NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 28 November 2019 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

AGENDA

No.	Item	Lead	Recommendation
1.	Apologies for absence *MAE, WH, MH*	Chair	Information
2.	Declarations of interest	Chair	Information
3.	Minutes of the Meeting held on 26 September 2019	Chair	Approval
4.	Matters Arising	Chair	Discussion
Standing Items and Update Reports			
5.	Public Questions	Chair	Information
6.	Patient Story		Information
7.	Clinical Chair's Update Report	Andy Seymour	Information
8.	Accountable Officer's Update Report	Mary Hutton	Information
9.	Performance Report	Cath Leech	Discussion
10.	Governing Body Assurance Framework	Christina Gradowski	Discussion
11.	ICS Update Report	Mary Hutton	Discussion
12.	Quality Report	Marion Andrews-Evans	Discussion
Items to Note:			

13.	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
14.	Governance and Quality Committee Minutes	Julie Clatworthy	Information
15.	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 30 January 2020 at 2pm in Board Room at Sanger House			

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

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Gloucestershire Clinical Commissioning Group

Governing Body

Minutes of the meeting held at 11:00am on 26 September 2019

Board Room, Sanger House

Members Present:		
Dr Andy Seymour	AS	Clinical Chair
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Mary Hutton	MH	Accountable Officer
Mark Walkingshaw	MW	Deputy Accountable Officer
Ellen Rule	ER	Director of Transformation and Service Redesign
Dr Lesley Jordan	LJ	Secondary Care Doctor
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 Marion Andrews-Evans	MAE	Director of Nursing and Quality Lead
Dr Will Miles	WM	GP Liaison Lead – Cheltenham Locality
Sheena Yerburgh	SY	GP Liaison Lead – Stroud and Berkeley Vale
Dr Will Haynes	WH	GP Liaison Lead – Gloucester Locality
Kim Forey	KF	Director of Integration
Sarah Scott	SS	Director of Public Health and Commissioning of Children's Services, GCC
Dr Lawrence Fielder	LF	GP Liaison Lead – Forest of Dean
In Attendance:		
Gerald Nyamhondoro	GN	Governance Officer (taking minutes)
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Jo Tym	JT	Member of the Public (*Presenting Patient Story*)

Karl Gluck	KG	Senior Commissioning Lead – Mental Health
There were two members of the public who attended the meeting		

1.	**Apologies**
1.1	Apologies were noted from Dr Alan Gwynn, Dr Caroline Bennett, Helen Goodey and Margaret Willcox.
1.2	The meeting was confirmed as quorate.
2.	**Declarations of Interest**
2.1	There were no declarations other than the usual declarations of general interest of GPs in the provision of primary care services.
	The Chair welcomed members of the public.
3.	**Minutes of the Governing Body Meeting Held on 25 July 2019**
3.1	The minutes of the meeting held on Thursday 25 July 2019 were approved as an accurate record subject to the first sentence of paragraph 16.1 being amended to read as follows: '*CGi presented the Risk Management report and Governing Body Assurance Framework*'.
4.	**Matters Arising**
4.1	**23/05/19, Item 11.6** Performance and Finance report. 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. MW responded that additional information would be included in the report which was to be presented to the Quality & Governance Committee. **Item closed.**
4.2	**23/05/19, Item 13.6** Quality Report. AS queried what appeared to be a

	lack of correlation between resources invested and the outcomes in the flu containment programmes. The Governing Body asked for further updates on the flu vaccination programmes. Penny Fowler (PF) provided a response on behalf of the Quality team and stated that the CCG was working on actions to improve flu vaccination uptake, particularly to "at risk" groups as well as to care home workers and carers/visitors. **Item closed**.
5.	**Public Questions**
5.1	There were no questions from the public.
5.1	A petition from members of the public drawing some attention to certain specific areas of health service delivery was presented to the Chair.
6.	**Patient Story**
6.1	JT, who came to the meeting companied by KG, presented the 'Patient Story' before the Governing Body. AS and members thanked JT for the points she raised on the need to redefine the provision of services in specialist areas.
	Jo Tym and Karl Gluck left the meeting at 11:25am
7.	**Clinical Chair's Report**
7.1	AS presented the report and stated that the acknowledgement of Gloucestershire's strong performance in primary health services was positive. He added that the county's integrated health system had been co-opted into the 'Wave 2' Primary Care Networks (PCNs). AS further stated that Gloucestershire's 14 PCNs continued to develop and grow. AS added that 10 PCNs had confirmed that they planned to employ additional Social Prescribing Link Workers (SPLW).
7.1	AS stated that by the end of 2024, a typical PCN in the county would

	hopefully constitute the optimal number of Clinical Pharmacists, Social Prescribing Link Workers, first contact Physiotherapists, Physician Associates and first contact Paramedics.
7.2	AS described PCNs as a vehicle for integrating community and primary care and he added that the CCG would endeavour to nurture a culture of collaboration between and within PCNs. AS stated that the CCG was contributing toward the refreshing of 'Primary Care Strategy' to cover the period of 2019-2024 and bring it into alignment with the 'NHS Long Term Plan' commitments set out for Primary Care.
7.4	AS explained that the CCG and its partners were committed to the digitisation of diagnosis and triage platforms through employment of the 'Doctorlink' software. AS stated that five initial pilots had gone live and patients were being encouraged to use the new system.
7.5	**RESOLUTION: The Governing Body noted the contents of the Clinical Chair's report.**
8.	**Accountable Officer's Report**
8.1	MH presented the report and gave a brief summary of: • Gastroenterology and Hepatology Referral Assessment Services (RAS); • Winter Planning arrangements for 2019/20; • support for new parents from the National Lottery Community Fund; • the work of the Gloucestershire Homesharing service; • mental health bids for the Long Term Plan Transformation Funding; • Fit for the Future Engagement.
8.2	MH stated that the changes made to the 'Referral Assessment Service' (RAS) showed initial success and, would be subject to further evaluation. MH also stated that planning for 2019/20 was at an

	advanced stage.
8.3	MH stated that 'Home-Start' Gloucestershire, a consortium of three local schemes, had secured £500,000 of 'National Lottery Community Funding' and the funds would be used across the county to support more families with parenting responsibilities.
8.4	MH explained that the CCG and its partners supported the 'Homesharing' scheme designed to enable an older person to share their house with a younger person in return for 10 hours of support each week. The scheme would help the older person to remain in their own home. The scheme would reduce loneliness and isolation for both parties.
8.5	MH described 'Fit For The Future' engagement and described it as a real opportunity to talk about ways services could be organised in future so that local people could get the very best service and benefit in critical areas such as urgent care, general surgery, emergency surgery, vascular surgery and radiology.
8.7	**RESOLUTION: The Governing Body noted the contents of the Accountable Officer's report.**
9.	**Finance and Performance Report**
9.1	Operational Performance
9.1.1	MW delivered the performance aspect of the report and stated that when measured against performance domains, 'Better Health', 'Leadership' and 'Sustainability' showed good performance whilst 'Better Care' required some improvement.
9.1.2	MW further summarised as follows: • category 1 ambulance performance remained inside the 7 minute national standard, in the month of August 2019;

	• category 2 ambulance performance remained above the target of average response time of 18 minutes, in the month of August 2019; • in the month of August 2019 the Gloucestershire whole system performance, measured against the emergency department 4-hour standard was 92%; • a national review of handover delays by NHS England (NHSE) had led to a country-wide focus on achieving a 50% reduction in 15 and 60 minute handover delays; • 52-week performance had been an area of concern, however, the pace of recovery in this area was consistent with the CCG projections.
9.2	<u>Cancer Performance Overview</u>
9.2.1	ER presented the cancer performance update and summarised as follows: • the July 2019 2-week wait performance was 92.8% for the CCG and 92.7% for GHFT, and the CCG had 174 breaches; • the 62-day performance had been consistent since 2016, with 2018/19 statistics showing an average of 74.5%. Constraints in achieving the 85% target resulted from GHFT's long term problems in urology specialty, surgical waits and complex pathways in general. GHFT was exploring ways to further improve performance.
9.3	<u>Mental Health and Community Health Overview</u>
9.3.1	KF delivered the mental health and community aspect of the report and summarised as follows: • recovery performance in 'Improving Access to Psychological Therapies' (IAPT) consistently met national target; • referral quality in 'Continuing Health Care' (CHC) continued to be an area of concern;

	• CHC assessment 28-day target remained unachieved and performance remained significantly below the 80% target; • the backlog of LD cases continued to impact negatively on CHC performance.
9.3.2	KF stated that 'Musculoskeletal Advanced Practitioner Service' (MSKAPS) and diabetes and bone health nursing services achieved above target performance in the month of July 2019. KF however explained that the performance of occupational therapy, podiatry, musculoskeletal (MSK), physiotherapy, and speech & language therapies remained below the 95% 8-week target.
9.3.3	KF described 'Fast Track' as a tool providing individuals, who were rapidly deteriorating and perceived to be entering a terminal phase, with special support rendered promptly in their preferred place of care. KF explained that Fast Track experienced operating pressures because it was designed to handle smaller numbers but was now handling a greater number than expected due to some patients living longer than the tool was designed to accommodate.
9.3.4	LF raised the concern of the increase of people residing outside the county who accessed local services within Gloucestershire and he enquired as to how planning accommodated such an influx when mapping out the delivery of services. KF promised to go back and get more data and return with additional information to present to the Governing Body. **Action: KF**
9.4	<u>Financial Performance</u>
9.4.1	CL presented the financial aspect of the performance report and described the performance of various contracts commissioned by the CCG. CL stated that Gloucestershire Hospital Foundation Trust (GHFT) 2019/20 contract value was £345.442m; a block contract had been agreed with GHFT for all services, but it excluded certain drugs. CL added that cost pressures were being experienced with secondary care drugs.

