019

Red

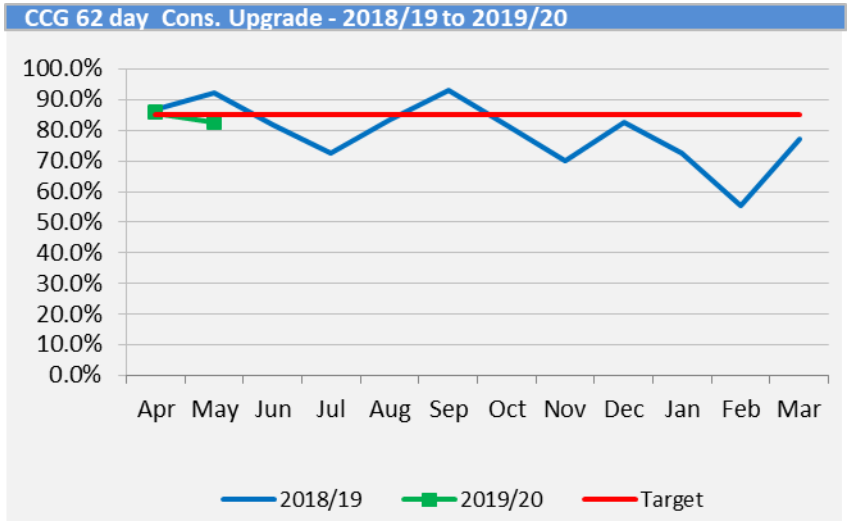
62 day: GP referral



62 day: Screening

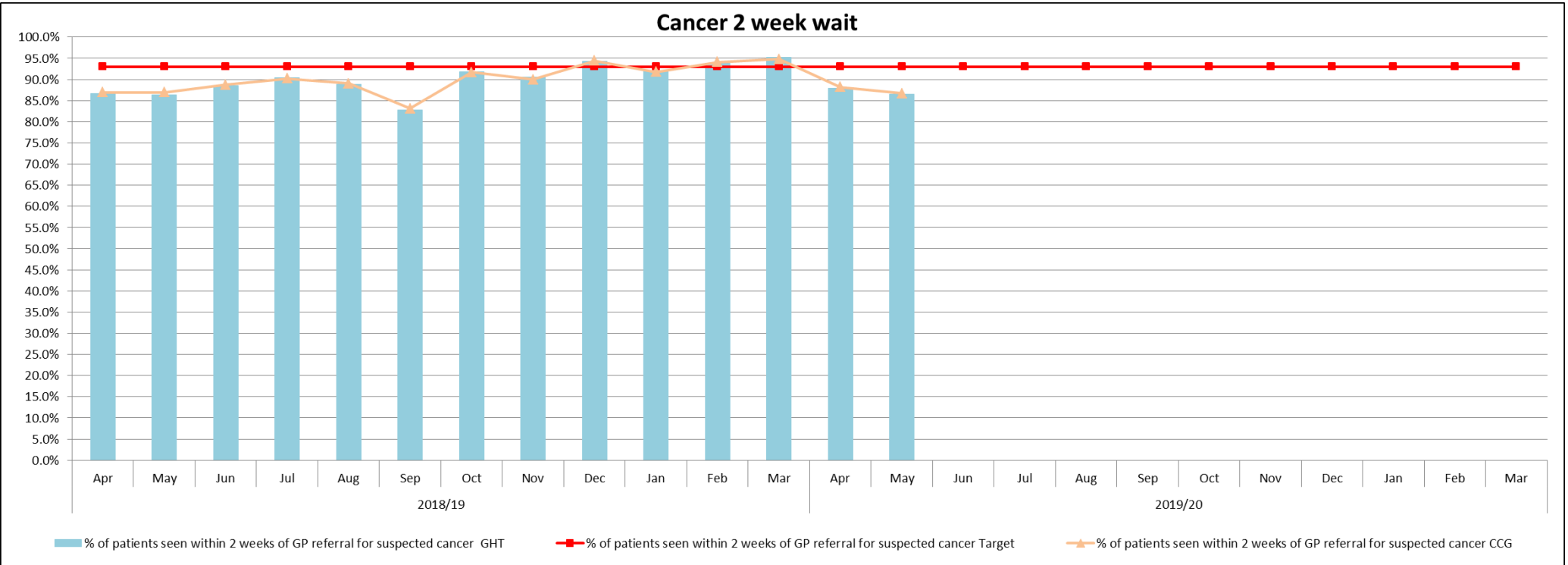


62 day: Consultant Upgrade



3.6 Cancer – 2 week waits

Amber



Top Line Messages:

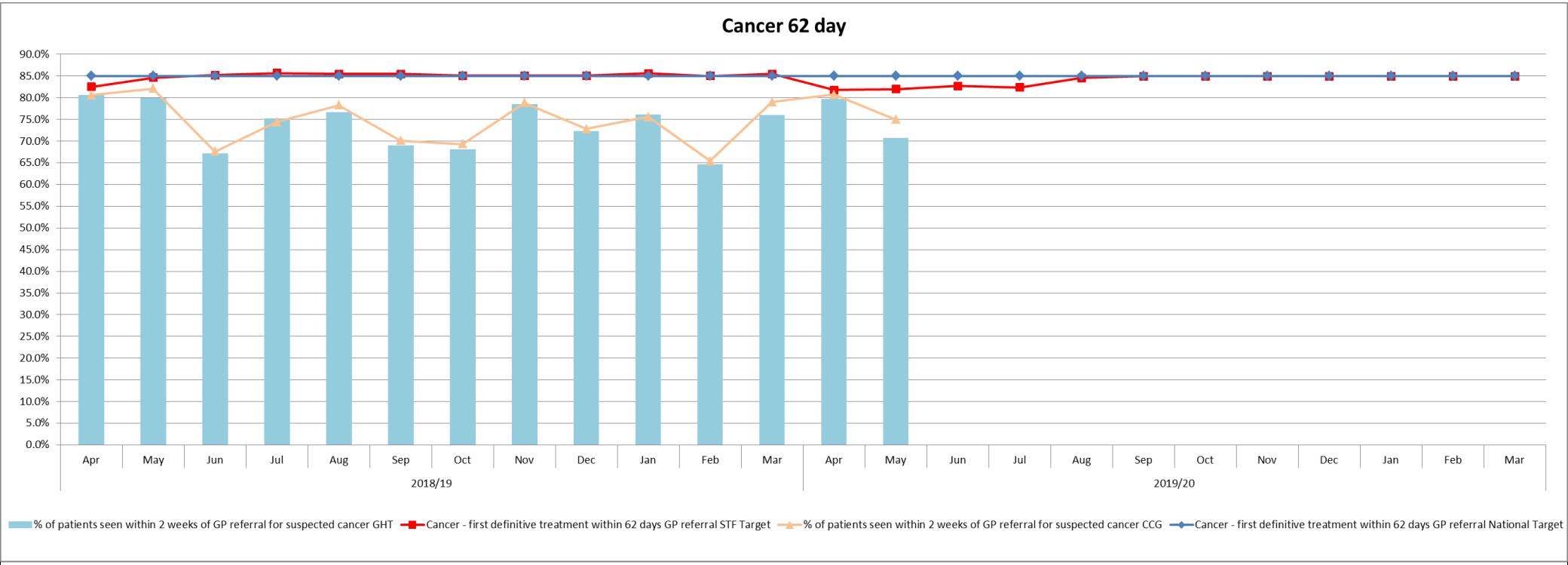
In May 2019, 2 week wait performance was 86.7% (CCG) with GHFT performance at 86.5%. For GCCG there were 285 breaches of the 2 week wait target – mostly in Lower GI (156 breaches – 56.8%) and Skin (83 breaches – 83.8%) specialties.

Performance has dropped slightly from the end of 2018/19 at GHFT, primarily due to a high volume of dermatology referrals and limited capacity within the specialty due to consultant sickness. This has now been resolved and is not expected to affect performance in June. Overall, referral numbers were higher in May than previous months, which GHFT has highlighted as an area of concern, however initial data suggests this has not continued into June.

Continuing their excellent performance in the breast surgery specialty, 98.4% of patients referred with suspected cancer and 97.3% of patients with breast symptoms (where cancer is not suspected) were seen within 2 weeks in May at GHFT.

3.7 Cancer – 62 days

Red



Top Line Messages:

62 day treatment performance has remained stable since 2016, with 2018/19 end of year performance averaging 74.5%. The ability of GHFT in particular to meet the 85% target has constrained by long term problems in capacity of their Urology specialty, however surgical waits in general (across several specialties in addition Urology e.g. Upper and Lower GI) have also contributed to pressure on this target.

May performance was 75.0%, down from the 80.7% achieved in April 2019. There were 40 breaches of the target of which: 2 were in Breast (94.1%), 3 in Gynaecology (70.0%), 2 in Haematology (66.7%), 3 in Head and Neck (25%), 5 in Lower GI (77.3%), 2 in Lung (86.7%), 1 in Sarcoma (50%), 2 in Skin (92.3%), 2 in Upper GI (71.4%), and 18 in Urology (41.9%).

In May 2019 there were 21 104 day breaches for first treatment for GCCG patients, of which 20 were first seen GHFT, and 1 at North Bristol Trust. This comprised: 2 in haematology, 2 Lower GI, 14 Urology (including the patient first seen at NBT), 1 Skin, 1 Sarcoma and 1 Lung.

3.7 Cancer – Actions and updates

Performance against the 62 day target excluding Urology at GHFT was 77.9% in May 2019. Urology performance for May was 41.8%, due to continued treatment of the backlog of patients – the majority of patients waiting over 62 days for treatment are awaiting RALPS surgery in the Urology specialty.

GHFT is looking to reliably improve performance across several specialties to mitigate the continuing impact of Urology performance on the 62 day target – this includes:

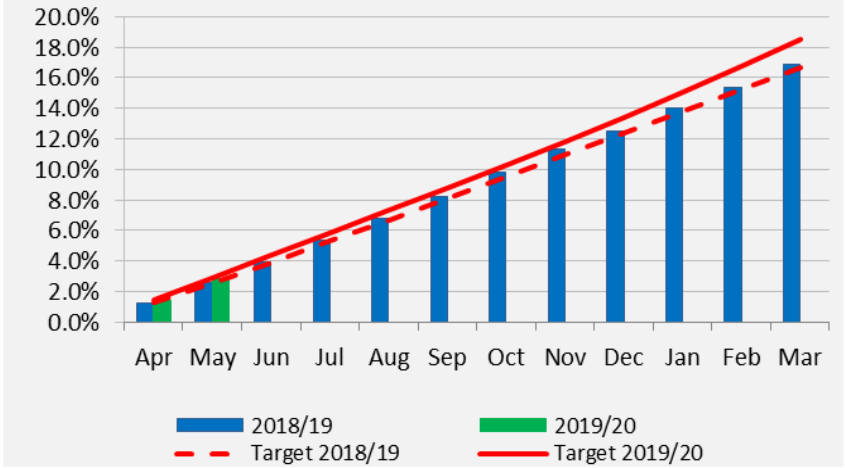
- Reducing reliance on tertiary centres for diagnostics in Upper GI;
- Review of CTC pathway;
- Introduction of best practice timed pathways (SWAG Cancer Alliance has supported the latest bid for this work);
- Direct Access for GPs for Ultrasound (PMB pathway) – pilot due for July;
- Dermatology currently scoping out the use of a Referral Assessment Service (RAS) in order to triage referrals and divert to most suitable pathway for patients;
- Adjustment of polling ranges down to Day 10 in a phased manner (phase 1 involves the smallest specialties) to assist with improving 62 day treatment and reaching the new 28 day diagnosis targets which are due to commence in 2020;
- Band 5 Pathway Coordinator and Pathway Tracker for Urology due to go out for interview in July.

3.8 System Overview: Mental Health - IAPT

Green

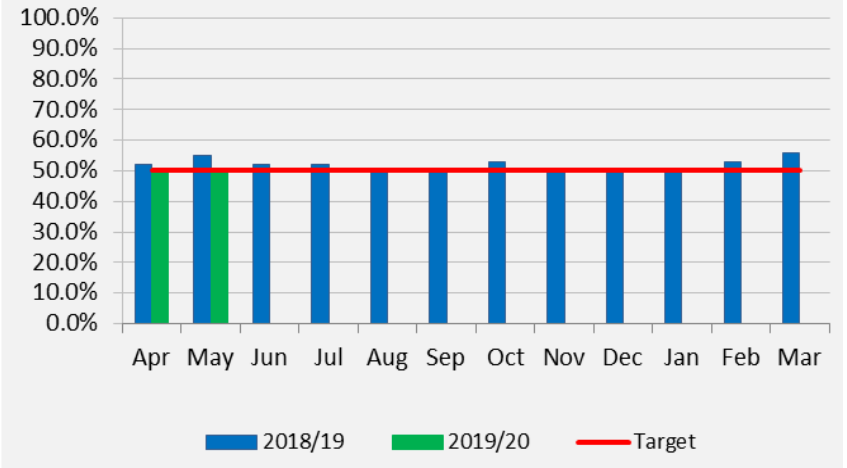
Access

IAPT Access - 2018/19 to 2019/20



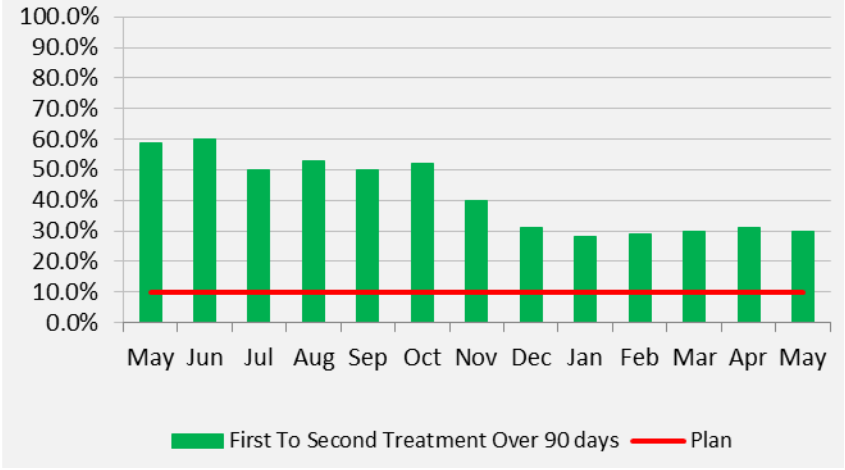
Recovery

IAPT Recovery - 2018/19 to 2019/20



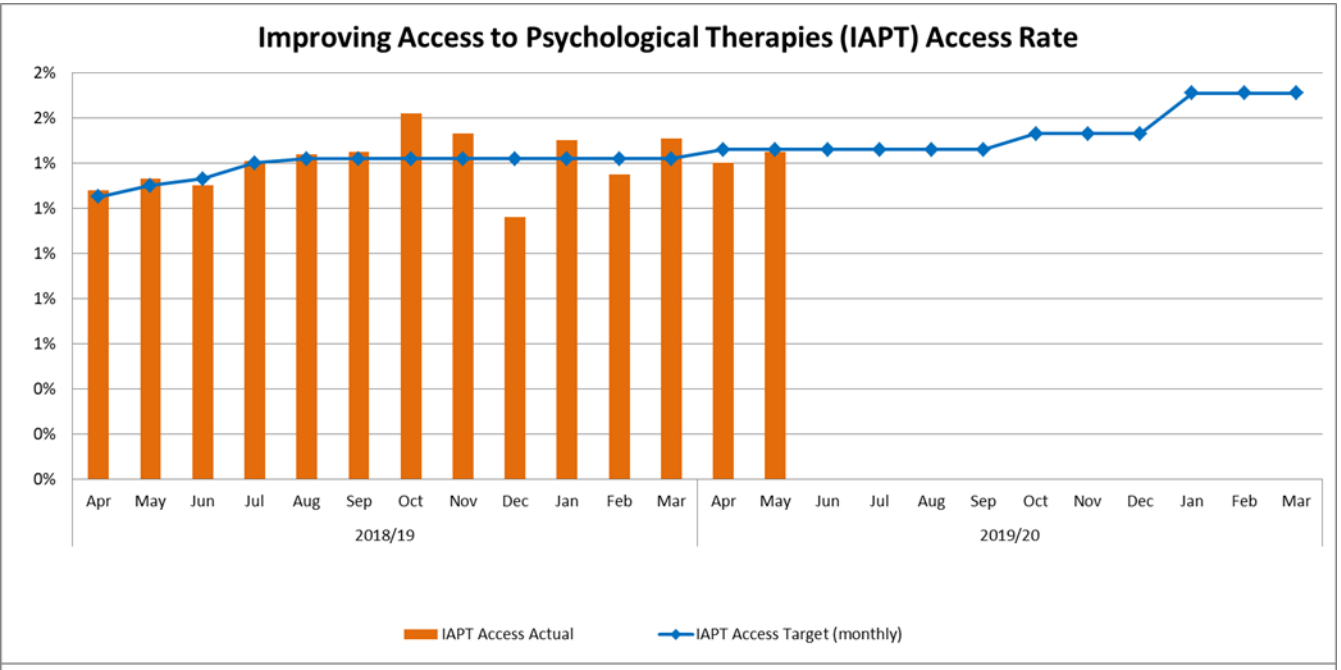
In-Stage Waits

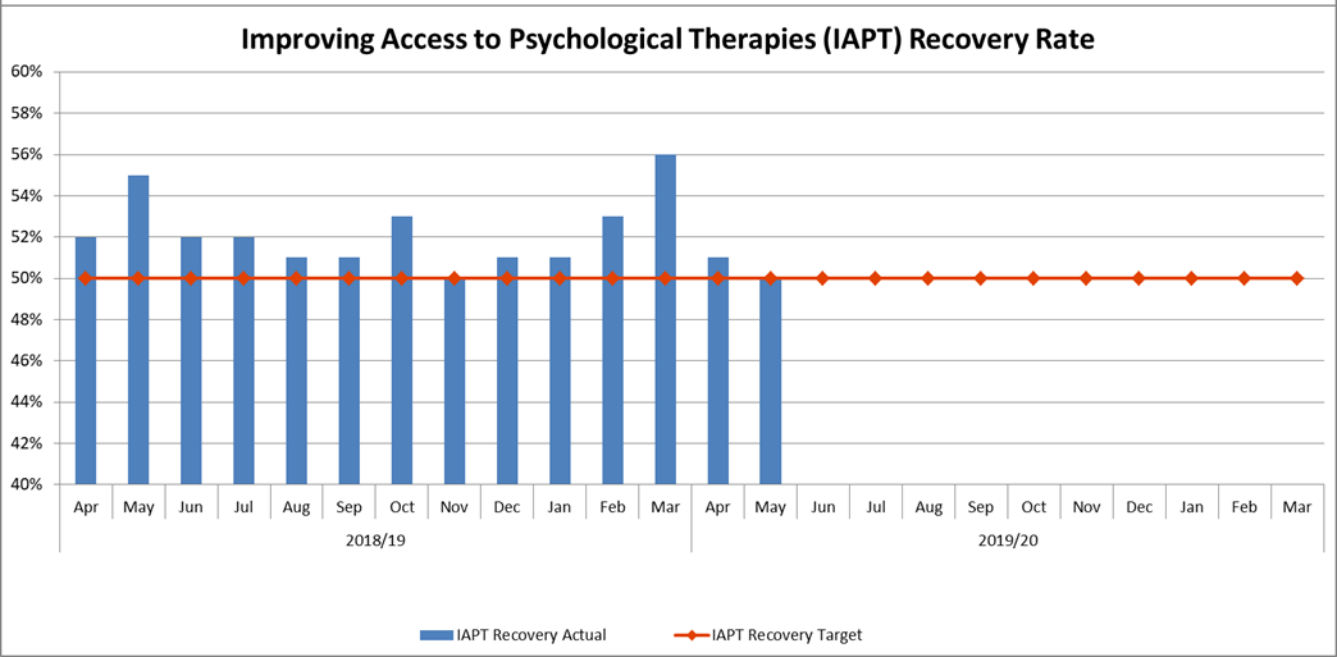
IAPT In stage waits- 2018/19



3.8 Mental Health - IAPT

Green





Top Line Messages:

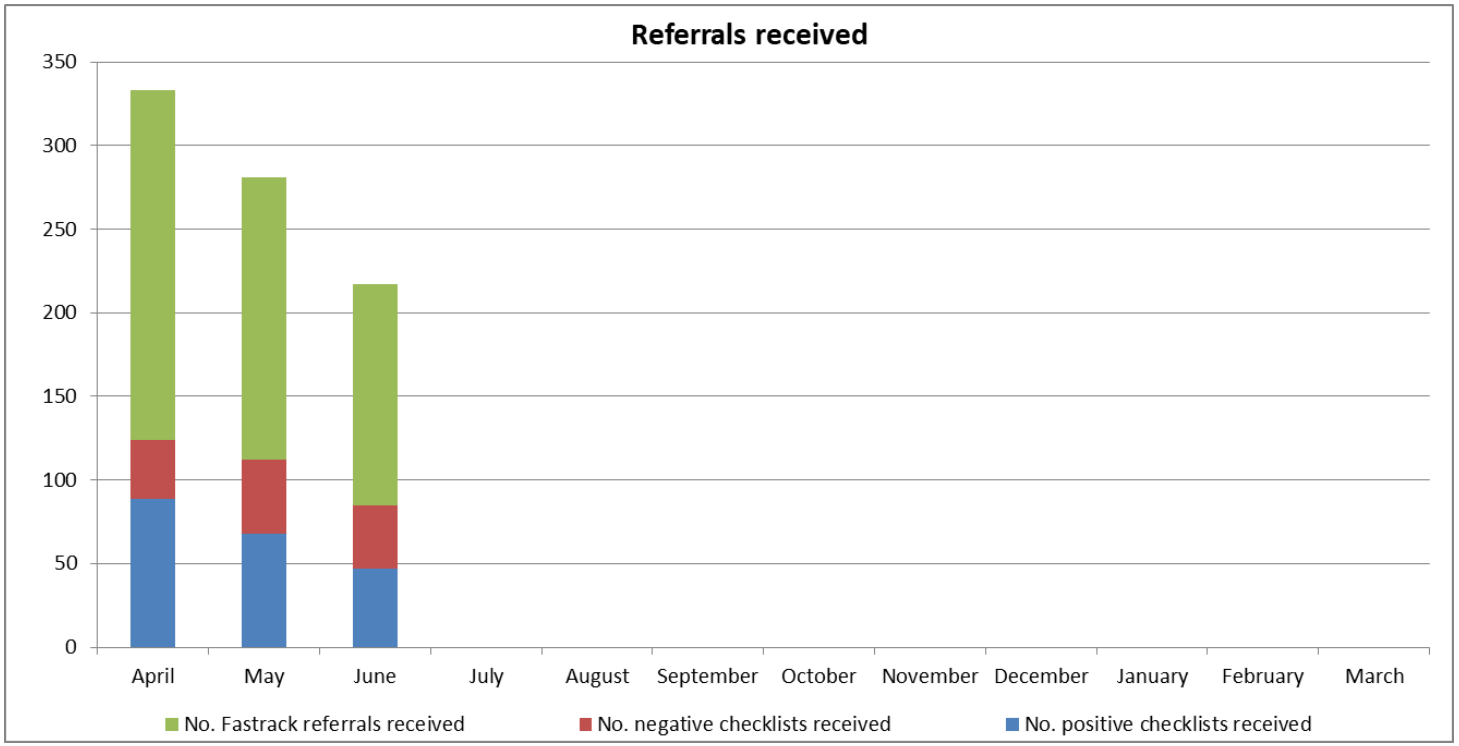
Access performance was slightly below the proposed quarterly target as at May 2019, however is on track to meet the quarterly position overall by the end of June. Due to Easter and May bank holidays, the access rate will be lower at the start of the quarter, with a planned increase in June to ensure the quarterly rate is met. May access rate was 1.45% (as planned) and the cumulative access quarter to date is 2.85% (target 2.9%).

Recovery performance has been excellent throughout 2018/19, with the 50% target being met in each month, and this has continued into the new financial year with May 2019 performance at 50%.

RTT performance for initial treatment remains high, with 99% of patients seen within 6 weeks. In-stage waits remain an area of concern, with 30% of patients currently waiting more than 90 days for a second appointment (service target is 10%).

3.9 Continuing Health Care – Referrals

Green



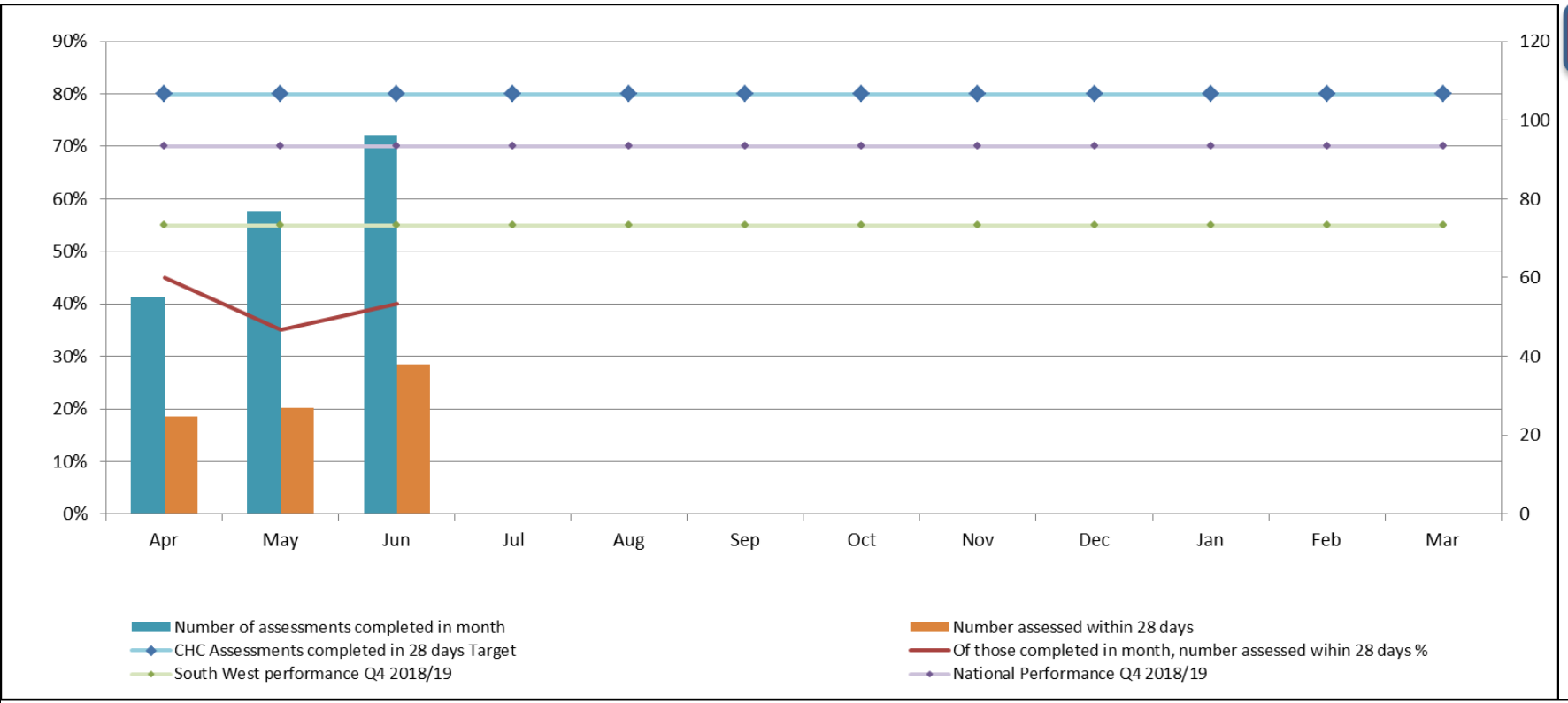
Referral volume has been steadily increasing in recent months, with positive checklists received rising in the first 2 months of 2019/20 to 78 on average (compared with the 2018/19 average (61/month)). Fast Track referrals have also been increasing, with an average of 189 referrals per month at the start of 2018/19.

June 2019 saw a reduction in both positive checklists (47) and Fast Track referrals (132) from average levels, with an increase in referrals discounted for both standard CHC and Fast track.

This is being reviewed by the CHC team and a project is being established to improve awareness and training for healthcare professionals referring patients for Fastrack funding in particular.

NHS
Gloucestershire
Clinical Commissioning Group

3.9 Continuing Health Care Assessments completed in 28 days



Red

Top Line Messages:

While performance has been significantly below the 80% standard in terms of the number of assessments completed within a 28 day timeframe, there has been a substantial improvement in the last quarter of 2018/19 in particular, bringing Gloucestershire just below South West average of 55% (GCCG Q4 average 45%). Latest performance data shows a stabilising position, with June 2019 performance at 40% and a significant increase in the volume of referrals concluded within the month. Actions to support performance include:

- Monthly audits now being completed by Business Manager to review the administration and recording of completed cases for full assessments, negative checklists & Fast Tracks.
- LA assessor and agency staff in place to support backlog reduction
- Improved communication and contact between Brokerage and care homes; Brokerage have also appointed to all posts and the priority for the new officers is to review visits for those homes where there hadn't been regular contact.

3.10 Gloucestershire Care Services

Service		2018/19 Outturn	Apr	May
Speech and Language Therapy (GCS activity) - % treated within 8 Weeks	Target	95%	95%	95%
	Actual	55.8%	69.4%	56.3%
Podiatry - % treated within 8 Weeks	Target	95%	95%	95%
	Actual	97.2%	88.8%	81.2%
Occupational Therapy Services - % treated within 8 Weeks	Target	95%	95%	95%
	Actual	75.5%	82.9%	83.7%
MSK Physiotherapy - % treated within 8 Weeks	Target	95%	95%	95%
	Actual	89.7%	80.4%	69.1%
ICT Physiotherapy - % treated within 8 Weeks	Target	95%	95%	95%
	Actual	82.8%	81.1%	81.9%
MSKAPS Service - % treated within 8 Weeks	Threshold	95%	95%	95%
	Actual	96.5%	92.4%	87.7%

RTT

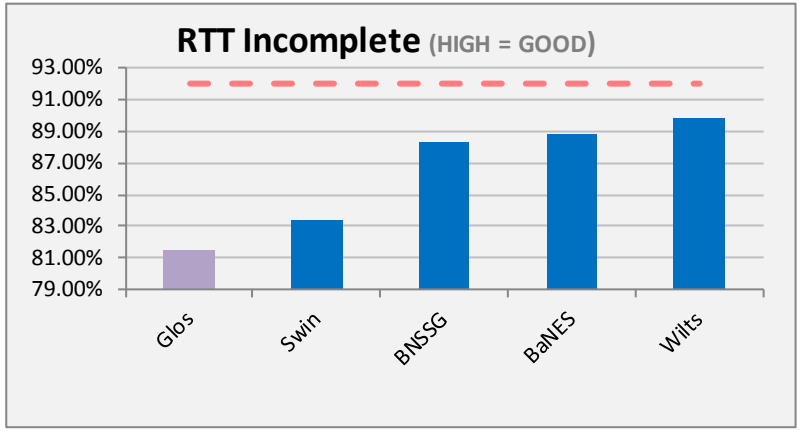
Community therapy services remains an area of concern, with Speech and Language Therapy in particular well below the target to see 95% of patients within 8 weeks. GCS have highlighted that triage and prioritisation means in most services, urgent patients are seen within 2 weeks and are working on profiling the PTL to give additional assurance in this area. Work is ongoing around service demand and capacity for OT and SLT.

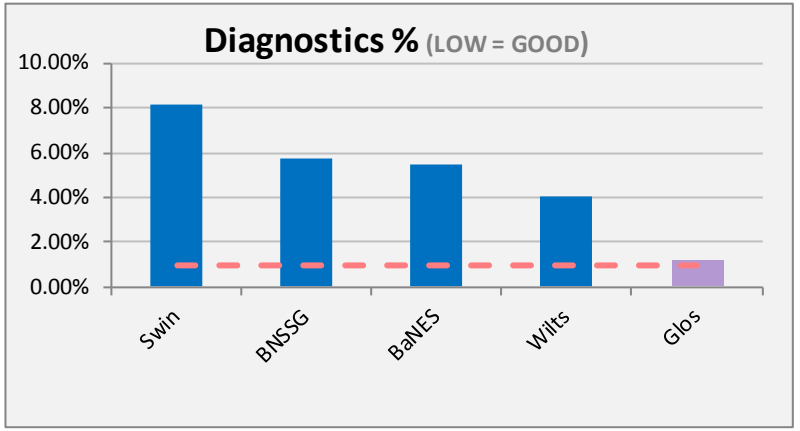
Children's SLT has also seen a deterioration in % treated within 8 weeks for both April and May despite maintaining good performance throughout 2018/19. This is being explored with the service to determine whether pressure on the SLT service is now affecting the children's provision.

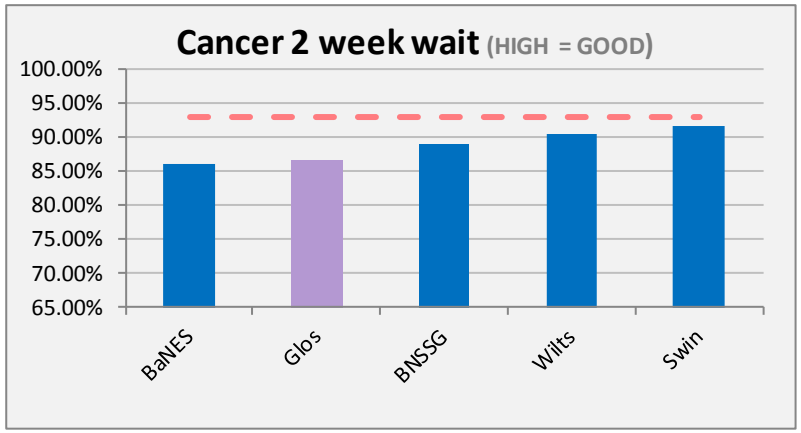
Complex Care at Home

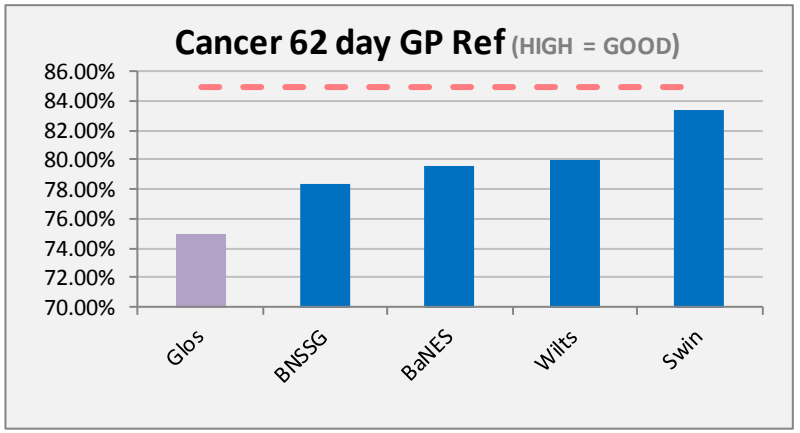
Following the success of the Complex Care at Home service in Gloucester and Cheltenham, this service has now expanded to cover the Forest of Dean.