9.4.2	CL stated that within the block contract, emergency activity and expenditure remained above planned level. CL also reported upon acute service overspends at University Hospital Birmingham NHSFT, University Hospital Bristol NHSFT and Oxford University Hospital NHSFT.
9.4.3	CL stated that the CCG forecasted overspend in Children's CHC, CHC nursing home placements, Learning Disability (LD) and Domiciliary Care. She added that the CCG continued to focus on improving CHC forecasts and processes.
9.4.4	CL stated that the CCG total budget was £933,529,000, with a cumulative expenditure of £380,024,549 against a cumulative budget of £388,970,376 as at month 5 (August). CL explained that the cost containment measures in place had resulted in a 5 month spending of £8,945,827 below budget.
9.4.5	CL presented the balance sheet position of the CCG as at 31 July 2019 and explained that the CCG's current assets were £10.941m, with cash and cash equivalents of £6.043m; and the current liabilities stood at £39.430m.
9.4.6	CL considered the CCG material risks impacting on finances as: • the growth and demand pressures in acute contracts; • the drug costs in GHFT contract; • the slippage in delivery of savings solutions; • the prescribing volatility.
9.4.7	CL stated that to mitigate these risks, there was the need to identify new saving schemes and the need to commit to balance sheet reviews. CL also stated that no controllable expenditure should be committed to if no tangible source of funding was identified.
9.5	**RESOLUTION: The Governing Body noted the CCG's performance**

	and financial forecast position and the inherent risks within the position.
10.	**Integrated Care System (ICS) Update**
10.1	MH delivered the update and described how the CCG supported the enabling programmes included within the 'One Gloucestershire Integrated Care System'.
10.2	MH outlined desired outcomes of the ICS as: • prevention of poor health; • promotion of self-care; • driving carer support; • medicine optimisation; • promotion of integrated commissioning; • supporting a culture of social subscribing; • system enablers such as Joint Digital Strategy, Primary Care Strategy, Joint Estates Strategy and Joint Workforce Strategy.
10.3	MH described the role of the 'Enabling Active Communities' project in building stronger and more sustainable communities to improve the health and wellbeing of the local people. MH gave an update on the progress made in supporting people, supporting workforce, supporting communities and supporting pathways.
10.4	MH articulated the 'Fit for the Future' programme as a platform for optimising the delivery of a collective vision and urgent care to patients when they needed the service most. MH emphasised that in order to make such vision a reality and provide safe and sustainable services into the future, it was necessary to consider ways of making best use of available resources and facilities.
10.5	**<u>RESOLUTION</u>: The Governing Body noted the contents of the ICS report.**

11.	**Quality Report**
11.1	MAE presented the quality report and highlighted areas of strong performance and areas that required increased attention. MAE defined 'Serious Incidents' as negatively impacting incidents which occurred in NHS-funded services. MAE explained that each reported incident and subsequent action plan was subject to review by the quality lead for the service provider where the breach occurred.
11.2	MAE defined 'Never Events' as serious incidents that were entirely preventable because guidance or safety recommendations providing strong systemic protective barriers were available, and should have been implemented by the service provider. MAE stated that some 'Serious Incidents' and some 'Never Events' had been reported and investigated.
11.3	MAE stated that infection control performance was satisfactory but 'Urinary Tract Infection' (UTI) was high and a redress was being robustly sought. MAE reiterated that overall the CCG performance was not disappointing if viewed in comparative terms.
11.4	MAE stated that 91 E.coli bacteraemia cases were reported in period April – July 2019. 20% of the cases had a hospital onset and 80% had a community onset. MAE explained that overall the CCG performance was higher than national average.
11.5	AE enquired as to whether there were pressures being faced in the provision of further training to nurses. MAE explained that challenges usually existed in the form of reluctance by some employers to release nurses for staff training. MAE emphasised that supporting up skilling for nurses through the provision of advanced staff training would help mitigate performance pressures.
11.6	**<u>RESOLUTION</u>: The Governing Body noted the contents of the Quality Report.**

12.	**Annual Public Health Report**
12.1	SS presented the report and articulated the key infrastructural support for reduction of inequality in Gloucestershire as being premised on the new model of inclusive growth in which investment in social infrastructure would be a significant factor in delivering good health. SS added that the new model was informed by the need to allow as many people as possible to contribute to inclusive economic growth, or other types of development supporting health.
12.2	SS stated that it was important to reduce inequality because inequality was not only a social problem, but also hampered long term economic performance and the productive potential of Gloucestershire. SS explained that inclusive economic growth required the alignment of essential transport, housing, digital infrastructure and human resource development, with local planning policy.
12.3	SS emphasised that social mobility was a significant factor in creating opportunities for all people regardless of their background. SS described social mobility as the link between a person's income and the optimal or higher level of income. SS described school readiness as another important factor in driving social mobility. SS added that generally, children in deprived areas tended to lag behind in school readiness.
12.4	AS referred to statistical evidence of the general poor school readiness in the county and he enquired as to what measures were being taken to address the problem of poor performance. SS responded that her team was looking at ways of redressing the problem. SS assured members that she was committed to providing further updates in the near future. **Action: SS**.
12.5	**<u>RESOLUTION</u>: The Governing Body noted the contents of the Annual Public Health report and supported the recommendations set out in the report.**

13.	**Governing Body Assurance Framework (GBAF)**
13.1	CGi presented the GBAF and explained that each directorate had a Risk Register that was updated on monthly basis. CGi further stated that the register was used as part of directorate meetings to shape discussions on emerging and current risks which needed more attention. GCi stated that the CCG had introduced a more advanced risk management and assurance tool called 4Risk. CGi added that the old risk management tool which relied on spreadsheets was being phased out.
13.2	CGi presented the CCG high level risks to members; which included risk K15. CCG explained that K15 was a new risk relating to at least 8 care homes within Gloucestershire. A number of residents in the care homes were placed in the homes by other authorities, or other CCGs. The Gloucestershire CCG was not able to monitor these homes because the placements were outside its contractual jurisdiction.
13.5	**RESOLUTION: The Governing Body noted the existing risks and the new K15 risk.**
14.	**Primary Care Commissioning Committee Minutes of the Meeting Held on 27 June 2019.**
14.1	**<u>RESOLUTION</u>: The Governing Body noted the contents of the Primary Care Commissioning Committee minutes.**
15.	**Quality & Governance Committee Minutes of the Meeting Held on 13 June 2019.**
15.1	**<u>RESOLUTION</u>: The Governing Body noted the contents of the Quality & Governance Committee minutes.**
16.	**Audit & Risk Committee Minutes of the Meeting Held on 7 May 2019.**

16.1	**<u>RESOLUTION</u>: The Governing Body noted the contents of the Audit & Risk Committee minutes.**
17.	**Audit & Risk Committee Minutes of the Meeting Held on 21 May 2019**
17.1	**<u>RESOLUTION</u>: The Governing Body noted the contents of the Audit & Risk Committee minutes.**
18.	**<u>Audit & Risk Committee Minutes of the Meeting Held on 2 July 2019</u>**
18.1	**<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 12:50pm

Date and time of the next meeting:

The next meeting would be held at 2:00pm on Thursday 28 November 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 – November 2019

Item	Description	Response	Action with	Due Date	Status
25.07.19 Item 11.2.3	Cancer Performance Overview. ER explained that there was a recovery plan in place to reverse the 62-day performance pressures. The Governing Body requested a detailed timeframe-based plan to be brought before members in a future Governing Body Development Session.	Following the update regarding cancer performance presented to the governing body in July 2019, a further update was presenting to the Finance & Performance Business Meeting for the Governing Body on 24th October (presented by Christian Hamilton and Kat Doherty). Cancer Performance improvement remains a key priority for the CCG teams and we will be keeping the Governing Body well appraised on progress. Kathryn Hall and Christian Hamilton are proposing that the next update should be an in-depth review of the Prostate Cancer pathway, with the intention of inviting a GHNHSFT lead to update directly on the work of the Trust's Task and Finish Group. We are liaising on confirming a date in the next couple of months.	ER	28 November 2019	Open

26.09.19 **Item 9.3.4**	Mental Health and Community Health Overview. LF raised the concern of the increase of people residing outside the county who accessed local services within Gloucestershire and he enquired as to how planning accommodated such an influx when mapping out the delivery of services. KF promised to go back and get more data and return with additional information to present to the Governing Body.	Please find attached appendices with information and documents demonstrating the work we and our partner agencies are undertaking to try and address the issue of 'into county placements'. Please also note that this issue has been flagged at national level. Work is taking place across the South West region to consider how we work collectively to address this issue and to implement best practice guidelines above and beyond current ADASS and NHSE guidance. Main points to address – 1. Suitability of care and support services 2. Information – who records/holds details of OOA placements 3. Quality and safeguarding issues 4. Process to inform host authorities - arrangements for making placements and appropriate information sharing 5. Reviews - who, frequency, responsibilities.	KF	28 November 2019	Open

26.09.19 Item 12.4	AS referred to statistical evidence of the general poor school readiness in the county and he enquired as to what measures were being taken to address the problem of poor performance. SS responded that her team was looking at ways of redressing the problem. SS assured members that she was committed to providing further updates in the near future.	Update to be provided	SS	28 November 2019	Open

Gloucestershire County Council
Shire Hall
Westgate Street
Gloucester
GL1 2TR

11 January 2019

Dear xxxx

Out of Area Placements into Gloucestershire

In Gloucestershire we have been working with our health colleagues over the last year to better understand those individuals placed within county where their place of ordinary residence/funding is outside of Gloucestershire.

In conjunction with this, I am writing to ask you for information about the individuals currently funded by your organisation and living within Gloucestershire.

On the 28 November 2018 ADASS published the '*ADASS and LGA Advice Note for Directors of Adult Social Services: Commissioning Out of Area Care and Support Services'.* This Advice Note outlines recommendations for local authorities responsible for commissioning services for adults with social care needs who are in out of area care and support services. The ADASS and LGA Advice note can be found in full by accessing the link below:

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/transforming-care/transforming-care-1

One of the recommendations from the Advice Note is that 'host local authorities should develop a method or system for holding information (under GDPR guidelines) provided by placing authorities'. This will allow us to fully understand the Gloucestershire landscape should any safeguarding concerns arise, allow us to identify contact points for placing authorities when making enquiries about the quality of a provider and improve communication generally between placing and host authorities.

To fulfil this, we would request you complete the specific information required as per the attached Excel spreadsheet '*Notification of Out of Area placements to Gloucestershire*' in the first instance, to capture existing placements, enabling us to fulfil this element of the Advice Note. ***Please send this back by your usual encryption method and attach a password to the document and send this in a separate email*.**

In order for us to continue to keep this information valid we would also request as a host authority, that your organisation provides pre-notification regarding any individual you are considering for placement. Please use the '*Pre-notification of an Out of Area Placement to Gloucestershire*' Form, also attached in this email prior to placement confirmation.

Obtaining this information will help us to establish the number of out of area placements currently within Gloucestershire in line with the Advice Note issued by ADASS.

We hope this process will start a dialogue with yourselves that will enable us to jointly move forward in sharing information that, when a placement is made, endeavours to deliver an appropriate service to meet the needs and outcomes you as a placing authority would require, whilst ensuring we respect the needs of the people at the property by ensuring compatibility of the new person.

Yours sincerely

Jane Reid
Outcome Manager
Integrated Disabilities Commissioning Team

cc Holly Beaman, Joint Lead Commissioner, Disabilities
cc Paul Yeatman, Chair Gloucestershire Adult Safeguarding Board
cc Margaret Wilcox OBE, Gloucestershire Director of Social Care

Name of the placing/funding authority - (where applicable indicate s117) *e.g. LA, CCG, joint funded*	**First Name**	**Surname**	**Date of Birth**	**NHS No.**	**Disability Type** *e.g LD PD MH Autism*	**Provider Name**	**Provider Address**
EXAMPLE *CCG/LA joint funded*	*Joe*	*Bloggs*	*1/1/1980*	*123 456 789*	*Autism*	*Care Provider*	*20 My Road, My Town, Postcode*

Name of the placing/funding authority - (where applicable indicate s117) *e.g. LA, CCG, joint funded*	**First Name**	**Surname**	**Address of property where SU will live**	**Type of support provided** *e.g Residential/Supported*	**Date provision commenced**
EXAMPLE *CCG/LA joint funded*	*Joe*	*Bloggs*	*14 My Street, My Town, Postcode*	*Supported Living*	*1/1/2000*

Name of the placing/funding authority - (where applicable indicate s117) *e.g. LA, CCG, joint funded*	**First Name**	**Surname**	**Brief description of SU needs** *e.g. Complex behaviour, PMLD, Autism, Down's syndrome etc*
EXAMPLE *CCG/LA joint funded*	*Joe*	*Bloggs*	*Complex behaviour*

Pre-notification of an Out of Area placement to Gloucestershire Form

Placing Organisational Information	
Your name:	
Your job title:	
Your contact details: *(Telephone and email)*	
Name of your placing/funding authority: *(where applicable indicate s117) e.g. LA, CCG, joint funded*	
Placement - Individual's Information	
Name of individual:	
Date of birth:	
Individual's NHS number:	
The type of disability: *e.g. PD, MH, LD, Autism*	
Placement Information	
Name of the provider:	
Address of the provider:	
Address of property where person will live:	
The type of support provided: *e.g. Residential/Supported Living*	
Date of provision commencing:	
Brief description of individual's needs: *eg Complex behaviour, PMLD, Autism, Down Syndrome*	
Indication of likely local health service involvement: *e.g. will CLDT involvement be required*	

Please send this completed form prior to placement to
disabilitiescommissioning@gloucestershire.gov.uk

CCG Governing Body (adapted from ICS Executive Care Outcomes Paper)

Name of Paper: % of children achieving good development

Name of Author: Beth Bennett-Britton and Sarah Hylton
Name of Executive Lead:
This outcome is collectively owned by Sarah Scott, Chris Spencer, Tim Browne.

The Director of Public Health has a responsibility to deliver the mandated health visiting contacts as well as a broad role in promoting health and wellbeing and reducing health inequalities. The Director of Children's Services is responsible for promoting high quality early years provision, including helping to develop the market, securing free early education for eligible 2, 3 and 4 years olds. The Director of Education was also consulted in the development of this paper as the Early Years Team sits within the Education Hub of GCC.

Who is the Responsible Owner? Beth Bennett-Britton and Sarah Hylton
What is the Governance?

We have established an informal "Improving Early Outcomes for Children" Group which has brought together key partners representing:
Primary Schools
Early Years Settings
Public Health Commissioning (Chair), GCC
Early Years Education, GCC
Children's Commissioning and Early Help, GCC
Public Health Nursing
Voluntary and Community Sector (Home Start and PATA)
Education Psychology

The Group has reported its findings to the Leadership Gloucestershire Social Mobility group as it is recognised that early child development is a key determinant of social mobility and inequalities in educational attainment and life chances.

What is the Expected Target:
The aspiration is to improve results in line with nearest statistical neighbours. In addition we hope that we would be able to see an improvement in outcomes such as reduced exclusions, fewer CIN or CIC, reduced escalation to high needs and improved health outcomes.

What is the Current Performance:

The Department of Education have recently published the 2018-19 Good Level of Development data. Gloucestershire results are statistically similar to the England average.

The position in Gloucestershire in 2018-19 (Source: Department for Education)	
% of children achieving a Good Level of Development at the end of Reception	Gloucestershire : 71.9 England : 71.8

The breakdown of the 2018-19 data by Free School Meal status is not yet available.

This result is a significant improvement on the previous year's figures, where Gloucestershire was statistically significantly below the England average for both all children and children with Free School Meal status.

The position in Gloucestershire in 2017-18 (Source: PHE Fingertips)	
% of children achieving a Good Level of Development at the end of Reception	Gloucestershire : 69.2 England : 71.5
% of children with free school meals status achieving Good Level of Development at the end of Reception	Gloucestershire: 48.9 England : 56.6

This improvement is a huge achievement and likely to be the result of the action led by the Early Years Team at GCC.

What factors influence this indicator?

This is a complex issue and some of the factors which may be influencing this indicator are given below:

- Attending an early years setting can provide an opportunity for early identification and support for any delay in development. The proportion of children accessing their entitlement of 2, 3 and 4 year old EY Education provision to support their development has improved in Gloucestershire and is currently above the England average (72.8% of eligible 2 year olds accessed their free entitlement compared to 68% nationally). However this still means almost 30% of eligible children are not accessing the education.
- Thresholds for accessing children's support services may mean additional needs are identified and responded to later than in other areas causing needs to escalate.
- There may be variability in the support schools provide to understand and meet a child's additional needs.
- There is a need for greater consistency in the timing and quality of the GLD assessments of young people by building confidence, consistency and capacity.

Has an Investigation been Conducted?

A comprehensive action plan of possible reasons and mitigating actions was developed by the Early Years Team in the GCC Education Hub.

The Improving Early Outcomes for Children Group have held five workshops/meetings with stakeholders to understand the issues, develop a vision and identify priorities for action.

Are there any Data Quality Issues or Reporting Problems?