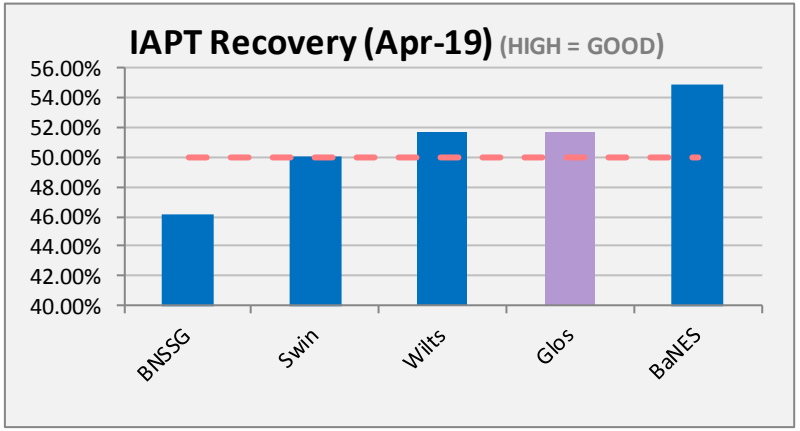
3.11 Regional Comparison – May 2019











4.0 Leadership *(slide 1 of 3)*

Green

Indicator	Component Measure	Narrative
Staff and member practice engagement	OD Plan Staff Survey Turnover Vacancies Sickness PDP/Training	**Turnover Rate:** turnover for May has increased to 15.05% from 14.31% in April. Overall turnover has been constant throughout the last 12 months, other than the increase to 15.05% this month. Last recorded 15% was April 2018. **Staff in Post and Starters and Leavers:** Staffing levels for May, 300 FTE equating to a total headcount of 366 - 3 new starters and 6 leavers. Over the last 12 months there have been 54 leavers (43.39 FTE) and 82 starters (68.05 FTE). **Leavers by Reason:** there were 54 leavers over the 12 month period, the main reason for leaving – 17 leavers due to Promotion, 7 leavers due to relocation and 7 due to retirement. **Sickness Absence Rate:** short term absence has slightly increased from 1.06% in April to 1.10% in May. Long term absence has increased to 2.82%. The report confirms overall absence % FTE over 12 months has decreased from 3.91% in April to 3.10%. **Sickness by Reason: f**or May 2019 absence due to anxiety/stress is 25.52%, a decrease from the figure of 39.04% in April. The overall cost of absence for May is £46,331 with a total of 409 days lost (365.15 FTE) over 45 occurrences. This equates to 287 days (9 occurrences) long term sickness and 122 days (36 occurrences) short term sickness. .

4.0 Leadership *(slide 2 of 3)*

Green

Indicator	Summary and headline evidence/ examples
1. Probity and Governance	The CCG has put in place strong clinical and non clinical leadership across all areas of the ICS, recent developments include investment in GP Provider leads to support local delivery and Integrated Locality Partnerships and Primary care Networks. ICS governance structures include CCG staff in senior leadership roles in all areas of the programme alongside provider leadership roles ICS work programmes progressing with outcomes being seen in a number of areas, including cancer, MSK and eye health and also across health and wellbeing projects such as the daily mile and the community wellbeing service. HR and OD plan aligns to that of the ICS and is overseen by the HR/OD group who meet quarterly. There is a refreshed workforce and OD strategy, setting out establishment of the Gloucestershire Local Workforce Action Board (LWAB) to oversee the enabling workstream for the ICS. Further modelling is being undertaken on the current workforce and future changes and challenges, stage two of the workforce capacity plan has commenced.
2. Staff Engagement	The CCG effectively engages with staff members with a Joint Staff Consultative Committee and an annual staff survey. The 2018 survey had a response rate of 73% which was positive. Amongst the top scores was the % of staff that confirmed the CCG provided equal opportunities 93%, 88% knew the CCG's vision & values and 86% confirmed the CCG supported staff with their health and wellbeing. A robust action plan has been produced and a series of staff training, events and focus groups are taking place, staff engagement is aligned to the ICS through the Social Partnership Forum and the Associate Director of Corporate Affairs leads on HR and OD internally, and attends associated ICS working groups to represent the CCG. Plans are linked to the overall ICS workforce development programme..
3. Workforce Race Equality	WRES data forms part of the CCG's annual Equality and Engagement report, reported to the Quality and Governance Committee. The 2018 annual report 'An Open Culture' will be considered by the Governing Body in March and published.
4. Effective Working Relationships	The 2018/19 360 survey results show that 99% of respondents responded positively when asked to rate the effectiveness of their working relationship with the CCG, maintaining our scores from 2017. 91% of stakeholder rated the CCG positively on effectiveness as a local system leader, i.e. as part of an Integrated Care System (ICS). 94%. Of stakeholders confirmed that the CCG considers the benefits to the whole health and care system when taking a decision. The report included a host of very positive comments from all stakeholders and especially from GPs about the support and help they are given by the Primary Care Team.
5. Compliance with statutory guidance on patient and public participation	The CCG is committed to embedding involvement in all areas of its commissioning activity and is able to provide clear evidence of progress against the 10 key actions including through the annual report, feedback website pages, communication engagement strategies and plans, consultation report, AGM and equality impact assessments. ICS engagement, first stage complete, Forest of Dean consultation completed and preparation underway for One Place Business case consultation, patient participation in urgent care pathway design workshops this spring secured.

Indicator:	Summary and headline evidence/ examples	Green
6.1 Leadership	ICS five year plan, developed from the FYFV signed off by all partners. CCG operational & financial plans developed from the STP plan, start point April 2017. ICS work programme developing using the agreed governance structure. The CCG is working with practices on developing their PCN structure and supporting the development of the ILPs. There is a strong relationship between the locality and the CCG through Integrated Locality Partnerships currently under development and the Primary Care Networks. Specific examples of good practice include several primary care events Commissioning event, Locum event, Productive Time etc. and an annual rolling programme of GP Practice visits and varied communication methods such as What's New This Week and G Care. CCG OD plan focus on staff development and includes strong emphasis on formal appraisal including PDPs. There is co-ordinated staff training including financial training at all levels including Governing Body and all budget holders. Gloucestershire health and social care partners have been awarded the status of an Integrated Care System in recognition of its mature and collaborative working relationships system wide.	
6.2 Quality of Leadership	There is a clear governance structure in place which enables a focus on quality, performance delivery including contracts and finance within the Q&G, Audit & Risk Committee, Governing Body business meetings and the formal bi monthly Governing Body. Information is reported to each committee with a focus on key area of risk as well as the overall performance / finance position. The Governing Body is well sighted on financial and performance issues with regular informal and formal reporting. Meetings are well documented to evidence the level of discussion and challenge. Governing Body members expertise range from governance, clinical, financial, commercial and patient experience enabling a strong challenge.	
6.3 Leadership Governance	The Governing Body has a clear constitution, policies, set roles and responsibilities which enable them to effectively challenge. A recent review has been undertaken of the risk management process with a dedicated Risk Management workshop organised for Governing Body members and senior managers, which focused on risk appetite. Further changes have been implemented with the Audit & Risk Committee taking responsibility for assuring the GB on risk management. Each committee carries out a self assessment annually to inform future development.. The CCG has a robust corporate governance framework including policies, committee structure and monthly reporting to the GB on financial & performance risk including those within providers and contracts. External expert advice is taken where required e.g. legal advice on a judicial review. Clean external audit reports since inception. Internal audit annually cover transactional areas as well as developmental areas and are reported to Audit & Risk Committee, clinical audits and internal audits focusing on clinical areas are reported to the Quality and Governance Committee.	
6.4 Transformational Leadership	The ICS has a clear governance structure supported by a MOU which has been agreed by all partners, this is currently being updated. The Governing Body receives bi-monthly ICS reports which provide updates on key achievements, performance and areas of focus. Providers also report on ICS achievements to their respective boards. For example, partners are involved in progressing the One Place programme to develop the urgent care system to improve the patient experience. A dedicated team has been put in place to drive this project. The Gloucestershire Local Workforce Acton Board is working through key workforce priorities, funding opportunities and evaluating R&R initiatives.	

5.0 Sustainability - Month 03

Green

Income and Expenditure	YTD surplus	FOV surplus	YTD Running costs	FOV Running costs
In Year	£0k	£0k	£0k	£0k
Cumulative	(£5,367k)	(£21,470k)	£0k	£0k

Savings Programme	YTD Savings	% YTD Savings	FOT Savings	% FOT Savings
	£3,368k	100%	£17,287k	100%

Other Metrics	BPPC	Cash drawdown	FOT Capital
	97.06%	26.8%	£0k

5.0 Sustainability – Executive Summary

Position

- Gloucestershire CCG is forecasting to achieve it's planned in year position of breakeven and a planned cumulative surplus of £21,470k

- A prescribing forecast of breakeven is included within the position; Prescribing data has only recently been received for April 2019 and few conclusions can be drawn from a single month's data.

- No flexibility remains within CCG budgets to offset any additional pressures that arise in year as all recurrent and non-recurrent reserves have now been fully utilised to cover recognised pressures in the budget setting process. The CCG, therefore, lacks the headroom to offset any material crystallisation of risk.

- As much of the in-year mitigation is non recurrent in nature, the consequence will be an additional pressure in 2020/21, as new savings will be needed to fill the funding gap.

- All significant contract financial envelopes have been agreed and contract signatures are being progressed with providers where sign-off has yet to be achieved.

- Work is underway with partners in the system to produce a five year plan to 2023/24 in accordance with the recent implementation framework guidance. The draft of this plan is due for submission on 27th September 2019, with the final submission on 15th November 2019.

5.1 Sustainability – Resource Limit

The CCG's confirmed allocation as at 30th June 2019 is £932.6m.

The following allocation transfers have been actioned in June; those listed below were non-recurrent in nature

£'000	Description
200	STP Funding
(39)	Excess treatment costs – national topslice
57	Diabetes Transformation funding – Structured Education & Multi Disciplinary Foot Team (Q1)
220	Community Transformation funding for Transforming Care Patients
1,157	Children & Young People project funding (partial allocation of Trailblazer project)
1,036	GP Forward View – STP Funding (incl practice resilience/GP retention/PCN support/training/online consultation systems)
49	Improving Access (increase to baseline for population growth)
40	Medicines Optimisation in Care Homes (MOCH) Qtr 1&2
550	Maternity Transformation funding
3,270	**Total change in month**

5.2 Sustainability – Acute Contracts *(1 of 2)*

Acute NHS Contracts **Key** **Indicates a favourable movement in the month** **Indicates an adverse movement in the month**	**Trend**	**Year end Forecast £'000**
Gloucestershire Hospitals NHS Trust (GHNHSFT) The 2019/20 Contract value for GHFT is £345,442k. A block contract arrangement has been agreed with the Trust for all services except excluded drugs which remain variable. Although the current financial forecast is breakeven, drug costs are being closely monitored as they are a material risk to the CCG and there are early signs of pressure against this budget. Within the block elements of the contract, emergency expenditure is above the planned level.	→ ←	0
University Hospital Birmingham NHSFT Based on a single month of data, initial indications suggest overspends within electives day case and inpatient activity for plastic surgery and non PbR drugs for Tocilizumab. There are underspends in non elective Hepatology that marginally offset this.	↓	50.0
University Hospital Bristol NHSFT Initial monitoring, based on two months of data, shows the following underspends: • Elective admission activity in cardiology & paediatrics • Non elective activity for cardiology • Non PbR in drugs costs for Adalimumab and homecare drugs This is marginally offset by overspends in: • Day cases in clinical oncology • Non PbR for critical care	↑	(249.9)
Oxford University Hospital NHSFT Key pressures are highlighted within non elective activity for trauma & orthopaedics (T&O) complex hip & knee and elective activity in clinical haematology & cardiology.	↓	250.0

NHS Gloucestershire Clinical Commissioning Group

5.2 Sustainability – Acute Contracts *(2 of 2)*

Acute NHS Contracts	Trend	Year end Forecast £'000
Great Western Hospital NHSFT There are a number of long stay patients with significant critical care bed days which is partially mitigated by underspends in Non Elective obstetrics and critical care.	↓	50.0
Wye Valley NHS Trust The contract performance highlights overspends in Electives and Emergency and non PbR insulin pumps.	↓	104.0
Winfield Hospital Information regarding performance against contract is continuing to show pressures within T&O inpatient activity. Further work to understand whether this is a recurrent trend is currently underway	↓	172.3
Ramsay Healthcare Uk Underspends are driven primarily by Elective T&O activity.	↑	(126.1)
Any Qualified Provider Contracts **Newmedica** – Although April invoiced amounts were within budget forecasts, May has seen an increase. The current forecast takes an average cost for the service and predicts forward to highlight a potential overspend of £222k **Care UK** – currently reporting an underspend Predominantly within Day case for T&O **Oxford Fertility** – The budget was reduced due to apportioning a savings programme which has yet to be realised in the early months of the financial year.	↓	383.6

5.3 Sustainability – Community

Acute Contracts	Trend	Year end Forecast £'000
South Western Ambulance Services NHSFT The current year contract includes a "break glass" clause which is triggered when activity reaches a pre-agreed threshold, in totality, across the commissioners who are party to the agreement. At the end of June, this threshold has been met and the forecast assumes that this level of over-performance will remain in July. Thereafter, it has been assumed that the contract performs to planned levels; this is based on actions that are being implemented to help manage the increased demand.	↓	168.0

5.3 Sustainability – Community

Community	Trend	Year end Forecast £'000
There is an overspend within Children in Care however this is being offset by a continued low take up in Telehealth which continues the trend of previous years.	↓	13.7

5.4 Sustainability – Prescribing

Primary Care Prescribing	Trend	Year end Forecast £'000
The budget for prescribing is £86m which includes a £5m QIPP programme. This budget was set using the 2018/19 outturn. Although the latest data from NHS Business Services Authority (NHS BSA) has been received for April, it is considered too early to estimate an outturn position and, hence, a breakeven position is forecast.	➔➔	0

5.5 Sustainability – Mental Health

Mental Health	Trend	Year end Forecast £'000
Mental Health Services Currently there is an overspend within Children & Adolescent Mental Health services (CAMHS) due to 1:1 costs for Registered Mental Health nursing which can be variable. Potential mitigations are being reviewed with NHSE.	↓	10.0

5.6 Sustainability – Primary Care

Primary Care	Trend	Year end Forecast £'000
Delegated Co-Commissioning – During the planning stage a pressure of £2.1m was highlighted and, hence, additional budget has been included over and above the ringfenced delegated allocation. The total budget is £86.3m versus an allocation of £84.2m – Maternity and sickness payments continue to be a pressure mitigated by other areas within the delegated budget – The forecast is breakeven	➔➔	0
Other Primary Care – A small underspend is forecast based on variances in a number of areas.	↑	(125)

5.7 Sustainability – Continuing Health Care & Placements

Continuing Health Care (CHC)/Funded Nursing Care (FNC)/Placements	**Trend**	**Year end Forecast £'000**
This area predominantly includes costs based continuing health care including domiciliary care, nursing home placements, other placements, funded nursing care (FNC) and personal health budgets. Domiciliary care costs have unexpectedly risen in the last three months and a detailed financial review is being undertaken to establish the reason and understand whether this is a recurrent increase. A forecast overspend of £500k has been included within the reported position which, also, includes an element of 2018/19 costs which exceeded the year end estimate. Costs have also risen in respect of LD cases which partially relates to an increase in the number of ongoing patients and increases in the cost of individual packages. A forecast overspend of £500k is forecast for this budget. This information is based on May's information, at the time of writing this report, June data on an individual case basis had yet to be received from Gloucestershire County Council.	↓	1,090.0

5.8 Sustainability – Other

Other	Trend	Year end Forecast £'000

• This area includes budgets for:
  • Void Properties
  • Patient Transport
  • NHS 111
  • Joining Up Your Care (JUYI)
  • Integrated Better Care Fund (iBCF)
 	
• The budget totals £31.1m
 	
• The forecast is currently overspent within patient transport and NHS 111 due to CQUIN pressures and Directory of Services restructure respectively.
	↓	14.0

5.9 Sustainability - Savings Plan

- The 2019/20 savings plan totals £17.287m. Savings schemes include those partially implemented in 2018/19 and some newly developed, including opportunities identified through benchmarking and national RightCare comparisons.

- The savings plan for 2019/20 covers all the main delivery priorities including Clinical Programme Approach (CPA), Reducing Clinical Variation – Medicines Optimisation and Urgent Care via the One Place, One Budget, One System Programme.

- At this early stage in the financial year, the forecast outturn is expected to be on plan, however, work is ongoing on mitigating financial risks associated with the savings plan e.g. Macmillan Next Steps Cancer Rehabilitation (MNSCR) and Centralisation of Surgery.

- RightCare is an integral part of the savings programme for 2019/20 with a minimum of 28.7% (£5.0m) of the programme aligned to RightCare. Pathways include MSK / Trauma, Respiratory, Diabetes, Cancer and Circulation. Work is on-going to identify the element of the Medicines Optimisation Programme that is RightCare related; once this work is complete, it should result in a higher % attributed to RightCare.

5.10 Sustainability - Savings forecast delivery

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Savings Programme 2019/20

Area	Planned Savings 2019/20 £	Forecast Before Mitigations 2019/20 £	Forecast After Mitigations 2019/20 £	Variance 2019/20 £
Clinical Programme Approach (CPA)	1,914	1,730	1,914	-
Planned Care Programme	1,502	1,380	1,502	-
One Place / Urgent Care Programme	1,100	875	1,100	-
Community & Prevention Programme	1,801	1,801	1,801	-
Medicines Optimisation Programme - Primary Care	5,000	5,000	5,000	-
Medicines Optimisation Programme - Secondary Care	3,404	3,404	3,404	-
Other	2,566	2,566	2,566	-
Grand Total	**17,287**	**16,757**	**17,287**	**-**

Risk share and contract mitigations are in place to offset potential financial risks (e.g. Macmillan Next Steps Cancer Rehabilitation (MNSCR) and Centralisation of Surgery) associated with the savings plan. The table shows the forecast before mitigations i.e. scheme delivery and a forecast after the application of mitigations e.g. contract risk shares applied to the position. The current forecast is one of break-even after applying these risk mitigations.

5.11 Sustainability – Risks & Mitigations overview for year

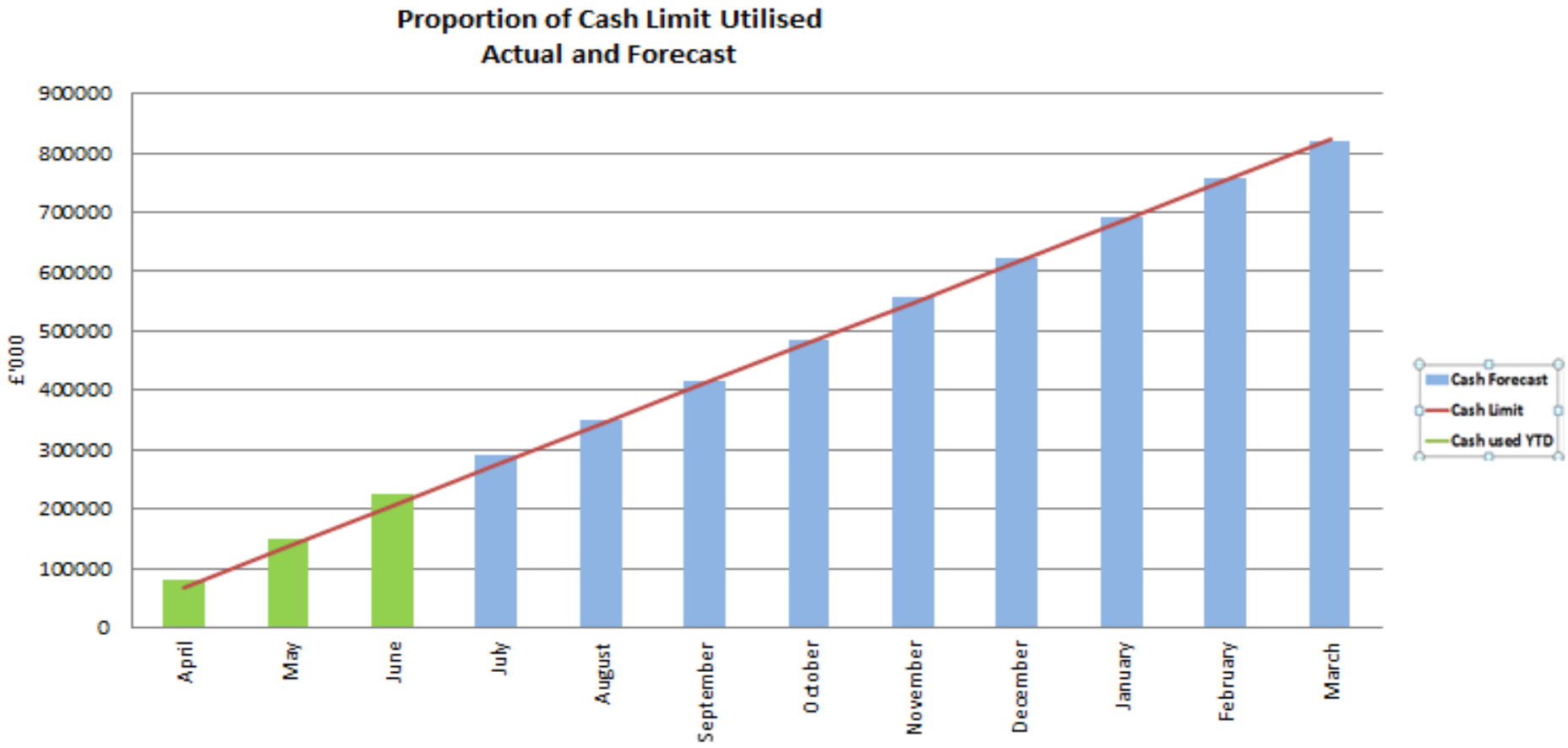
Risks

- Transforming Care/LD placements and CHC pressures (including backdated costs)
- Growth & demand pressures in acute contracts/AQP providers
- True impact of transfers of activity from Specialised Commissioning
- No reserves to cover additional cost pressures in year
- Slippage in delivery of saving solutions
- Prescribing volatility

Mitigations

- Slippage on developments – non-recurrently retained centrally
- System agreement on application of transformation funds
- Identify new savings schemes
- Urgent care reset plan
- No controllable expenditure to be committed if no identified funding source
- All commitments against new allocations identified
- No appointments made without identified funding
- Developments - release subject to business case sign off.

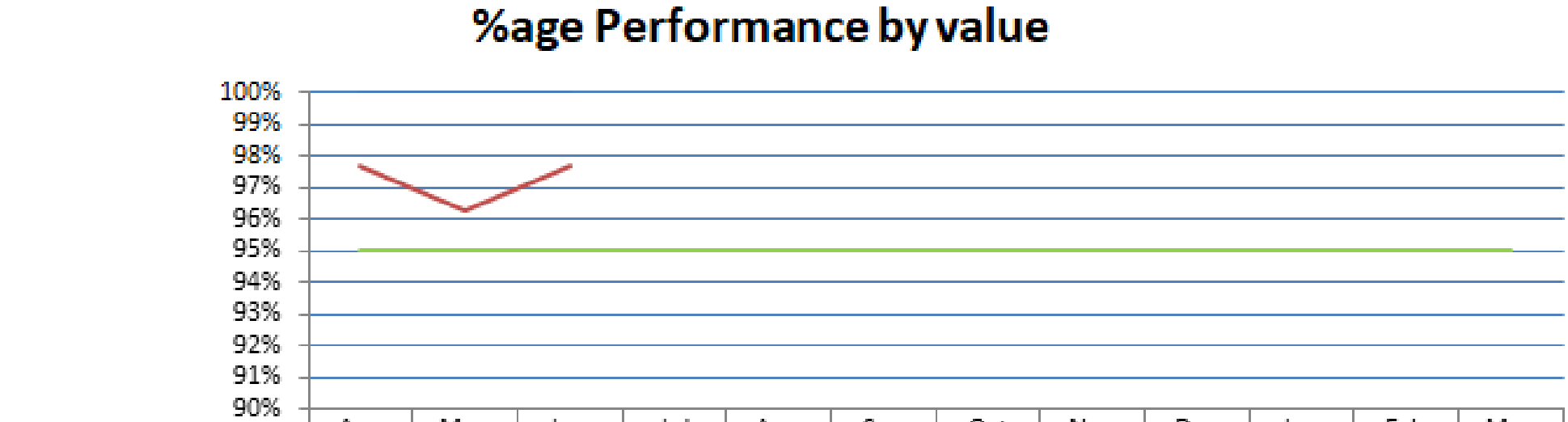
5.12 Sustainability – Cash Drawdown



At the end of June £243.5m had been drawn down (26.8%) of the maximum cash drawdown available.
The cash balance at 31st June 2019 was £8.9m.

NHS Gloucestershire Clinical Commissioning Group

5.13 Sustainability – BPPC performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS	100.00%	100.00%	100.00%									
Non NHS	97.64%	96.25%	97.66%									
Target Performance	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

NHS Gloucestershire Clinical Commissioning Group

5.14 Sustainability – I&E Position for Month 03 – June

Level 3 name	Level 4 name	Total Budget	YTD Budget	YTD Actual	YTD Variance	TOTAL Forecast Variance	Prv Mth Forecast Variance
⊟PROGRAMME	ACUTE	437,350,965	109,255,745	110,224,383	968,638	851,810	(1)
	COMMUNITY HEALTH SERVICES	86,992,765	21,403,622	21,441,133	37,511	13,650	1
	CONTINUING CARE	50,730,132	12,682,293	13,117,661	435,368	1,090,000	(1)
	MENTAL HEALTH	89,288,947	22,322,107	22,169,840	(152,267)	10,000	(0)
	OTHER	30,189,946	6,851,380	6,909,755	58,375	13,972	(0)
	PRIMARY CARE	198,807,815	49,688,778	49,787,831	99,053	(124,999)	1
	RESERVES	4,274,430	2,204,829	751,153	(1,453,676)	(1,854,434)	0
PROGRAMME Total		**897,635,000**	**224,408,754**	**224,401,755**	**(6,999)**	**(1)**	**0**
⊟ADMIN	RESERVES	(957,464)	(238,629)	(11,178)	227,451	87,336	(0)
	CORPORATE	14,539,464	3,634,129	3,413,677	(220,452)	(87,335)	(0)
ADMIN Total		**13,582,000**	**3,395,500**	**3,402,499**	**6,999**	**0**	**(0)**
⊟SURPLUS	SURPLUS	21,470,000	5,367,497	0	(5,367,497)	(21,470,000)	(21,470,000)
SURPLUS Total		**21,470,000**	**5,367,497**	**0**	**(5,367,497)**	**(21,470,000)**	**(21,470,000)**
Grand Total		**932,687,000**	**233,171,751**	**227,804,254**	**(5,367,497)**	**(21,470,000)**	**(21,470,000)**

5.15 Sustainability – Balance Sheet – M03 June

Statement of Financial Position
As at 31st May 2019 (Month 2)

	Opening Position as at 1st April 2019	Closing Position as at 31st May 2019
	£000	£000
Non-current assets:		
Premises, Plant, Fixtures & Fittings	326	326
Total non-current assets	**326**	**326**
Current assets:		
Trade and other receivables	7,899	11,889
Cash and cash equivalents	9	5,771
Total current assets	**7,908**	**17,660**
Total assets	**8,234**	**17,986**
Current liabilities		
Payables	(50,642)	(54,037)
Provisions	(2,876)	(2,705)
Total current liabilities	**(53,518)**	**(56,742)**
Non-current assets plus/less net current asse	**(45,284)**	**(38,756)**
Non-current liabilities		
Total non-current liabilities	**0**	**0**
Total Assets Employed:	**(45,284)**	**(38,756)**
Financed by taxpayers' equity:		
General fund	(45,284)	(38,756)
Total taxpayers' equity:	**(45,284)**	**(38,756)**

NHS Gloucestershire Clinical Commissioning Group

If you require more information than the data provided in the Monthly Performance Report or Accompanying Scorecard please contact:

Performance Department - GLCCG.GCCGperformance@nhs.net

Agenda Item 11

Governing Body

Meeting Date	**Thursday 25th July**
Report Title	**Integrated Care System (ICS) Lead's Update**
Executive Summary	This report provides an update on Gloucestershire Integrated Care System. The report provides an insight into the progress being made in the ICS transformation programmes against the system vision and priorities.
Key Issues	This report provides focus in the main programme areas; • Enabling Active Communities; • Reducing Clinical Variation; • One Place, One Budget, One System • Clinical Programme Groups. This report also includes an annex paper showing a high level overview of the NHS Long Term Plan Implementation Framework and an outline of the One Gloucestershire approach to developing the local system response to the Long Term Plan. The response is due for final submission by mid-November 19 (draft submission September 19). The Implementation Framework outlines the expectations on systems to ensure that system responses are clinically led and locally owned and summarises the "foundation commitments" within the Long Term Plan that have specified timelines for delivery. Partner Organisation Boards and Governing Body will be consulted on the draft response in October/November.
Risk Issues:	ICS programme risks are regularly reported to

Original Risk (CxL) **Residual Risk (CxL)**	ICS Executive as a standing item. Further consideration is being given to the development of a view of system-wide risk.
Management of Conflicts of Interest	N/A
Financial Impact	N/A
Legal Issues (including NHS Constitution)	N/A
Impact on Health Inequalities	The report supports the effort to reduce health inequalities
Impact on Equality and Diversity	The report positively impacts on improving equality and diversity
Impact on Sustainable Development	N/A
Patient and Public Involvement	The report considers the matters of public engagement and is also submitted to the Health and Care Overview and Scrutiny Committee.
Recommendation	Governing Body/Board members are asked to note the content of the report.
Author	Emily Beardshall: Deputy ICS Programme Director
Sponsoring Director (if not author)	Ellen Rule: Director of Transformation & Service Redesign

One Gloucestershire
Transforming Care, Transforming Communities

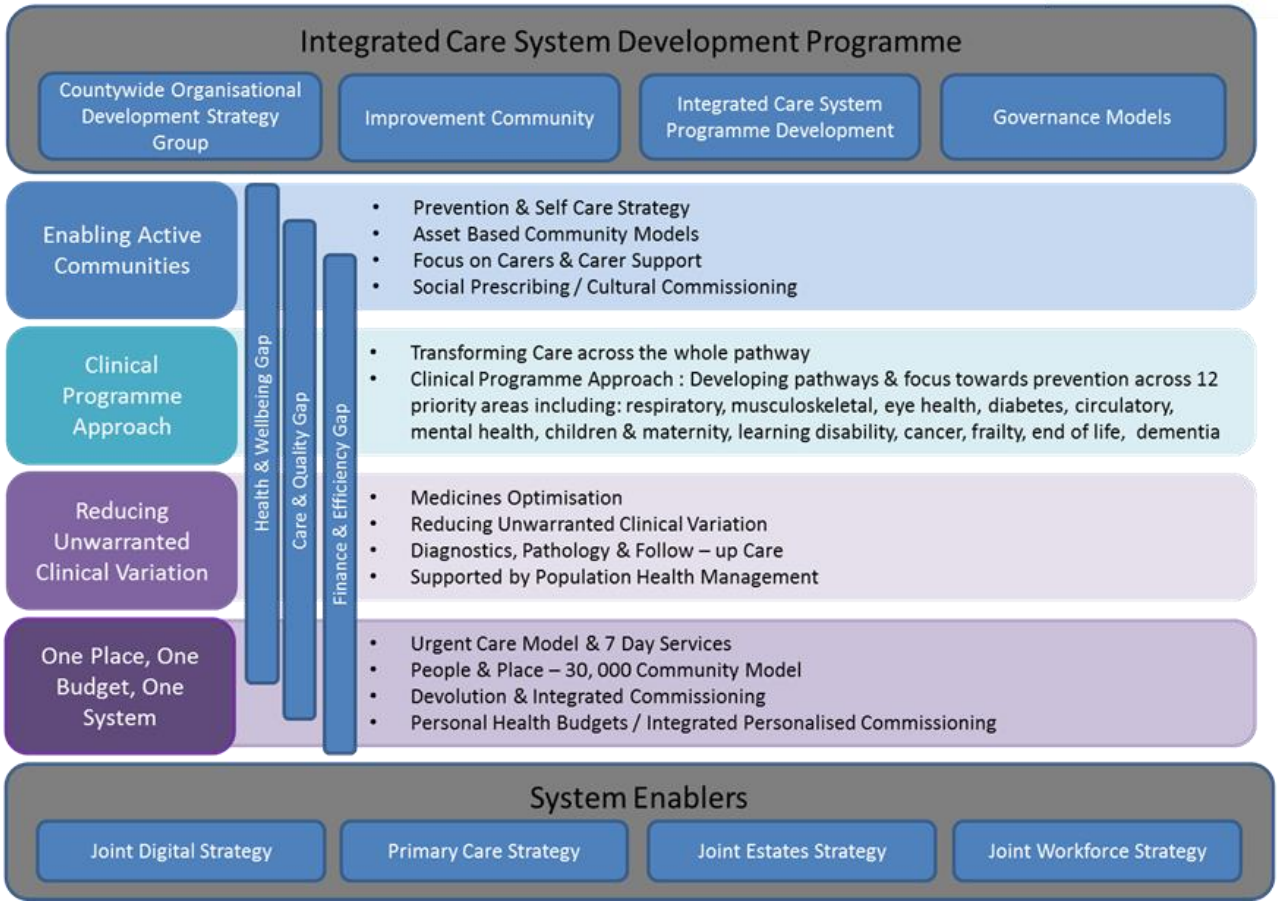
July 2019

One Gloucestershire Integrated Care System Lead Report

1. Introduction

The following report provides an update to Governing Body/Board members on the progress of key programme and projects across Gloucestershire's Integrated Care System (ICS) to date.

Gloucestershire's Sustainability & Transformation Plan commenced year three of four in April 2019 continuing priorities against the central transformation programmes with refreshed delivery plans in place that will transition the system into delivering against the Long Term Plan. In this report we provide an update on 2019/20 plans and the progress made against the priority delivery programmes and supporting enabling programmes included within the One Gloucestershire Integrated Care System.



Gloucestershire's ICS Plan on a page

2. Enabling Active Communities

The Enabling Active Communities programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector.

The development of the Gloucestershire Prevention and Shared Care Plan, led by Public Health, aims to reduce the health and wellbeing gap and recognises that more systematic prevention is critical in order to reduce the overall burden of disease in the population and maintain financial sustainability in our system.

Key priorities for 2019/20 will align to the refreshed Health & Wellbeing Strategy and are split across the 4 main workstreams: supporting pathways, supporting people, supporting places and communities and supporting our workforce.

Supporting Pathways

- There have been 3,237 referrals onto the **National Diabetes Prevention Programme** (NDPP) with a 60% referral uptake.
- **Tier 2 Child Weight Management –** There is a focus on increasing awareness and engagement in the community; we have identified families for focus groups and to support co-production throughout the project.
- A key achievement has been the running of a one-day **Blue Light** training event on the 17th June, delivered by Alcohol Concern. The event was targeted at Cheltenham staff and 23 people attended.
- **Postpartum contraception:** this way of working is embedded and there is sustained delivery from the ward team. The Cheltenham Midwifery teams have now received training and are due to join the pilot this should increase uptake of postpartum contraception.

Supporting People

- The **Early identification of domestic abuse** pilot project that was due to end on 30th June 2019 has identified further funding. The service will be commissioned by Gloucestershire County Council through the Gloucestershire Framework for Domestic Abuse.
- **Healthy food for NHS staff, visitors and patients:** good progress was seen in a recent review and further work is planned over the coming year to continue to improve the healthy food offer. This work is being overseen by the Gloucestershire Hospitals NHS Foundation Trust (GHFT) Health and Wellbeing Board.
- **Social Prescribing Plus -** Approximately 50 people have been referred into the **Breathe In Sing Out** project which is delivered by the local music charity Mind song. A network of arts based self-management groups for people with living with chronic pain is being developed. This will offer an accessible option for patient led self-management before, after or instead of pain management programme. Two local arts organisations, Artshape and Cinderford Artspace are running an **arts based project for Children & Young People who have Type 1 Diabetes** with accompanying mental health needs. Around 18 children and young people who have Type 1 Diabetes have been referred into the project.

Supporting Places & Communities

- **Gloucestershire Moves Programme Update:**
  - 2 Schools have signed up to the **Cotswold's Walking Project**
  - **Special Olympics Gloucester –** Big Health check day delivery is complete. 1,500 people attended with 14 accessible sports provided. This was delivered in partnership with volunteer students from Hartpury College.
  - **Beat the Street** launched in June 2019. A focus on the programme is given below
  - The **Dear Daily Mile** case study campaign is working with primary schools across the county to share their stories of doing the daily mile, in particular overcoming barriers and the impact it had in their school.
  - **Strengthening Local Communities -** Work continues to engage with local communities and groups to understand how they can work together to benefit the community.