As above, there is a need for a continued focus on the consistency in the timing and quality of the GLD assessments of young people by building confidence, consistency and capacity

Please summarise the work underway to improve early outcomes for children

The Improving Early Outcomes for Children Group and Early Years Team within the GCC Education Hub have initiated a number of interventions to better understand the reasons behind performance and improve outcomes. These are summarised below:

- A 1 year temp EYFS Quality and Improvement Advisor post has been set up in the EY Service team to focus on: 1) schools with lower than average numbers of pupils with a GLD at the end of reception and 2) GLD inequality gaps. This post is the only dedicated support we provide for reception classes.
- Development of leaflets for families and professionals to facilitate a shared

understanding of what we mean by 'school readiness' and how families can prepare their children for school (these can be viewed here https://www.gloucestershire.gov.uk/media/2092781/gcc_2655-school-readiness-leaflet-families_aw.pdf)

- Improving the transition process from Early Years (EY) to statutory education.
- Two DfE funded projects are currently running:
    - The Early Outcomes Project (value £347,662 for 1 year) will identify and support children who are at risk of or display early signs of atypical language development from the ante-natal period onwards, particularly 0-30 months, in order to intervene at the earliest opportunity to minimise the achievement gap by age 5. The project will run in Gloucester City only.
    - The Professional Development Programme (total value £391,800 over 2 years) will provide access to literacy, language and numeracy training for selected EY practitioners who will then cascade this training within their settings. Gloucester, Cheltenham and FoD will receive training.
- Investigating the feasibility of using the principles of nurture corners in Early Years settings to complement the existing nurturing approaches used in primary and secondary schools.
- Development of a pathway to identify early language and communications difficulties.
- Participation in the EYFS National Research Initiative – EYFS practitioners' training for 1 year.
- Linking health visitor data with data on take up of free 2 year early years education to identify children who have not been seen by a health visitor and are not in an early years setting as these may be at higher risk of poor outcomes. Targeted support to access these services can then be provided.
- There is a Childcare Sufficiency Assessment and Action Plan which is used to develop the market for early year's education provision.

Improvement Trajectory?
As stated above, the data for 2018-2019 shows significant improvement, with performance statistically similar to the England average. However more analysis is needed to identify inequalities due to deprivation and gender. The aim is to improve performance and reduce inequalities in line with our nearest statistical neighbours.

What are the Risks?

There is a risk that the actions that the Improving Early Outcomes for Children implement are not sufficient to address the inequality issues which are preventing disadvantaged children from performing as well as their peers.

There is a risk that funding cannot be secured to continue the temporary EYFS Quality and Improvement Advisor post which could impact on the ability to do more to close the inequalities gaps.

There is a risk that any benefit gained from the DfE funded schemes is not sustained beyond the duration of the funding.

What are the Issues?

There is an issue related to the significant recruitment and retention of skilled/qualified nursery staff.

There is an issue due to governance as the Improving Early Outcomes for Children Group does not currently report to a decision making body.

What Decisions need to be made?

A decision is required related to governance. It is envisaged that should a Children's sub-board of the Health and Wellbeing Board be established, the Improving Early Outcomes for Children Group can report into this and will be a key theme within the proposed Children's Plan.

A decision is required related to long term sustainability of the outputs from the Improving Early Outcomes for Children Group and Early Years Team's work.

Questions from the Public

Patient Story Shared with the Governing Body

NHS Gloucestershire Clinical Commissioning Group

Agenda Item 7

Governing Body meeting

Meeting date	**28 November 2019**
Title	**Clinical Chair's Report**
Executive Summary	This report provides a summary of key issues and updates arising during October and November 2019 for the Clinical Chair.
Key Issues	Key topics for this report: • Primary Care Infrastructure • Primary Care Strategy progress including our work with the Health and Wellbeing Board • Improving access • Workforce • Digital First Primary Care • Care Quality Commission and mergers • Adverse Childhood Experiences • Gloucestershire Health & Wellbeing Board • Meetings September to November 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

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NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item

Governing Body

28 November 2019

Clinical Chair's Report

1. Primary Care Infrastructure

1.1 I am delighted to report that a new health centre in Stow-on-the-Wold opened on Monday 28 October, bringing fresh, modern, spacious facilities to the town. The surgery on Maugersbury Road has seven GP consulting rooms, four nurse consulting rooms, two phlebotomy rooms, an area for minor procedures, a further two consulting rooms specifically for trainee GPs and a number of meeting rooms. The accommodation was designed with people who have disabilities and dementia in mind, with signage and access ensuring the area is easy to navigate.

1.2 At October's Primary Care Commissioning Committee, members received a report on the Business Case for the development of a new surgery for the people of Minchinhampton. Approving the development, which is planned for Vosper Field, Cirencester Road, will ensure a building large enough to serve up to 9,000 patients together with the ability to host new primary care network (PCN) team workers, multi-disciplinary team meetings, an increase in clinical sessions and additional clinics such as those in sexual health, minor operations, midwifery, community pharmacy, respiratory, counselling, dementia and mental health. This is another exciting new premises development for the county, with opening expected in October 2021.

2. Primary Care Strategy Progress

2.1 The Primary Care Strategy document was updated and circulated to all stakeholders during September, updated and incorporated as an appendix

to our ICS Long Term Plan Response and submitted as a standalone document to NHSE on 30 September. Primary Care Commissioning Committee members reviewed the strategy at their October meeting and it will be presented to the Governing Body in January 2020.

2.2 In this period practices and PCNs had to decide whether to transfer into their PCN, their NHS England scheme related to Clinical Pharmacists. Meaning that there was a choice to be made about transferring Clinical Pharmacists employment to PCN employment. We not only had one of the highest numbers of Clinical Pharmacists in a CCG, but also one of the highest ratios of transfer into the PCN. In addition to the above some of our PCNs have now recruited to posts under the Additional Roles Reimbursement Scheme (Clinical Pharmacists and Social Prescribing Link Workers for 2019/20).

2.3 I am pleased to report that the Data Protection Officer (DPO) for general practice, which is a mandatory requirement within the Long Term Plan, is now in place.

2.4 Finally, we are progressing with the PCN and Clinical Director development. We are currently surveying all Clinical Directors on their development needs and working with PCNs through the locality team to understand PCN development needs. This is being dovetailed with the work being undertaken in the Primary Care Training Hub to have complementary development and education opportunities.

2.6 Integrated Locality Partnership members, have since my last report, been discussing and agreeing priority areas of work which will contribute to the delivery of the NHS Long Term Plan by Place. Members from each ILP have participated, along with local people, in discussions on the future of urgent care in Gloucestershire.

3. Improving Access

3.1 We continue to deliver over and above the national mandated target of thirty minutes per thousand population for the Improved Access target. In this period we received a visit from the national Access Team from NHS England as part of their investigations to inform the Access Review. We coordinated this visit and were pleased to be able to report back on how Improved Access is working locally, including visits to practices in the

Forest of Dean and Gloucester City. We await feedback from NHSE following the access visit.

4. Workforce

4.1 The additional roles in primary care could have a detrimental impact on our wider workforce in Gloucestershire. We are mindful of this risk and are in the process of establishing cross system task and finish groups, reporting to our Local Workforce Action Board (LWAB) initially focused on Clinical Pharmacists and Advanced Physiotherapist Practitioners. These will build on the work already undertaken by partners on their staffing offer to GP Practices, with an initial stakeholder workshop for Clinical Pharmacists planned for early December.

4.2 The Annual Workforce Survey is underway to provide a robust representation of Gloucestershire's primary care workforce and to support workforce planning. Part of the Annual Workforce Survey included questions on whether GP practices were taking on learners and finding out reasons why not, if that were the case.

4.3 The CCG supports many career development opportunities for GPs in the county and last month I updated on the new GP Fellowship programme and our Wise 5 programme. In addition to these an Early Career GP Lead was employed on an initial 12 month basis for one session per week. The lead will focus on supporting F1 and F2 GPs, in particular, when they were deciding which area of medicine to pursue. Later this year we plan to recruit, in partnership with the Primary Care Training Hub and Health Education England, a fellow to act as a liaison between the GP vocational training scheme and GP trainees in county.

4.4 There are currently ten GP retainers in the county with requests increasing. The CCG contributes funding towards this scheme in which eligible GPs may request to work for between one and four sessions per week.

4.5 Our newly qualified GP scheme has been running for two years. Four host practices took part in the scheme in 2019/20 with six out of eight GPs who participated in this scheme remaining in the practices in which they were

placed.

4.6 A new Clinical Development and Education Matron has commenced in post at the CCG with a focus on a training analysis. In addition each locality has a nurse coordinator to provide support and also education and training needs. The nurse coordinators, who form part of the parachute nursing team, are being utilised to provide nursing support to cover unexpected short term gaps in general practice.

5. Digital First Primary Care

5.1 The Long Term Plan states that "every patient has the right to be offered digital first Primary Care by 2023/24" which would enable patients to be able to access advice, support and treatment digitally. Twenty six percent of patients in Gloucestershire have an Online Account which compares favourably to the minimum target of 10%.

5.2 Gloucestershire's use of the Electronic Prescription Service is one of the highest in the country. In this service a prescription can be sent directly to a patient's nominated pharmacy of their choice and thereby remove the necessity to attend the GP practice.

5.3 The NHS app has been implemented across Gloucestershire although not yet widely advertised. Advertisement will dovetail with a national communications campaign this Autumn.

5.4 The new website (Footfall from Silicon Practice) supports Care Navigation and signposting to self-help and other services. This allows secure electronic communication between patients and practices and supports administrative functionality, which should reduce telephone calls to practices and therefore moderate the associated workload. Twenty four practices have already upgraded with another thirty having accepted the FootFall solution. If all these practices go ahead with installation circa 476,000 Gloucestershire patients will have access to digital on-line consultation. The remaining practices have been contacted to ascertain how they will provide digital communication in 2020.

6. Care Quality Commission (CQC) for General Practice and mergers

6.1 Four GP Practices in Gloucestershire have a CQC overall rating of "Outstanding", the majority (68) have a rating of "Good" and two have a rating of "Requires Improvement".

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

7.1 Adverse Childhood Experiences

7.2 Gloucestershire Safeguarding Children Partners have set themselves a very ambitious target – to produce viral change and embed ACEs and trauma informed care across Gloucestershire. The aim is to change our approach to situations from 'why did you do that?' to 'what has happened to you?