Supporting Workforce

- **Workplace Health and Wellbeing:** The workplace wellbeing newsletter is now reaching an audience of 720 people. Work continues to expand the readership. There is ongoing work to engage and support workplaces across Gloucestershire. New workplaces are being supported to develop healthy workplace policies.

Focus on Beat the Street

Originally implemented as part of Active Gloucestershire, Beat the Street aims to increase levels of physical activity in those least active and most vulnerable (less than 30 mins per week). Target cohorts are: older people; those with long term health conditions/disabilities; women; people from lower socio-economic groups; BME communities. In addition, it will look to change behaviour across the county as a whole to one where physical activity is the norm, including enabling the infrastructure to support sustained behaviour change.

Hugely successful in 2018, Beat the Street turns Gloucester into a giant game; it's a fun, free challenge which aims to make physical activity part of daily life. The scheme was so successful last year that it is being re-introduced to Gloucester from 26th June to 7th August 2019.

Highlights from 2018 Beat the Street Gloucester:

- 71 Beat Boxes across the City
- 10 distribution points including libraries and leisure centres
- Over 10,000 participants
- 74,000 miles travelled in total
- 1200+ Facebook and twitter followers
- Over 4,300 people registered providing health, travel and behaviour data
- 60% of registered players were female
- 20% of registered adults were inactive (<30mins a week)
- The proportion of adults using their car every day decreased from 32% before the game to 25% six months later
- 11% increase of players meeting physical activity guidelines
- 1200+ Facebook, Twitter and Instagram followers
- 42.9% weekly newsletter engagement rate

Comments from participants included that the scheme created a real buzz around the City and that they enjoyed "spending time with family" and "finding new places". Some examples are featured below:

"I cycled to places I'd never been to; found cycle paths in places I didn't know. I looked forward to the challenge and felt excited when looking for the boxes. Felt a sense of achievement and motivated to go out and exercise after work"

"We spent time as a family, planning routes then going out and completing them. We would go out every Sunday for a long walk and then a few times during the week. It made us enjoy being together and outside! We've tried to keep it up since"

This inclusive initiative is suitable for individuals, families, schools, community groups and workplaces to take part in. To join in, players just pick up a card and map from a distribution point, register on the website and pick a team.

The website features leader boards for schools and communities and spot prizes can be won during the game, the more active you are the greater the chance of winning a prize.

Players use the map and move between tap point boxes. If 2 different boxes are tapped within an hour, this will record as 1 journey (10 points). The more journeys you make, the more points you get.

For 2019 Beat the Street has:

- more beat boxes 93 total and has new locations
- Eye catching signs above the Beat Boxes
- More distribution points including supermarkets and community hubs
- New bonus points events and themed weeks
- Prizes and incentives for registering, playing and completing end of game survey

- The game runs into the summer holidays
- Better partnerships, more of a legacy and better connections to existing local activities and facilities

  Success will be measured via:

  - Sport England evaluation framework
  - Player registration, end of game survey and 6/12 month follow up surveys
  - Participants asked about their activity levels, travel behaviours, mental wellbeing and connection to their community
  - Case studies, quotes and focus groups

To find out more and get involved please visit the website and signpost groups and individuals there:

- www.beatthestreet.me/Gloucester

3. Clinical Programme Approach

The Clinical Programme Approach has been adopted across our local health care system to ensure a collaborative approach to systematically redesign the way care is delivered in our system, by reorganising care pathways and delivery systems to deliver right care, in the right place, at the right time. During 2019/20 we have identified 4 clinical programmes for acceleration with faster paced work with Integrated Locality Partnerships. These Clinical Programmes are Respiratory, Diabetes, Circulatory and Frailty & Dementia.

Respiratory: The Respiratory CPG has made strong progress with integration, initially concentrating on the Chronic Obstructive Pulmonary Disease (COPD) pathway. The test and learn cycles have resulted in changes to how patients are seamlessly transferred between acute and specialist community elements of the pathway.

An education and training programme to embed the pathway is being developed, to be delivered at a Primary Care Network Level.

A focus will be placed on prevention in 2019/20 including smoking cessation, the use of pulmonary rehabilitation and links with local communities

Diabetes: The CCG has been selected as an early implementer sit to use the HeLP online tool for people with type 2 diabetes. The new offer will mean people with type 2 diabetes have evidence-based information and support available at the touch of a button, via an online portal, giving them convenient and quick help to deal with the physical and mental challenges of diabetes.

The resource will make the right advice available from home, work or on the move, helping people manage their health and wellbeing independently, potentially preventing the need for extra medical attention or the condition becoming worse.

Trials of the online package showed people making use of the online courses and information reduced their blood glucose levels, a crucial part of managing type 2 diabetes.

There are 11 pilot sites nationally and Gloucestershire will be the only pilot site in the South West.

24 children with Type 1 diabetes attached a camp over the early May Bank Holiday to help provide a peer network and support to children and their families. The camp was well-received by those who attended.

The number of patients attending the NHS Diabetes Prevention Programme continues to increase with 3155 patients having attended this programme aimed at supporting those at high risk of developing diabetes with behaviour change and reducing their risk.

A draft 10 Year Diabetes Strategy has been produced and is being reviewed by stakeholders.

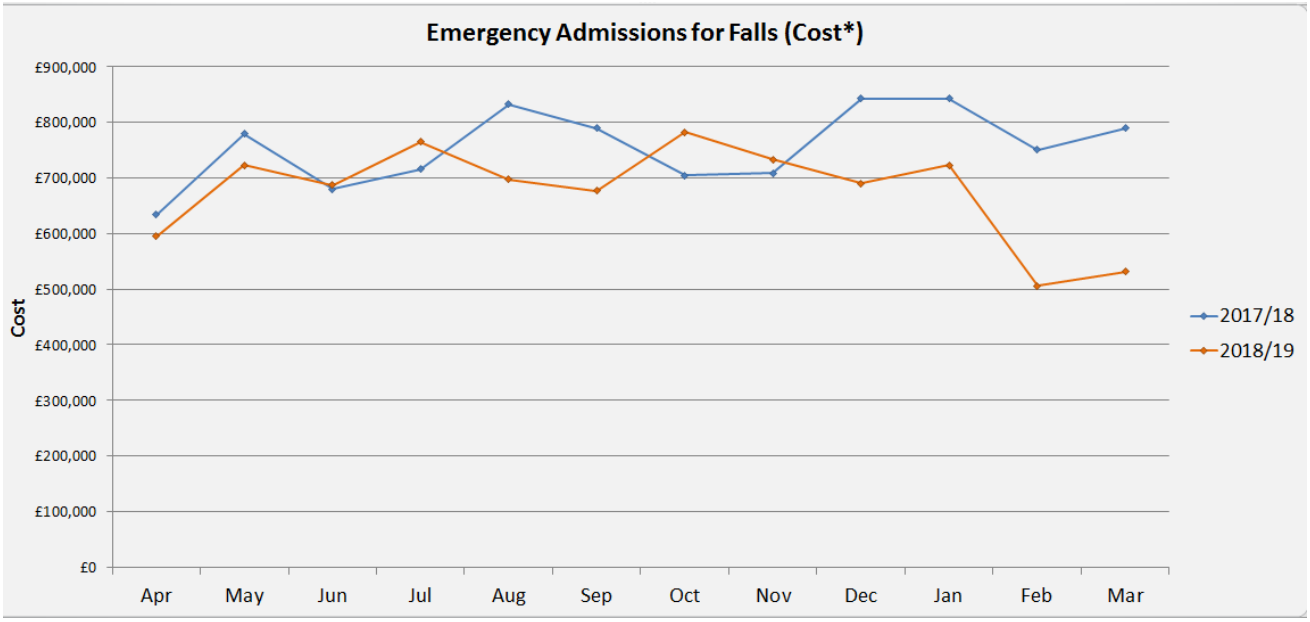
Circulatory:

- The Cardio Vascular Disease (CVD) prevention work has been well aligned with NHS Long Term Plan and NHS Rightcare National Priority Initiative.
- Community blood pressure programme has commenced and work is underway to improve the management of Atrial Fibrillation.
- Proposal from Gloucestershire Wildlife Trust for a Social Prescribing offer for Cardiac rehab has been agreed

Frailty & Dementia

Work is underway to agree a **Frailty Strategy** for Gloucestershire. As part of the Frailty Strategy, the Frailty CPG will develop and agree a core set of requirements for PCN based frailty services.

Work is well underway in the re-commissioning the **Falls Assessment and Education Service** (FAES which has shown excellent results in reducing falls; the graph below shows the year on year reduction in the cost of emergency hospital admissions for patients following a fall.



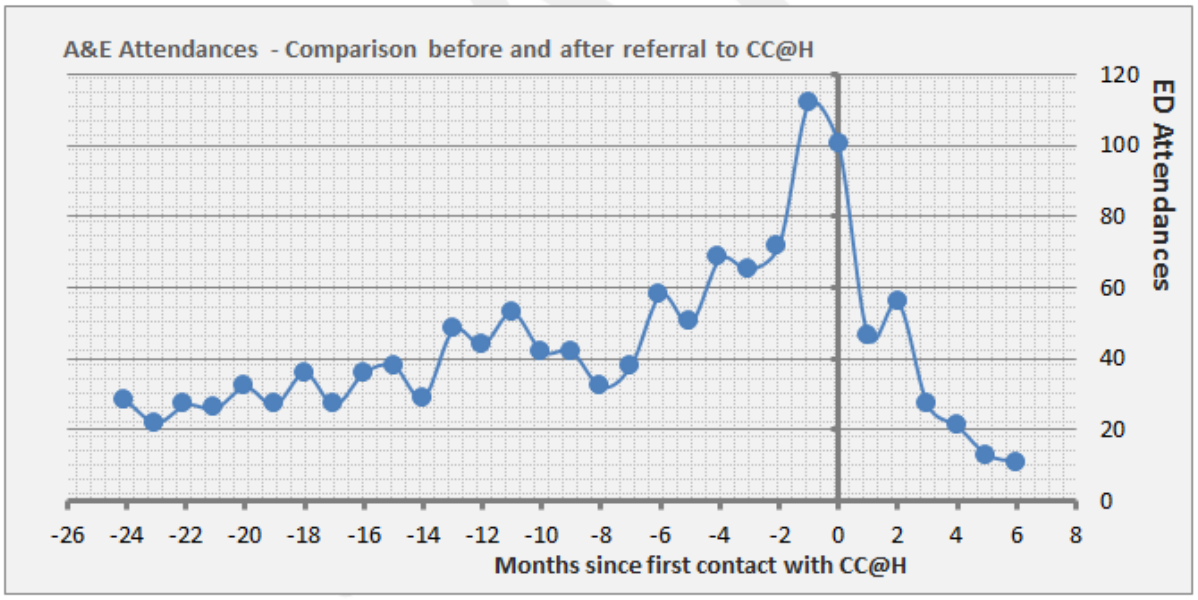
Active Gloucestershire have been working closely with the Frailty Clinical Programme to produce a **Strength and Balance** exercise leaflet

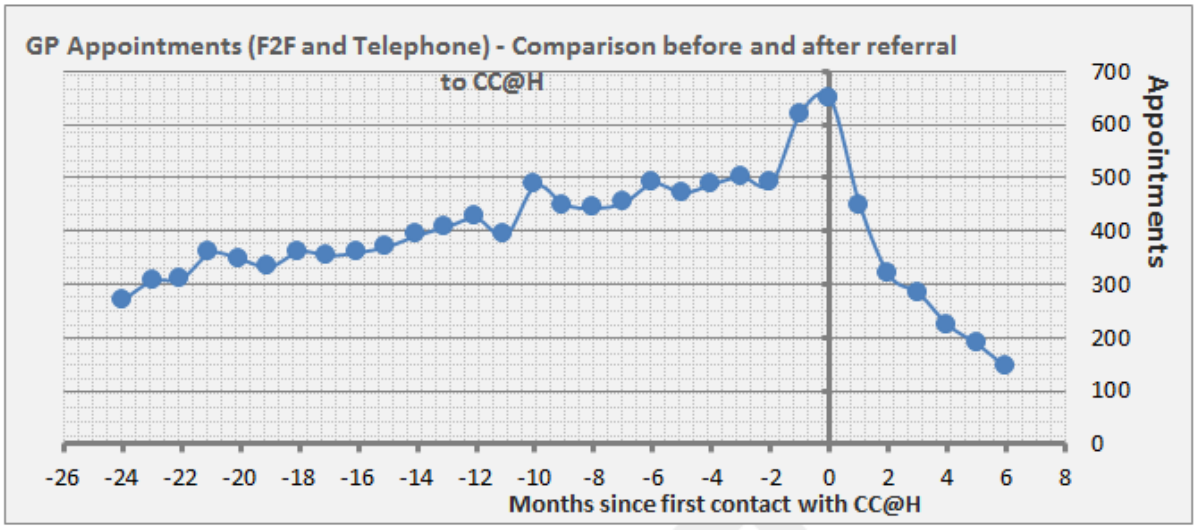
Focus on Complex Care @ Home

The **Complex Care @ Home** service was launched on 1st April 2018 with a phased approach to recruitment and implementation. The service focuses on identifying people who are losing resilience and independence, increasing in frailty and at risk of hospital admission or long term care. The team is multi-disciplinary led by Community Matrons and includes dementia specialists, therapists, wellbeing coordinators, a dietitian and social care practitioners. They adopt a person-led care planning approach and promote the self-management of health conditions by using health coaching and the Patient Activation Measure. The team works closely with the person and resources in the community to identify and access longer term low level support to maintain benefits.

The service has recently undertaken an evaluation and to 31st January 2019 the service has worked with 423 people.

The evaluation showed a significant reduction in A&E attendances and GP appointments for patients before and after the support from Complex Care at home as shown below.





Alongside this analysis the evaluation also presented really positive case studies for individuals who had benefitted from being supported. One of the case studies is shown below.

Person
Mrs H. Lives at home with husband independently, neither have support from Adult Social Care
Living Circumstances
Mrs H has a history of falls with a number of hospital admissions. She has Arthritis, spinal damage, poor mobility, probable difficulties with short term memory and a catheter in situ. The Reablement Service identified no long term care needs following the most recent hospital admission

Complex Care @ Home Team intervention
Joint visits were undertaken by the Care Navigator and Matron to support Mr and Mrs H. The team supported Mr H to better provide personal care for Mrs H. A range of equipment was suggested allowing Mrs H to elevate her legs during periods of the day to reduce the risk of falls. Occupational therapy intervention provided for handrail in bathroom and to promote independence with personal care. Information and advice was given on preventative support – fall detectors, Gloucestershire Fire and Rescue Service Fire Safe and Well check and Carer Support as well as the Adult Social Care process. Mrs H was supported to contribute to daily living tasks and now helps with meal preparation and going out jointly on shopping trips relieving pressure on her husband. The whole intervention entailed: • 6 Community Matron Visits • 1 visits by Occupational Therapist • 2 visits by Physiotherapist • 9 Wellbeing Coordinator visits • 2 Care Navigator visits
Outcomes
Mrs H's risk of falls has reduced; she now contributes to daily tasks. They are going out as a couple and enjoying the summer. They both have improved wellbeing due to: • Provision of equipment and reduced risk of falls • Promotion of independence in daily living and personal care tasks • Improved social interactions as the couple are accessing the community together • Reduced anxiety due to safer environment because of equipment and digital technology Admission to permanent care is prevented at this time.

Overall the evaluation has informed the action plan for the service going forwards over the next 12 months to further refine and improve the service alongside recognising the success of the programme to date whilst also considering the next steps for the roll-out of the service more widely within the county.

4. Reducing Clinical Variation

The Reducing Clinical Variation programme looks to elevate key issues of clinical variation to system level and have a new joined up conversation with the public around some of the harder priority decisions we will need to make. This includes building on the variation approach with primary care, promoting 'Choosing Wisely' and a Medicines Optimisation approach, undertaking a diagnostics review and working to optimise Outpatient services.

Key priorities for 2019/20 are

- We will make continued use of the successful Prescribing Improvement Plan (PIP) to ensure the early in-year savings, and subsequent in-year benefit for as much of the year as possible. Actions include working with GP practices via the prescribing support team to identify and record beneficial changes to prescribing activity.
- We will continue to work with secondary care colleagues to consider areas for mutual benefit within medication choice and supply routes.
- Continued inclusion of Medicines Optimisation topics within the annual Primary Care offer to support primary care colleagues to maximise efficiencies available from appropriate prescribing
- Continue the successful provision of the Clinical Pharmacist team working within many GP practices by recruiting to fill current vacancies.
- Implement a two year programme Medicines Optimisation in Care Homes (MOCH) scheme, specifically in residential homes.
- Develop and improve mechanisms to allow GPs to access specialist opinion/advice and guidance.
- Develop appropriate alternatives to secondary care outpatient services where there are opportunities to manage patients in a less specialist and lower cost setting.
- Support transformation in the outpatient approach across the system.
- Strengthen our approach to commissioning thresholds through changes and developments to the CCGs Effective Clinical Commissioning Policies list.
- Develop stronger secondary care gatekeeping functions through effective referral triage/management processes.
- Undertake a review of diagnostic provision across the system to support transformational programmes.

What we've achieved so far:

- Work within the practices is progressing towards achievement of the **2019-2020** Prescribing Savings target through the updated Prescribing Improvement Plan and Primary Care Offer which have been merged for the first time this year.
- Our team of Prescribing Support Pharmacists (PSPs), Prescribing Support Technicians (PSTs) and Clinical Pharmacists (CPs) are working to continue to interact with their allocated practices and provide support to achieve the allocated prescribing savings to individual practices.
- The Go-live of phase 1 of the community Ear Nose & Throat (ENT) service (microsuction for ear wax removal, nose bleeds, and otitis externa) is planned from 1st July 2019.
- Work is progressing towards the Gastroenterology Referral Assessment Service (RAS) with an estimated go live date on 15th July 2019.
- There has been continued growth in Advice and Guidance usage in April and May 2019.
- Outpatient service transformation is focusing on 4 key specialties at Gloucestershire Hospitals with the intent to roll-out improvements. The specialties are dermatology, diabetes, neurology and rheumatology.
- We are building the strategy for diagnostic service across the county in-line with the development of a national approach.

5. One Place, One Budget, One System

New Models of Care & Place Based Model

The One Place, One Budget, One System programme takes a place based approach to resources and ensures we deliver best value. Our community care redesign will ensure responsive community based care is delivered through a transformative system approach to health and social care.

The intention is to enable people in Gloucestershire to be more self-supporting and less dependent on health and social care services, living in healthy communities, benefitting from strong networks of community support and being able to access high quality care when needed. New locality led 'Models of Care' pilots commenced in 2016/17 to 'test and learn' from their implementation and outcomes, working across organisational boundaries, and leading to the formation of 16 locality clusters across the county.

Key priorities for 2019/20 are

- Operational and Strategic partnership of senior leaders of health and social care providers and locally elected government and lay representatives informing and supporting integration at Primary Care Network (PCN) level, unlocking issues and sharing responsibility for finding local solutions to deliver ICS priorities and tackling issues which arise for their population which can only be resolved collectively.
- Clinically-led integration, involving staff and local people in decisions, to support more people in the community and out of hospital.
- Integrated Locality Partnerships (ILP) Plan to deliver defined population strategy including prevention and public health, with aligned priorities agreed to improve outcomes.
- Develop multidisciplinary workforce models which will operate at PCN level.

What we've achieved so far:

- Integrated Locality Partnerships (ILPs) have now commenced in all geographical areas.
- Primary Care Networks have confirmed their boundaries and Clinical Directors have been appointed.
- The Place based development group are now routinely meeting with representatives from education and Gloucestershire Voluntary Community Services Alliance (VCSA). The first "Place development session" has been organised for 9th July.
- South Cotswold Community Frailty Service have been working with Specialist Falls physiotherapists and they have been looking at strength and balance awareness project in flu clinics.

5. One Place, One Budget, One System

Urgent Care

Our vision for Urgent Care will deliver the right care for patients, when they need it. In order to make this vision a reality and provide safe and sustainable services into the future, we need to consider how to make best use our resources, facilities and beds in hospitals and in the community.

We want to improve arrangements for patients to access timely and senior clinical decision making about their treatment and ensure specialist support is accessed as soon as possible. We propose potentially changing the way some care and support is organised in Gloucestershire to meet changing demands, make best use of our staff, their skills and the money we have.

Regular updates on the One Place Programme have been shared with HOSC, describing how the programme aims to deliver an integrated urgent care system and hospital centres of excellence to ensure we realise the vision for urgent care a further update on progress is given at the July meeting in addition to this paper.

Our key deliverables for 2019/20 include;

- Continue to develop and refine the “One Place” strategy focussing upon development of same day urgent care services, Centres of Excellence and Integrated Urgent Care (Clinical Advice and Assessment Service).
- To further develop and deliver schemes identified within the Emergency Department attendance, admission avoidance programme and length of stay management (overseen by the Urgent and Emergency Care Alliance).
- To further develop and deliver schemes identified within the improving system flow programme which will reduce bed occupancy of long stay patients by 25%:
- To further develop and deliver schemes identified within the Community Admission Prevention programme.
- To further develop and deliver schemes identified within the Find and Prevent programme.

Current progress

Pre-consultation engagement will continue through the summer to support a developing dialogue on the solutions for Centres of Excellence and same day urgent care services.

6. Enabling Programmes

Our vision is underpinned by our enabling programmes which are working to ensure that the system has the right capacity and capability to deliver on the clinical priorities.

Joint IT Strategy: Local Digital Roadmap - The WiFi project has been completed across all 74 Practices. Cyber security action plans have been consolidated. The latest Primary Care data shows Gloucestershire has 25% of patients registered for patient facing services. All practices have enabled patient online services with some practices achieving in excess of 30%. E-Consultations are now live across the 5 pilot practices within the County, with 5 more being planned to go live. As part of the Cinapsis Advice and Guidance workstream, the average time GPs wait for a call response is 19 second. 24 Practices across Gloucestershire have now received a demonstration of Cinapsis with 57 GPs having used the service. There are 1000+ users now live on Joining Up Your Information (JUYI) providing an, average of over 200 accesses per day and over 18,000 patient records viewed overall since initial Go-live. This is an additional 400+ users since the previous report.

Joint Workforce Strategy – system-wide workforce planning workshops are taking place over the summer to support our long-term workforce strategy. The third cohort of the ICS Leadership Development Programme started on 18th June with 20 leaders attending from organisations across the county. Organisation executives are currently making nominations for the fourth which is prioritised for Dementia & Frailty. The programme has been highly recommended by previous attendees and has been funded by Health Education England (HEE) Workforce Development funding and the South West Leadership Academy. This will ensure as many of the system leaders as possible can benefit from, and implement, the programme learning.

Joint Estates Strategy – The ICS Estates Strategy is being developed which brings together updated organisational estates strategies of each constituent, as part of the long term plan. Within the Primary Care Infrastructure Plan, an updated Primary Care Infrastructure Plan with forward look to 2026 is being drafted and developed. The South Western Ambulance NHS Foundation Trust strategy for future estate provision will deliver a range of operational sites. These will consist of the development of new Hubs (Make Ready Centres) mainly close to Acute hospitals and supported by a network of Book On locations (staff start and finish shifts) and Spokes (standby points). Each Hub will be subject to a detailed Business Case for approval by the Trust.

Primary Care Strategy – Our local digital first primary care strategy is to have a core offer for all practices, while also testing further digital enhancements to establish the benefits for patients and practices, while keeping an eye to the future developments with 111 Online and the NHS App roll out.

7. Integrated Care System

As a Wave 2 Integrated Care System we are working towards increased integration to improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to local people.

The System Development work stream captures the work to develop the overarching ICS programme. The responsibilities of this programme are as follows:

- Provide Programme Direction to the Gloucestershire ICS
- Manage a Communications and Engagement approach on behalf of the ICS, including ensuring the Health and Social Care Act duties regarding significant services changes are met in relationship to the ICS
- Ensure the ICS has a robust resources plan in place that all ICS partners are signed up to and that is aligned to organisational level plans.
- To ensure that the ICS has clear governance and performance management in place to ensure the system can manage and oversee delivery.

Our key achievements made since the last report include;

- Completion of the “what matters to you” engagement on the deliverables within the Long Term Plan. We are currently awaiting the final output of engagement and will use it to inform our next steps in building the One Gloucestershire response to the NHS Long Term Plan.
- We continue to seek additional transformational funding for the county to support being at the forefront of developments in care.
- We have relaunched the ICS Strategic Stakeholder Group which brings together a wide variety of stakeholders to steer the direction of the ICS and support delivery of our priorities.
- The Implementation Framework for the Long Term plan has now been published and we will be building the One Gloucestershire response aligned to the timeframe laid out with our response being finalised by mid-November 19 (please see separate slide pack for NHS Long Term Plan Implementation Framework Overview).

8. Recommendations

This report is provided for information Governing Body/Board members are invited to note the contents.

Mary Hutton
ICS Lead, One Gloucestershire ICS

One Gloucestershire
Transforming Care, Transforming Communities

Long Term Plan Response

Organisational Boards/Governing Body

July 2019

@One_Glos

Background

The NHS Long Term Plan was published in January 2019. The plan sets out the direction for health services over the next five years. It builds on the Five Year Forward View and lays down national commitments to deliver changes in care and outcomes across a range of areas.

The plan particularly focuses on

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well

To ensure that the NHS can achieve the ambitious improvements for patients, the NHS Long Term Plan also sets out actions to overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. Doing things differently
2. Preventing illness and tackling health inequalities
3. Backing our workforce
4. Making better use of data and digital technology
5. Getting the most out of taxpayers' investment in the NHS

Long Term Plan Implementation Framework

- Each STP/ICS area is expected to respond setting out how we will deliver on the commitments laid out
- An Implementation Framework published late June 19 gives further guidance on what is expected in system responses and gave some further support.
- The implementation framework brings together the NHS Long Term Plan with the direction set out for primary care set out in Investment and Evolution (A five year framework for GP contract reform to implement The NHS Long Term Plan)
- Clear emphasis on closer working at place level of primary care and community services
- The framework contained further detail on support available to systems to support delivery alongside transformation fund allocation information.

Implementation Framework Structure

Chapter 1. Introduction to the NHS Long Term Plan Implementation Framework
- An integrated approach to strategic and operational planning
- A proactive approach to prevention and reducing health inequalities
- Investment to support transformation

Chapter 2. Delivering a new service model for the 21st century
- Transformed 'out-of-hospital care' and fully integrated community-based care
- Reducing pressure on emergency hospital services
- Giving people more control over their own health and more personalised care
- Digitally-enabling primary care and outpatient care
- Better care for major health conditions: Improving cancer outcomes
- Better care for major health conditions: Improving mental health services
- Better care for major health conditions: Shorter waits for planned care

Chapter 3. Increasing the focus on population health

Chapter 4. More NHS action on prevention

Chapter 5. Delivering Further progress on care quality and outcomes
- A strong start in life for children and young people
- Learning disabilities and autism
- Better care for major health conditions
- Cardiovascular disease
- Stroke care
- Diabetes
- Respiratory disease
- Research and innovation to drive future outcomes improvement
- Genomics
- Volunteering
- Wider social impact

Chapter 6. Giving NHS staff the backing they need

Chapter 7. Delivering digitally-enabled care across the NHS

Chapter 8. Using taxpayers' investment to maximum effect
- Financial and planning assumptions for systems
- Improving productivity
- Reducing variation across the health system

Chapter 9. Next steps

- **Annex A:** Funding the Long Term Plan
- **Annex B:** Financial assumptions for strategic plans
- **Annex C:** LTP headline metrics
- **Annex D:** Supporting wider social goals

System Response Principles

1. Clinically-led
2. Locally owned
3. Realistic workforce planning
4. Financially balanced
5. Delivery of all commitments in the Long Term Plan and national access standards
6. Phased based on local need: systems will be able to develop phasing of local implementation to reflect the needs of the local population
7. Reducing local health inequalities and unwarranted variation
8. Focussed on prevention
9. Engaged with Local Authorities
10. Driving innovation

LTP Headline Metrics

The Implementation framework contains some “foundation commitments” which have fixed implementation timelines. There are 20 headline “metrics” which will be measured; these are aligned to the following themes

- A new service model for the 21st century
- More NHS action on prevention and health inequalities (including an inequalities reduction trajectory)
- Further progress on care quality, access and outcomes (including maternal & child health, mental health, LD & autism, cancer survival and waiting times/clinical standards)
- NHS staff will get the backing they need
- Digitally enabled care will go mainstream across the NHS
- Taxpayers’ investment will be used to maximum effect (5 financial test)

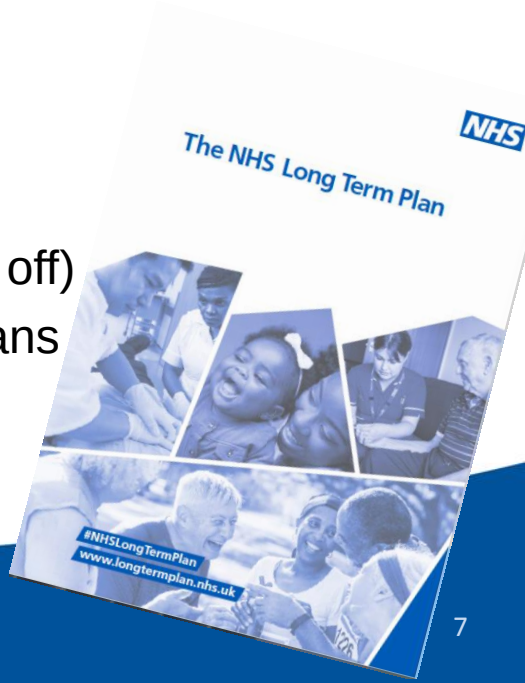
Expectations of system plans

System (ICS) plans for delivery through to 2023/24 covering

- **System Narrative Plan:** to describe how systems will deliver the required transformation activities to enable the necessary improvements for patients and communities as set out in the Long Term Plan.
- **System Delivery Plan:** to set out the plan for delivery of finance, workforce and activity, providing an aggregate system delivery expectation and setting the basis for the 2020/21 operational plans for providers and CCGs. The system delivery plan will also cover the LTP “Foundation Commitments”

Timeline

- End of September 2019 – draft submission
- Mid-November 2019 – final submission (requires Board sign off)
- Christmas 2019 – National publication on implementation plans



The One Gloucestershire approach to response

- Utilise feedback from "*What Matters to You*" engagement
- Utilise population health management information to tailor phasing to local need
- Work with Primary Care Networks and Integrated Locality Partnerships to tailor the priorities for each of the places within One Gloucestershire
- Recognise what is already working well: as a system we are already delivering on a number of the commitments within the Long Term Plan and have plans in place for around 60% of the system commitments and deliverables outlined.
- Develop our response alongside the existing and emerging strategies and plans already within our county
- Take an assets based approach to our solutions and ensure that we have an impact on inequalities and the wider determinants of health
- Continue to challenge and plan around the deliverables we haven't yet got clear plans for ensuring we can deliver outcomes within the resources we have available to the system
- Engage existing groups to ensure the plans are clinically lead and owned across our system partners. We will make prioritisation decisions together as a system.
- Use the opportunity of the response to bring people together across the county to restate our ambition for health and care services in 2025.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Governing Body

Meeting Date	**Thursday 25 July 2019**
Report Title	**Quality Report**
Executive Summary	This report provides assurance to the Governing Body that quality and patient safety issues are given the appropriate priority.
Key Issues	The Quality Report provides an overview of activity undertaken within the CCG to monitor and improve quality of commissioned services. . The report highlights areas of strong performance and areas which may require increased surveillance.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	Failure to secure quality, safe services for the population of Gloucestershire
Management of Conflicts of Interest	Not applicable
Financial Impact	There is no financial impact
Legal Issues (including NHS Constitution)	Compliance with the NHS Constitution, NHS Outcomes Framework and recommendations from NICE and CQC.
Impact on Health Inequalities	A focus on the delivery of equitable services for the residents of Gloucestershire and which will reflect the diversity of the population served.
Impact on Equality and Diversity	There are no direct health and equality implications contained within this report.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	There is no impact
Recommendation	The Governing Body is asked to note the contents of this report.
Author	Marion Andrews-Evans
Designation	Executive Nurse and Quality Lead
Sponsoring Director	Not applicable

(if not author)	

1 Introduction

The Governing Body Quality Report is produced to provide assurance of the quality monitoring and support work being undertaken by GCCG with providers in county.

Formal assurance of the quality of NHS services is by way of the Governance and Quality Committee, minutes of which are received by the Governing Body. This report provides succinct detail on activity undertaken and areas of strong performance or concern.

2 Summary Serious Incidents & Never Events

2.1 A 'Serious Incident' is defined by the National Patient Safety Agency (NPSA) as an incident that occurred in relation to NHS-funded services and care. These are often referred to as STEIS incidents after the reporting system. The Strategic Executive Information System (STEIS) allows us to break down the numbers being reported into categories.

2.2 Each reported incident and subsequent action plan is reviewed by the Quality Lead for that specific provider. This allows for identification of any potential themes or trends and can inform more in-depth discussions at the relevant Clinical Quality Review Group (CQRG). Full details, split by category, are provided to Quality and Governance Committee.

2.3

Gloucestershire Hospitals NHF FT	Q4 17/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20 April/May
Never Event	1	1	1	0	1	1
Serious Incidents	16	11	6	5	5	5
	17	**12**	**7**	**5**	**6**	**6**

2.4

Gloucestershire Care Service NHS Trust	Q4 17/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19 Jan & Feb	Q1 2019/20 April/May
Never Event	0	0	0	0	0	0
Serious Incidents	9	3	1	5	2	5
	9	**3**	**1**	**5**	**2**	**5**

2.5

[2]gether NHS FT	Q3 17/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19 Jan & Feb	Q1 2019/20 April/May
Never Event	0	0	0	0	0	0
Serious Incidents	10	7	3	10	5	3
	10	**7**	**3**	**10**	**5**	**3**

2.6 The Never Event reported at GHNHSFT relates to a patient receiving a wrong site injection. Although the incident met Never Event criteria, the patient was unharmed.

3 Patient Advice and Liaison Service (PALS) Activity

3.1 **National Friends and Family Test Review Update**

Recommendations from the National FFT Review project are still with senior management for consideration, so it is not yet possible for the project team to share details of any changes, publish revised guidance or set timescales for implementation.
When decisions have been made, NHSE will notify chief executives of trusts, primary care professional bodies and CCGs by email so they have sight of any changes as quickly as possible. The email will ask them to cascade the information to patient experience and quality leads, though we will additionally share the information with heads of patient experience via the HOPE Network.

Revised guidance will then follow as soon as possible with implementation likely to be scheduled for about six months after that. As part of NHSE communications activity about the new guidance,

they will be running some stakeholder webinars to explain any changes in detail with an opportunity to ask questions.

3.2 **GCCG Patient Advice and Liaison Service (PALS)**

The table below gives a breakdown of the types of enquiries the CCG PALS team has responded Q1 2019/20.