7.3 Gloucestershire remains at the forefront in this area and is the only CCG to fund a Lead Health role for ACEs embedded in Safeguarding Children. This has enabled Health to be fully committed to challenging professionals to review their practice in the knowledge of the impact of trauma and to focus on improving outcomes by building resilience
Within children's services:

- Health professionals have received an awareness training session as part of mandatory training.
- Midwifery has developed a maternity screening tool (which is currently being evaluated). The aim is to link with Early Help and improve outcomes for the unborn baby.
- A number of teams have been involved in piloting the Children's Services ACEs toolkit facilitating better multi-agency working.
- ACEs/trauma are fundamental elements in the delivery of the Trailblazers programme and embedded in Crisis working teams/CIC teams etc.
- ACEs were the focus of the Annual Safeguarding update for Train the Trainer for GPs last year. A group of GPs are now working to

produce videos and toolkits for use in GP practices.

- All new training materials are incorporating the work on ACEs/trauma with the focus to build resilience within individuals and communities.
- The updated training strategy is being launched with new training material including an e-learning programme.
- There has been a showcase event where professionals from other counties and NHS England attended as they had heard of our work and have used various materials we have developed to begin their own programmes.
- There was a very successful Ambassadors meeting to define their roles and where stories were shared as to how we can make a difference (the demand was so great a further meeting is planned for the New Year).
- There are plans for a further ACEs Conference in June 2020 to update professionals and to continue to work on 'so what?' – how do we improve outcomes?

7.4 The above is a small selection of some of the work undertaken and planned. There is a website that provides additional resources/contacts. The view is that change has begun and it needs to continue to drive it with Health being an integral partner

8. Gloucestershire Health and Wellbeing Board

The Health and Wellbeing Board meets on five occasions throughout the year. The Board is chaired by Cllr Roger Wilson, and includes representatives from across Gloucestershire's health, care and public sector agencies. The Board is well represented by the CCG, I currently hold the post of Vice-Chair. Dr Hein Le Roux, CCG Deputy Clinical Chair and Mary Hutton, Accountable Officer are also members of the Board. At the September meeting the Board considered reports on Housing and Health, Healthy Weight, the NHS Long Term Plan, the Better Care Fund Plan as well as the Director of Public Health's Annual Report.
Agendas and papers for board meetings are available from Gloucestershire County Council's website:
http://glostext.gloucestershire.gov.uk/documents

9. Meetings September to November 2019

- Friday 27 September National Review of access to general practice services
- Monday 30 September Practice visit to Royal Crescent Surgery, Cheltenham
- Thursday 3 October CCG Event, Cheltenham Racecourse
- Monday 7 October Meeting with Mark Pietroni, GRH
- Thursday 10 October Leadership Gloucestershire, Gloucestershire Constabulary
- Thursday 10 October Locum event, Hatherley Manor Hotel
- Monday 14 October Practice visit to Stow Surgery
- Thursday 17 October GP/Consultant meeting, Sandford Education Centre
- Thursday 24 October PCN Clinical Directors meeting, Sanger House
- Thursday 24 October Engagement Hearing, Chase Hotel
- Friday 25 October A&ED Delivery Board Meeting, Sanger House
- Friday 25 October Meeting and hospital visit with Laurence Robertson MP, Tewkesbury
- Monday 28 October Meeting with Cllr Tim Harman, Sanger House
- Tuesday 29 ICS Board, Sanger House
- Thursday 31 October NHSCC Annual Members Event, London
- Monday 11 November Practice visit, St George's Surgery, Cheltenham
- Wednesday 13 November PCN Development Group, Sanger House
- Thursday 14 November LMC Main Meeting, Farmers Club
- Thursday 14 November ICS Clinical Reference Group, Sanger House
- Thursday 14 November ICS Reducing Clinical Variation Programme Board, Sanger House
- Thursday 14 November Outcome of Engagement Hearing Fit for the Future, University of Gloucestershire
- Monday 18 November Exec Away Day, Prinknash Abbey
- Monday 19 November Health and Care Scrutiny Committee, Shire Hall
- Monday 19 November Health Chairs Meeting, Shire Hall
- Tuesday 26 November ICS Board, Sanger House.

10. Recommendation

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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 8

Governing Body

Governing Body Meeting Date	**Thursday 28 November 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 October and November 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: • **ICS Workforce and Organisational Development update** • **Carers update** **Other updates** • **Procurement update** • **Stop think…campaign set for relaunch** **Planned Care updates** • **Cinapsis** • **Dermatology Training** **Meetings attended in October and November 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	None.
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	Mary Hutton
Designation	Accountable Officer

Accountable Officer's Report

28 November 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 27 September 2019.

1. Integrated Care System (ICS) Workforce and Organisational Development update

1.1 Gloucestershire Health and Care partners have set up a Local Workforce Action Board (LWBS) to work jointly on a workforce and organisational development strategy that supports our desire to work together and provide solutions and services to meet the needs of our local population. The LWAB is chaired by the CCG's Accountable Officer and has representation from directors of human resources, as well as HR / OD professionals from Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospitals NHS Foundation Trust (GHFT), Gloucestershire County Council (GCC), South West Ambulance Service (SWAST) and Health Education England (HEE).

1.2 *The ICS Joint Workforce and OD Strategy has nine key objectives*:

- Develop a shared culture across One Gloucestershire moving from organisation to system culture along with exemplary leadership skills and make belonging to One Gloucestershire an attractive prospect.

- Person- and Community-Led ways of working need to become widely understood and valued as core to the whole health and care system.

- Improvement - Develop a culture that holds a patient/service user focus and improvement of services for patients/service users at its heart.

- Enable Right Skills to deliver ICS Clinical Priorities - Ensure cohesive and cost effective systems are in place.

- Effective ICS education system - Develop systems with local education providers to support all workforce development.

- Ensure that One Gloucestershire is at the forefront of apprenticeship. developments to capitalise on those developments at post-graduate level to develop advanced skills and to ensure that the maximum use is made of the apprenticeship levy.

- Ensure sufficient resources (capacity and skills) across the system to support the workforce planning, analysis and modelling required to support the Clinical Programme delivery required by the ICS.

- Recruitment and Supply - Develop a shared and streamlined system for attracting and employing new staff across One Gloucestershire.

- Work collaboratively across the One Gloucestershire system to describe and design the workforce and the ways that workforce will work together in the future. The focus will be on sustainability, flexibility, career pathways, rotations and supply.

1.3 **Key priorities**

In line with the Long Term Plan there are three distinct priorities for our HR / OD strategy:

- Making the NHS the Best Place To Work
- Improving the Leadership Culture
- Releasing Time to Care.

1.4 **Making the NHS the Best Place to Work**

1.4.1

- HR and OD colleagues are currently working on a number of joint initiatives as well as pursuing individual organisation projects, where learning and best practice is shared. This includes: **Talent Management / Succession Planning**. The ICS partners have chosen to pilot the new NHS High Potential Scheme with the Leadership Academy that aims to support leaders with potential by providing them with a structure development programme. The scheme will be rolled out in 2020.

- **Staff Health and Wellbeing**. A One Gloucestershire approach to health and wellbeing is being planned, building on the work already undertaken by health and care organisations to support staff with health and wellbeing. This includes schemes such as Health and Hustle – getting staff active, training staff in Mental Health First Aid,

fast track' access to support for staff with musculoskeletal issues, access to occupational health services, counselling and mindfulness sessions as well as courses in stress management. The introduction of GHFT's 'Health and Wellbeing Hub' where staff can ask questions/be signposted to resources and obtain support is an exemplar of best practice. The learning from this initiative is currently being shared with ICS partners and the CCG's Health and Wellbeing intranet pages are modelled on this work.

- **Equality & Diversity**. There are numerous schemes that ICS partners have implemented as part of their commitment to ensuring that everyone regardless of their ability or disability have the same opportunities to access meaningful occupation. This includes Disability Confident accreditation, signing up to Going the Extra Mile - the GEM programme supports vulnerable young people to get into the workplace. There are also plans to implement the 30/30 challenge that provides work based learning opportunities to vulnerable and disabled young people, in early 2020 within the CCG, as well as Better 2 Work scheme that provides support to people with mental health difficulties currently run by GHC. There are also plans to introduce a Black and Minority Ethnic coaching and mentoring network. Additionally all NHS organisations have targeted recruitment of Non-Executive Directors \ Lay Members for BAME requirements. For example the CCG was part of the Insight Programme in 2018 that placed a BAME Lay Member with the CCG for 6 months. Unfortunately the programme is not running in the south west during 2019.

- The OD Steering Group will introduce Equality, Diversity and Inclusion as one of the primary drivers to deliver our aspirations around leadership, culture, values, coaching and health-wellbeing during 2020. We will focus on identifying specific actions we can collaborate on and work together to support minority groups which are more vulnerable to discrimination. In particular BAME and disabled colleagues.