3.3

Type	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
Advice or Information	63 (PC20)	111 (PC 27)	1 (PC 12)	110 (PC 22)	38 (PC8)	38 (PC 11)
Comment	0	11		11 (PC 4)	0	1
Compliment	2 (PC1)	4	2	2	2	2
Concern	55 (PC 19)	*97* (PC 23)	110 (PC 14)	75 (PC 22)	72 (PC)	50 (PC 10)
Complaint about GCCG	2	2	5	7	5	7
Complaint about provider	9 (PC2)	22	18	18 (PC 5)	35	33 (PC 7)
NHSE complaint responses copied to GCCG PALS	0	1	0	0	1	10
Other	68	32 (PC 4)	52 (PC 5)	34 (PC 4)	67 (PC 9)	74 (PC 6)
Clinical Variation (Gluten Free)	3	0	2	0	1	1
Total contacts	202	280	288	257 (PC 57)	221	216

3.4 **Themes identified from GCCG PALS Contacts**

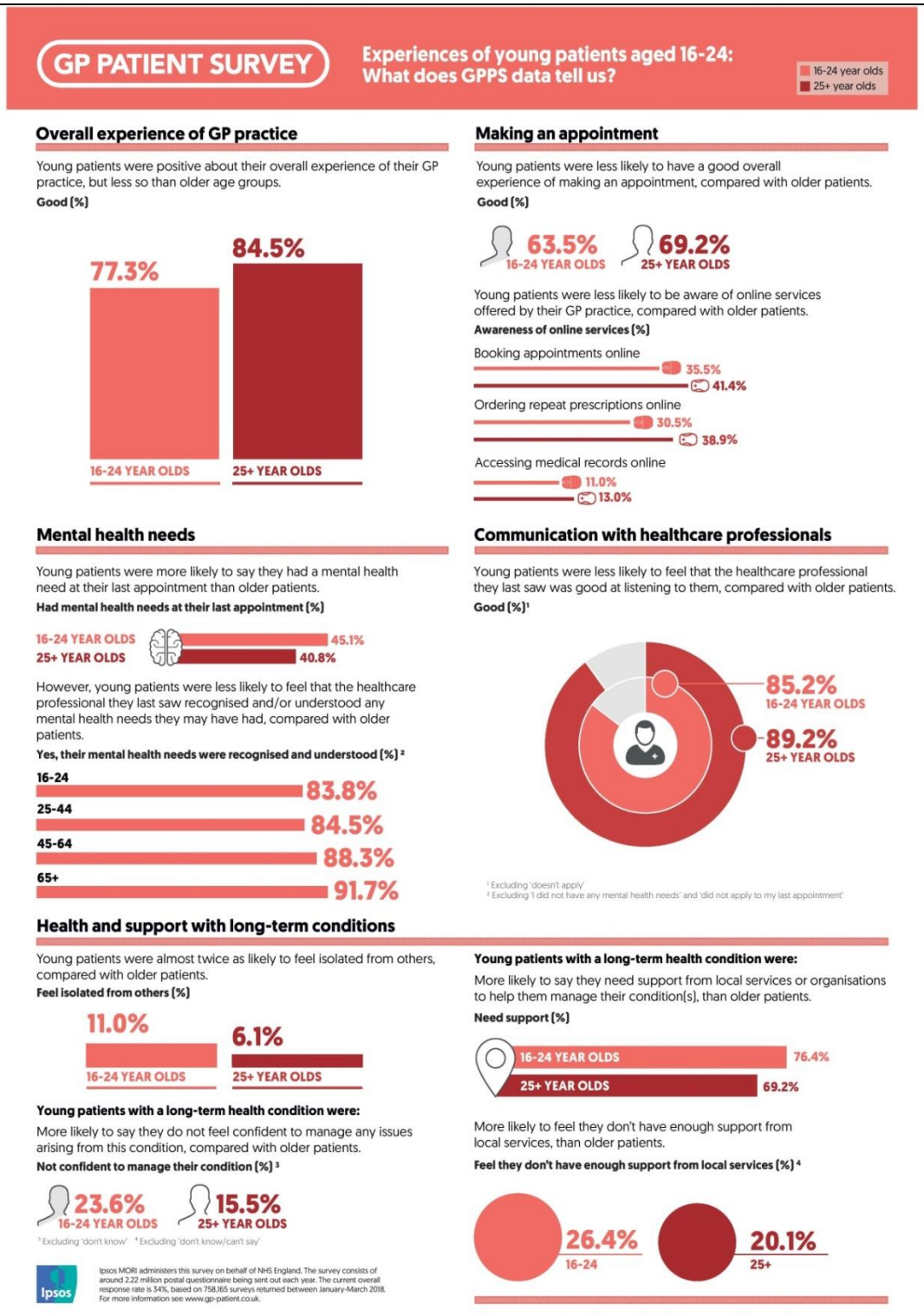
PALS have received a high volume of calls which have been of a complex nature, which have been frequent, challenging, time

	consuming and covering a variety of services. There has been an increase of MP Enquiries, and the PALS team have developed a good working relationship with the case workers.
4	**Infection Control**
4.1	**Seasonal Flu** The CCG is working on actions to improve our flu vaccination uptake particularly to “at risk” groups as well as care home workers and carers/visitors. Promotional material for carers and visitors is planned to encourage these groups of people to protect residents by having a flu vaccination and not visiting when they have respiratory infections.
4.2	<u>Escherichia coli (E.coli) Infections</u> The Quality Premium for 17/19 aims to reduce E.coli Gram Negative Bloodstream Infections (GNBSIs) by 10% and reduce inappropriate antibiotic prescribing for Urinary Tract Infections. In 2018/19 the Gloucestershire target for the year was 256 (or less) cases. In 2018/19 286 cases were recorded exceeding our threshold target by 30 cases. In 2019/20 between 1 April 2019 and 30 June 2019 there have been 70 cases of E.coli blood stream infections. Fifteen cases (21%) have been reported as having a hospital onset and 55 cases (79%) with a community onset. A Gloucestershire strategy has been developed with actions across the Gloucestershire health economy to reduce E.coli bloodstream infections. Improvement plans include a hydration project focusing on reducing infections within the community and amongst older people.
4.3	<u>C. Difficile Infections (CDI)</u>

	The target for GCCG is cases of CDI over 12 months. For the 2018/19 184 CDI cases were reported in Gloucestershire. These cases were proportioned as follows: 125 (68%) cases allocated as having a community onset and 49 cases (32%) a hospital onset. For 2019/20 the threshold target has been set as 194 cases. The total no of cases between 1 April 2019 and 30 June 2019 was 42 cases. These cases were proportioned as 5 cases (12%) with a hospital onset and 37 cases (88%) a community onset. A short life working group has been established since 2017. Recently the action plan has been revised to address the problems identified recently through Post Infection Reviews. An assurance process is in place.
4.4	<u>Other HCAI</u> Surveillance figures for the other Healthcare Associated Infections in 2019/20 between 1 April 2019 and 31 June 2019 includes MRSA Bacteraemia – 1 case (hospital onset), MSSA – 18 cases (No target), Kliebiella sp – 21 (No target) and Pseudomonas. Aeruginosalin- 3 (No target).
5	**Provider Updates**
5.1	<u>Official Opening of 2g Gloucester Hub</u> An official opening has been held at the new base for 2g NHS Foundation Trust's community-based mental health and learning disability teams, in Gloucester. Pullman Place, in Great Western Road, is now home to more than 260 staff. As well as office space, the building also includes clinics and rooms where therapy sessions, medication reviews and clinical assessments can be carried out. Pullman Place is located in Gloucester City with good public transport links. It is also near to other health and social care partner premises, such as Gloucestershire Royal Hospital, and is close to Wotton Lawn Hospital.
5.2	<u>Gloucestershire Hospitals NHS Foundation Trust</u>

	The CQC inspection report was published at the end of February 2019. The Trust received an overall rating of Good. The Trust have taken action to address all immediate concerns on the Must Do list and are working to progress the Must Do action improvement plan of which the twelve Must Do Actions have been categorised into six themes as follow: • Timely commencecement of treatment in ED • Control of hazardous substances • Routine checking of emergency equipment • Standardising procedures in relation to the risk management process • Access to acute cardiac services • Application of the Mental Capacity Act and the Mental Health Act The action plan is a formal standing item at each CQRG. The GCCG receive copies of the updated action plan along with the supporting assurance and documentation as evidence of progress/achievement of the actions completed to date. Progress is also being made with the Should Do actions of which there were 40 Should Do actions across the four core services inspected. The improvement plan is being monitored monthly by the Quality Delivery Group with quarterly updates to the Quality and Performance Committee. The Should Do actions plan is being monitored through respective delivery groups and divisional boards. The improvement plan is being led by the Director of Quality and Chief Nurse with executive owners identified for each action.
5.3	**Young people's experiences of primary care** Data about young patients' experience of primary care was the subject of a feature on the Ipsos MORI website in May 2019. It features an

	infographic (below) summarising the national learning from the 2018 GP Patient Survey, which invited feedback from 16 and 17 year-olds for the first time. Results for GCCG mirror the national picture with regards to a positive 'Overall experience of GP practice' reported amongst 16-24 year olds locally, but less so than the older age groups: In Gloucestershire 16-24 year olds reported 84% good overall experience, compared to 88% of the 25+ year olds.



6	**Quality Team Activity**

6.1	Emergency Planning The CCG have worked closely with all GP Practices in the county to ensure quality of Business continuity plans. The evidence of this best practice has seen resolution to incidents such as loss of Gas, Water, Electricity and Flooding within four practices already During April, the CCG tested its ability to establish an Incident Coordination Centre (ICC) in response to a major incident (in this case the test scenario was a crashed aircraft at Gloucestershire Airport). The exercise commenced with a cascade communications exercise with all of our providers, GCCG staff then set up the ICC and managed the information process as if in response to a real incident. The exercise was considered to be very successful. In December 2017, GCCG staged a Cyber resilience test in conjunction with the Gloucestershire Constabulary and the South West Regional Cyber Security Team. This is thought to be the first time such an event has taken place anywhere in the UK for the Healthcare Community and included penetration tests, recognition, response and recovery from a genuine worldwide threat that of cyber attack. The CCG Emergency Planning and Business continuity Officer is now working with NHS Digital, NHSI, NHSE South in the development of a regional wide response plan to a cyber attack. Over the winter period, the CCG coordinated the Local Health Resilience Partnerships response to the severe weather that affected the county on three separate occasions. This is the first time that such a coordinated response has been managed and enabled an overview of the difficulties to be understood and shared across all partner agencies in the county.
6.2	Nurse Education We are pleased to announce that GCCG and GDoc are working together to deliver a new support model for Practice Nurses. The main components of the new support model are; mentoring support for new practice nurses and mentoring support for nurses undertaking chronic disease management or specialist courses. A parachute nursing

	service, providing general/specialist practice nurses to GP surgeries in crisis and a practice nurse coordinator for each locality in the county. The new service commenced in May 2019 and albeit early days, the CCG has already received some very positive feedback and will work closely to work closely with the GDoc to evaluate, develop and review.
6.3	<u>Safeguarding</u> **Multi Agency Safeguarding Hub** Children Social Care has seen an increasing rise in workload into the Multi Agency Safeguarding Hub (MASH). From the end of September 2018 MASH has been the single entry point ('front door') for all multi-agency referrals. CCG has commissioned an independent review of the health care provision to understand and analyse the specific needs for an appropriate health contribution. **Working Together 2018** The Working Together 2018 safeguarding arrangements have been agreed by all agencies, and will be fully implemented on 15th July 2019 ahead of the national timetable deadline set as September 2019. The Gloucestershire Safeguarding Children Executive (GSCE) has met in shadow Board on 3 occasions whilst the old Gloucestershire Safeguarding Children Board ceased after 13th June 2019. Under a transition period, plans are clearly outlined to assure oversight of current Serious Case Reviews pending completion and publication. The CCG Governing Body has received a presentation outlining Gloucestershire's detailed new arrangements, and NHSE has been provided with a copy. Details and documents are available on the CCG website.
6.4	<u>Patient Transport Advice Centre (PTAC)</u> From April 3rd 2018 all pre-booked Patient transport in Gloucestershire has gone through the Centre. The team based at PTAC take the Patient through a list of questions to

	establish whether they are eligible and meet the criteria to access Arriva services. The team have been up and running in the Somerset area for over 10 years and it has proved to be very successful. A key part of the service they offer is to find the Patient another alternative, should they not meet the criteria. This could be Community Transport, Volunteer Services, the best bus routes, so it a more holistic approach.
6.5	<u>Engagement</u> **Learning from patient and staff experience** The CCG Engagement Team are currently supporting a wide range of teams from across the CCG to gather feedback from patients, service users, GPs and practice staff. Since January 2018, we have used SmartSurvey (our survey software) to develop a number of online and paper questionnaires relating to: • Emotional Health and Wellbeing support for Children with long term conditions and their families • Tewkesbury Home Visiting Service (improved access) • Hypertension - Patient and GP surveys • Dermatology: Minor Operations – GP practice survey • Support for Carers – surveys for carers, cared for and professionals (5 versions) • General Practice Forward View Event 2018 – Primary care staff survey • Colorectal Cancer Support Group Survey • Advice and Guidance - GP Survey • Maternity voices • Rehabilitation for Acquired Brain Injury • Urgent and Emergency care in Gloucestershire – ED Minors The information gathered is analysed and used to inform further service/care pathway developments, work of clinical programmes and service/pilot evaluations.
6.6	**Engagement with GP Practices' Patient Participation Groups (PPGs)** The most recent PPG Network event was attended by approximately 50 PPG representatives. The agenda included: Urgent Care/Centres of

	Excellence, GP Five Year Forward View – future of the Primary Care Workforce, Improving patients confidence of self-managing their minor aches and pains and increasing the number of patients self-referring into Core physiotherapy, Accessible information for patients and an update on the New National GP Patient Survey. The CCG Engagement Team continues to support PPGs and practices with matters such as mergers, branch closures, member recruitment, governance and action planning.
6.7	**Online Counselling Service for young people in Gloucestershire** In March 2018, five young people from Stroud District Youth Council (SDYC) met with us to receive presentations from the two bidders for the Online Counselling Service contract. SDYC members agreed unanimously which of the bidders they preferred. As always, the young people brought huge amounts of enthusiasm and professionalism to the process. They asked some probing and challenging questions and provided insightful feedback on the presentations they received. Their feedback was presented to members of the Evaluation Panel as part of the moderation meeting.
6.8	**Health and Wellbeing for the future: Community Hospitals in the Forest of Dean – Public Consultation: Next Steps** http://www.fodhealth.nhs.uk/ Following the Governing Body meeting on 25 January 2018, work has continued to support the development of a new, state of the art community hospital for the Forest of Dean. We have met with a number of community partners to provide updates on the decision to proceed with a new hospital and the commitments made by the Governing Body and the Board of NHS Gloucestershire Care Services. We have, in partnership with GCS, appointed Citizens Juries Community Interest Company (CIC) to run an independent citizens' jury, to consider the location of the new hospital. Citizen's Juries CIC is a social enterprise dedicated to designing and running citizens' juries, supported by the University of Manchester. It works in partnership with the Jefferson Centre, the US-based charity which developed the citizens' jury method. The "jury" will be made up of 18 local residents. Citizens Juries CIC

	are inviting applications from local residents to be involved in the jury, ensuring a balance in terms of age, gender and geography. The jury will sit for four and a half days at the end of July 2018, when they will be presented with information and hear from expert witnesses to enable them to take a view on whether they think the new hospital should be located in, or near, Cinderford, Coleford or Lydney.

Agenda Item 13

Governing Body /Committee

Meeting Date	**Thursday 25 July 2019**
Report Title	**Realising the Research Potential for Gloucestershire as an Integrated Care System: A Vision for OneGlos Research4Gloucestershire (R4G)**
Executive Summary	**Our Vision** Research4Gloucestershire will be recognised as a dynamic and forward thinking collaboration which develops and delivers world-class health and care research aligned as part of the Gloucestershire Integrated Care System. We will achieve the Vision by 2024: • Developing a joined up approach to research relevant to the Integrated Care System to improve the population's health and care in Gloucestershire and deliver the local response to the NHS Long Term Plan and the strategic goals of the National Institute for Health Research • Commissioning an approach to improving health and wellbeing that will be evidence based • Achieving a portfolio of research that can demonstrate income generation to ensure future sustainability of research and development and therefore minimise the contributions from individual member organisations • Realising the benefits this could bring to patients, staff, the wider Gloucestershire research community and the local economy The R4G Vision has been coproduced by the five constituent organisations of the Integrated Care System (ICS), the University of Gloucestershire

	and Cobalt Health. R4G will work with the ICS member organisations and other partners, notably University of Gloucestershire to produce a system-wide health and care research plan.
Key Issues	Identify the key issues that the report is attempting to address here, and any issues that have arisen during the project / programme / production of the paper itself. Include any other bodies / individuals / groups that have been involved.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	Without a strong commitment from all relevant ICS system partners Gloucestershire fails to gain national recognition as a system committed to research. The R4G Vision seeks to address this risk at a strategic level. 3x4 3x2
Management of Conflicts of Interest	n/a
Financial Impact	All system partners currently invest in research and development independently. These arrangements will not change, but one of the aims of the Vision is to: • Achieve a portfolio of research that can demonstrate income generation to ensure future sustainability of research and development and therefore minimise the contributions from individual member organisations
Legal Issues (including NHS Constitution)	n/a
Impact on Health Inequalities	No specific impact identified
Impact on Equality and Diversity	n/a
Impact on Sustainable Development	n/a

Patient and Public Involvement	An objective set out in the Vision it to: • Ensure all Gloucestershire patients are aware of and have access to appropriate access clinical trials , including recruitment to the Genomes project
Recommendation	The Committee/Governing Body (delete as appropriate), as one of the five constituent members of the Gloucestershire ICS you are asked to: • Comment on the paper • Endorse the approach to research outlined in this paper • Continue to commit your organisation's support for R4G • Endorse the possibilities of University status for either individual stakeholders or the system
Authors	**Research for Gloucestershire Steering Group:** • Peter Lachecki- Chair of GHNHSFT Trust (Chair of the R4Glos Steering Committee) • Lorraine Dixon- Head of School, Health and Social Care, University of Gloucestershire • Simon Lanceley- Director of Clinical Strategy, GHNHSFT • Jane Melton-Director of Engagement and Integration, 2gether NHS Foundation Trust • Michael Richardson-Deputy Director of Nursing Gloucestershire Care Services • Sarah Scott- Director of Public Health, Gloucestershire County Council • Chantal Sunter- Associate Director R&D, GHNHSFT • Mark Walker- Head of R&D, 2gether NHS Foundation Trust • **Becky Parish- Associate Director, Engagement and Experience NHS Gloucestershire Clinical Commissioning Group**
Designation	Associate Director Engagement and Experience, GCCG
Sponsoring Director (if not author)	Marion Andrews-Evans, Director of Nursing and Quality, GCCG

Realising the Research Potential for Gloucestershire as an Integrated Care System:

A Vision for OneGlos Research4Gloucestershire

Version 8 June 2019

1. Purpose

This paper will describe the current arrangements for health and care research in Gloucestershire, our vision for the future and recommendations for each of the five constituent organisations of the Integrated Care System (ICS), the University of Gloucestershire and Cobalt Health to consider to enable the realisation of the vision.

2. Our Vision

Research4Gloucestershire will be recognised as a dynamic and forward thinking collaboration which develops and delivers world-class health and care research aligned as part of the Gloucestershire Integrated Care System

We will achieve the vision by 2024:

- Developing a joined up approach to research relevant to the Integrated Care System to improve the population's health and care in Gloucestershire and deliver the local response to the NHS Long Term Plan and the strategic goals of the National Institute for Health Research
- Commissioning an approach to improving health and wellbeing that will be evidence based
- Achieving a portfolio of research that can demonstrate income generation to ensure future sustainability of research and development and therefore minimise the contributions from individual member organisations
- Realising the benefits this could bring to patients, staff, the wider Gloucestershire research community and the local economy

3. Background

In 2016 the University of Gloucestershire (UoG), Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), Gloucestershire County Council Public Health and Social Services, 2gether NHS Foundation Trust, Gloucestershire Care Services NHS Trust and Gloucestershire Clinical Commissioning Group formed a collaborative partnership - ***Research4Gloucestershire (R4G)***, culminating in a signed and formalised joint Statement of Intent.

As major organisations within Gloucestershire, we have much in common, and are committed to working together to benefit our patients, students, staff and wider community. Research is identified as a strategic priority for all organisations, with the evidence that the patient, staff and student experience for those organisations is enriched by working in, or being cared for in, an environment that is underpinned by research.

The Gloucestershire Health Community had had a long history of working together as the Gloucestershire Research and Development Consortium (now known as Research4Gloucestershire). The Consortium provided the overview for health care research in the county for many years, from both a strategic and governance perspective. It has allowed for productive networking and sharing of good practice. The Consortium has changed due to the need to place more emphasis on each individual organisation's responsibility for managing its own performance and financial management and it was agreed to develop a new approach.

A Statement of Intent was signed by key partners and Research4Gloucesteshire (R4G) was established. This has enabled and refocused efforts to develop and then lead a shared vision for health and care research. Peter Lachecki, Chair of Gloucestershire Hospitals NHS FT has agreed to chair R4G until October 2019. Research4Gloucestershire has successfully held several networking events leading to a number of important projects that have demonstrated the value of the Statement of Intent.

Gloucestershire has been selected to be one of only 14 Integrated Care Systems (ICS) across the country. This means that health and care services will be working even more closely together to support people to remain healthy and independent, develop care and services in people's own homes and communities and ensure high quality, safe hospital and community services are there when needed. Consequently R4G will work with the ICS member organisations and other partners, notably University of Gloucestershire to produce a system-wide health and care research plan.

4. Development of a Strategy

In order to realise its ambition R4G sets out the following principles to develop a Strategic Plan to achieve the vision detailed above.

A. Develop research governance and operational structure that supports the sustainable growth of research activity that leads to transformation of health and care services through amalgamation, sharing and growth of resources. Complimenting and building upon existing national research strategies.

B. Support ICS member organisations to become centres of research excellence. This could include options to develop joint research facilities that align to our ambition for the provision of research in Gloucestershire.

C. Improving the scale, pace and impact of research and innovation is a key theme of the NHS Long Term Plan. Research4Gloucestershire will lead the local response to the research and innovation section in the NHS Long Term Plan. This will involve agreeing how Gloucestershire will prioritise and pull on enablers to achieve the objectives and outcomes we have defined and respond and contribute to the challenges set by the NHS Long Term Plan:

    - Increase the number of people registering to participate in health research to 1 million (national)
    - Sequence 500,000 whole genomes
    - Implement Regional Test Bed Clusters

D. Develop a five year operational plan which sets out how the following objectives for Research4Gloucestershire will be achieved:

    - Grow research leadership capacity within each organisation and develop the opportunities for joint appointments and combined research teams ensuring a more sustainable infrastructure for research for the future, providing better facilities and equipment for research, and greater sharing of facilities, skills and equipment

    - Develop a series of metrics to define success and impact

    - Increase our collaboration with research focussed funding bodies and grants, including the Academic Health Science Network, Applied Research Centre and Local Clinical Research Networks and the National Institute for Health Research.

    - Continue to develop Gloucestershire's reputation for research in the areas of for example:

        - Early cancer diagnosis (link to Biophotonics)
        - Eye Health (link to diabetic screening)
        - Dementia diagnosis

- Develop Gloucestershire's expertise for research in the area of prevention and population health that utilises and influences the population health management programme so that patient information and research programmes can be monitored and measured

- Support partner organisations including Primary Care Networks and Social Care to attract and retain its future workforce through innovative practice and opportunities for research and development within their work and so having staff that are the 'best in field'

- Ensure all Gloucestershire patients are aware of and have access to appropriate access clinical trials , including recruitment to the Genomes project

- Develop closer relationships with relevant commercial and Voluntary, Community and Social Enterprise (VCSE) organisations, where these relationships add to the scale, range and pace of our research agenda

- Exploring and defining the types of research relevant in the Integrated Care System that are necessary to achieve the R4G vision.

5. Recommendations

As one of the five constituent members of the Gloucestershire ICS you are asked to:

- Comment on the paper
- Endorse the approach to research outlined in this paper
- Continue to commit your organisation's support for R4G
- Endorse the possibilities of University status for either individual stakeholders or the system

Authors:
Lorraine Dixon- Head of School, Health and Social Care, University of Gloucestershire
Peter Lachecki- Chair of GHNHSFT Trust (Chair of the R4Glos Steering Committee)
Simon Lanceley- Director of Clinical Strategy, GHNHSFT
Jane Melton-Director of Engagement and Integration, 2gether NHS Foundation Trust
Becky Parish- Associate Director, Engagement and Experience NHS Gloucestershire Clinical Commissioning Group
Michael Richardson-Deputy Director of Nursing Gloucestershire Care Services
Sarah Scott- Director of Public Health, Gloucestershire County Counci
Chantal Sunter- Associate Director R&D, GHNHSFT
Mark Walker- Head of R&D, 2gether NHS Foundation Trust

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Developing our local NHS Long Term Plan

What matters to you?

www.onegloucestershire.net
@One_Glos

One Gloucestershire
Transforming Care, Transforming Communities

Developing our local NHS Long Term Plan

The National NHS Long Term Plan

- Published in January 2019
- Ambitions for how the NHS can improve over the next decade
- Covering all three Life stages:
  - Making sure everyone gets the best start in life
  - Delivering world class care for major health problems
  - Supporting people to age well
- Consistent with how support and services are developing locally

What we have been doing in Gloucestershire

Developing our Long Term Plan for Gloucestershire, asking ***What matters to you*** about?

The Place - how you and your family get health advice, support and services when you need them, in your home, neighbourhood, community and county

The Life Course – your health priorities at every stage in life

Supporting better care – supporting staff, making best use of technology, reducing waste and making best use of resources

Local Engagement – Spring 2019

What matters to you?

- Staff and public engagement on developing the NHS Long Term Plan locally
- Booklet and survey – hardcopy and on-line
- Community Events/Awareness Raising (aligned with Health and Wellbeing Strategy engagement events)
- Working with **Healthwatch Gloucestershire**
- Further engagement and consultation planned in 2019/20

www.onegloucestershire.net

@One_Glos

One Gloucestershire
Transforming Care, Transforming Communities

Developing our local NHS Long Term Plan

Engagement to date

Ongoing engagement/coproduction through representatives and wider public engagement.

HOSC and Healthwatch Gloucestershire regular updates

Healthwatch Gloucestershire co-production/co-delivery

- 2017/18 Sustainability and Transformation Plan/Partnership (STP) engagement
- 2018 One Place urgent care workshops, urgent care survey
- 2019 Centres of Excellence Open Space Event
- 2019 (spring) LTP engagement – outcome report *in draft*

Headlines from STP engagement

What you have been telling us

We sought local people's views in 2016/17 and these are the headlines from what you told us:

72% of respondents agreed:

A greater amount of the budget should be spent on supporting people to take more control of their own health

88% of respondents agreed:

There should be a greater focus on prevention and self-care

95% of respondents agreed:

We should develop joined up community health and care services

69% of respondents agreed:

We should bring some specialist hospital services together in one place

70% of respondents agreed:

We should focus on caring for people with the greatest health and care needs

If you need to see a specialist, the most important thing to you would be:

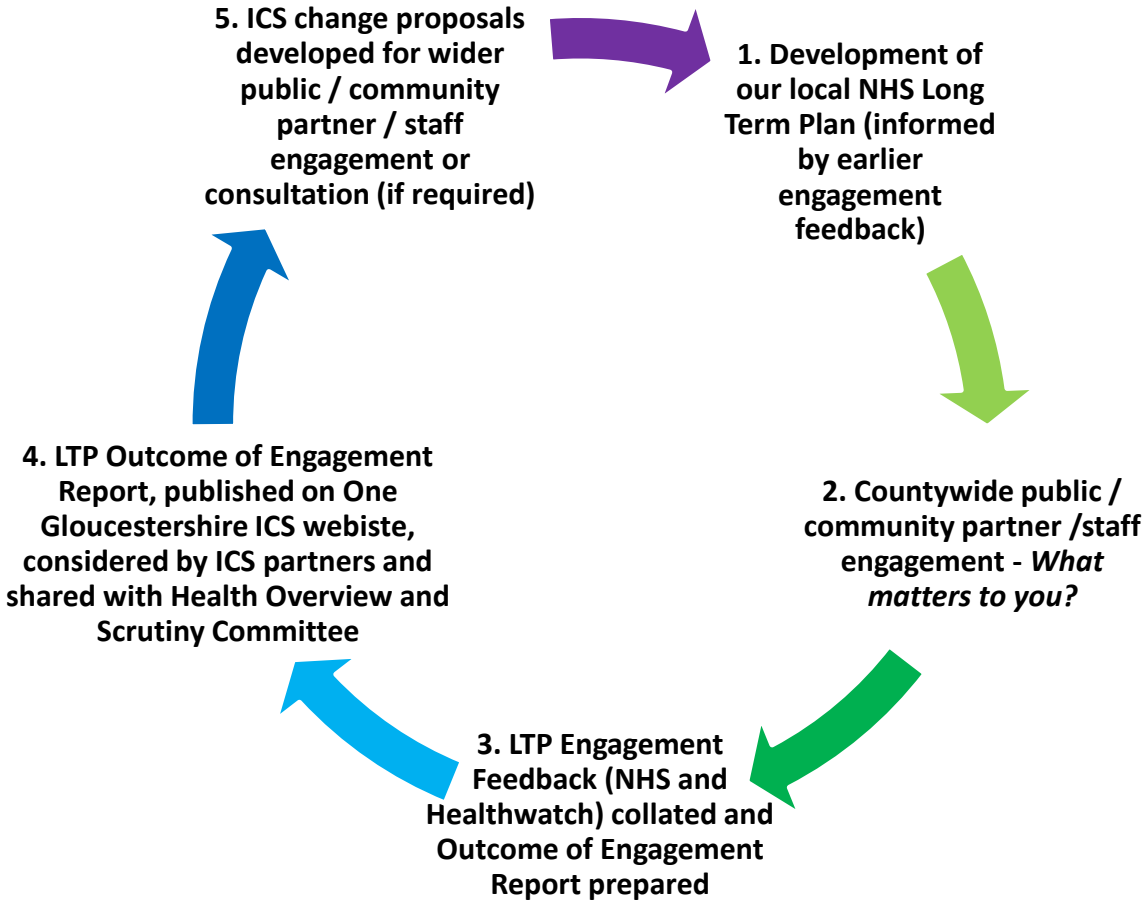
- 59% The expertise of the specialist I see
- 29% The time I have to wait for an appointment
- 8% The distance I have to travel
- 4% Having as few appointments as possible

If you need urgent or emergency care services, the most important thing to you would be:

- 35% **Prompt assessment and decision making** about my treatment and onward care
- 33% **Ability to access services** - 7 days a week
- 14% **Centres/services staffed by specialists** in dealing with my illness or injury
- 10% **Services that are joined up** and can access information about my health and care needs
- 8% **The distance I have to travel**

One Gloucestershire
Transforming Care, Transforming Communities

Using the feedback from engagement



Communications supporting LTP engagement

The online booklet was available on the One Gloucestershire website: https://www.onegloucestershire.net/yoursay/

Approximately **7000** copies of the printed booklet distributed.

Communications supporting LTP engagement

- Comprehensive/proactive system wide media schedule
- **Vox Pops** x **10** incl. Betty the 'wing walker'

- One Gloucestershire **website**
  1731 views
  - Have your Say: **1,051** views
  - What-matters-to-you-conversation-gets-underway-on-the-local-nhs-long-term-plan, Media release: **121** views
  - Engagement Events: **139** views

Social media was used to raise awareness

Facebook/Twitter

- **15** Facebook posts, reach of **15,551**
- **438** 'engagements', **107** were shares
- **27** tweets, **24,217** impressions, **520** 'engagements'

Engagement activities

- **Correspondence (3)**
- **Recorded events**: One Gloucestershire Partners 46 / **Healthwatch Gloucestershire 16 (Total 62)**
- **Information Bus (12 visits)**
- **Staff engagement**
- **Targeted engagement**
- **Invited engagement**
- **Face-to-face contacts**: One Gloucestershire Partners **945** / **Healthwatch Gloucestershire Campervan Tour 500+ (Total 1445+)**

Targeted engagement

Healthwatch Gloucestershire

- Chinese community
- LGBT+ community
- Young people classed as Not in Employment, Education or Training (NEET): Gloucestershire HITZ

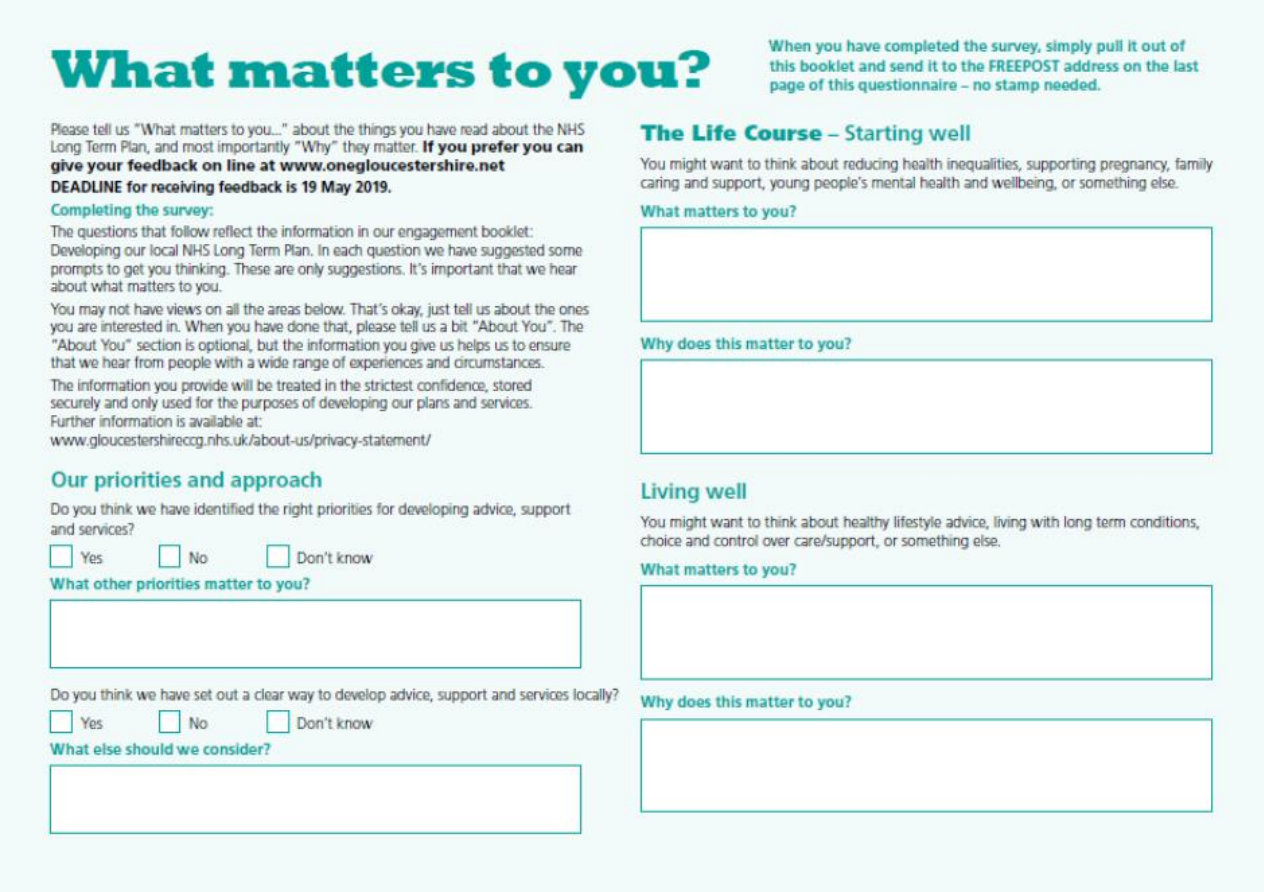
One Gloucestershire Partners

- Community Friendship Group (Elderly)
- PPG representatives
- Voluntary & Community Sector partners
- Personality Disorder Group
- Young people, Carers / Young Adult Carers
- People with mental health challenges

One Gloucestershire Partners

- Schools
- Housing with Care Programme
- Housing Associations
- Know your Patch (community stakeholders)
- District Councils x 3
- Cancer Patient Reference Group
- Social Science Students
- Chinese Point of Contact Information Group
- LGBT+ Partnership
- Churches together
- Forest Health Forum
- Groups rep Protected Characteristics
- Asian Elders Women's Group

Survey



What matters to you?

When you have completed the survey, simply pull it out of this booklet and send it to the FREEPOST address on the last page of this questionnaire – no stamp needed.

Please tell us "What matters to you..." about the things you have read about the NHS Long Term Plan, and most importantly "Why" they matter. **If you prefer you can give your feedback on line at www.onegloucestershire.net**
DEADLINE for receiving feedback is 19 May 2019.

Completing the survey:

The questions that follow reflect the information in our engagement booklet: Developing our local NHS Long Term Plan. In each question we have suggested some prompts to get you thinking. These are only suggestions. It's important that we hear about what matters to you.

You may not have views on all the areas below. That's okay, just tell us about the ones you are interested in. When you have done that, please tell us a bit "About You". The "About You" section is optional, but the information you give us helps us to ensure that we hear from people with a wide range of experiences and circumstances.

The information you provide will be treated in the strictest confidence, stored securely and only used for the purposes of developing our plans and services. Further information is available at:
www.gloucestershireccg.nhs.uk/about-us/privacy-statement/

Our priorities and approach

Do you think we have identified the right priorities for developing advice, support and services?

☐ Yes ☐ No ☐ Don't know

What other priorities matter to you?

Do you think we have set out a clear way to develop advice, support and services locally?

☐ Yes ☐ No ☐ Don't know

What else should we consider?

The Life Course – Starting well

You might want to think about reducing health inequalities, supporting pregnancy, family caring and support, young people's mental health and wellbeing, or something else.

What matters to you?

Why does this matter to you?

Living well

You might want to think about healthy lifestyle advice, living with long term conditions, choice and control over care/support, or something else.

What matters to you?

Why does this matter to you?

Completed surveys

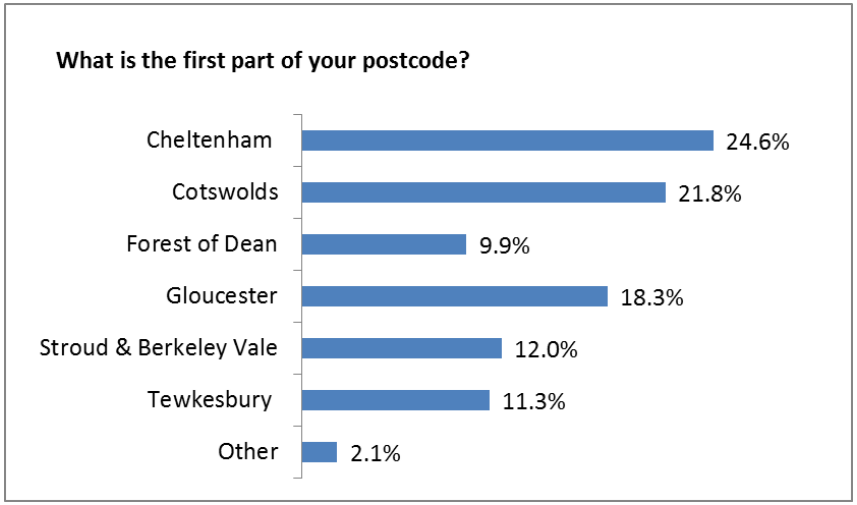
One Gloucestershire Partners **204** / Healthwatch Gloucestershire general survey **215**, conditions specific survey **26 (Total 445)**

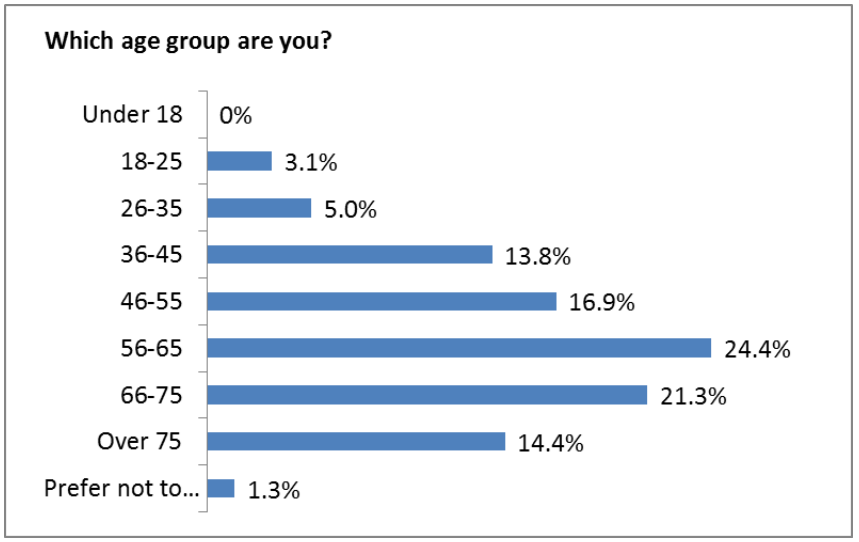
Comments (3000+)

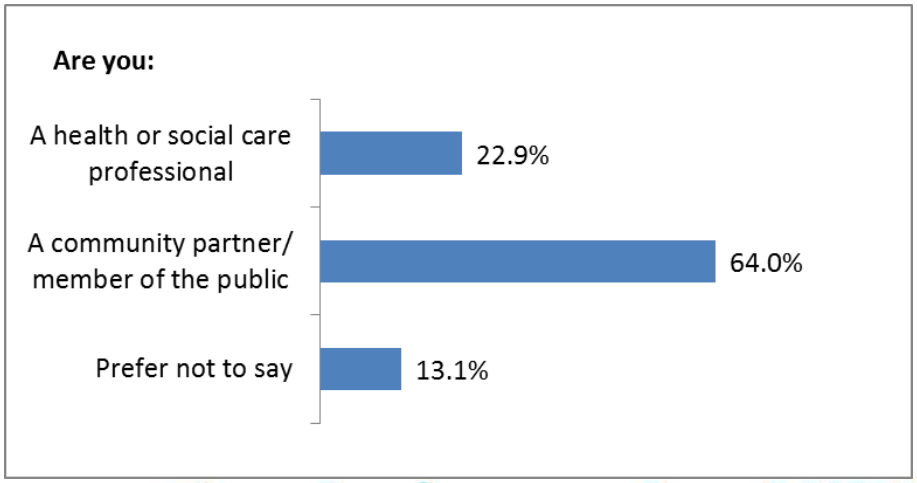
One Gloucestershire
Transforming Care, Transforming Communities

Developing our local NHS Long Term Plan

Survey respondent demographics



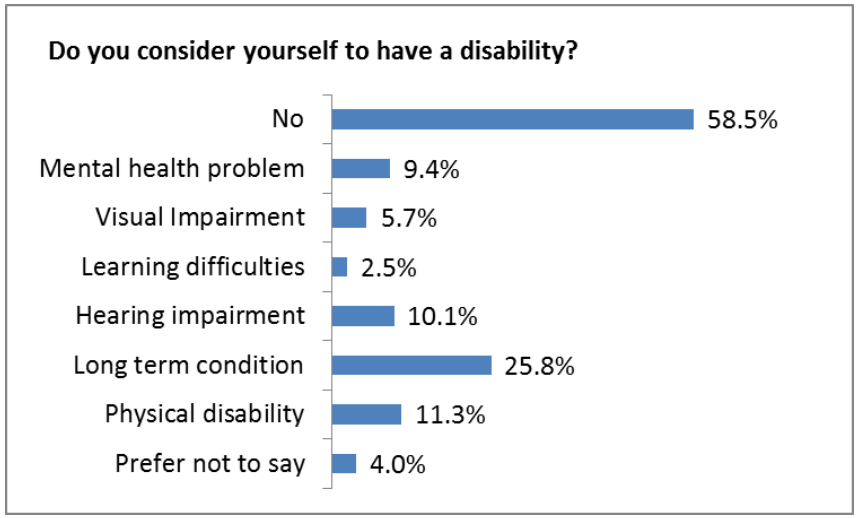


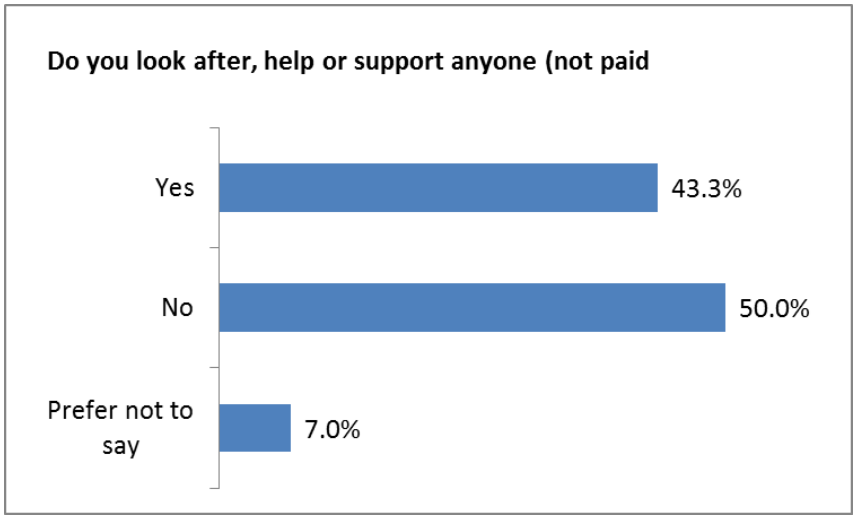


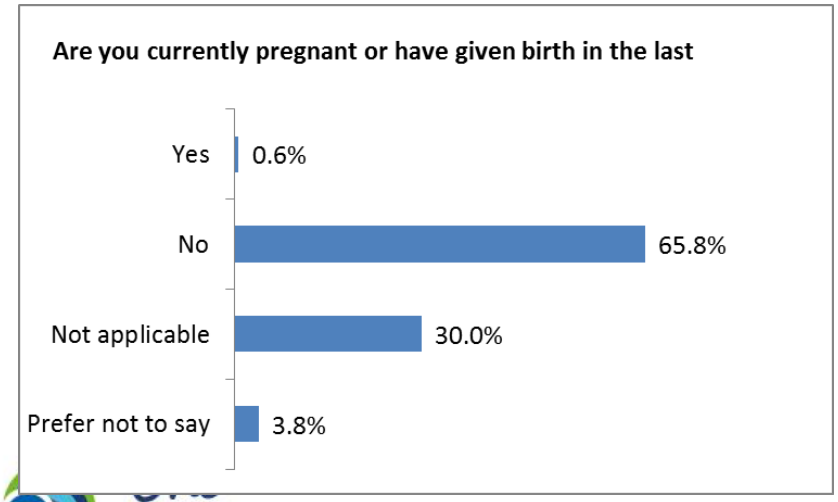
One Gloucestershire
Transforming Care, Transforming Communities

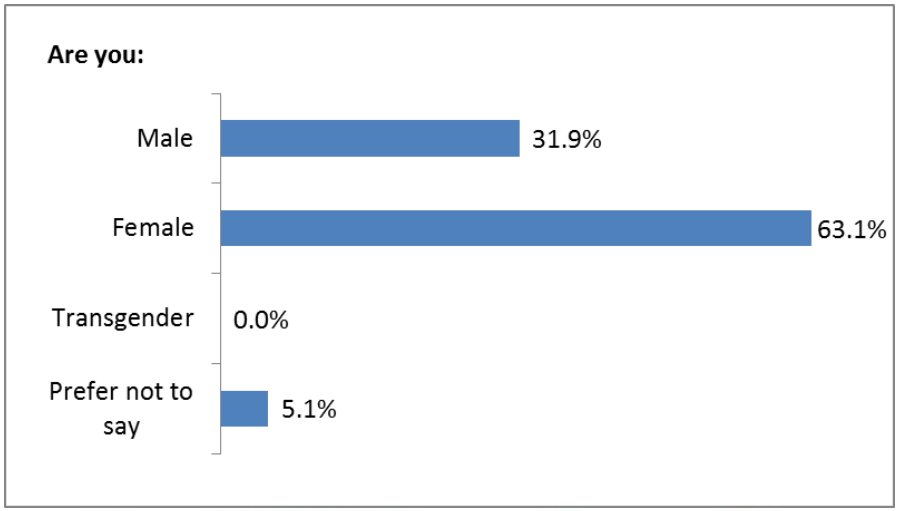
Developing our local NHS Long Term Plan

Survey respondent demographics

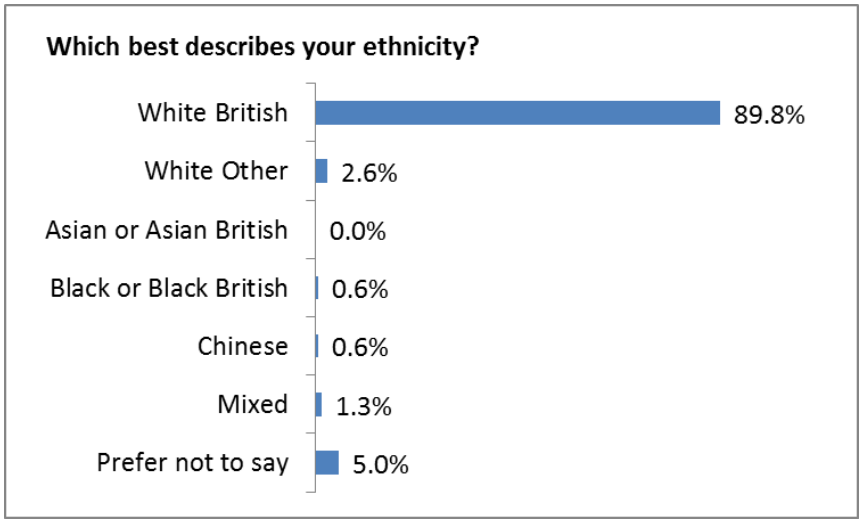


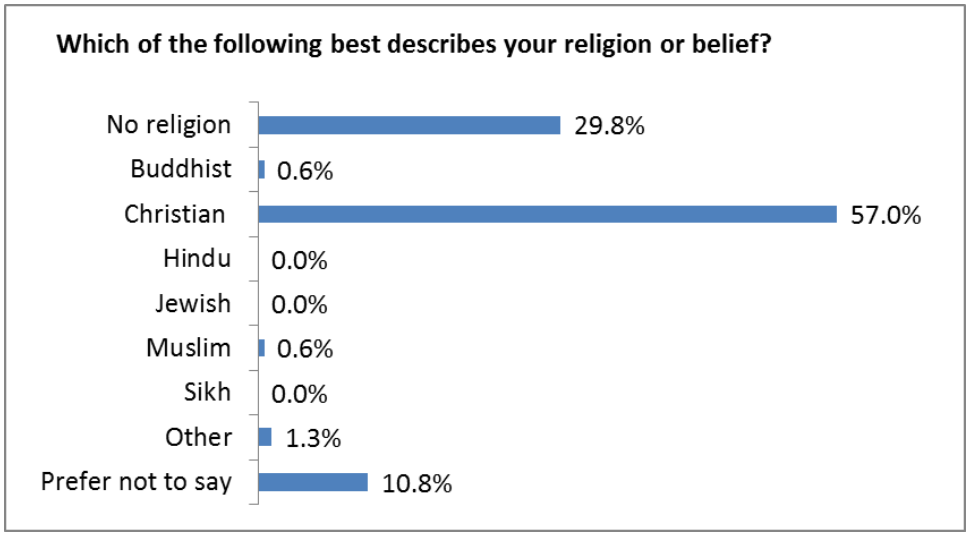


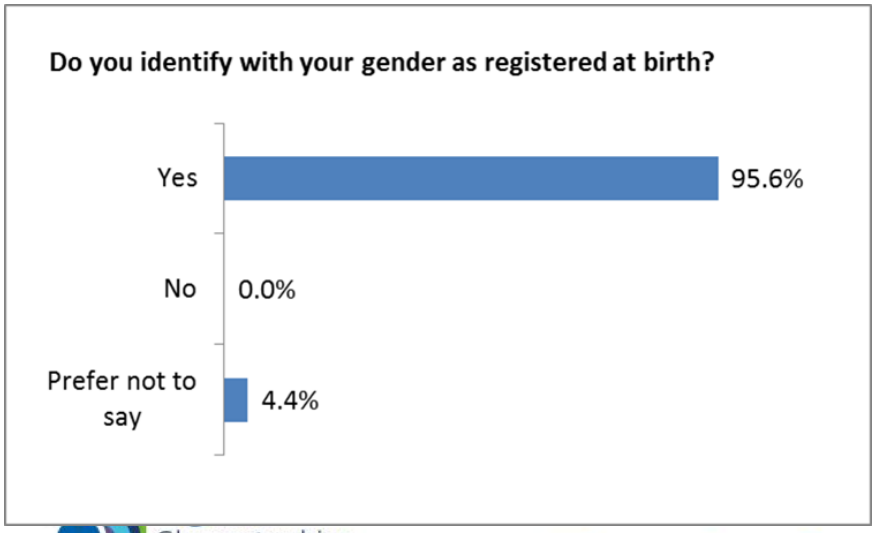


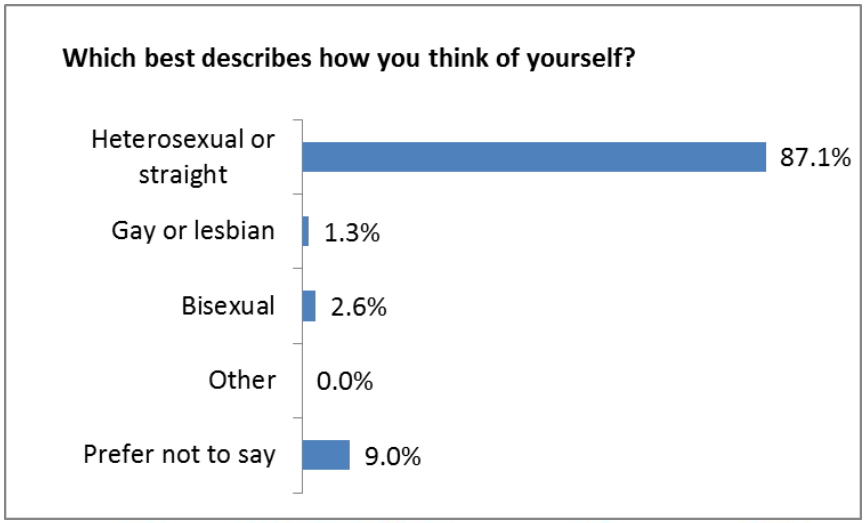


Survey respondent demographics





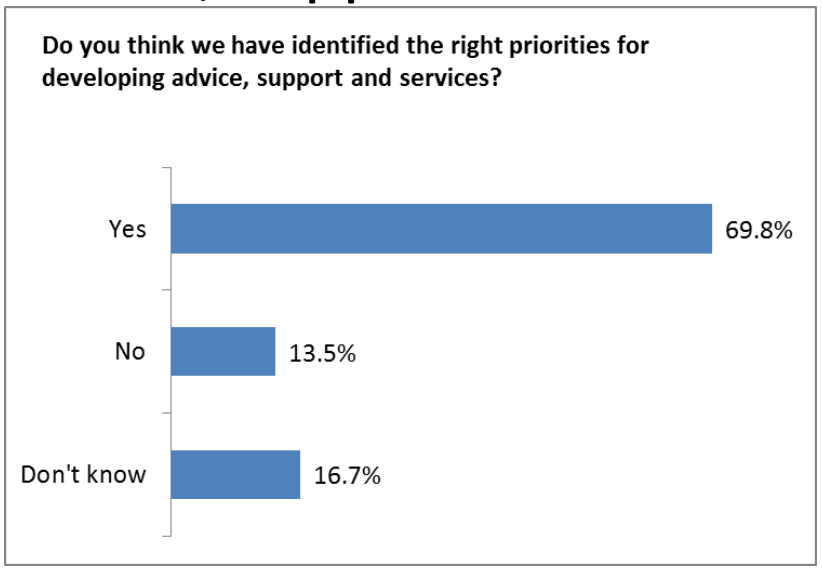




Summary of feedback *(w.i.p.)*

Our priorities and approach

- Do you think we have identified the right priorities for developing advice, support and services?

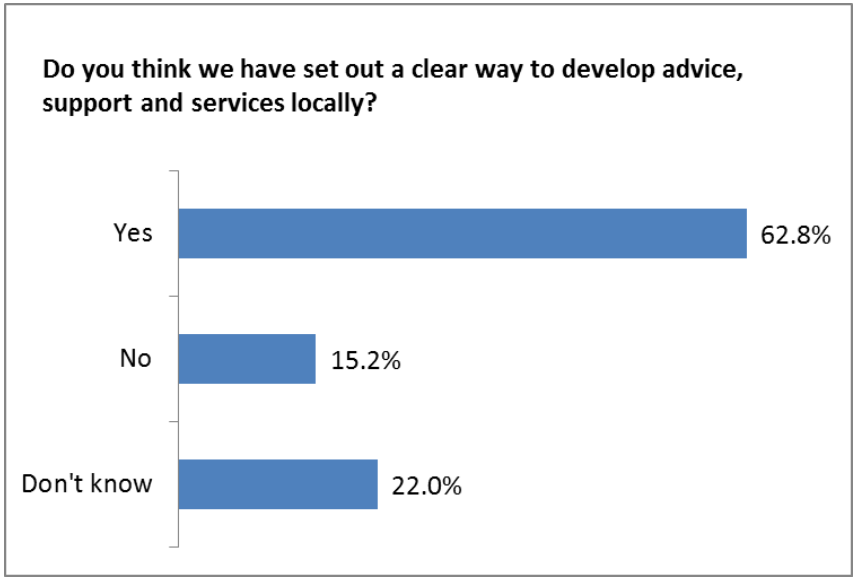


What we said we want to achieve in Gloucestershire

- People confident to take greater control of their own health, and that of their family
- Healthy, active communities with strong networks of support
- A simpler way to get advice, support and services, 7 days a week
- The vast majority of care available in, or near, home
- High quality, joined up services with the right care, staff skills and equipment in the right place
- Outstanding hospital care when you are very unwell
- Best use of the 'Gloucestershire £' for health and wellbeing priorities

Summary of feedback *(w.i.p.)*

- Do you think we have set out a clear way to develop advice, support and services locally?



Other priorities you told us matter to you

Main themes included:

- Timely access to appointments – both GP and hospital
- Maximising use of technology
- Supporting mental health (including Children and Young People, Learning Disability, Carers and Funding)
- Navigating your way more easily around information, advice and services
- Local provision of services

Other things you think we should we consider

Main themes included:

- Prevention, healthy lifestyles promotion
- Travel and transport
- Use of technology including greater use of social media
- Local provision of services

One Gloucestershire
Transforming Care, Transforming Communities

Developing our local NHS Long Term Plan

The Life Course

Starting well

- Children and Young People's mental health
- Maternity/ family support – parenting support
- Healthy lifestyles

Living well

- Personalisation – choice and control
- Healthy lifestyles – quality information and support to stay healthy

Ageing well

- Help to maintain independence
- Self - care
- Connection to the community
- End of life – planning a 'good' death

Supporting better care

Reduce waste and duplication

Make best use of technology

Support workforce (pastoral and skills training)

Best use of resources

One Gloucestershire
Transforming Care, Transforming Communities

Developing our local NHS Long Term Plan

Evaluation

Considerations and learning points for future engagement and communication activities

- STP Checklist for governance and engagement
- Quality improvement methodology, using an iterative process: Plan, Do, Study, Act (PDSA cycle)

Action: Establishment of a One Gloucestershire Equalities/Health Inequalities Lay Reference Group

One Gloucestershire
Transforming Care, Transforming Communities

Involving you in developing ideas *'Fit for the Future'* – Summer/Autumn 2019

An open dialogue with the public and staff informed by evidence about the need for change and describing ideas and a range of potential solutions and ways to evaluate these.

The scope of Fit for the Future – Ideas to…..

- Make it easier, faster and more convenient to get advice, support and services, 7 days a week - wherever you live in Gloucestershire (including booking appointments)
- Improve ‘same day’ urgent (non-emergency) care services across local communities – illness and injury
- Ensure outstanding specialist hospital services when you need them, including *Centres of Excellence* in Cheltenham and Gloucester

Key engagement activities planned

Public engagement activities to include: information, surveys, public drop ins, awareness raising, presentations

Independently facilitated:

- Workshops (public/staff) with representatives from protected characteristic groups and Healthwatch Gloucestershire volunteers
- Engagement Hearing – in public and live-streamed
- Citizens' Jury
- Options Appraisal process in public

Informing the development of the best solutions and consideration of options for change to achieve our shared priorities and meet the challenges we face together.

Independently facilitated engagement activities 1

Local Solutions Development Workshops

A series of Workshops (public/staff) with invited representatives from protected characteristic groups and Healthwatch Gloucestershire Volunteers to develop potential solutions to achieve our shared priorities and meet the challenges we face.

Engagement Hearing

An opportunity for members of the public to share their thoughts and ideas about what should be taken into account, what is essential in arriving at the best solution, plus any new ideas or alternative proposals they may have. Hearings are live events held in public, live streamed to the internet, and recorded.

Independently facilitated engagement activities 2

Citizens' Jury

The Citizens' Jury will consider the outcome of engagement to date, together with evidence regarding the need for change and local priorities. The Jury will focus on the subject of improving specialist hospital services and developing Centres of Excellence and make recommendations for the best potential solutions to take forward and evaluation criteria.

Locality Workshops

Locality Workshops, made up of local people and clinicians, will consider the subject of ensuring everyone can access consistent primary, community and urgent care services.

Options Appraisal Exercise in public

An Options Appraisal Exercise will be completed by clinicians and other health professionals, together with representatives of the members of the public involved in developing the proposed solutions.

Consideration of all the elements of engagement

The Citizens' Jury and Localities' recommendations, together with the outcome of the Options Appraisal Exercise, will be considered by NHS Boards and CCG Governing Body.

HOSC members will be regularly updated and views sought.

The public would be consulted about any possible changes as required.

Agenda Item 15.1

Governing Body

Meeting Date	**25 July 2019**
Title	**Risk Management Report** **Governing Body Assurance Framework**
Executive Summary	This risk report highlights the key changes to the Governing Body Assurance Framework that have taken place over the past two months. These changes are highlighted in red text for ease of reference. The Audit and Risk Committee reviewed the Risk Report and GBAF at its meeting held on 2 July. It was noted that the GBAF omitted some key risk updates as they had not been finalised prior to the submission of the committee papers. Therefore it was agreed at the meeting that updated risks would be included in the report and signed off by the Audit and Risk Committee prior to the Governing Body. This took place the week commencing 15 July 2019. The Audit and Risk Committee has an important role in reviewing and approving the closure of risks, which have been effectively managed and mitigated. The committee also approves the inclusion of new risks. The Governing Body is ultimately responsible for risk management and ensuring that the CCG has a risk aware culture that is embedded across the organisation. A risk management report and the Governing Body Assurance Framework is reported to each meeting.
Key Issues	See narrative report.
Management of Conflicts of Interest	None identified

Risk Issues: **Original Risk** **Residual Risk**	The absence of a fit for purpose GBAF could result in risks not being identified, acted upon and reported and gaps in control / assurances not being identified and addressed. 12 (3x4) 4 (1x4)
Financial Impact	See finance risks
Legal Issues (including NHS Constitution)	Legal issues are highlighted in risks contained within the CRR.
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 asked to note the inclusion of the following new key risks • Q24 and T21 The closure of the following risks • L5, L9 and C27.
Author	Christina Gradowski
Designation	Associate Director of Corporate Affairs
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

Governing Body

25 July 2019

Introduction

1.1 Each directorate has a risk register that is updated on a monthly basis and are used as part of directorate meetings to shape discuss emerging and current risks that need to be effectively managed and mitigated. The risk registers also include guidance on how to succinctly identify and describe risk, how to score risks and instruction on the inclusion of the trend arrow (indicating an upward / downward / same trajectory).

1.2 The Corporate Risk Register is reported to the Quality and Governance Committee with a particular focus on quality risks while the Audit and Risk Committee has taken on the assurance role for risk and receives the Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF). The Governing Body is ultimately responsible for managing risk and ensuring that there is a pro-active risk culture within the CCG, and that risk management is embedded in the policies, procedure and working practices of the organisation. The Governing Body reviews high level risks, those rated 12 or more that potentially affect the CCG's ability to meet its corporate objectives.

May review

Each directorate was asked to complete their own risk register in May and June; some further updates were given in July. The risk register is sent to the directorate risk leads with feedback from the Audit and Risk Committee about the quality of risk identification, reporting and management. Directorates are encouraged to discuss and agree risks at their directorate team meetings, so that risks are shared and owned. The following directorates submitted their updated risk registers according to the timescales for this committee:

- Finance Directorate
- Integration Directorate
- Quality Directorate
- Primary Care and Locality Development Directorate
- Commissioning Implementation Directorate.

- Transformation and Service Redesign Directorate

The Audit and Risk Committee was asked to include the following new risks. The Committee approved the inclusion of the new risks (see below)

A recommendation was made by the Quality Directorate to include a risk relating to NICE Guidance, which was discussed at previous Quality and Governance Committee meetings. The committee supported the inclusion of this risk on the CRR.

Q24 **Deviation from NICE Guidance;** there are some clinical areas where NICE guidance has not been implemented. Therefore there is a potential risk to patient care and outcomes. This is currently rated as 6 (yellow).

T21 **Risk of a lack of alignment** between newly formed Integrated Locality Partnerships / Primary Care Networks work priorities with those of the Care Programme. This may lead to some programmes experiencing:

• Lack of engagement at local level
• Variable engagement (high in some areas and low in others) leading to an impact in standardisation of pathways as local solutions are reached

The change to the funding of Primary Care Networks may also lead to a destabilisation of workforce within current pathways as PCNs are funded to increase their establishment of specialist clinical and non-clinical staff.

The Audit and Risk Committee was asked to close the following risks. The Committee approved closing the risks listed below.

L5 (including L8) Clusters are unable to deliver Improved Access Pilots sustainably). L5 there is a potential risk about the roll out of the Improved Access Pilots across the clusters; resulting in the GCCG's inability to commission Improved Access and patients unable to access a national requirement for urgent and routine appointments 6.30pm and 8pm and at weekends. Since the last report the two Gloucester

clusters who had found delivery of IA challenging are revising their models in their newly formed PCN to ensure delivery of IA and Extended Hours DES from 1st July 2019. This risk has been reduced from 12 (Amber) to 4 (yellow). The Primary Care team has asked that this risk is now closed.

L9 There is a risk that clinical tasks are missed in Improved Access pilots where pilots are using Information systems to send clinical tasks. All practices have been visited and system configurations checked. IA governance meetings continue. No new serious incidents have been reported. This risk was originally rated as 12 (Amber) reduced to 8 (Amber) and reduced further to 4 (Yellow). Therefore the Primary Care Team recommends that this risk should be closed.

C27 Non-emergency patient transport; actions and assurances have been updated. This is no longer a risk, as the contract with Arriva has ceased and a new contract with a new provider commenced on 1 June 2019. The risk has been reduced to 4 (yellow), with a recommendation to close this risk.

Highest risks RED

There are three high rated Red risks (see L10, L11 and F11).

All updates are marked in red on the GBAF

Amber risks

Objective 1: Commission high quality, innovative services

- K1 / K2 Impact on discharges re-enablement. The April report showed that the risk had originally increased from 6 (Yellow) to 12 (Amber) and has remained unchanged. It should be noted that K1 *and K2 Impact on discharges* have been amalgamated as they are essentially the same risk around discharges. However the delays are caused by the re-enablement service (K1) and the availability of independent sector domiciliary care (K2). For this report the progress on actions has been updated and the risk rating remains the same at 12 (Amber).

- T20 Risk that delayed implementation of changes to pathways through the Clinical Programme Approach fail to deliver the anticipated benefits; resulting in: transformation projects may not deliver the expected outcomes for patients and the whole system. This risk remains unchanged at 12 (Amber).
- Q22 SWAST has identified a risk in the SW to patients due to call stacking. In Gloucestershire the risk is in category 2 patients where waits are longer than target times though Category 1 patients are responded to within the required times. There are delays in responding to Category 4/5 health professional calls but this is not considered to pose a risk to the patients. This risk is rated as 12 and remains unchanged.
- T15 Risk around the lack of a detailed plan for specialised services transfer resulting in uncertainty in relation to future plans. This risk was identified in January 2018 and originally rated as 12 (Amber) it then increased to 16 (Red) in February and for the June report was reduced to 12 (Amber). This has been split into two risks, one solely around the role in PMO to have specialised commissioning liaison incorporated rated as 12 (Amber), the other around Diabetes see (T18). This risk was reviewed in January and the risk rating remains unchanged as 12 (Amber).

Objective 3. Transform services to meet the future needs of the population, through the most effective use of resources

- C5 Discharge. The actions have been updated and the risk score remains unchanged at 12 (Amber) down from an original risk rating of 16 (Red).
- T18 Lack of a detailed plan for specialist services transfer. CCG commissioners monitoring the situation. NHSE recommissioned diabetic eye screening for April 2019 onwards**.** This was a new risk added in December 2018 and rated as 12 (Amber) and remains unchanged for this report.
- C15 Constitution targets - cancer. The risk remains unchanged at 12 (Amber).

- C8 (including C28). There is a risk of failure to reduce demand and prevent unnecessary acute attendances. The actions have been updated. The risk remains unchanged at 12 (Amber).

Objective 4: Secure continuous improvement in the quality of services, tackling health inequalities and ensuring parity of esteem in mental health

- T11 Risk of financial cuts to public health services. Due to reduced budgets. Resulting in: likelihood of having a medium and long-term impact on population health and NHS resources. This risk has been spilt into two risks see below risk T19. The risk has been reappraised following on from a Governing Body Business Session where Public Health attended and where the cuts to services were discussed. This risk has been reappraised and is now rated at 12 (Amber).
- Q20 Mortality review. This risk remains unchanged as does the risk rating 12 (Amber).

Objective 6: Deliver strong leadership as commissioners ensuring good governance and financial sustainability

- K9 Risk that the CCG is unable to meet the national target for CHC. Due to: Currently there are 42 CHC funded individuals with a Learning Disability, a piece of work has been undertaken to identify when this cohort of individuals last had a review in line with the National Framework for Continuing Healthcare. The actions have been updated and the risk has been rated as 12 (Amber) and remains unchanged.
- C3 Procurement – risk of legal challenge. The actions have been updated and the risk rating has been reviewed and is unchanged at 12 (Amber).
- C16 & F11 were combined as they were duplicates. F11 risk has been rearticulated to read:
  There is a risk that the CCG does not meet its breakeven control total in 2019/20 through one or a combination of

- non delivery of transformational savings
- Unplanned prescribing demand
- Growth and demand increases (incl CHC and LD)
- changes in commissioning responsibilities
- Primary care expenditure in excess of allocation.

This risk is rated as 16 (RED).

This will have an adverse impact on cash balances held by the CCG.

- T10 (including F12) Risk that delayed implementation of ICS Solutions and/or failure of projects to deliver anticipated benefits, this risk remains unchanged at 12 (Amber).
- F16 Potential transfers of commissioning responsibilities and service lines from/to CCG may lead to cost pressures. The risk rating remains unchanged at 12 (Amber)
- F24 Implementation of the electronic patient record system now incorporates K7 (Maternity Data). This risk has decreased to 12 (Amber) from 16 (RED). This risk remains unchanged.
- F26 Local Digital Roadmap. Resources may not be available to deliver the programme. The controls and actions have been updated and the risk remains unchanged at 12 (Amber).
- F27 Risk of Cyber Attack. The actions have been updated and the risk remains unchanged at 12 (Amber)
- Q23 EU Exit arrangements. Due to the uncertainty surrounding EU-Exit arrangements there is a risk that some areas of healthcare delivery will be affected. This risk is currently rated as 12 (Amber).

Objective 7: Develop plans for proactive care with partners that focus on early intervention, prevention and detection of physical and mental health conditions

- Q19 Health needs of children in care. This has been reviewed and the risk remains unchanged at 12 (Amber).

3. Recommendation

3.1 The Governing Body is asked to note the following new risks:
  - L10, L11, Q24, T21

The following risks are closed:

- L5, L9 and C27.