1.5 Improving the Leadership Culture

1.5.1 ICS partners have collaborated on a range of programmes to improve leadership at all levels of an organisation. The plans will be further

enhanced during 2020; they seek to improve leadership culture with a focus on better care through: positive leadership; compassionate leadership and improvement focused leadership. The following schemes / programmes have been implemented:

- **ICS Leadership Development Programme** was developed in 2018, funded via HEE monies, which was delivered to 48 leaders (comprising two cohorts of 24 leaders) across health and care organisations. The programme was aimed at leaders working at a strategic level, who were informing and developing service improvements across health and care organisations. In 2019 a second wave was commissioned using HEE and Leadership Academy funding; it was broadened to include leaders from GCC, voluntary and community groups, GP practice staff, SWAST and the Police. During 2019 / 20 there will be 4 cohorts of leaders trained (a total of 96 leaders). Each cohort has run with a different focus: Urgent Care; Dementia & Frailty; CVD & Diabetes; Respiratory & End of Life Care – delegates from these work areas have been encouraged to attend. Alumni from previous cohorts are supporting ICS wide projects and initiatives.

- Training and development. Each ICS organisation has a training and development programme. The CCG is currently hosting the Training Hub for General Practice that provides learning and development opportunities to general practice staff. GCC has implemented an Adult Social Care Leadership and Management Development Pathway open to GCC staff; GHFT has established a coaching faculty of 20 qualified coaches with GHC working on a coaching culture for the newly merged trust. The CCG has a coaching scheme currently operating with three qualified ILM coaches offering 6-10 coaching sessions for staff who have expressed an interest in being coached.

1.6 Releasing Time to Care

1.6.1 ICS partners are working collaboratively to improve productivity and efficiency in line with the Lord Carter recommendations including:

- Using technological solutions such as eJob Planning and eRostering.
- Reducing agency spend and looking at more flexible and collaborative ways to recruit and employ staff.

- Identifying opportunities from the Model Hospital work.

1.6.2 A range of technological solutions have been implemented by provider organisations to better plan their day to day workforce requirements including e-rostering, an employees relation tracker to enable HR Advisory services to better support staff and managers with grievances, sickness management and disciplinary cases, and the SafeCare Live acuity and dependency measuring tool. All organisations have plans in place to reduce agency spend, improve the recruitment of permanent staff and offer flexible employment opportunities to staff. A 5-year workforce plan is being developed which establishes existing gaps and future gaps. It was informed by series of workforce planning workshops held during the summer 2019 with clinical, operations, HR and workforce teams.

2 Carers update

2.1 The jointly commissioned Adult Carers Support Service, provided by Gloucestershire Carers Hub, has been operational for 6 months. Transition from the incumbent provider has been smooth and mobilisation has been going well.

2.2 **Key highlights include:**

Continued improvement of the Carers Emergency Scheme. A project team, with membership from commissioners and providers, completed the Quality, Service Improvement and Redesign course and as a result has reviewed and streamlined the registration paperwork. A recent visit to Amica24, where the activation calls are taken, proved helpful to ensure the process is robust. Support for carers will be a particular focus during the Breaking the Cycle week at Gloucestershire Royal Hospital in November. As part of this people will be working closely together to ensure as many carers as possible register with the Carers Emergency Scheme, and staff will then continue to promote the scheme throughout the winter period.

2.3 **The Carers Partnership Board has met twice.** Chaired by Nick Relph, the Chair of the Integrated Care System Board, this board has representation across the system, including from Adult Social Care Operations, GFirst Local Enterprise Partnership, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Health and Care

Foundation Trust, Primary Care, providers, the Voluntary and Community Sector and carers themselves. The Board will be co-chaired by two carers and we are currently recruiting to these roles. It is a very vibrant and energised board which is encouraged by seeing our commitment to carers in our response to the NHS Long Term Plan.

2.4 **Improved access to training for carers.** The November and December Carers Training schedule has been published and take up has so far proved successful. Alongside the traditional Positive Caring Programme (which will be reviewed and refreshed in 2020), there have been Wellbeing Sessions that include half day training on topics such as 'Getting a good nights sleep' and 'compassion fatigue'. Feedback includes "She has the ability to establish rapport with people very quickly.

2.5 **Recognising the impact of social isolation**. The session was extremely interactive and our group members were all given the opportunity to discuss their anxieties. The trainer enabled us to 'offload' and gave sound suggestions as to how we could think positively and problem solve." Training has also broadened out to include other topics such as 'Developing a Personal Resilience Plan' and 'Eating Well on a Budget with limited Time'. Gloucestershire Carers Hub have also started working in partnership with local organisations to ensure their partner's training is accessible to carers.

2.6 **Recognising the impact of isolation**
A key area of concern among adult carers regarding their perceived quality of life is social isolation. We recognise the importance of addressing this and therefore one of the key indicators proposed for measuring the success of the Gloucestershire Joint Health and Wellbeing Strategy 2019-2030 is to improve the percentage of adult carers who have as much social contact as they would like**.**

2.7 **Continued staff development in Gloucestershire Carers Hub.** Staff have had initial training in the Three Conversation Model and discussions are in place about embedding this culture to ensure carers are supported to be empowered to connect with their local community. We know this can be especially hard for carers, who are often isolated due to their caring role. The new key worker roles, with two workers based in each locality, will help with this.

2.8 **Supporting carers from Black and Minority Ethnic Communities.** An event was recently held at the Friendship Café in Gloucester. Over 90 carers from BME communities attended and heard about the support available in the community, including the Carers Emergency Scheme. The event had good energy and we will continue to build on this work.

2.9 **Supporting Parent Carers.** We have met with a number of parent carers over the last few months and plan to improve the support available to them from the Carers Hub; this will sit alongside the re-establishment of the Parent Carers Forum In Gloucestershire and the work of the GCC engagement officer.

2.10 **Working with GPs**. Our young carers in Gloucestershire have filmed "Young Carers' top tips for GPs" and these are available on the G Care portal. Gloucestershire Young Carers will shortly launch a new process whereby, with consent, the names of newly referred young carers will routinely be shared with their GP. Where a practice is alerted for the first time, they will also receive their GP resource pack which includes these local top tips for GP's, information to support the new CQC Quality Markers and online resources.

2.11 Robust monitoring of our providers continues, with strategic support from commissioners to ensure carers are valued, empowered and respected across Gloucestershire.

3. Other updates

3.1 Procurement update

3.1.1 Procurement staff are now in the process of re-procuring direct access Computerised Tomography, Magnetic Resonance Imaging and Endoscopy services. The new services are expected to mobilise in July 2020 on an Any Qualified Provider contract basis. In addition a further AQP procurement is being scoped for the provision of Assisted Conception / IVF services.

3.2.1 Stop! Think…campaign set for re-launch

3.2.2 The NHS in Gloucestershire is re-launching its high profile *Stop! Think…* winter campaign at the end of November.

The hard hitting campaign promotes simple messages about what to do if residents are ill or injured and highlights the different healthcare options available across Gloucestershire so people can access the right advice and care for them, easing the pressure on A&E.

The campaign that lasts over a three month period includes:

- High impact video content
- A strong digital element to the campaign e.g. sponsored social media adverts
- Integrated media packages – print, on-line and social media
- Door to door advertising through 'Local Answer'
- Eye catching collateral e.g. posters and concertina credit cards promoting the community service offer
- Collateral for local outlets, waiting room screens, community publications, community social media accounts and 'Top 10' employers
- Outdoor advertising.

Evaluation will be carried out through a service point survey, review of digital take up e.g. shares, downloads, views etc. and performance monitoring.

4. Planned Care updates

4.1 Dermatology Training Day - 10 October 2019

4.1.2 Gloucestershire CCG in conjunction with Gloucestershire Hospitals NHS Foundation Trust (GHFT) are working together to move towards a virtual model for dermatology. The aim is for clinicians in primary and secondary care will work together towards a virtual model of rapid diagnosis of skin conditions; particularly skin lesions, and deliver the most appropriate treatment, in the right place and at the right time.

4.1.2 Funding from the Primary Care Training Hub has enabled Gloucestershire CCG to provide training sessions to all clinicians within GP practices in Gloucestershire to support this vision. The first training day was held in March 2019. This day was extremely successful and subsequently another training day was held on 10 October 2019. The training days are an opportunity for GPs to learn how to identify skin lesions and to learn how to use a dermatoscope to take high quality

images with a smartphone and access rapid specialist advice from a dermatology consultant. Both training days were well received with over 50 GPs attending the first training day, and 40 attending the day in October. Feedback from both days was excellent with comments as below:

> • Excellent session - this will certainly help me refer less on a 2ww. I feel much more confident and empowered now with skin lesions, I feel my patients will benefit hugely. Thank you!!
>
> • Looking forward to save more lesions! Very useful for my day to day work. Very grateful. Thank you. Very GP focused which is great.
>
> • Thank you. I feel enthused to have learnt a new skill and look forward to applying the skills.

4.1.3 Further resources to continue to support learning have been provided on our G-care website dermatology educational resources section. This includes a dermoscopy quiz to reinforce some of the learning from the training day, along with four videos which include how to use a dermatoscope and how to request advice and guidance.

4.2.1 **Cinapsis update**

4.2.2 The Cinapsis dermatology module went live on 16 September 2019. Cinapsis provides a combined Information Governance (IG) compliant solution for capturing images using a smartphone with a secure end to end Advice and Guidance platform to allow GPs to quickly and easily seek specialist advice on skin conditions from local dermatologists. This represents an important upgrade to the local tele-dermatology offer to support further expansion of this service.