4. Appendices

Appendix 1 Governing Body Assurance Framework

Governing Body Assurance Framework 25/06/2019 **Agenda Item 9.3**

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating LxS	Current risk rating LxS	Trend	Progress with actions
Strategic Objective	**Objective 1: Commision high quality, innovative services**								
Date added 21.03.2019 **Directorate** **T20 Transformation** Executive Sponsor **Ellen Rule** **Lead Manager** Kelley Matthews **Review date** 31.03.20	Risk that delayed implementation of changes to pathways through the Clinical Programme Approach fail to deliver the anticipated benefits Resulting in: transformation projects may not deliver the expected outcomes for patients and the whole system.	Robust project management planning by the Tranformation Team supported by the PMO, Information & BI Teams.	None	Progress of pathway changes reported through to CPB on a bi-monthly basis along with the benefits realised from pathway transformation	None	**3x4=12**	**3x4=12**	⟺	1. KPIs developed with baselines developed. 2. Ongoing monitoring of each scheme with a view to assessing optimium pathways and benefits realisation from changes to pathways through transformation. 3. Dashboards developed eveloped to inform and report on pathways along with soft measures & intelligence. 4. Regular monthly meetings with service leads. 5. Regular discussion regarding delivery with the Clinical Programme Board (CPB) and Core Team with a focus on escalation of risk and issues.
Date added 01.01.19 **Directorate** **T 18- Transformation** **Executive Sponsor** Ellen Rule **Lead Manager** Kathryn Hall **Lead Committee** Audit & Risk Committee **Review date**	Lack of a detailed plan for specialist services transfer. CCG commissioners monitoring the situation. NHSE recommissioned diabetic eye screening for April 2019 onwards.	1.CCG specialised commissioning lead to monitor the situation.	None	Performance Reports to Governing Body, weekly situation report, project status updates	None	**3x4=12**	**3x4=12**	⟺	1. CCG proposing to re-configure Tier 4 weight management service (bariatric surgery) to ensure the greatest health gain within the finite resource 2. CCG invited to participate in the reprocurement of diabetic eye screening service. CCG attends the quarterly diabetic eye screening board meetings. The new procured service will be in place by April 2019. GHFT is the current provider.
Date added 10.01.2019 **Directorate** **T15- Transformation** **Executive Sponsor** Ellen Rule **Lead Manager** **Lead Committee** Audit & Risk Committee **Review Date** 31.03.2020	Lack of NHSE detailed plan for specialist services transfer. CCG commissioners monitoring the situation. Role in CPG to have specialised commissioning liaison incorporated	CCG specialised commissioning lead to monitor the situation	None	Assurance from NHSE Area Team	None	**4x4=16**	**3x4=12**	↓	It is the intention for a member of the CPG team to take on specilaised commissioning on their return from maternity leave in early 2019
Date added **Directorate** **Q24 Quality Directorate** Executive Sponsor **Marion Evans Andrews** Lead Manager **Teresa Middleton** Lead Committee **Audit & Risk Committee** Review Date	Risk of deviation from NICE Guidance: There are some clinical areas where NICE guidance has not been implemented. Therefore there is a potential risk to patient care and outcomes.	Reviewed by the CCG Clinical Effectiveness (CE) Group to ensure no adverse effects on patients by not implementing guidance.	None	Review at Clinical Effectiveness Meetings	None	**2x3=6**	**2x3=6**	NEW	On-going systematic review of all areas where non-compliance with NICE guidance to ensure patient outcomes are not affected. The CE group maintain a list of NICE guidance and where there is local deviation and why.
31.03.20120 **Date added** 01.04.18 **Directorate** **K1 including K2 Integration** **Executive Sponsor** Kim Forey **Lead Manager** Donna Miles **Lead Committee** Audit & Risk Committee **Rev date: 30.09.20**	Risk that discharges are being delayed in the acute sector. Due to delays with the re-ablement service and delay with sourcing independent sector domicillary care. This leads to a disruption of patient flow and pressures placed on urgent care and meeting the 4 hour target, increased length of stay and poor patient experience.	JCPE QIPP Board Reports GCCG Board Reports USC Briefing Report Performance reports and action plans monitored through contract quality monitoring groups.	None	Performance Reports to Governing Body	None	**3x4 = 12**	**3x4=12**	⟺	A new operating model has been agreed
Objective 3. Transform services to meet the future needs of the population, through the most effective use of resources									
Date added 01.02.14 **Directorate** **C27 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Gill Brigland **Lead Committee** Audit & Risk Committee **Review date** 30.11.20	Risk to Non Emergency Patient Transport KPI delivery and Patient experience. Due to: Operational issues, financial sustainability of the Non-Emergency Patient Transport contract and procurement risks for new contract due to commence June 2019.Resulting in: Poor patient experience. **RECOMMENDATION TO CLOSE RISK**	Risk to be managed consistently across Gloucestershire, Swindon, Wiltshire and BaNES CCG	None	Monthly Contract Board Meetings and ad hoc meetings with ATSL and other commissioners. Ad hoc performance reports to Governing Body and HCOSC	None	**4x4=16**	**1x4=4**	↓	Monthly Contract Board Meetings and ad hoc meetings with ATSL and other commissioners. 6 month contract extension agreed to allow time for development of a revised service specification, procurement and mobilisation (avoiding winter implementation of new service). Procurement process nearing completion. There is a new provider running the contract from 1 June 2019, the transition went smoothly. Therefore it is suggested that this risk is obsolete. .
Date added 4/1/2018 **Directorate** **C5 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Maria Meatherall **Lead Committee** Audit & Risk Committee **Revi ew Date**: 31.03.20	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. Due to: Operational pressures. Resulting in: Poor patient experience.	A&EDB, weekly partnership meeting & bi-weekly oversight meeting	None	Performance Reports and dashboards, critical milestones reviewed, regular programme stocktake.	None	**4x4=16**	**3x4=12**	↓	Urgent & Emergency Care Summit facilitated with representation across health & social care partners. Three high priority system actions developed with supporting actions to enable delivery during 2019/20
Date added 1/1/2017 **Directorate** **C6 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Maria Meatherall **Lead Committee** Audit & Risk Committee	Non-delivery of the Constitution standard for maximum wait of 4 hours within the emergency department. Due to: Operational pressures. **Resulting in:** Negative patient experience.	A&EDB & Attendance Avoidance sub-group	None	Reports to GB at Business Sessions; GB meetings	None	**3x4=12**	**3x4=12**	⟺	Urgent & Emergency Care Summit facilitated with representation across health & social care partners. Three high priority system actions developed with supporting actions to enable delivery during 2019/20.
Date added 01.04.2017	Failure to fully comply with all NHS constitution standards.	Acute provider contracts, including AQP.	None	Reports to GB at Business Sessions; GB meetings	None				Progress with actions 1. Significant improvement in performance continues – including delivery of ED 4 hours standard, diagnostics,

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating	Current risk rating	Trend	Progress with actions
Directorate **C15 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Christian Hamilton **Lead Committee** Audit & Risk Committee **Review date** 31.03.20	**Due to:** Delivery of changes required to recover performance and address issues related to capacity and demand. **Resulting in:** Potential delays to patient care					**3x4=12**	**3x4=12**	⟺	cancer 2 ww and DTOCs. 2. Further concentrated work on delivering recovery plan for cancer 62 day standard, to reduce number of over 52 ww breaches **and recommencement of RTT reporting.** 3. Service re-design led by Clinical Programme Groups continues – including focus on demand management initiatives. 4. Sharing of information with GP Localities. 5. Clinical validation undertaken at 52weeks and >62 days which includes harm review. 7. Good progress made on joint STP elective care programme aimed at reducing demand, managing follow ups and improving efficiency.
Date added 01.04.17 **Directorate** **C8 & C28 Commissioning** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Maria Meatherall **Lead Committee** Audit Committee Haydn Jones **Lead Committee** Audit & Risk Committee **Review date** 30.09.20	(Signposting & Admission Avoidance) High Impact Action 2: Risk of failure to reduce demand and prevent unnecessary acute attendances and emergency admissions. (Signposting & Admission Avoidance) High Impact Action 2: Risk of failure to reduce demand and prevent unnecessary acute attendances and emergency admissions. **Due to**: Failure to implement agreed plans to reduce unnecessary ED attendances and emergency admissions. **Resulting in**: ED attendances and emergency admissions above planned levels.	A&EDB, Attendance & Admission Avoidance Task & Finish Group, Urgent Care Strategy Group	None	Performance Reports to Governing Body, weekly situation report, project status updates	None	**3x4=12**	**3x4=12**	⟺	Urgent & Emergency Care Summit facilitated with representation across health & social care partners. Three high priority system actions developed with supporting actions to enable delivery during 2019/20.
Objective 4. Secure continuous improvement, in the quality of services, tackling health inequalities and ensuring parity of esteem in mental health									
Date added 01.04.2018 **Directorate** **T11 Tranformation & Service Redesign** **Executive Sponsor** Ellen Rule **Lead Manager** Emma Savage **Lead Committee** Audit & Risk Committee **Review date** 31.03.20	Risk of financial cuts to services provided by public health. This includes, and is not limited to, public health campaigns, smoking cessation services etc. Resulting in: likelihood of having a medium and long-term impact on population health and NHS resources	Regular joint meetings and agreement of joint work plans with links to H&WB Board	None	Assurance from NHSE Area Team	None	**2x4=8**	**3x4=12**	⇧	1. PHE appointed 2 substantive public health consultants one of which is an additional post. 2. CCG has re-instated CCG/Public Health interface meetings to oversee delivery of the Public Health Core Offer and keep abreast of any funding cuts to Public Health budget and impact on service delivery. These will re-commence from January 2019.
Date added 01.04.18 **Directorate** **Q20 Quality** **Executive Sponsor** Marion Evans Andrews **Lead Manager** Julie Symonds **Lead Committee** Audit & Risk Committee **Review date:** 31.03.2020	There could be a risk of high mortality rates at the GHFT. Due to: 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. Resulting in: potential higher mortality rates	Monthly mortality briefings provided by Dr Foster. Trustwide mortality strategy reviewed at CQRG.	None	Reviewed by IGQC on behalf of the Governing Body	None	**3x4=12**	**3x4=12**	⟺	The SHMI is being driven by out of hospital deaths within 30 days of discharge. A decision was made to undertake a joint provider, morality review on a a number of these deaths. Data on the detail of these is not easily accessible and it is being explored how this data can be obtained. This review will report to STP clinical reference group. MI position improved. Establishment of STP mortality group to align mortality review policies. Multi-agency reviews have commenced The LeDeR mortality review is driving the systemwide process and as such GCCG is producing information for primary care. To date the LeDeR mortality review process has not identified significant concerns
Objective 5: Work together with our partners to develop and deliver ill health prevention and care strategies designed to improve the lives of patients, their families and carers.									
Date added 18.05.19 **Directorate** **T21 Transformation & Service Redesign** **Executive Sponsor** Ellen Rule **Lead Manager** Kelly Matthews **Lead Committee** Audit & Risk Committee **Review date:** 31.03.2020 31.03.2019	With the formation of Integrated Locality Partnerships and Primary Care Networks there is a risk that the work and priorities for transformation programmes may not align to the planned work and priorities for the Primary Care Networks. This may lead to some programmes experiencing: • Lack of engagement at local level • Variable engagement (high in some areas and low in others) leading to an impact in standardisation of pathways as local solutions are reached The change to the funding of Primary Care Networks may also lead to a destabilisation of workforce within current pathways as PCNs are funded to increase their establishment of specialist clinical and non-clinical staff.	Dir: Ellen Rule Lead Managers: Kelly Matthews	None	To be defined		**2x4=8**	**NEW RISK**		NEW RISK
Objective 6. Deliver strong leadership as commissioners ensuring good governance and financial sustainability									
Date added 24.05.13 **Directorate** **C3 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** David Porter **Lead Committee** Audit & Risk Committee **Review date:** 31.03.2020	Increased risk of CCG receiving legal challenge. **Due to:** 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). **Resulting in:** Could result in any contract that has been negotiated / signed being 'set-aside' by the courts and / or a fine being levied against the CCG which may be equivilent to the loss of profits for the challenging organisation.	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. Continued risk which applies to all procurement process but particularly those which exceed the Light Touch Regime threshold (£615,278.00 total [illegible] value)	None	Project reports to Core Executive Team and Governing Body	None	**3x4=12**	**3x4=12**	⟺	A revised CCG procurement strategy document was approved by the Governing Body on 29 November 2018 and formally came into effect on 1 December 2018 for a period of 2-years
Date added 01.04.2019 (updated) **Directorate** **C16 combined with F11 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw / Cath Leech **Lead Manager** Christian Hamilton / Andrew Beard **Lead Committee** Audit Committee **Review date** 31.03.20	There is a risk that the CCG does not meet its breakeven control total in 2019/20 through one or a combination of - non delivery of transformational savings - Unplanned prescribing demand Growth and demand increases (incl CHC and LD) - changes in commissioning responsibilities - Primary care expenditure in excess of allocation This will have an adverse impact on cash balances held by the CCG.	Robust financial plan aligned to commissioning strategy. QIPP plans developed with appropriate governance processes including monitoring. CCG constitution including Standing Orders, Prime Financial Policies and Scheme of Delegation approved. Monthly contract monitoring in place	None	Reports to GB at Business Sessions; GB meetings, specifically around savings plans and updates on contracts	None	**4x4=16**	**3x4=16**	⟺	1. Plans approved by Governing Body, updates to each Governing Body meeting and quarterly Audit Committee reports, QIPP plans being monitored on a monthly basis with scheme-specific KPI's developed behind each to assess achievement. Regular reporting at Direct reports and Senior Manager meetings. Weekly updates on key themes at Core Team. 2. NHS contracts for 2019/20 now mainly agreed. Financial plans for 2019/20 have been approved by Governing Body. Risk has been mitigated by agreement of block contract with GHNHSFT, with the exception of Drugs 3. Regular review of risks and mitigations within overall financial position 4. More deep dives at F & P development sessions planned 5. Progress in monitoring across providers by specialty 6. Provider challenge process strengthened 7. Regular alignment across providers 8. Ongoing cash monitoring and reporting to Governing Body including progress against Maximum Cash Drawdown limit
Date added 01.04.2018	Risk that the CCG is unable to meet the national target for CHC. Due to: Currently there	Monthly perfromance reports reported to the Core	None	Governing Body Performance Reports; reports to the Audit	None				Update: 20.02.19 Several unsucessful recruitment campaigns with only one individual appointed (due to commence in April 2019). Review of cases continues with 15 outstanding cases to be completed.

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating	Current risk rating	Trend	Progress with actions
Directorate **K9 Integration** **Executive Sponsor** Kim Forey **Lead Manager** Miriam Street & Debbie Sanders **Lead Committee** Audit & Risk Committee **Review date** 31.03.2020	are 42 CHC funded individuals with a Learning Disability a review conducted showed that there are 28 individuals who have not had a review. Resulting in missed target and poor patient experience for the actual patient and their family	Leadership team and to the Governing Body at the Business Sessions and formally as part one of the Governing Body meeting.		and Risk Committee and performance monitoring by NHS England		**4x4=16**	**3x4=12**	↓	Monitoring of all LD CHC cases continues on a weekly basis to ensure the CCG meets the 28 day timeframe.
Date added 01.04.2018 **Directorate** **T10 including F12 All Directorates** **Executive Sponsor** Cath Leech **Lead Manager** Haydn Jones **Lead Committee** Audit & Risk Committee **Review date** 31.03.2020	Risk that delayed implementation of transformation & Savings Projects and/or failure of projects to deliver anticipated benefits Resulting in: non delivery of non financial benefits and under-delivery on planned savings targets.	Robust project management planning and reporting to the PMO.	None	Budgets approved by the Governing Body. Monthly performance reporting to CCG Governing Body and quarterly reporting to the CCG's Audit Committee.	None	**3x4=12**	**3x4=12**	↔	1. KPIs developed and uploaded to Verto performance management system. 2. Ongoing. 3. QIPP Portal developed to inform and report on QIPP schemes along with soft measures & intelligence. 4. Triangulation of information data and finance for year to date position and improved QIPP scheme forecasts. 5. Regular monthly meetings with service leads for scheme reviews. 6. Regular discussion regarding delivery with Core Team with a focus on escalation of risk and issues.
Date added 01.04.2018 **Directorate** **F16 Finance** **Executive Sponsor** Cath Leech **Lead Manager** Andrew Beard **Lead Committee** Audit & Risk Committee **Review date** 31.03.2020	Potential transfers of commissioning responsibilities between organisations from/to CCG may lead to cost pressures.	Assess all transfers and compare with current position to validate any proposed financial and workload impact.	None	Monthly performance dashboard for larger contracts with robust out of county contract monitoring reflected within performance reports. Monthly prescribing & CHC information including trends Internal audit reports and recommendations to be reported to Audit Committee.	None	**3x4=12**	**3x4=12**	↔	All provider monitoring is being reviewed to spot anomalies within activity data that may have been potentially transacted on a different basis to which the funding was transferred from NHSE. Any material issues are being raised with the Specialist Commissioning Team which has resulted in some correction to the original allocation transfers. These transfers have been actioned recurrently in 2018/19 opening RL Transfers under the TCP programme being followed through and financial implications discussed with NHSE and guidance being worked through with joint GCC/CCG commissionerson an ongoing basis. These will have a significant financial impact on the CCG. Initial deep dive report to F & P development session in July with increased monitoring during the year. TCP impact being actively managed with LD commissioners to minimise financial risk Future likely impact of transfers being modelled using nationally available modelling tool.on CCG activity.
Date added 01.04.2018 **Directorate** **F24 Finance / K7 Maternity** **Executive Sponsor** Cath Leech **Lead Manager** Andrew Beard **Lead Committee** Audit & Risk Committee **Review date** 31.03.2020	Implementation of Electronic Patient Record system within our main acute provider There is also a risk that there is no reportable data for maternity services. This is due to the implementation of the electronic patient record system within GHNHSFT. Resulting in: reporting issues for clinical correspondence, national performance reporting and contractual management.	Development of a remedial action plan supported by CCG/CSU staff to mitigate risks of adverse clinical communication and incomplete reporting	None	Governing Body Business Session through performance and finance reports to the Governing Body discussion of risk at Quality and Governance Committee	None	**4x4=16**	**3x4=12**	↓	1. Comprehensive recovery programme **in place and delivering in line with plan**. 2. Key work streams are focussed upon data quality, people and process, clinical safety and finance. 3. The Trust has put in place strengthened project infrastructure which includes support from the CCG. 4. The quality and comprehensiveness of activity and financial reporting continues to improve 5. Majority of the contract is block therefore mitigating some of the financial issue however elective performance monitoring and establishing a baseline for next financial year will be challenging.
Date added 30.03.17 **Directorate** **F26 Finance** **Executive Sponsor** Cath Leech **Lead Manager** Fiona Robertson **Lead Committee** Audit & Risk Committee **Review date** on-going	Local Digital Roadmap - Resources (financial and workforce) may not be available to deliver the programme or projects within the STP which will **Resulting in** an impact on delivery and benefits.	Digital Executive Steering Group, County Wide IM&T Steering Group and associated sub groups in place reporting to Delivery Board and each organisation	None	ICS Delivery Board and each organisation's Board / Governing Body	None	**3x4=12**	**3x4=12**	↔	1. On going dialogue within the Countywide IM&T Group on resourcing and potential risk to delivery. 2. Bidding to national funds in progress. 3. Risks regarding capital vs revenue funding model highlighted to NHSE. 4. Strategy refresh commenced to review resourcing requirements over the next few years. 5. Digital Workforce Group initiate
Date added 07.06.17 **Directorate** **F27 Finance** **Executive Sponsor** Cath Leech **Lead Manager** Fiona Robertson **Lead Committee** Audit & Risk Committee **Review date**	There is an increased risk of a cyber attack **Due to**: cyber threats continuing and become more sophisticated which, if successful, would **Result in:** the CCG's systems and information are at greater risk of being compromised.	The CCG has policies in place to reduce the probability and contracts with the CSU and CITs which include cyber security advice and services.	None	The CCG has policies in place to reduce the probability and contracts with the CSU and CITs which include cyber security advice and services. Monthly reports to the LDR Infrastructure Group. NHS Digital ongoing assurance	None	**3x4=12**	**3x4=12**	↔	1. 2 Cyber Exercises have taken place with Lessons Learnt reports creating new actions. 2. DSPR and Cyber Essentials + action plans are being worked through across the organisations and reported on monthly. 3. GPIT Cyber Security PID & Windows 10 PID submitted to NHS England for approval. 4. Vulnerability Scanning software is now in place and reporting in CITS and GHFT. 5. Software now live across the Gloucestershire domain to spot unusual account activity. 6. Asset managment tool deployed to audit devices and software versions on the GHC network. 7. Security monitoring system installed on the GHC network . 8. Mobile device management software installed and roll out has started. 9. New Anti-Virus software installed and deployment started. 10. New County Wide WAN & LAN delivered.
Date added 22.02.19 **Directorate** **Q23 Quality** **Executive Sponsor** Marion Evans Andrews **Lead Manager** Emergency Accountable Officer **Lead Committee** Audit Committee **Review date** 31.03.2020	Due to the uncertainty surrounding EU-Exit arrangements there is a risk that some areas of healthcare delivery will be affected. These include: • supply of medicines and vaccines; • supply of medical devices and clinical consumables; • supply of non-clinical consumables, goods and services; • workforce; • reciprocal healthcare; • research and clinical trials; and • data sharing, processing and access. B251	LHRF Business group are co-ordinating the planing arranegements and liaising with the LRF SCG. If no-deal by last week of March then the Exec LHRP will meet to co-ordinate actions at a tactical level. NHSE and CCG are members of the LRF SCG.	None	All providers have been asked to undertake risk assessments and develop contingency planns. Also they ahev been asked to contact their suppliers to make sure they also have plans in place.	None	**3x4=12**	**3x4=12**	**NEW**	All Trusts have plans in place. GPs and hospices have been provided with check-lists and advice. Non-NHS providers have been asked for assurance. An exercise to test continhgency plans across the system has been arranged for 11th March. 2 meetings of the LRF SCG have taken place.
Objective 7 Develop plans for proactive care with partners that focs on early intervention									
Date added 06.01.17 **Directorate** **Q19 Quality** **Executive Sponsor** Marion Evans Andrews **Lead Manager** Julie Symonds **Lead Committee** Audit & Risk Committee **Review date:31.03.20**	There is a risk that children and young people in care do not get a review of their health needs, or that the healthcare plan is not implemented effectively. **Due to:** The number of CiC has grown significantly, meaning that the services providing RHAs are struggling to manage the increased demand. 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 main service that provides RHAs (public health nursing) is the responsibility of the county council, making the situation and its resolution more complicated. **Resulting in:** This is known to have a negative impact on subsequent longer term health and	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.	None	Performance reports to the Governing Body	None	**4x3=12**	**4x3=12**	↔	The CCG and GCC have agreed to fund additional dedicated CIC nurses and additional nurses are in the process of being recruited to the team

NHS
Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee
(*meeting held in public)*

Minutes of the meeting held at 9.45am on 28 March 2019
Boardroom, Sanger House

Present:		
Alan Elkin (Chair)	AE	Lay Member - Patient and Public Engagement
Mary Hutton	MH	Accountable Officer
Joanna Davies	JD	Lay Member- Patient and Public Engagement
Colin Greaves	CG	Lay Member – Governance
Julie Clatworthy	JC	Registered Nurse
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Stephen Ball	SB	Locality Finance Manager *(Deputising for Cath Leech until item 10)*
Dr Andrew Seymour	AS	Clinical Chair
Cath Leech *(item 10 &11)*	CL	Chief Finance Officer

In Attendance:		
Jeanette Giles	JG	Head of Primary Care Contracting
Helen Edwards	HE	Associate Director of Primary Care Locality Development
Becky Parish	BP	Associate Director Engagement and Experience
Andrew Hughes	AH	Associate Director of Commissioning
Stephen Rudd *(item 5)*	SR	Head of Locality and Primary Care Development
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Sophie Atkins	SA	Governance Manager

1.	**Apologies**
1.1	Apologies were received from Cllr Roger Wilson and Helen Goodey.

1.2	AE confirmed that the meeting was quorate.
2.	**<u>Declarations of Interest</u>**
2.1	AE asked members to declare any interests in relation to any of the agenda items. CG declared an interest in item 6 as a patient at Crescent Bakery Surgery. AE noted that although CG had declared a conflict of interest, there were no decisions being taken at the meeting which were relevant to his declared interest.
3.	**<u>Minutes of the meeting held on 31 January 2019</u>**
3.1	The minutes of the meeting held on Thursday 31 January 2019 were approved subject to the following amendments: • Page 1 Lesley Jordan's title should have been 'Secondary Care Doctor' not 'Lay Member – Governing Body'. • Page 1 neither Lesley Jordan nor Alan Thomas were members of the committee so were 'in attendance' rather than 'present'. • Page 1 Cath Leech was 'in attendance' therefore Andrew Beard could not have been deputising and was 'in attendance' not 'present'. • Page 3, 4.7 the first sentence should have been 'CG commented that this related to C.Diff in Primary Care' not 'CG commented that this related to C.Diff.' • Page 3, section 4.6. and 4.7 titles should have been 'Primary Care Quality Report' not 'Primary Care Quality Report – Safeguarding'. • Page 11, 5.13 JC clarified that the context of the comment made was that there would be a role for quality at the Primary Care Network level and some of the quality issues would be about care delivery and how teams functioned. • Page 14, 6.8 the first sentence should have been 'The committee noted that all networks…' not 'The committee noted that all clusters…' • Page 17, 8.2 the third sentence of the second paragraph should have been '…isolating patients and giving appropriate treatment.' not '…isolating patients

	and giving antibiotics.'
4.	**<u>Matters Arising</u>**
4.1	**29/11/2018, Item 6.1, Inter-Practice Minor Surgery Enhanced Service.** AE stated that it was the scale of the services provided that was of interest and the actual procedures covered. HE responded that a list of procedures could be provided as an appendix to show the scale of minor operations being undertaken in practice. **Update**: HE would send a copy to CGi to circulate this with the minutes. **31/1/2019 update:** HE mentioned the procedure list for this enhanced service was set out in the minor surgery enhanced service specification. Minor surgery service was being reviewed. AE was concerned about the volume of procedures. **28/03/19 update** – AE confirmed that the original request for a list of procedures that would be undertaken had been provided in an Appendix, however, JC had expected to have had some input into the list of procedures and for this to be reported back to the committee. She also sought assurances that the new agreement was in line with the new guidance issued by the Royal College of Surgeons and GPs. HE confirmed that the principle of having designated centres for minor surgeries had been agreed previously and remained the same. JC added that there was a need to strengthen assurance regarding clinical premises, to ensure their suitability for minor surgery. The committee agreed that the original item was closed, however, a new action would be opened and the new document would be reviewed by the committee once completed. **ACTION JG.** **This item was closed.**
4.2	**29/11/2018, Item 7.6 Primary Care Quality Report – Safeguarding. 31/1/2019 update:** Concerning C.Diff. MAE had asked the Infection Control Nurse to prepare a report to circulate because numbers were higher in primary care. Root cause analysis findings revealed patients were susceptible if on the same antibiotics. Most acquired C.Diff as hospital patients. MAE updated that an alternative antibiotic was being used.

	ACTION: MAE to circulate report after the meeting. **28/03/19 update** – MAE confirmed that the report had been circulated. **This item was closed.**
4.3	**29/11/2018, Item 4.11 West Cheltenham Surgery (previously known as Springbank) – provision of general medical services from Hesters Way Living Centre.** MH requested an update in 6 months, after the transition plans were complete. **31/1/2019 update:** HE gave a verbal update. Now named West Cheltenham Surgery. The primary care team met regularly on a daily basis after moving to a bigger practice. The wait for GP routine appointments was 2 weeks max. 8:00 – 1830 Monday to Friday as well as weekend appointments. Overall feedback from the practice manager had been positive. AE commented that the main issue of concern was the continuity of care as there was difficulty with appointing new GPs. HE advised the practice was committed to substantive appointment of GPs. HG/HE were in regular contact with the practice and Crescent Bakery both of which had recruited, fully. Registration numbers had increased by 300. MAE stated there were plans in place for the practice to become a GP training practice. Item to remain open for an update involving future planning to encourage further training and funding. **ACTION: MAE to report back to the committee.** **28/03/19 update -** MAE confirmed that the update for this item would be incorporated within the update to the committee in August in accordance with 29/11/2018 Item 6.4 so recommended closing this item. The committee agreed. **This item was closed.**
4.4	**26/7/18 Item 8.9 – Prescribing Update.** MAE explained that there was no prescribing data available so this would be brought

	to a future meeting. **31/1/2019 update:** AE confirmed this item was scheduled for March 2019. **28/03/19 update -** MAE confirmed that this came to the last meeting. **This item was closed.**
4.5	**04/10/18, Item 5.18 Gloucester City Hub Development.** The committee requested that an update on progress with developing the plans should be made to the committee in six months' time. On the April/June Agenda. **28/03/19 update –** this was on the agenda. **This item was closed.**
4.6	**04/10/18, Item 7.13 Enhanced Service Learning Disabilities Health Checks.** The committee requested that a strategic review was undertaken and an update brought to the committee in June / August 2019. **This item remained open until June / August.**
4.7	**29/11/2018, Item 6.4 Primary Care Workforce Health Inequalities Fellowship.** ZN provided an overview of the Primary Care Workforce Health Inequalities Fellowship. MAE informed the meeting that access to training was not the issue, but releasing nurses from their practice. This was problematic due to the difficulty of securing backfill arrangements. It was noted that the CCG had a Continuing Professional Development (CPD) contract with the University of the West of England (UWE) that needed to be utilised. MAE and JC had picked this up around the parachuting nurse's service and needed to prioritise releasing nurses for training. It was suggested this issue was dealt with outside the meeting. There was a need to seek solutions to try and focus on training,

	instilling a good use of capacity. AE suggested that an update was brought back to the committee in 3-4 months' time. **ACTION: JC, and MAE agreed to meet with Helen Goodey and thereafter report back to the committee in August.** **This item remained open until August.**
5.0	**<u>Primary Care Network contract to implement The NHS Long Term Plan</u>**
5.1	SR gave a presentation on the new GP contract framework and The NHS Long Term Plan. SR highlighted that: • This represented the biggest change to GP services in 15 years. • This would put General Practice and Primary Care at the centre of ICS's. Primary Care Networks (PCN) would be at neighbourhood level then aggregate up to Place, locally referred to as Integrated Locality Partnerships (ILP), then up to the ICS. • PCNs would typically cover a 30,000-50,000 population. • CCGs would be able to commission services in the future through PCNs. • PCNs would have to cover 100% extended hours for their patients. • Funding would commence 1st July 2019. • There would be seven new service specifications introduced in a phased way: o Structured Medications Review and Optimisation (April 20); o Enhanced Health in Care Homes (April 20); o Anticipatory Care (April 20); o Personalised Care (April 20); o Supporting Early Cancer Diagnosis (April 20); o CVD Prevention and Diagnosis (2021); and o Tackling Neighbourhood Inequalities (2021). • Each PCN would have a Network Agreement, appoint a 0.25 WTE Clinical Director and had to define their business model.

	• A Network Dashboard would be available by April 2020.
	• Additional new staff would be funded by NHS England:
	  ○ Social Prescribing Link Workers;
	  ○ Clinical Pharmacists;
	  ○ First Contact Physiotherapist;
	  ○ Physician Associates; and
	  ○ First Contact Community Paramedics.
	• GPFV schemes would be extended until 2023/24 and there would be new fellowship schemes.
	• Mental Health community staff would aligned to PCNs.
	• There would be a number of digital improvements and new initiatives implemented including:
	  ○ patient access to online video consultations (April 2021);
	  ○ patient access to their full records (April 2020/new registrants by April 2019); and
	  ○ online booking required for at least 25% of appointments (July 2019).