4.2.3 A total of 93 requests have been made via Cinapsis since the launch of the service, with 60% of requests resulting in advice to support the GP to manage the patient in primary care. Feedback to date from consultants and GPs has been very positive. Dermatology Advice and Guidance continues to be available for GPs to use alongside Cinapsis, but it is anticipated that the benefits of Cinapsis will gradually encourage GPs to move over to the new platform.

5. Meetings

Meetings that I have attended from September to November 2019

30 Sep	Meeting Cheltenham Borough Council
02 Oct	Joint Commissioning Partnership Executive (JCPE)
03 Oct	Commissioning Event
03 Oct	ICS Executive Board
07 Oct	NHS South West Chief Executive Meeting, Taunton
08 Oct	Gloucestershire Parent & Carers Alliance meeting
09 Oct	Enabling Active Communities Meeting
10 Oct	Leadership Gloucestershire
14 Oct	Practice Visit - Stow Surgery
16 Oct	Countywide Finance Away Day-presentation on ICS
16 Oct	Gloucestershire System planning meeting
17 Oct	ICS Board
18 Oct	Meeting & Hospital Visit with Sir Geoffrey Clifton-Brown MP
21 Oct	Tewkesbury Borough Council Presentation - Councillor Fit For The Future seminars
22 Oct	Stroud District Council Members Seminar Fit For The Future
23 Oct	Cotswold District Council Members Seminar Fit For The Future
24 Oct	Engagement Hearing
25 Oct	Meeting & Hospital Visit with Laurence Robertson MP

29 Oct	ICS Board
30 Oct	Local Workforce Action Board (LWAB)
04 Nov	Population Health Management (PHM) Development Programme Workshop
05 Nov	Health & Wellbeing Board with Safer Gloucestershire
05 Nov	Joint Commissioning Partnership Executive Meeting (JCPE)
07 Nov	ICS Executive Meeting
07 Nov	New Model of Care Board (NMOC)
11 Nov	Gloucestershire Hospitals NHS FT Single Item QSG
13 Nov	Joint Outpatients Board
18 Nov	Exec Away Day
19 Nov	Health & Care Scrutiny Committee Meeting
21 Nov	ICS CEO's Meeting
21 Nov	Gloucester Women's Centre Lunch Club
26 Nov	ICS Board

6. Recommendation

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

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Agenda Item 9

Governing Body

Paper by e-mail	**28th November 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 date (as available). The Finance report within the paper gives the forecast outturn as at Month 7. The finance paper outlines the net risk within the financial position and the significant risk within the financial position for the year and thus in achieving a breakeven position. Dedicated management action is required to recover the financial position.
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

10

	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 36-54
Legal Issues (including NHS Constitution)	Section 223H of the Health and Social Care Act 2012 sets out the duty for CCGs to break even on their commissioning budget for both revenue and capital. GCCG is required not to exceed the cash limit set by NHS England, which restricts the amount of cash drawings that the CCG can make in the financial year. The CCG must also comply with relevant accounting standards. The CCG has set an annual plan to achieve breakeven.
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 to: • discuss and note the CCG's performance • discuss and note the CCG's financial forecast position including the net financial

	risks within the position, any additional actions and the implications for the 2020/21 budget.
Author	Katharine Doherty Andrew Beard
Designation	Performance Manager Deputy Chief Finance Officer
Sponsoring Director (if not author)	Mark Walkingshaw – Deputy Accountable Officer Cath Leech - Chief Finance Officer

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CCG Monthly Performance Report

November 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	

NHS Gloucestershire Clinical Commissioning Group

2.3 Executive Summary - Sustainability

Amber

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 (%)	

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3.0 Performance Dashboard

Amber

Unscheduled Care

4 Hour A&E Oct (System)	4 Hour A&E Oct (GHFT)	Category 1 Ambulance September 19 (Gloucestershire)	Category 1 Ambulance YEAR TO DATE (Gloucestershire)	Delayed Transfers of Care (DToC) Sept 19 (GHFT)
86.4%	80.6%	7.3 mins	7.0 mins	4.51%

Planned Care September 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)
82.9%	82.4%	75	72	1.92%	0.8%	1.6%	0.8%

Cancer Dashboard (September 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)	96.2%	99.3%	93.3%	92.7%	100%	85.7%	79.2%	100%	88.9%
GHFT Performance	96.5%	99.3%	91.0%	97.6%	100%	80.8%	71.1%	100%	66.7%

IAPT (September 2019)

Access *(target 1.42%)*	Recovery *(target 50%)*
1.37%	51%

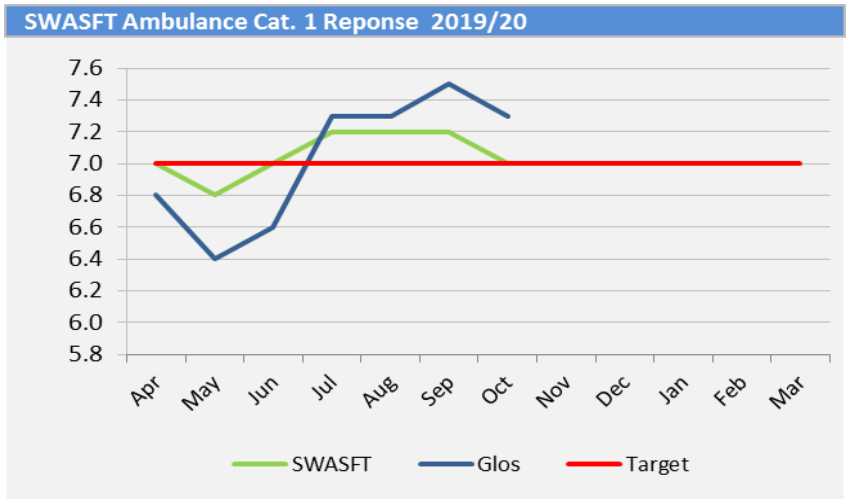
Dementia Diagnosis (September 2019)