5.2	CG queried whether some of the practices in the Forest of Dean were still wavering about signing up to the new contract. SR confirmed that they were. They were particularly concerned about the detail around extended hours; as the PCNs would be responsible for 100% extended hours service, and there was a query around how the funding would be received to achieve this. HE added that there were also decisions to be made as to which PCN(s) some practices would choose to work with.
5.3	CG stated that the CCG was funding some of the new roles already so queried if they would transfer over. SR clarified that NHSE would take a staffing baseline and the nationally funded staff would have to be new, not existing. CG noted that the CCG would be penalised for being proactive and innovative. MAE added that the currently employed Clinical Pharmacists were being paid at higher bands than NHSE had suggested. SR agreed that this would need to be addressed. HE mentioned that as the roles had to be above current baseline, work was being undertaken to review where the current, higher banded, social prescribers would be best placed to add their value and expertise.
5.4	AE clarified that there were two principal issues:

	• the impact on finances; and • the acceptability of the proposals to General Practice across the county.
5.5	SR explained that there were issues related to changes to pensions. AS explained that the issues around the pension cap had had a knock on effect, with senior GPs reducing their hours. It was noted that there were ongoing discussions to review alternative solutions to avoid this in the future. An additional pension issue was that GP partners had to pay their staff employer contributions, which would be increased, however practices would not be expected to bear that cost over the next 5 years. This would, therefore, impact on CCG finances.
5.6	AH raised an issue that some people were saying that no space would need to be provided for record storage in future as there would be no paper records. However, mention of paper records was absent from the recommendations. SR responded that it was implicit within the recommendations, as there would be a requirement for digital records. JC added that the records management regulations would still apply. There would still be a need to keep paper notes, especially if a litigation case arose and there was a need to refer back to the original notes. AH surmised that it would be 'paper light' not 'paper free'.
5.7	SR confirmed that there would probably be 14 PCNs and summarised the programme plan. SR had set up a repository on CCG live for practices to access the wealth of available information.
5.8	AE queried how Primary Care was responding. AS reported that generally the profession was positive about the contract. It was seen as a way to encourage working at scale with appropriate skill mix. Bureaucracy was inevitable but most practices were getting on with it, so generally a positive response. AE wondered if there would be issues around appointing the Clinical Director. AS thought most Clinical Directors would be self-selecting, with a few new faces. It was noted that the appointment processes were underway. HE added that Stroud was re-grouping into two PCNs and Berkley Vale would become a separate PCN. Gloucestershire was fortunate to have more leaders interested in continuing to be

	involved than possibly required. There was a general view that there would not be enough funding to implement everything. However, PCNs would not need to deliver all the elements of service on their own; this would be where the community partners and Integrated Locality Partnerships (ILP) would provide support. AE noted that the Clinical Director role would play a part in the ILPs and ICS, not just PCNs.
5.9	JC highlighted the national debate that it would be a Clinical Director role, not a Medical Director role but the BMA expected that it would be a GP. This raised issues around diversity and succession planning for the future. As consideration should be given to the appointment of other healthcare professionals not just medical professionals. AS recognised that this was a journey and the future success of Primary Care would be based around diversity. The first round of appointments would likely be GPs to encourage practices to get involved at this stage.
5.10	MAE pointed out that it was disappointing that there was no quality included within the PCN dashboard. An internal quality dashboard had been developed and the plan was to split it down to PCN level to be reviewed. AE queried whether that would make the process more complicated. MAE responded that reviewing the quality of the services should be an integral part of the process. AS endorsed quality as being an important part of the PCN dashboard, as there needed to be a balance between finance and quality. It was noted that QoF would be managed at practice level which would be positive as there were some practices that were very engaged and others not. HE reported that Chris Roche and his team had developed a local dashboard and Chris and Dr. Alan Gwynn were also members of the national team working on dashboard development. JC added that quality, performance and finance would always be integrally linked.
	<u>RESOLUTION:</u> The committee noted the presentation on the Primary Care Network contract to implement The NHS Long Term Plan.
6.0	**<u>Cheltenham, Prestbury Road Premises Development</u>**
6.1	AH noted that a full paper had been to the closed PCCC session

	in January and an extensive discussion had been held. The business case had been formally approved subject to the District Valuer issuing an interim report and the practices had submitted a BREEM plan. AH confirmed that, due to commercial sensitivity, the documents had not been shared with the committee, however, the Chair had reviewed them and they were available for committee members to review if they wished to do so. AH requested that the committee formally ratified the previous approval prior to it being made public. AH would write a formal letter to the practices setting out the full Terms and Conditions which would be authorised by the Accountable Officer.
6.2	AH reported that the Outline Business Case (OBC) had been discussed at the NHSE panel on 18th March. MH received a letter back from NHSE in response to the submission. NHSE confirmed that provided the questions raised were answered they would progress the OBC outside a panel meeting.
6.3	AE confirmed that the documents had been provided to himself and CGi and on that basis was happy to proceed to approve.
6.4	AH added that the practices would be submitting a detailed planning application the following day and would be surprised if it did not get approved at the end of June. Therefore, it was expected that the building works would start before the end of the calendar year.
6.5	**<u>RESOLUTION</u>: Following receipt of the District Valuation interim report and submission of the Practices BREEAM pre assessment report with a plan, the committee ratified the formal approval granted at the private session of the PCCC meeting in January 2019 to develop a new Primary Care Centre at Prestbury Road, Cheltenham.**
7.0	**<u>Application for change of practice boundary from Leckhampton Surgery</u>**

7.1	JG presented the paper and summarised that: • Leckhampton Surgery had been working to the proposed boundary since before the CCG delegated arrangements were implemented. • Once they had been informed that they were not working to their contractual boundary, they started to do so and worked towards submitting this request to reduce their boundary. • The practice would not remove any patients from their list that lived in the affected area. If any relatives moved into one of those households they would accept their registration. • The practice was concerned regarding their building as it had been built for 10,000 patients. Due to the planned new housing developments the number of patients was anticipated to increase to 14,000 by 2031. • Leckhampton had consulted with its Patient Participation Group (PPG) who supported the application as the practice had been working to the requested boundary for some time. • The practice had contacted surrounding surgeries, as had the CCG. Two comments had been received in response as detailed in the repot. • The Local Medical Committee (LMC) had no objections to the application on the basis that the practice would not de-register any patients. • An alternative solution would be to de-register patients from outside their boundary; however, the practice did not want to do this. They were patient focused and keen to ensure continuity of care. This would also impact on surrounding practices.
7.2	CG queried the recommendation from Primary Care Operational Committee (PCOG). JG confirmed that PCOG recommended approving the request.
7.3	AE was surprised by Portland Practice's response as the request did not really change anything as Leckhampton had been working to the requested boundary for some time. JG agreed.
7.4	JC suggested that the Quality and Sustainability Impact

	Assessment Tool be amended to include the impact on other practices. JG agreed that, where there were concerns from other practices, it would be useful to include this in the assessment, in future. **ACTION JG.**
7.5	**RESOLUTION: The committee:** • **Considered the recommendation from the Primary Care Operational Group (PCOG) meeting on 19th March 2019 which was to recommend for approval the application from Leckhampton surgery to amend its boundary;** • **Approved Leckhampton Surgery's application to amend its practice boundary.**
8.0	**Primary Care Premises Report**
8.1	AH presented the Premises Report highlighting that: • The legacy proposals were on track to be delivered. • The exchange of contracts was expected in the next few days for Cinderford Health Centre. • Locking Hill and Stroud Valleys practices were progressing a third party led town centre development and likely to submit a business case in August and may make a presentation at the August PCCC meeting. **ACTION AH.** Beeches Green Surgery would remain at the existing Health Centre. • Brockworth and Hucclecote had submitted a pre application. A potential issue was car parking. • Minchinhampton was progressing and the business case may be ready for the June meeting **ACTION AH.** • There were concerns regarding the housing developments around Stonehouse and the existing practices working together to support the future population increase.
8.2	AH informed the committee that through reviewing the Primary Care Infrastructure Plan a discrepancy had been identified between the OSS prediction of housing growth and what had, and was due, to happen in Gloucestershire. This would have a big impact on Primary Care.
8.3	JC reported that other community schemes she was involved with had been asked to review plans up to 2030, so horizon

	scanning was a positive step. MAE added that there were also many developments in the very south of the county that Gloucestershire currently do not provide services for. Some Gloucestershire patients had chosen to register with Welsh practices, but if the growth in those areas increased then they may have to revert back to Gloucestershire, which would impact on practices.
8.4	**RESOLUTION: the committee noted the Premises Report.**
9.0	**Primary Care Quality Report**
9.1	MAE and BP summarised the Primary Care Quality Report: • Very few significant events had been reported. Disappointingly the requirement to report these had not been included in the new GP contract. • A number of CQC visits had taken place. Where there were inadequate ratings, it was around medicines management. The pharmacists had visited these practices and the CQC was happy that actions had been taken. • A new CQC inspection regime had been implemented. MAE would provide a full report at the next meeting **ACTION MAE.** • Practices continue not to submit the Family and Friends Test (FFT) results despite having the forms completed. • Patient Advice and Liaison Service (PALS) had received a number of contacts relating to the Aspen Medical Centre regarding telephone waiting times. • The one practice that did not have a PPG had a date in the diary to meet with some of its patients. There was hope that this would be resolved by the next meeting. • Presentations on the ILPs/PCNs had been given at a number of PPGs. • A common thickener policy was being agreed across the county which would be rolled out in Primary Care. • There had been a number of MRSA cases. • The threshold for C.Diff was 156 cases and the current number of cases was 173. There had been a rise in the number of cases related to the use of a particular antibiotic. In future any patients in the community who contracted C.Diff within 30 days of being in hospital, then

	this would count as hospital acquired. • A workshop had been held to learn from the last year's flu vaccination programme. • Education events for practice nurses had been held on travel health and wound care.
9.2	AS declared an interest with regards to the Aspen Medical Centre. AE noted this.
9.3	JC queried whether there would be thickener advice for nursing homes. MAE confirmed advice had already been circulated and a part time dietician employed to train staff within the homes.
	CL joined the meeting at 11:13
9.4	**RESOLUTION: the committee noted the Quality Report.**
10.0	**Delegated Primary Care Financial Report**
10.1	SB presented the report. There was an overspend of £502,000 at the end February due to the additional 1% on the GP contract. Other pressures included maternity and sickness, enhanced services and dispensing and prescribing costs. There had been a slight underspend on business rates due to re-evaluations.
10.2	AE queried if it had been flagged nationally that there was a shortfall in funding to cover the new GP contract. CL confirmed there had been discussions regarding this and the response was that the increase had been included in the funding allocation.
10.3	CG stated that maternity and sickness costs were a pressure last year and thought it had been taken into account this year, so asked if the costs would be accounted for next year. SB clarified that the rules had changed, so an outturn position was taken into account from last year but it was higher than anticipated. For next year the outturn position would be based on this year.
11.	**Any Other Business**
11.1	There was no other business.

	The meeting closed at 11.20am **Date and time of next meeting:** **The next meeting would be held at 9.45am on Thursday 27 June 2019, Boardroom, Sanger House.**

Quality and Governance Committee (Q&GC)

Minutes of the meeting held on Thursday 25th April 2019 at 9.00am, in the Boardroom, Sanger House

Present:		
Lesley Jordan	LJ	Secondary Care Doctor (Chair)
Alan Elkin	AE	Lay Member, PPE
Marion Andrews-Evans	MAE	Executive Nurse & Quality Lead
Peter Marriner	PM	Lay Member – Business
Dr Will Miles	WM	Commissioning Lead, GP Governing Body member *(Quality Lead – GCS)*
Dave McConalogue	DM	Consultant in Public Health, GCC
Dr Lawrence Fielder	LF	Commissioning Lead, GP Governing Body member *(Quality Lead – 2G)*

In Attendance:		
Christina Gradowski	CGi	Associate Director of Corporate Governance
Julie Symonds *(Item 5.4)*	JS	Deputy Director of Nursing
Hannah Williams *(Item 5.5)*	HW	Commissioning Manager - EOL
Teresa Middleton *(until end of item 5.4)*	TM	Deputy Director of Quality/Chief Pharmacist
Emma Savage *(Item 8.1a)*	EM	Associate Director Clinical Programmes
Becky Parish *(Items 9 & 10)*	BP	Associate Director Engagement and Experience
Rob Mauler *(Item 5)*	RM	Senior Quality and Safety Manager
Lisa Netherton	LN	Governance Officer (taking minutes)

1.	**Apologies**
1.1	Apologies were received from Julie Clatworthy, Mary Hutton, Mark Walkingshaw, Andy Seymour, Caroline Bennett and Cath Leech. Alan Elkin would arrive late.
1.2	The meeting was not quorate until the arrival of Alan Elkin. The committee were reminded that they would be unable to approve any

	minutes or papers until the meeting was quorate.
2.	**Declarations of Interest**
2.1	LJ requested declarations of interest in relation to any agenda items.
2.2	LF and WM declared a professional interest for all GPs to the relevant clinical agenda items. LJ noted the professional interests and there were no grounds for the GPs not to take part in discussions and decision making, as the matters under discussion did not pose a conflict of interest.
3.	**Minutes of the Meeting held on Thursday 14 February 2019**
3.1	The minutes of the meeting held on Thursday 14 February 2019 were reviewed **but could not be approved until the arrival of Alan Elkin**. The following amendments were noted: • At 4.3 change title of meeting to Q&G • At 5.1.8 should read "is a process for reviewing"
4.	**Matters Arising and Actions**
4.1	**Q&G 274 Item 5.25.3, Primary Care Quality Report - GP Dashboard** *Update 25/4/19* Although this action was closed, for accuracy 'C&GC' was amended to 'QGC' under the note/update section.
4.2	**Q&G 275 Item 7.8, Mortality Briefing - Policy** *Update 25/4/2019* There would be an update from JC at the June meeting. **ACTION JC. Item to remain Open.**
4.3	**Q&G 278 Item 10.2, 15/02/18 Policies** **Item open – legacy policies to April 2019 meeting.** *Update 25/4/19* CGi reported she had been reviewing old HR legacy policies and that a number of policies were being reviewed. At the June meeting it was intended that a number of policies would be presented together with an updated policy schedule. This was an ongoing process. . **ACTION CGI to share the Policy Schedule. Item to remain Open.**

4.4	**Q&G 293 Item 5.3, Quality Report - Boost** *Update 25/4/19* JC/TM confirmed that BOOST could now be closed as they had received assurance from GCS and GHFT. **Item Closed.**
4.5	**Q&G 305, Item 5.2.2 – GHFT Serious Incidents** *Update 25/4/19* RM updated that the issues were covered in the quality report. He agreed to bring updates to the committee every 6 months. There had been positive improvement with the reporting and management of serious incidents with learning and feedback. **Item Closed.**
4.6	**Q&G 306, Item 5.2.3 – GHFT Serious Incidents** **Item now Closed.**
4.7	**Q&G 327 Item 4.1, LeDeR** *Update 14/2/19* JC had confirmed update on the Agenda. **Item Closed.**
4.8	**Q&G 328 Item 4.1, SCR** *Update 25/4/2019* This is on the Agenda within the 2G Report. **Item Closed.**
4.9	**Q&G 337 Item 5.2, Quality Report** *Update 25/4/19* RM to update at this meeting in the April County-wide Quality Report. **Item to remain Open.**
4.10	**Q&G 338 Item 5.1.2, 14/2/19 County-wide Quality Report** *Update 25/2/19* AB to update during the County-wide Quality Report. Structures for safeguarding were included in the Working Together included in the papers. **Item Closed.**

4.11	**Q&G 339 Item 5.1.7 14/2/19 NICE Guidance** *Update 25/4/19* MAE would provide 6 monthly reports to the committee in June and December. **ACTION MAE. Item Closed.**
4.12	**Q&G 340 Item 5.1.8, 14/2/19 MRSA Infections** *Update 25/4/19* – DC stated there was a review in process. **Item Closed.**
4.13	**Q&G 341 Item 5.1.12, 14/2/19 PALS** *Update 25/4/19* There was an update within the County-wide Quality Report. **Item Closed.**
4.14	**Q&G 342 Item 5.2.2, 14/2/19, Appendix 1.1 CEG Minutes 15.11.18** *Update 25/4/19* The Blended Diets paper would be presented by ES at Item 8.1a. **Item to remain Open.** **ACTION ES** will present the amended paper at the June 2019 meeting.
4.15	**Q&C 343 Item 5.2.3, 14/2/19, CEG Minutes 15.11.18** *Update 25/4/19* The Gosport Report would be discussed within Matters Arising. **Item Closed.**
4.16	**Q&G 344 Item 6.1.2, Item 14/2/19, LeDeR Review Briefing** *Update 25/4/19* **Item Closed.**
4.17	**Q&G 347 Item 5.9.5, Appendix 4 GCS Report Quality of discharges** *Update 25/4/19* MAE updated the committee that there had been a general issue with GHFT about its quality of discharges and this had been raised with the Trust. JS advised that the discharging issue was related to catheter use. LF mentioned patients were still being released late at night. Carol Webster would be looking at improving discharges. It was noted that this was a complex area but there was some improvement. **ACTION MAE to monitor. Item to remain Open.**
4.18	**Q&G 348 Item 7.2.2, 14/2/19, Corporate Risk Register** *Update 25/2/19* T11 and T19 risks needed to be split. CGi would put the risks back on

	the Public Health Core Service. **ACTION CGi. Item to remain Open.**
4.19	**Q&G 349 Item 10.1.3, 14/2/19, Data Security and Information Governance Update** *Update 14/2/19* CGi updated that MAE (Caldicott Guardian) CL as the Senior Information Risk Officer (SIRO) and she Data Protection Officer (DPO) were set to have a meeting regarding the requirements for GPs to have a dedicated DPO. MAE stated that GP practices had realised that with the new GP contract the CCG was responsible for arrangements in primary care for a DPO. CL was exploring various possibilities including obtaining support from the CSU. It was agreed to involve Helen Edwards regarding the Primary Care issue. **ACTION CGi to discuss with CL and MAE and involve HE/Tony Ware and report back to QGC.** **Item to remain Open.**
	LJ enquired why some minutes were not attached to the Agenda? CGi explained that the Agenda contains standing items including sub-group minutes. These were requested early but sometimes were not available as the meeting had not taken place or minutes not written up. MAE suggested minutes that were available were highlighted in bold on the Agenda.
4.2	**<u>Gosport Report Briefing</u>**
4.2.1	MAE and TM updated that there were a significant amount of comments from the Clinical Effectiveness Group: • GCS had immediately instigated an internal review. • Within the CCG there had been a prescribed opiates review in primary care. • GHFT had sent the report which had been inadequate so had been returned for further updating and revision. The CCG was still waiting for a more thorough report. As soon as it is ready CCG will have sight.
4.2.2	JS commented that she had pressed for the Report, but it had not been forthcoming. TM advised there had been a series of statements but no actions and no patient experience consideration had been returned. LJ enquired when the committee may expect to see the report. JS advised sometime in May 2019.

	ACTION: MAE/TM to provide the committee with the report when received.
4.2.3	**<u>RESOLUTION</u>: The committee noted the Gosport Report Briefing.**
5.	**<u>County-wide Quality Report – SWAST Update (Item 5)</u>** *LJ explained that as RM had to leave the meeting early his items would be addressed first.*
5.1	MAE gave a brief overview of the issues related to SWAST which were recorded on the CCG's corporate risk register (CRR) and assurance framework (AF). MAE explained that SWAST had identified a risk to South West patients due to call stacking. In Gloucestershire the risk was in Category 2 patients where waits were longer than target times, though Category 1 patients were responded to within the required times. There were delays in responding to Category 4/5 health professional calls but was not considered to pose a risk to the patients. RM reported there had been many meetings about this issue. GCCG along with other CCGs had increased their investment in ambulance services by funding additional vehicles and crews. Penny Smith of NHSE Quality Surveillance Group (NHSE QSG) had noted demand was outstripping supply and requested more resources. SWAST had rated the risk as 25 in relation to this issue. The CCG had assessed the risk to CCG residents and reduced the risk rating from 16 to 12 (see CRR).
5.1.1	RM stated the patient safety Category 1 calls were answered within a seven minutes response time. Category 2 had been lower and better than the national average. The major category 3 to 4 calls need more support and SWAST were looking at different ways of commissioning those calls.
5.1.2	RM advised that call handlers had a huge job but had been working extremely hard to prioritise emergency calls with a single point of access. LF enquired if the CCG knew more details about a recent incident regarding an emergency call, threatening suicide? RM confirmed he knew about the case. He explained that on arrival the patient had been assessed as not being at risk but later committed suicide. LF wanted to know how call handlers assessed a suicide threat. RM advised that SWAST would be giving him the details and he would look into the circumstances. The ongoing investigation had

	discovered that the patient had not allowed access to his GP records. LF hoped that SWAST would be part of the investigation. **ACTION: RM to take this up with SWAST and report back with feedback.**
5.1.3	MAE stated there had been discussions about the cross border use of the ambulance service due to the mutual agreement between SWAST and the Welsh ambulance service to assist each other during busy times with high volumes of calls. It was noted that the handover time at Gloucestershire Hospitals had been good but at the Newport Hospital there were significant delays with ambulances waiting for up to 6 hours in the hospital car park to access A&E. MAE would be formally raising this due to the fact it had been affecting the SWAST response times and service. **ACTION: MAE to investigate Welsh SWAST response times and report back to the committee.**
5.1.4	**RESOLUTION: The Committee noted the SWAST report.**
5.1.5	**Dialysis Mileage Reimbursement Scheme**
5.1.6	RM explained that the scheme offered patients the choice of taking themselves to hospital for ongoing care appointments by providing a mileage scheme of 30p per mile. This had benefited a significant number of people. Currently there were 49 registered users with £300 reimbursed so far. The scheme enabled people to be independent and take control whilst freeing up the ambulance service for emergency call outs. LF queried if this involved patients receiving chemotherapy treatment? MAE advised cancer patients still used the ambulance service as treatment was too traumatic so patients required specialist care. HW explained that Macmillan provided a fund for transport by sharing the cost and GHFT were actively promoting this service. BP added that patients wanted to be independent and to look after themselves. RM explained that the service had been running since February 2019 and was found to be improving the patient experience. **ACTION: HW to speak with GHFT to actively promote the Dialysis Mileage Reimbursement Scheme**
	AE joined the meeting at 10:38 am. ***The meeting was now Quorate.***
5.1.7	**RESOLUTION: The committee noted the Dialysis Mileage Reimbursement Scheme.**

5.2	**<u>Clinical Effectives Group (CEG) – NICE Guidance (Agenda Item 5.2)</u>**
5.2.1	TM gave an update. There had been a paper presented to the CEG from the Lead Commissioner of Children and Young People's Service (CYPS) summarising the low risk deviation from the NICE guidance. At section NG87 it stated: "*Mental Health Services for children, young people and adults, and child health services, should form multidisciplinary specialist ADHD teams and/or clinics for children and young people"*. It was recommended by the Q&GC that the CCG add this deviation from NICE guidance to the CCG risk register and review in twelve months. **ACTION: CGi to send to Cate White (Risk Coordinator for Quality)**
5.2.2	**<u>RESOLUTION:</u> The Committee noted the Clinical Effectiveness Group NICE Guidance.**
5.2.3	**<u>Research and Development</u>**
5.2.4	MAE updated the committee. There had been a presentation on GHFT's ambitions to become a University Hospital. This would support and enable research and funding as the Trust wanted to be a member of the University Hospitals Association. BP stated she had been to a recent networking event which encouraged research on acute and primary care. The networking event had included GP partners and key note speakers. DC commented that the Local Authority had also been included. MAE agreed it had been a new forum to share information. **ACTION: MAE to forward an update every six months to the committee. This needed to be embedded fully within the dashboard at the monthly meetings.**
5.2.5	**<u>RESOLUTION:</u> The committee noted the Research and Development paper.**
6.	**<u>Agenda Item 6 – Working Together (Included in Agenda Item 5)</u>**
6.1	The Report was taken as read and MAE went through the highlights: To date the Gloucestershire Local Authority had been lead agency but

	would now be shared between three agencies focusing on safeguarding arrangements. The agencies were the CCG, Gloucestershire Police and GCC. MAE explained that Appendix 1.2 in the report outlined the new local children's safeguarding arrangements. MAE recommended the committee read page 21 of the report which explained the remit of the groups involved.
6.1.2	MAE explained that the Safeguarding Executive (SE) would oversee the CCG Safeguarding and Delivery Board (SDB). The Board would be required to publish its findings allowing three months for implementation and would be chaired by an Executive on a rotational basis with next year being the CCG's turn. There would be an independent lay person monitoring and scrutinising, observing and challenging the Board. The post was currently being advertised. There would also be a sub group overseeing quality and performance.
6.1.3	LJ enquired if this would entail a lot of work? MAE advised that Andy Dempsey and Dave Jones (GCC) were covering the operational and implementation work. The CCG considered that there would be separate Agendas for adults and children, which had worked very well in county and therefore did not want to change these arrangements. MAE explained there would be an independent scrutineer going before the Executive who would report to the Chief Executive of the Council. PM enquired about Teens in Crisis? LJ stated that "Working Together" was a very comprehensive document and both Andy Dempsey and Dave Jones should be commended for their hard work.
6.1.4	PM stated that the Report had detailed a range of KPIs which had not been achieved. He enquired what additional work or efforts could be put in place to achieve these. MAE advised that there was a requirement for robust data as the data received to date was incomplete. It was noted that the data input into Liquid Logic by social workers had been inaccurate and incomplete. MAE explained that the dashboard of activity would go to the Executive and focus on improvement but this would be challenging in some areas. MAE advised that the Health and Wellbeing Board (HWB) would be responsible for reporting its findings every six months. The Strategic Health Forum (SHF) is meeting monthly and will consider the dashboard which detailed all the actions agreed.
6.1.5	**<u>RESOLUTION:</u> The committee noted and commended the Working Together Report.**

	The committee returned to Agenda Item 5, page 4 of the Quality Report.
5.2.4	**<u>Quality Report - Children in Care- Agenda Item 5 (page 4)</u>**
5.2.5	The report was taken as read with MAE highlighting the following areas: • There were 700 children currently in care across Gloucestershire, with 300 placed in Gloucestershire by other local authorities. • According to statutory guidance the CCG should ensure sufficient resources were available to meet identified health needs of the children in care. • The number of children in care continued to rise including children placed in Gloucestershire from other local authorities. • As numbers increased this would have a significant impact on the capacity of specialist health teams. There were still problems within the social work service particularly around recruitment and retention and placed additional pressures on school nurses. MAE stated it had been identified that children were able to relate to nurses better than social workers as children were more open about their problems with a nurse. This could be due to school nurses being based in many schools.
5.2.6	LF enquired if out of county referrals were increasing due to lack of appropriate placements for the children? MAE explained that it would be the CCGs responsibility to care for children placed within the Gloucestershire area. Currently there were 319 children out of county that the CCG was responsible for. AE asked why the numbers were so high, was it that the relationships with other organisations were not good? MAE advised there were a host of complex reasons why children were placed out of county. Some of those reasons related to the lack of appropriate care settings / placements, others to the need for the child to be at a distance to their family, friends and acquaintances, if those relationships were damaging to the child. For example children involved in criminal activity and drug running.
5.2.7	**<u>RESOLUTION:</u> The committee noted the Children in Care Report.**
5.3.1	**<u>GHFT Serious Incidence Report Agenda item 5.3 (Appendix 2)</u>**
5.3.2	The report was taken as read. JS updated the committee on the following: • There had been one Never Event declared of a wrong site surgery incident where the incorrect finger had been operated on.

	• One incident in ophthalmology of a patient being wrongly injected in both eyes. • An oxygen cylinder had run out. This correlated with how patients were monitored and related to agency staff. • There was a missed incident where an ambulance patient presented with chest pains. After an ECG more complex issues were found. Lessons were being learnt regarding the ambulance to hospital handover.
5.3.3	JS continued by highlighting: **Risk Register** • There had been delayed follow-ups and a deep dive meeting had been held concerning interim ophthalmology issues. **Staffing** • Fill rates were stable with a new deputy chief nurse looking at staffing models. • June 2019 – awaiting a substantial report on staffing. • The Trust Quality Summit had found GHFT was well within the infection control limits.
5.3.4	**RESOLUTION: The committee noted the GHFT Serious Incident Report.**
5.3.5	**Cancer Performance** - JS stated cancer performance remained a concern relating to the 62 day pathway. **Ophthalmology** - the CCG were planning to hold 'a deep dive' meeting with the Trust about some of the serious concerns raised at the Eye Health Clinical Programme Group meeting (EHCPG). This had been due to delayed follow-ups resulting in some patients experiencing visual field loss. **Rheumatology** – there had been an issue with long waits, particularly for the early arthritis clinic appointments posing a potential risk for patients experiencing worse outcomes and delays in initiating treatment. This would be reviewed by the Trust.
5.3.6	JS informed the meeting that the CQC inspection report had been published at the end of February 2019. The Trust received an overall rating of 'Good'. The Trust had taken action to address immediate concerns and categorised these into six themes: • Timely commencement of treatment in ED.

	• Control of hazardous substances. • Routine checking of emergency equipment. • Standardising procedures in relation to risk management. • Access to acute cardiac services. • Application of the Mental Capacity Act and Mental Health Act.
5.3.7	MAE stated that GHT was aiming to achieve an 'Outstanding' rating. The committee discussed the findings. AE enquired about staffing levels and JS advised that she would include in the report better details about vacancy levels. She had been encouraged by the staffing review that had taken place and greater detail would be given at the next Q&GC meeting. Clinical evaluations were happening with an exercise concentrating on Urgent Care. JS also commented that there was still a way to go to receive "Outstanding". LJ emphasised that she was concerned about the number of never events. LJ considered that there was a need to evaluate the improvements made and obtain the Trust's assurances that the learning had been shared and implemented. HW advised a letter should be sent to the CQC to pick up on this issue. LJ clarified that she was waiting for an invitation to visit the Trust and a meeting date had arrived, the aim was for them to view and observe the improvements that have been made.
5.3.8	LF enquired about the never event occurring in SWAST? JS stated a Case Review would be undertaken. JS reiterated there had been a communication and handover problem but had received assurances that lessons were being learnt.
5.3.9	**ACTION: JS** to report back to the committee on the issues within the report and update on any progress made.
5.3.10	**<u>RESOLUTION</u>: The committee noted the report.**
	The committee returned to the County-wide Quality Report page 6.
5.1.8	**<u>Patient Experience- Quality Report Agenda Item 5.</u>**
5.1.9	BP updated the committee that PALS had continued to monitor Aspen Health Centre's call system. There were still ongoing problems with patients finding it very difficult to get through on the phone to make appointments. The Primary Care team had visited and viewed the new 8 day diary appointments where an error had been found and this would need to be rectified.

	BP informed the meeting that the Patient Experience team had been out and about in Gloucestershire publicising the Long Term Plan (LTP) and encouraging members of the public to give their views. When the period of engagement ended, an outcome of engagement report would be produced and shared with the committee.
5.1.10	**RESOLUTION: The committee noted the Patient Experience report.**
5.1.11	**Prescribing Agenda Item 5, page 10**
5.1.12	TM/MAE gave an update on prescribing. The report was taken as read. WM flagged up that the level of savings and price changes for drugs was not available but there were a lot of initiatives there to help with savings.
5.1.13	**Infection Control Update**
5.1.14	The report was taken as read. The committee discussed the key issues within the report. DM enquired about flu vaccinations? There had been a Care Homes pilot and the uptake of the vaccination had increased and the evaluation of the pilot had been viewed as largely positive with Influenza not spreading in Care Homes. TM advised there had been an increase regarding inoculations for pregnant woman. LF commented that social media had been promoting inoculations with midwives encouraging pregnant mothers to have the flu jab. MAE explained that this winter the uptake had been good with a coordinated effort between different agencies increasing the vaccination rate. The majority of patients that had received the vaccine had been in the high risk group. LF stated that midwives would not vaccinate patients. TM advised this may be due to the cost but it was a complex issue. MAE reported there had been a measles issue out of county.
5.1.15	**RESOLUTION: The committee noted the Prescribing and Infection Control updates.**
5.4.1	**2G Quality Report - Staffing (Agenda Item 5 Appendix 3)**
5.4.2	LF updated the committee and the report was taken as read and discussions took place about the report. LF commented that staffing levels were being maintained although Berkley House had been a challenge. There had been a predominance of temporary staff in post, especially locums, with a problem retaining consultants due to locum

	salaries being higher.
5.4.3	**<u>Incidents</u>**
5.4.4	MAE continued that there had been no never events. Regarding Serious Incidents (SI) – there had been incidences of self-harm and attempted suicide but a Zero Suicide Policy (ZSP) was in place and the committee would be seeking assurances about this at the next meeting. The ZSP had been in place from March 2019. The national target was 10% with Gloucestershire being one of the lower areas for suicides.
5.4.5	**<u>Learning from Deaths</u>**
5.4.6	LF advised this had become somewhat challenging. Unfortunately there was no further national funding available for undertaking the reviews. Currently the CCG was funding a senior nurse to undertake the reviews.
5.4.7	**WM declared an interest as the discussion involved one of his patients. LJ noted the interest.**
5.4.8	**<u>Warrington (previously Arbury Court) Safeguarding Adult Review (SAR)</u>**
5.4.9	MAE's report was taken as read by the committee. MAE highlighted that timescales for publication of the SAR were slightly delayed due in part to the depth of the review and workload. The first draft of the report was with the SAR Review Group which had met early April 2019. The CCG had been represented and provided detailed chronologies and Individual Management Reviews with two learning events held. One in October 2018 which had been a Commissioner focused event and another one which had been Practitioner led in January 2019 about self-harm and personality disorder.
5.4.10	**<u>Independent Review of 2G Care</u>**
5.4.11	MAE and CGi updated the committee that the CCG had commissioned an Independent Review of the case specifically looking at 2Gs care and treatment of the patient in question. The CCG, WSAB and family, who were intrinsically involved, were establishing the Terms of Reference (ToR) and agreeing the process to complete the work.

5.4.12	MAE commented that there had been a Review for General Learning and the ToR had not changed. The 2G staff were interviewed and the Safeguarding Review had been delayed. **ACTION MAE: to monitor and report back to the committee.**
5.4.13	**RESOLUTION: The committee noted the above reports within the 2G Quality Report.**
5.4.14	**St Andrews Hospital (SAH) – SCR reported to 2G**
5.4.15	LF advised that 2G had reported the death of a patient whom the CCG had commissioned as an out of county placement. The 2G Director of Quality (DoQ) had received the SAH investigation report in February 2019 and had expressed his disappointment and concerns regarding the report. LF explained there would shortly be a site visit.
5.4.16	**2G Q3 Quality Report**
5.4.17	The report was taken as read and MAE made the following points: • The 2G Q3 report shows overall only one target not being met, that of numbers of service users being involved in their care. Although the results were encouraging and currently on trajectory for being met at year end. • The CCG continued to monitor progress on implementing the Trust's Quality Report priorities with quarterly meetings.
5.4.18	**Flu and Sepsis Quality Report**
5.4.19	LF advised that 2G had engaged fully and been very open and honest and he commended them. MAE explained that News2 had been rolled out. LF advised that 2G had engaged fully and cooperatively and he wanted to commend 2G.
5.4.20	**Friends and Family Test**
5.4.21	LF updated that there had been a delayed transfer of care which had been an issue which had involved specific and complex needs. This would be an overall issue with people who have complex needs.
5.4.22	**2G Risk Register:** LF stated that the planned merger between 2G and GCS was on track. Assurances from the Trusts had been provided that it would not impact on day to day operational business with the merger planned for

	October 2019. The CCG must ensure that governance is maintained.
5.4.23	**RESOLUTION: The committee noted the 2G Quality Reports.**
5.4.24	**CQC Action Plan**
5.4.25	LF advised the action plan had been closed with assurances and MAE confirmed this. There had been a review of Berkeley House by the CQC and 2G were actively engaged. MAE commented that there will be one national report where themes are highlighted and national actions undertaken.
5.4.24	**CQC Mental Health Act (MHA) Inspection – Berkeley House**
	MAE updated the committee that CQC undertook a MHA inspection on 2 February 2019 with the Trust submitting an Action Plan to CQC to provide assurance and this had been shared with the CCG. Agreement had been made that the Trust would provide a quarterly update report on CQC MHA inspections. The Berkeley House Action Plan would be shared at the next 2G CQRG meeting on 18 April 2019. LF noted that CQUINS were good and enquired if the ZSAP results were forthcoming. **ACTION MAE: to collate the feedback from the Zero Suicide Action Plan and report back.**
5.4.25	**RESOLUTION: The committee noted the CQC reports.**
5.5	**Gloucestershire Care Services NHS Trust (Agenda Item 5.5)**
5.5.1	The committee took the report as read. HW and WM gave the following updates: • There had been an issue with obtaining parental consent prior to flu vaccinations. The problem had been with the current IT system consent template creating confusion whether consent had been given or not. • The second SI declared involved a patient who had fallen and sadly died from their injuries. The case was currently under investigatory review by the Coroner. • Safety Thermometer: The overall safety thermometer harm free score was 94.6% in February 2019. An improvement from January. • The 'new harms' score declared by GCS remained above the national benchmark with the Clinical Governance team (PaCE

	Directorate) providing support to the operational teams. • There had been no C-diff incidents reported since February 2019. • District Nursing: There was a recruitment problem with particular hotspots being the Cotswolds, Cheltenham and Gloucester at band 5 and 6 level. The CCG would continue to monitor the situation although improvements had been noted and the exact numbers had been requested by HW.
5.5.2	**<u>CQUIN 2018/19 Performance and SaLT</u>**
5.5.3	WM updated the committee that GCS had met the required milestones throughout the year. Of particular note was the flu vaccination rate for staff which saw GCS achieving their highest rate of 77%. With regards to SaLT waiting times they had been a problem, but GCS had a robust improvement plan in place and were working hard to resolve this.
5.5.4	**<u>Family and Friends Test</u>**
5.5.5	WM confirmed to the committee that the rates were good at 94%. The single point of access call rates had gone up in February 2019 due to the increase pressure in winter. The majority of calls were answered within 60 seconds.
5.5.6	**<u>Performance - QCQ Action Plan</u>**
5.5.7	WM updated the committee there were concerns raised regarding continence assessments and had sought assurance from GCS in relation to how first line continence assessments were being managed within the Integrated Care Teams. HW stated that she had not been convinced by the proposed plan so further details were required. The effects on people were twofold: • If mismanaged then significant skin conditions would worsen and the patients' dignity would be compromised. • Assessments need to be timely otherwise this impacted on patient experience and quality of life. HW had requested details on waiting times and the number of people waiting. As yet this had not been provided. A request had been made for the details to be provided as soon as possible. **ACTION: HW to update the committee with feedback.**
5.5.8	**<u>Staff Survey 2018 – Mandatory Training</u>**

5.5.9	WM reported that the response rate to the Staff Survey had been 40.6%. GCS had provided a detailed Report to the April CQRG in relation to the staff survey with their proposed actions. Key findings included: • 59% had improved over 2017. • 16% stayed the same as 2017. • 24% worsened. Two themes showed statistical improvements: the safety culture and staff engagement. It had been discovered that there were five areas where improvement needed to be made: • Immediate managers. • Morale. • Quality of Appraisals. • Quality of care. • Safe Environment – Bullying and Harassment. **ACTION: MAE to bring a short survey to the next committee with the analysis details. CGi to assist MAE.**
5.5.10	**RESOLUTION: The committee noted the Gloucestershire Care Services NHS Trust report.**
5.6	**Primary Care Quality Report – Agenda Item 5.6**
5.6.1	**Primary Care Education Update** The committee took the report as read. MAE gave an update and explained that there would be a new system of support for practice nurses with the CCG providing funding for a parachute nursing scheme. LF enquired how long would the parachute service be in place? MAE confirmed that it would be decided on the nature of the crisis but hoped a permanent solution would be achieved as soon as possible. Practices would liaise with the GDOC when in need.
	BP and RM left the meeting at 12:05 pm.
5.6.2	**RESOLUTION: the Committee noted the Primary Care Report**
8.1a	**Position Statement Dietary Advice for People with Diabetes – Agenda Item 8.1a**

8.1.2	ES gave her position statement for the committee's approval and this was taken as read. She explained that the paper concentrated on people with Type II Diabetes and concerned a low carbohydrate diet. Previously ES had been advised by the committee to prepare a wider position statement. ES updated the committee that the position statement would offer dietary advice and choices to patients and will be embedded into the Diabetes Charter forming part of the Diabetes enhanced Service Practice and included in the GCare pathway.
8.1.3	AE commented that he thought the statement paper did not underline the risk analysis that should be undertaken, for example the statement included the words "may". ES assured the committee that the position statement did not recommend particular diets.
8.1.4	LJ advised that the position statement was not ready for approval by the committee as it was felt that the risk assessment elements should be mentioned at the beginning of the statement with more emphasis on the patients' choice after seeking professional advice. These elements needed to be made very clear to the committee before it would approve the position statement.
8.1.6	**RESOLUTION: The committee agreed to approve the paper virtually once the amendments had been made.**
	The Committee had a break from 12:10 – 12:24 pm. The committee then returned to the Minutes of 14 February 2019 as the meeting was now Quorate.
3.0	**Minutes of the meeting held on 14 February 2019 – Agenda Item 3**
3.2	The committee reconvened after a short break and approved the minutes save for the agreed changes made at 3.1.
5.7	**County-wide Quality Report – Care Homes Report Appendix 7**
5.7.1	The committee returned to Item 5.7 of the Agenda. The report was taken as read by the committee. MAE added that there had been concerns about the Dean Neurological Centre. A visit had been made to the Dean by HW and a medic where they had the opportunity at the visit to speak to staff. HW advised she had met with senior staff and the Clinical Director and she had not seen any immediate dangers. The main areas of concern were planning, medication and nursing. NHSE and CQC were due to make an unannounced inspection within 4

	weeks. The home had been very open and honest and HW had felt the Clinical Director had been willing to share information with them. However, HW considered that the Clinical Director may not remain in post for long. There were ongoing significant concerns. There had been an infection control review and a plan of support. At the present time there were 26 Gloucestershire residents with a total of 55 people receiving support. HW commented there had been a similar issue in Salisbury.
5.7.2	HW stated that the County Council had been very supportive and she would be working very closely with the GP surgery. The palliative care consultant had been informed.
5.7.3	**<u>RESOLUTION</u>: The committee noted the Care Homes Report (Appendix 7).**
7.0	**<u>Risk Management Report/ Corporate Risk Register Agenda Item 7</u>**
7.1	The committee took the report as read. CGi highlighted the following key points: • Q22 SWAST risk was included in the Corporate Risk Register and the Governing Body Assurance Framework had met the threshold for inclusion. This risk had been discussed during the first part of the meeting. • Q23 EU Exit this risk had emerged due to the uncertainty surrounding EU-Exit arrangements. There had been a risk that some areas of healthcare delivery would be affected. These included the supply of medicines and vaccines. The risk has been rated as 12 (Amber). It was noted that this risk had been discussed at length at a Governing Body Business Session held on 21 March 2019 and formally reported at the Governing Body meeting held in public on 28 March 2019. Weekly reporting to NHS England was undertaken by the Quality Team. • T20 this risk focused on the delayed implementation of changes to pathways through the Clinical Programme Approach which could fail to deliver the anticipated benefits. This could result in transformation projects that may not deliver the expected outcomes for patients and the whole system. At this present time the risk was rated as 12 (Amber).

7.2	**<u>RESOLUTION</u>: The committee noted the Corporate Risk Register report.**
8.0	**<u>Acorns Respite Care Placements for Children with Complex Needs – Agenda Item 8</u>**
8.1	The committee took the policy statement as read and CGi provided the following summary: • The policy statement set out the conditions under which parents and their children (with complex health needs) could obtain respite care from Acorns Charity without having the days / nights deducted from their health care package provided by GCS and commissioned by the CCG. • The policy would make it fair and transparent that Acorn was not a replacement package for healthcare provided by the NHS but was additional to that care. CGi asked for the committee's approval of the policy statement.
8.2	**<u>RESOLUTION</u>: The committee approved the commissioning policy statement for Acorns respite care placements for children with complex needs.**
	BP had left the meeting earlier. Therefore, Items 9 and 10 would be presented by MAE.
9.0	**<u>Complaints and Feedback Policy and Procedure – Agenda Item 9</u>**
9.1	The committee took the paper as read. The committee noted the main areas of the report. PM had found some amendments: • At 19.1, page 13 needed to be amended as there were asterisk symbols which needed to be deleted and dates added. AE commented that he had read the policy in detail and found it to be excellent. MAE found further amendments: • 'PALS' – needs to be upper case throughout. • It was important to keep in the use of a facsimile machine in emergency situations as this had been part of the CCG's contingency plans.

9.1.1	**<u>RESOLUTION</u>: The committee approved the Complaints and Feedback policy once the amendments had been made.**
9.2	**<u>Patient and Public Reimbursement Policy – Agenda Item 9.2</u>**
9.2.1	The committee took the paper as read. There were a few amendments to a make: • Change "IGQC to Q&GC". • At page 7, 2.5 should read "Patient".
9.2.2	**<u>RESOLUTION</u>: The committee approved the Patient and Public Reimbursement Policy once amended.**
10.0	**<u>Engagement and Experience Strategy Refresh – Agenda Item 10</u>**
10.1	The committee took the papers as read and MAE responded to questions posed by the committee. MAE emphasised that examples had included lay person / patient involvement and this needed to be reflected in the report. MAE added that the report was outstanding. PM found the following amendments: • Page 7 at 2.5 'Patiet' should read 'Patient'. • Page 7 'CCH should read CCG'
10.2	**<u>RESOLUTION</u>: The committee approved the Engagement and Experience Strategy Refresh Policy once amended.**
11.0	**<u>Staff Survey 2018 – Agenda Items 11a-11c</u>**
11.1	The survey was taken as read by the committee and CGi highlighted the following points within the report. 73% of CCG staff responded to the survey which had been an 8% improvement on the previous year. Overall the results were positive with the following areas showing tangible improvement from the previous year 2017. CGi outlined some of the key highlights: • Line manager's commitment to flexible working. • The CCG's commitment to equal opportunities. • Positive culture for people with caring responsibilities. • Knowing who to ask and go to with regards Data Security and Counter Fraud (although the latter is a lower score than 2017).

	• Knowing and understanding the CCG's vision and values. • Valuing the purchase of additional annual leave. • The CCG's culture that supports staff with their mental health wellbeing. • Staff reporting that the 1:1 meetings with their manager are effective. • The CCG being supportive of a good work/life balance. • Staff being able to make valued contributions to their team / department. There were also positive scores for staff knowing their work responsibilities, being able to demonstrate their commitment to their job and satisfaction with the level of pay to mention but a few. The improvement in level of pay was most likely to be attributable to the national policy to raise NHS staff pay across the board.
11.2	CGi gave an overview of the improvements which were incorporated into the Staff Survey action plan: • Improving career opportunities within the CCG. • Improving career conversations between managers and staff. • Reviewing and improving the learning and development opportunities that are available. • Improving communication between senior managers and staff. • Improving feedback given by managers to staff and involving them in decisions. • Involving staff in the long term strategic direction of the CCG. • Improving the health and wellbeing of staff at work by addressing issues around stress, workload and attending work while ill. • Exploring the background to bullying and harassment in the CCG and developing actions to address it. • Exploring staff concerns about equity and fairness in terms of promotion, career opportunities and grades as well as some concerns around flexible working.
11.3	PM enquired why the ratings for staff experiencing bullying and harassment had worsened. CGi explained there could be a multitude of reasons although it should be noted that as a non-patient facing service the CCG rates were relatively low compared to other NHS

	organisations. CGi explained she had been working with the HR team Victoria Nangreave and Andrew Mitchell to set up a series of focus groups to explore staff experiences of bullying and harassment, fairness and equity and career progression. The additional feedback would help shape the action plan.
11.4	Committee members queried if it would be possible to find out where the main areas of concern were within the CCG so that actions could be targeted. CGi advised that the survey did not provide information at Directorate level. This had been deliberate to guarantee staff anonymity when completing the survey. Therefore, it was not possible to detect hotspot areas for key concerns. AE stated that in his experience a very small organisation such as the CCG could not provide the wealth of career opportunities that the staff wanted. CGi responded that the HR team had produced a report which revealed that over 10% of CCG staff had been promoted within the last 12 months to a higher graded job.
11.5	**RESOLUTION: The committee noted the Staff Survey 2018.**
12.0	**Data Security & Information Governance Update – Agenda Item 12.1 – 12.4**
12.1	CL had sent her apologies to the committee. Item 12 would be presented at the next Q&GC on 13 June 2019.
13.0	**HR Dashboard January/February 2019 – Agenda Item 13**
13.1	CGi provided an overview of the key staffing indicators for February 2019: • The CCG headcount had increased to 364 Staff in post, 297 WTE. There were 3 new starters and 5 leavers. Over the last 12 months there have been 50 leavers (41.22 FTE) and 81 starters (66.29 FTE). • Turnover for February increased slightly by 1.33% to 14.26% and above the 12% CCG target. • There were 50 leavers over the 12 month period. The main reason for leaving was promotion accounting for 17 staff members. In February 3 left due to redundancy. • Long term absence has decreased from 1.62% to 1.48%, Short term absence has decreased from 1.79% to 1.36%.

	• For Feb 2019 absence due to anxiety/stress is 41.12% this had increased from 12.03% in January. The overall cost of absence for February has been £32,008 with a total of 260 days lost (236.30 FTE). PM enquired what actions the CCG had undertaken to tackle issues around anxiety and stress. CGi explained that the figures related to a handful of staff on long term sick leave. The CCG had commenced a health and wellbeing programme, with lunch time events and activities. Work was underway to explore various training courses to improve resilience and improve health and wellbeing. PM noted that the CCG was required to make 20% worth of savings on staffing costs. He asked what the split was between ICS and CCG staff. CGi stated that she would need to find out that information from Finance. **ACTION: CGi to provide a breakdown of staffing to QGC.**
13.2	**RESOLUTION: The committee noted the HR Dashboard.**
14.0	**Health and Safety Report – Agenda Item 14**
14.1	The committee took the report as read. MAE highlighted that it had been noted that there had been repairs to doors and air conditioning within the CCG but there were no major incidences. The building had been managed well and compliance with regulations had been high.
14.2	**RESOLUTION: The Committee noted the Health & Safety Report.**
15.0	**Any Other Business**
15.1	There was no further business.
	The meeting closed at 13:20 pm.
	Date of Next Meeting: Thursday 13 June 2019, 9:30 am in the Boardroom, Sanger House.

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire Clinical Commissioning

Audit & Risk Committee

Minutes of the meeting held at 9:00am, 12 March 2019, Board Room, Sanger House

Members Present:		
Colin Greaves	CG	Chair, Audit & Risk Committee
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Alan Elkin	AE	Lay Member, Patient and Public Experience
Jo Davies	JD	Lay Member, Patient and Public Experience
Peter Marriner	PM	Lay Member, Business
In Attendance:		
Cath Leech	CL	Chief Finance Officer
Gerald Nyamhondoro *(Agenda Item 11)*	GN	Corporate Governance Administrator (taking minutes)
Andrew Beard *(Agenda Item 12)*	AB	Deputy Chief Finance Officer
Christina Gradowski *(Agenda Item 8)*	CGi	Associate Director of Corporate Governance
David Porter *(Agenda Item 9)*	DP	Head of Procurement
Kate Ball *(Agenda Item 5)*	KB	Internal Audit Manager, BDO
Justine Turner *(Agenda Item 5)*	JT	Internal Audit Manager, BDO
John Micklewright *(Agenda Item7)*	JM	Interim Counter Fraud Manager
Alex Walling *(Agenda Item 6)*	AW	Engagement Lead, Grant Thornton
Debbie Sanders *(Agenda Item 4.1)*	DS	Clinical Manager CHC, Integration Directorate
Kim Forey *(Agenda Item 4.1)*	KF	Director of Integration
Miriam Street *(Agenda Item 4.1)*	MS	Lead Commissioner CHC, Integrated Directorate
Haydn Jones *(Agenda Item 10)*	HJ	Associate Director, Business Intelligence
Mark Walkingshaw *(On behalf of Mary Hutton)*	MW	Deputy Accountable Officer

1. Apologies

1.1 There were no apologies given.

1.2 The meeting was confirmed as quorate.

2. Declarations of Interests

2.1 No declarations were made.

3. Minutes of the Audit & Risk Committee meeting held on 11 December 2018

3.1 The minutes of the meeting held on Tuesday 11 December 2018 were approved as an accurate record, subject to the following amendments:

3.2 Paul Kerrod's initials in the third sentence of paragraph 7.2 should read 'PK, and not KP'.

3.3 The second sentence of paragraph 14.13 should read 'Jo Davis left the meeting at 11:28am'

Jo Davies joined the meeting at 09:05am

4. Matters Arising

4.0.1 **11/09/2018, Item 5.2.4** Internal Audit Safeguarding Report. PM commended the report as it highlighted areas for improvement and requested that CGi ensure the report was included on Q&G committee agenda. **Item closed.**

4.0.2 **11/09/2018, Item 5.2.4** Internal Audit Safeguarding Report. JT confirmed that as action dates became due the lead would be contacted for an update and evidence of completion. The Internal Audit report presented on 12 March 2019 provided a detailed update on the position. **Item closed.**

4.0.3 **11.09.18, Item 6.1.1** Due to a change in the audit software being used for 2018-19 and the requirement to ensure that there was full addressing

of the issues facing the CCG, external auditors presented the audit plan to the Audit & Risk Committee on 12 March 2019. **Item closed.**

4.0.4 **11.09.18, Item 9.4.1** Corporate Risk Discussion on Risk Appetite. It had been suggested to the Chair of the A&R Committee that the A&R Committee was delegated responsibility for developing a risk appetite statement for inclusion in the Risk Strategy / Policy. **Action: Ongoing. Item remains open.**

4.0.5 **11/09/18, Item 10.3** Summaries of Procurement Decisions. The Governing Body needed to approve the Assisted Conception service procurement and it queried as to when would such matter be brought before the Governing Body.

Action: It was still unknown when the procurement process for the provision of Assisted Conception Services would commence. The procurement team was awaiting instruction from Planned Care commissioners regarding this matter. The CCG Contracts Team was in the process of extending the existing contract with Oxford Fertility Unit by an additional 12 months, to 31 March 2020. **Item remains open.**

4.0.6 **13/03/18, Item 12.9** Threshold of Waivers was reviewed (see agenda item 12). Recommended by Audit & Risk Committee for approval by the Governing Body. **Item closed**.

4.0.7 **11/12/18, Item 4.23** Verbal Update on Personal Health Budget (PHB) and Continuing Health Care (CHC). The Audit & Risk Committee expressed concern that the budget provision for CHC showed financial risk arising from material underestimates. The committee requested that KF and DS should return at a future date and provide information on how such material risks occurred and how the risks were being addressed. **Action.** KF and DS presented further details on 12 March 2019. **Item closed.**

4.0.8 **11/12/18, Item 10.2** Declarations of interest. CG stated that the level of non-compliance was worrying and there was a need to improve compliance to a satisfactory level. CG emphasised that the executive team should further investigate the problem.
Action: Executives resolved, at Core meeting, to enforce the policy.

Compliance rose to 95.5%. **Item closed.**

4.0.9 **11/12/18, Item 10.3** Declarations of interest. CGi explained that the Corporate Governance team developed a programme to train and appraise staff, during team briefings, on managing conflicts of interest. Programme on going. **Item remains open.**

The Chair directed that Agenda Items 5.1 would precede Agenda Item 4.1.

5. Internal Audit

5.1 Progress Report

5.1.2 JT explained that all audit field work had been completed for the year and in line with audit plan, and she emphasised that their audit work complied with Public Sector Internal Audit Standards. JT commented that the internal audit team enjoyed good cooperation from the CCG staff.

5.1.3 JT stated that the Internal Audit team was making good progress in the delivery of the 2018/19 audit plan and was pleased to present the General Data Protection Regulations report, the Key Financial Systems report and Data Protection and Security Toolkit. JT added that Management was providing responses to the draft reports for STP Solutions, and Conflicts of Interest and the Continuing Healthcare reports were being finalised.

5.1.4 JT presented a sectoral update which gave a snapshot of current issues relevant to health provision. JT outlined the NHS England new five year framework for General Practice which provided framework for GP contract reform pursuant to realignment with NHS Long Term Plan. JT explained that included was the requirement to establish Primary Care Networks (PCN) across the whole country by July 2019.

5.1.5 JT explained that the NHS Long Term Plan aimed to integrate health delivery systems in England using Integrated Care Systems (ICS) as a tool. JT added that this would be achieved through GP network contracts linking primary health care with community services; including augmentation of the pool of general practitioners and the strengthening of regulation of Senior NHS Managers. JT commended that their team

was starting to notice evidence of shared /corroborative working in the generality of health delivery sector.

5.1.6 JT drew attention to the need to factor into risk management and planning, the potentially adverse effects of Brexit and she emphasised that service providers should consider informed guidance in their Brexit preparations and existing business continuity plans.

Kim Forey, Miriam Street and Debbie Sanders joined the meeting at 09:10am

The Chair re-directed the meeting to Agenda Item 4.1

4.1 <u>Verbal Update on Personal Health Budget (PHB) and Continuing Health Care (CHC)</u>

4.1.1 The CHC team led by KF delivered a verbal presentation relating to CHC and PHB. KF introduced CHC as an act of processing person-centred needs, and KF revealed that the team got 65-75 referrals per week to the CHC service.

4.1.2 KF stated that the Integrated Commissioning directorate had assembled a team of 55 colleagues to spearhead the redesigning of processes and pathways to improve CHC delivery.

4.1.3 KF acknowledged that there were challenges which risked undermining the desired health deliverables. One of such challenges related to Funded Nursing Care (FNC).The CHC team stated that they relied on provision of relevant data on patient admissions from care homes, but the data supplied by the care homes was not always delivered in a timely manner; and at times it was not delivered at all. KF explained that lack of reliable data had an adverse impact on CHC health delivery as the CHC team would not be always aware of the homes' funding needs.

4.1.4 DS stated that the CHC was experiencing cost and performance pressures but emphasised that the CHC team was developing proactive and collaborative models to drive up performance and achieve the target by the end of year 2019/20. DS added that the CHC team had worked hard to open up communication channels with service providers and this had resulted in significantly improving CHC's FNC outcomes.

4.1.5 KF explained that, regarding the CHC, the CCG was one of the best regional performers when measured against the 28-day South West average. DS nevertheless cautioned that the CCG was still performing at 40-45% which was below the 80% national target. DS added that the CCG aimed to achieve the national target by the 2nd quarter of year 2019/20.

4.1.6 KF explained that Learning Disabilities (LD) CHC service was transitioned into the wider CHC service in year 2018/19 and this had revealed 86 LD cases that were awaiting a full CHC assessment. KF emphasised that the CHC team was engaged on clearing the backlog.

4.1.7 KF reassured members that the 86 needy people were in practical terms not neglected because of the backlog; they had access to alternative funding.

4.1.8 CG raised concern over CHC budget overspends shown by available statistics and he enquired to as how the CHC team planned to contain costs.

4.1.9 KF acknowledged the existence of cost pressures inherent in CHC operations and explained that a LD costs were high, and to make the matters worse the CCG had to take on new cases arising from new service users moving into the county. KF added that the duty of care required the CHC team to take care of new comers' needs and this resulted in unplanned costs.

4.1.10 PM enquired as to whether the CHC team was collaborating with other service providers and requested details justifying the high CHC costs. CL explained that the CHC metrics were benchmarked and aligned with market rates. PM emphasised that members were interested in the demonstration of the CHC team's innovation to drive down the costs.

4.1.11 KF explained that the CHC team was developing innovative models to support empowerment of service users and reduce costs of service user upkeep. KF stated that such models inherently made the life of the service user more fulfilling and meaningful.

4.1.12 DS added that sustainable cost containment measures required additional resources, and this included recruitment of LD nurses.

4.1.13 RESOLUTION: The committee noted the Verbal Update on Personal Health Budget (PHB) and Continuing Health Care (CHC).

Kim Forey, Miriam Street and Debbie Sanders left the meeting at 09:50am

The Chair re-directed the meeting to Agenda Item 5.2

5.2 General Data Protection Regulations (GDPR)

5.2.1 JT delivered the GDPR and stated that from May 25 2018, the General Data Protection Regulation (the GDPR) replaced the Data Protection Act 1998 as the regulation governing the protection of data in the UK. JT warned that GDPR was a sharper data protection and regulation instrument and therefore increased the risk of significant financial and reputational damage should the security of the CCG's information be found to have been breached. This placed greater need for substantial assurance on design and management of data.

5.2.2 CG probed the reliability and reassurance level of Data Protection Impact Assessment (DPIA) applied by the CCG. CG cautioned that failing to adequately conduct a DPIA would breach the GDPR and could lead to significant fines. CL responded that risk containment and prevention measures premised on DPIA methodologies had been ongoing for a year. CL reassured members that the information team, assisted by Tony Ware who is the Information Governance Manager, had designed robust processes to provide favourable risk containment outcomes.

5.2.3 CL stated that the Finance & Information directorate and the CCG's Data Security Assurance Working Group continued to close gaps. She added that the directorate and Working Group partnered to roll out a programme to train colleagues on information governance and compliance with projected deliverables of 95% compliance to be achieved by financial year 2019/20.

5.3 Key Financial Systems

5.3.1 JT and KB presented the report and summarised as follows:

- The CCG was required to maintain sufficient effective controls over its key financial systems to support effective management of

resources.

- The Internal Audit team sought to gain evidence of the satisfactory operation of the controls to verify the effectiveness of the controls through use of a range of tools and techniques.
- The Internal Audit team observed that the CCG presented performance and finance results to the Governing Body tested financial information with evidence of traceable supporting documentation.
- The design and effectiveness of internal control systems was overall found to be firm.

5.4 Data Protection Tool Kit

5.4.1 JT explained that in April 2018, the Data Security and Protection Toolkit (DSP Toolkit) replaced the Information Governance Toolkit (IG Toolkit) as the standard for cyber and data security for healthcare organisations and their partners.
JT added that the new tool was introduced to reinforce the effectiveness of information governance and data protection in the health sector.

5.4.2 JT summarised that the Internal Audit team was satisfied that:

- The CCG had a Data Security and Protection Policy in place and a Data Security and Protection Staff Handbook to ensure that information governance was embedded across the CCG.
- All employment contracts included sections on data privacy and information governance and were accompanied by a confidentiality statement, which all new joiners were required to sign.
- A staff training needs analysis was performed to identify the training requirements regarding all aspects of Data Security and Confidentiality as advised by the National Data Guardian and the Information Commissioner.
- A Cyber Security Group was set up and met on regular basis, with the DSP Toolkit being a standing agenda item.

KB summed up by stating that the only area of disagreement between the Internal Audit team and the CCG was on the area of risk rating.

5.5 Internal Audit Follow-Up of Recommendations

5.5.1 JT presented Internal Audit recommendations on Adult Safeguarding, Risk Maturity, Human Resources and Corporate Governance, and summarised as follows:

- The CCG should draft an Adult Safeguarding Policy to ensure that staff and providers were aware of the roles and responsibilities of the CCG, and how safeguarding should be managed.
- Safeguarding priorities should be specific, measurable, accurate, realistic and time-bound.
- The effectiveness in discharging risk management responsibilities should be evaluated as part of the individual performance review or appraisal for those members of staff with risk management responsibilities.
- A process should also be discussed with Information and Communications Technology (ICT) teams, and a solution implemented to provide the CCG with assurance that leavers were removed from its systems and email account.
- The CCGs risk appetite should be agreed, communicated and clarified across the organisation so that it could be applied in day-to-day work undertaken by all staff.
- The constitution should be updated to reflect the current corporate governance trends and requirements.

5.5.2 CG commended the Adult Safeguarding Policy and stated that it was important to ensure that staff and providers were aware of the roles and responsibilities of the CCG. CG added that how safeguarding was managed was a focal point to Adult Safeguarding. JT confirmed that the CCG had been proactive and engaged partners on matters of learning and creating value from experience. The Internal Audit team were of the view that the CCG had effectively played its part therefore there was no need for further review in this area.

5.5.3 CG enquired as to the rate of progress regarding the writing of the constitution and CGi explained that the rewriting of the constitution was in progress. CG stated that the committee needed to support CGi in her effort to produce a new constitution for the CCG.

5.5.4 RESOLUTION: The committee noted the following reports:

- **Internal Audit Internal Audit Progress Report**

- **General Data Protection Regulation Report**
- **Key Financial Systems Report**
- **Data Security and Protection Toolkit**
- **Internal Audit Follow-Up of Recommendations**

5.6 Internal Audit Strategic Plan 2019/22

5.6.1 JT delivered the Internal Audit Strategic plan which mapped audit to CCG strategic objectives covering a wide range of themes including key financial systems, risk management systems, continuing health care, safeguarding, partnership working, cyber security and corporate governance. JT added that NHSE required a draft of the plan.

5.6.2 CL stated that ICS drove the new challenges faced in the CCG strategic planning because the CCG was required to focus on partnership synergy promoting integrated strategic plans and operational budgets.

5.6.3 CG stated that the committee was happy with the three year strategic plan, but it would limit itself to approving the 2019/20 part of the plan.

5.6.4 RESOLUTION: The committee approved the 2019/20 Internal Audit Plan.

6. External Audit

6.1 Audit Progress Report and Sector Update

6.1.1 AW delivered the External Audit Progress report and Sector Update and explained that healthcare was a rapidly changing sector. AW added that providers and commissioners of healthcare faced the pressures of rising public expectations and ageing population tested against a continuing drive to achieve greater efficiency in the delivery of public services.

6.1.2 AW stated that increasing demand and rising costs put a strain on primary care systems and this was likely to worsen over time. AW suggested that one of the solutions to such risk was to create GP super practice as an approach to ensure long-term sustainability of primary

care.

AW defined a GP super practice as a creation of formal merger of a number of independent GP practices into a single larger entity. AW explained that GP practices could thus achieve significant cost savings, secure wider benefits from more specialist services and offer a more attractive working environment.

6.13 AW emphasised focus on safe health delivery service and she stated that there was strong commitment across the service delivery spectrum to make the care of patients as safe as possible.

6.1.4 AW pointed out that risks of slippages could arise from prevailing shortages of essential staff, including nurses, doctors, allied health professionals and care staff. AW warned that such pressures could create risk of failure to cope with demand and allow many people living with mental health problems to fall through the gaps.

6.1.5 AW summed up by emphasising that CCGs were instrumental in delivering desired change despite facing the risk of budget busting pressures.

6.2 External Audit Plan

6.2.1 AW delivered an audit plan which provided an overview of the planned scope and timing of the statutory audit of the CCG.

6.2.2 AW outlined external factors that create material risk for the CCG. AW stated that financial pressures created risk as demonstrated by a NHSE report which exposed collective overspend of £690 million for CCGs in 2017/18. AW added that pressures on health delivery were exacerbated by political uncertainty.

6.2.3 AW highlighted internal risks as arising from factors such as staffing pressures and uncertain outcomes deriving from the TrakCare electronic patient system.

6.2.4 RESOLUTION: The committee noted the External Audit report.

7. Counter Fraud Update

7.1 Counter Fraud Progress Report

7.1.1 JM delivered the Counter Fraud update and started by advising members that Lee Sheridan was returning to the Counter Fraud team. JM stated that the Counter Fraud team were developing the Fraud Self Review Tool (SRT) and the tool would require a sign off by the Chief Finance Officer (CFO) and the Audit & Risk committee chair.

7.1.2 JM also stated that the Counter Fraud team was driving forward the fraud awareness programme and 35% of the CCG staff completed the counter fraud survey, and more staff now knew about counter fraud policy. JM added that the drop-in programme was producing positive outcomes and was proving to be a good platform in managing the risk of fraud, bribery and corruption, and meeting the statutory obligation required by the NHS Counter Fraud Authority.

7.1.3 JM stated that Counter Fraud newsletters had been issued and cascaded to staff via Team Brief which was the organisation's tool for highlighting warning around the methods and techniques employed by cyber criminals to defraud people on popular social media websites and online auction sites. JM advised that the newsletters were also available on the CCG's intranet.

7.1.4 JM explained that the Counter Fraud team was remodelling the 'E-Learning' tool developed by the NHS Counter Fraud Authority to meet the specific needs of Gloucestershire population. JM emphasised that E-Learning training would be mandatory for all CCG staff and would be an addition to the ongoing face to face awareness training.

7.1.5 PM enquired as to when would the E-Learning programme be rolled out and JM explained that the team did not have a specific date at the time of presenting the report before the members, but it would be in the medium term.

7.1.6 JM stated that the Counter Fraud team had identified gaps in fraud

awareness which it would address. JM summed up by emphasising that he encouraged the CCG and its partners to involve the Counter Fraud team in developing their systems at the early stages. JM emphasised that involving the Counter Fraud team had the benefit of making barriers to fraud systemic rather than patched up work to plug up avoidable gaps and associated risks.

7.1.7 RESOLUTION: The committee noted the Counter Fraud report

7.2 Counter Fraud Work Plan for 2019/20

7.2.1 JM delivered the Counter Fraud team Work Plan and summarised the plan as follows:

- Provided counter fraud coverage to ensure that staff were fully aware of the fraud risks that the CCG faced.
- Ensured that the CCG, its management and staff were protected.
- Rolled out bespoke fraud awareness sessions to all staff either through mandatory training or via the induction programme.
- Opened fraud drop-in sessions three times per month at Sanger House.
- Published quarterly newsletters focusing on fraud.
- Conducted annual counter fraud survey.
- Reviewed of organisations policies.
- Worked jointly with key stakeholders including NHSE, Gloucestershire County Council and Community Transport Groups.

7.2.2 RESOLUTION: The committee approved the Counter Fraud Work Plan for 2019/20

John Micklewright left the meeting at 10:25am

David Porter joined the meeting at 10:25am

8. Risk Management

8.1 CGi delivered the Risk Management report and stated that a number of risks had been identified and were recommended for inclusion in the CRR / GBAF. CGi summarised and follows:

- Each directorate was asked to review its risk register.
- In February the following directorates submitted changes made to their risk registers and/or introduced new risks.
    1. Quality.
    2. Primary Care.
    3. Integration

8.2 The Quality Directorate requested the inclusion of the following risks.

- Q22 SWAST had identified a risk in the South West to patients, due to call stacking. In Gloucestershire the risk was in category 2 patients where waits were longer than target times. However, Category 1 patients were responded to within the required times. There were delays in responding to Category 4/5 health professional calls; but this was not considered to pose risk to the patients. The risk was originally rated at 12 but had increased to16.
- Q23 Brexit. Due to the uncertainty surrounding EU-Exit arrangements, there was a risk that some areas of healthcare delivery would be affected. These included the supply of medicines and vaccines. This risk was rated as 12 (Amber).

8.3 The Transformation directorate requested the inclusion of the following risk:

- T20 Risk that delayed implementation of changes to pathways through the Clinical Programme Approach failed to deliver the anticipated benefits, resulting in transformation projects that could fail to deliver the expected outcomes for patients and the whole system.

8.4 CGi informed the committee that MAE was charged with matters surrounding Brexit risk and this was a new risk to the Gloucestershire county population.

8.5 CG raised the concern that the risk management tool employed by the CCG did not competently factor in integration and new models of care.

CGi concurred and added that external assurance was fundamental to strategic objectives of the CCG. CGi further explained that a new risk management tool, namely 4Risk, was being acquired and the new tool provided functions that aligned with the CCG strategic objectives.

8.6 CG suggested that directorates should be further sensitised and equipped for risk assurance functions.CG commended the Audit Assurance Framework and added that there was still room for further improvement.

8.7 RESOLUTION: The committee approved the inclusion of Q22 and Q23 along with T20 risks onto the CRR and GBAF.

8.8 Risk Appetite

8.8.1 CGi distributed a paper to members for discussion on risk appetite and introduced discussion on the risk appetite of the CCG. CGi stated that the CCG was risk averse. In addition to adopting a zero risk appetite to patient safety, quality, governance and compliance with legislation, it had a low risk appetite to capacity and financial sustainability.

8.8.2 JT concurred and added that there was no need to be afraid of risk all times because innovation was associated with risk and innovation drove change.

8.8.3 RESOLUTION: The committee noted the discussion and pledged to support CGi on the development of risk appetite tools.

9. Procurement

9.1 DP stated that there were three new procurement decisions to note in the third Quarter (Q3) namely Procurement of Community Vasectomy Services, Care Navigation Training (Pilot) and Provision of Primary Care Medical Services (Marybrook Medical Centre)

9.2 DP presented the 11 waivers of standing orders for noting by the committee and most of the waivers were of low value.

9.3 CG probed the Teens in Crisis Plus (TIC+) Waiver (reference 335/12/2018) for provision of face to face counselling services to

children and young people. The waiver had a value of £1,126,872.

9.4 AE requested detailed justification for the Teens in Crisis Plus (TIC+) Waiver. **Action: DP**

9.5 RESOLUTION: The committee noted the Procurement Waiver of Standing Orders.

David Porter left the meeting at 10:55am and Haydn Jones joined the meeting.

10. STP Solutions Report

10.1 HJ delivered the STP Solutions report which provided an overview of the 2018/19 STP Solutions Programme delivery and summarised as follows:

- Overall risk adjusted delivery at Month 10 was £17.281m out of a total savings target of £18.602m (92.9%).
- The savings plan of £18.602m was included in the financial plan for 2018/19. Slippage in the savings plan had been included in the financial forecast for the year.
- Financial risk for 2018/19 was mitigated by:

    1. A risk share agreement with GHFT for specific schemes whereby the contractual value of the Point of Delivery (POD) was reduced by an agreed amount.
    2. GHFT agreed a block contract for all activity except elective inpatients and day cases. Therefore, even if there was slippage on a specific scheme, the financial risk to the CCG for 2018/19 was limited through the block contract for the relevant PODs.
    3. A risk share with GCS for specific schemes where GCS provided services to support delivery of schemes such as MSK.

10.2 HJ also stated that PBR elective admissions were showing a slight underperformance of £146k against plan and emergency admissions continued to show a significant over performance against plan. HJ explained that General Medicine and General Surgery were the two

significant specialties contributing to overspend.

10.3 **RESOLUTION: The committee noted the STP Solutions Report**

Haydn Jones left the meeting at 11:10am

11. Declarations of Interest Update

11.1 GN presented the Declarations of Interest update and reported a significant improvement in terms of compliance with the CCG declarations of interest policy. GN stated that as of 25 February 2019, all members complied with the statutory requirement to declare interests compared to the previous Quarter where compliance level stood at 87.5%.

As of 25 February 2019, 93.7% employees in Band 8 and above and those below Band 8 but with interests to declare complied with the statutory requirement to declare interests compared to the previous Quarter where compliance level was 66.2%.

11.2 GN stated that the Clinical Programme Groups (CPGs) and One Place performed poorly. GN explained that the structure of the CPGs was very fluid and they had a very small core membership who had long term tenure. The Governance team therefore considered that it would be more effective and appropriate if CPG members declared their interests in their respective meetings and noted the declarations in the minutes.

11.3 CGi informed members that One Place had been largely showing low activity, but the Governance team was engaging Matt Woodward who was One Place Project Coordinator to create better leverage regarding compliance. GN explained that if CPGs and One Place were excluded from relevant data, the relevant data reflected the correct compliance level of 95.5% for the CCG.

11.4 RESOLUTION: The committee noted the Declarations of Interest Update.

12. Finance and Planning

12.1 AB presented the Aged Debt report. The report provided a summary of the Aged Debt as at 27 February 2019. AB outlined that the outstanding

debt as per the Sales Ledger was £3,663,419 of which £3,335,021 was NHS and £328,398 was non NHS.

12.2 AB outlined final accounts timetables and plans and cautioned that there was a small risk to the accuracy of the accounts due to tight timescales for completion. AB stated that the date for the draft annual report, excluding accounts, was 5pm on Thursday 18 April and the date for draft accounts was 9am on Wednesday 24 April. AB added that the audited accounts needed to be submitted to NHSE by 9am on Wednesday 29 May.

12.3 Regarding Losses & Special Payments, AB stated that the CCG made two Special payments during 2018/19. The first payment of £670.05 related to an employee who had suffered an additional tax liability in 2018/19 for hours worked in 2017/18. The other payment of £618.66 related to payment made to an employee whose vehicle was damaged while parked while he attended a meeting on behalf of the CCG.

12.4 RESOLUTION: The committee noted the Finance and Planning report.

13. Any Other Business

13.1 CG enquired as to the position regarding the Draft Annual Governance report. CGi explained that the draft required some additional data which was still to be provided to the Governance team and she added that once the draft was finalised it would be sent electronically to members.

13.2 CG reminded members that they could start directing their thoughts to the approaching self-assessment and set themselves objectives for year 2019/20 as a committee.

The meeting was closed at 11.25am

Date and time of the next meeting

The next meeting would be held at 9:30am on Tuesday 07 May 2019, in the Prout Room, Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Audit Committee:
Signed (Chair):_____ Date:_____