Estimated Diagnosis Rate (Target 66.7%)
68.2%

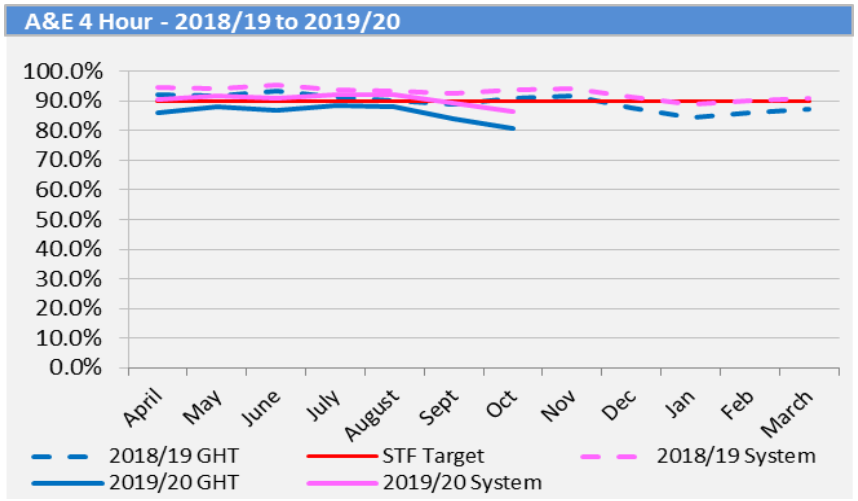
Arrow direction reflects performance

3.1 System Overview Unscheduled Care

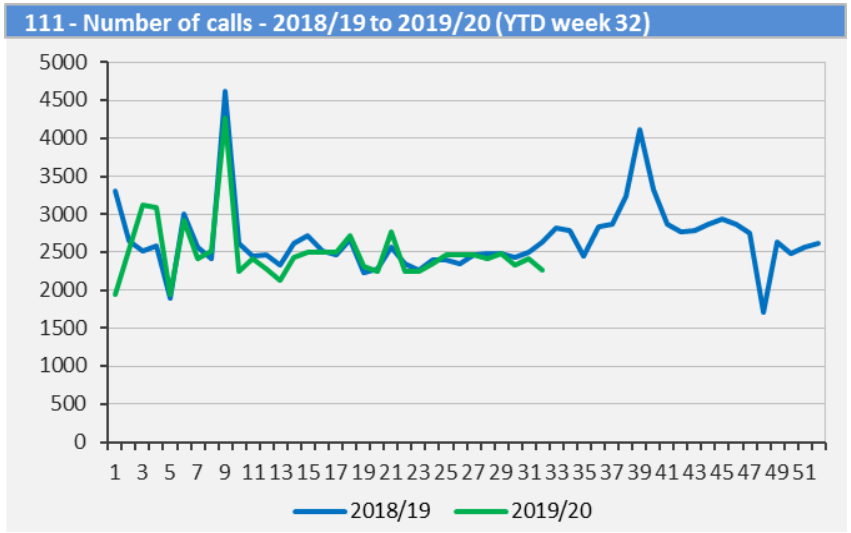
Ambulance – Category 1



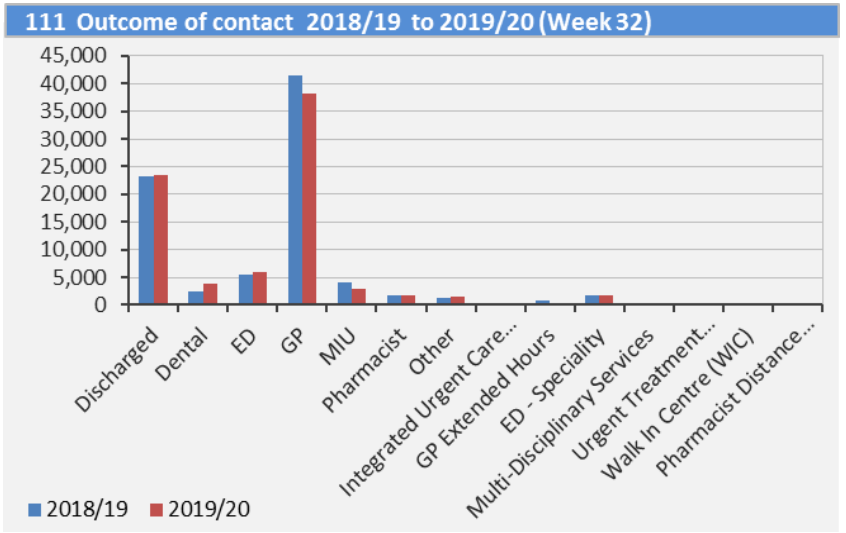
System A&E 4 hr Performance



111 Call Volume

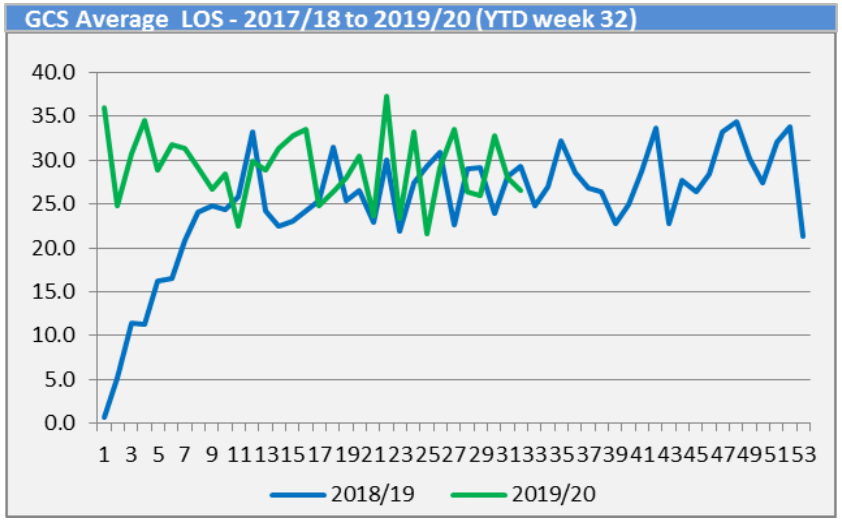


111 Disposition

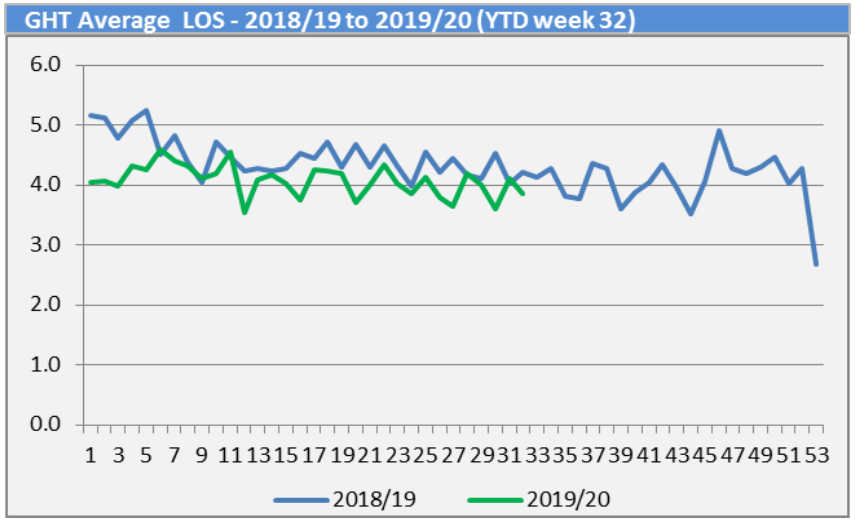


3.1 System Overview Unscheduled Care

GCS average Length of Stay

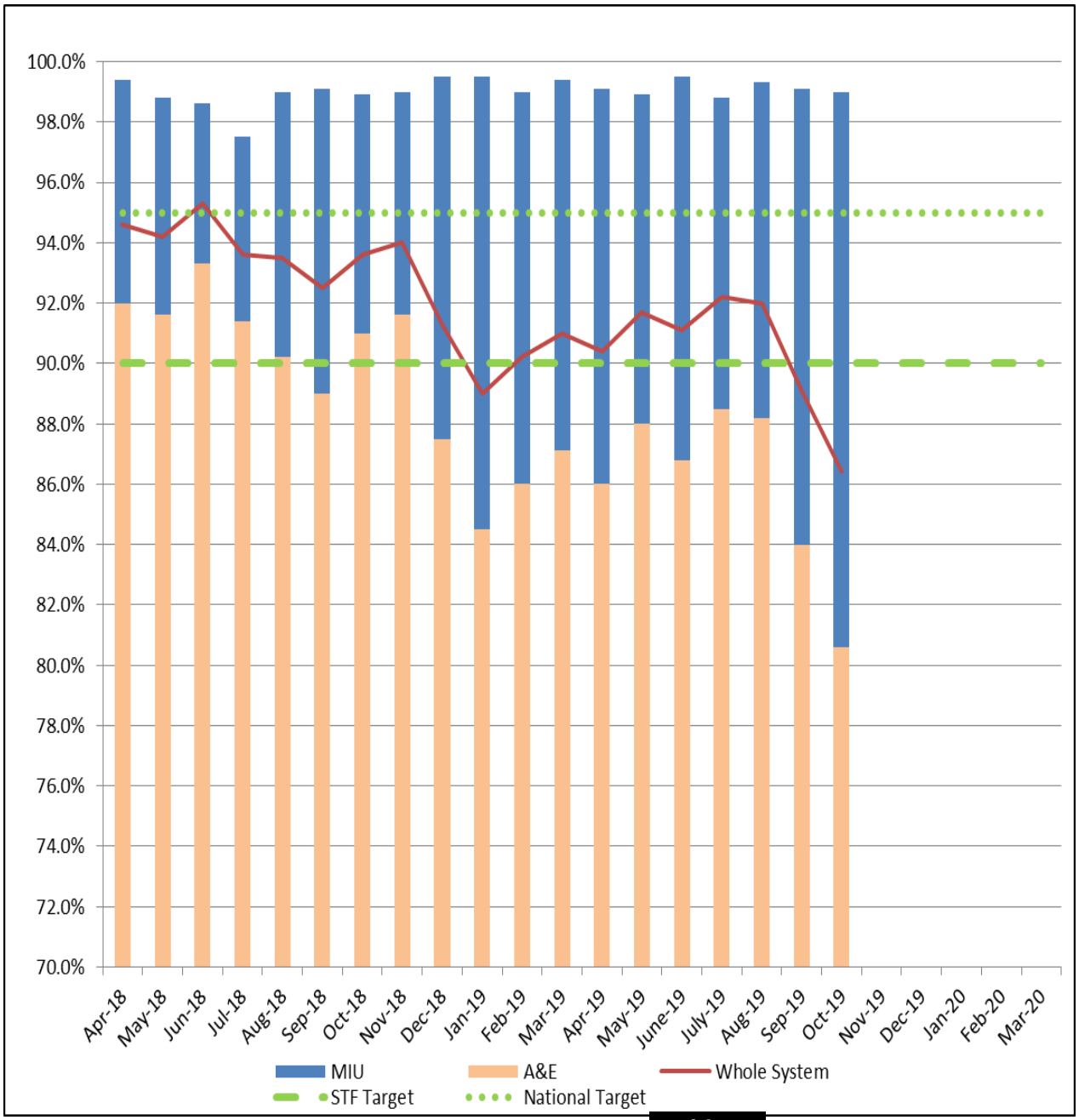


GHFT average Length of Stay



3.1 Unscheduled Care – 4 hour A&E

Amber



Top Line Messages:

Gloucestershire whole system performance was 86.4% in October 2019, reflecting performance of 80.6% against the 4 hour target at GHFT and 99.0% across all MIIU sites. YTD whole system performance is 90.5% against the 4 hour target, with GHFT YTD performance at 86.0%.

Nationally performance against the 4 hour target has dropped to the lowest level since the introduction of the target – reflecting sustained pressure on unscheduled care across the country.

To address system performance in Gloucestershire, and improve resilience a "Breaking the cycle" event was held week commencing 11th November. This event focussed on acute hospital front door (attendances) and system flow to determine whether patients were on the most appropriate pathways and where opportunities may exist to support alternatives to A&E presentations.

3.1 Unscheduled Care

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

- EIO (including positive decision making)
- Cinapsis
- Primary Care streaming

This has led on to 4 additional areas of focus for operational actions:

I. Readmissions
II. Respiratory
III. Mental Health pathways in ED (the impact of £480K transformation fund)
IV. Re-engineering of FAS and IAT at ED front door to have an enhanced offer across both GRH and CGH sites

Following the deployment of Shrewd, work is in progress to triangulate understanding of capacity over the system using this app. This will aid the proactive management of black escalation in particular.

Cinapsis:

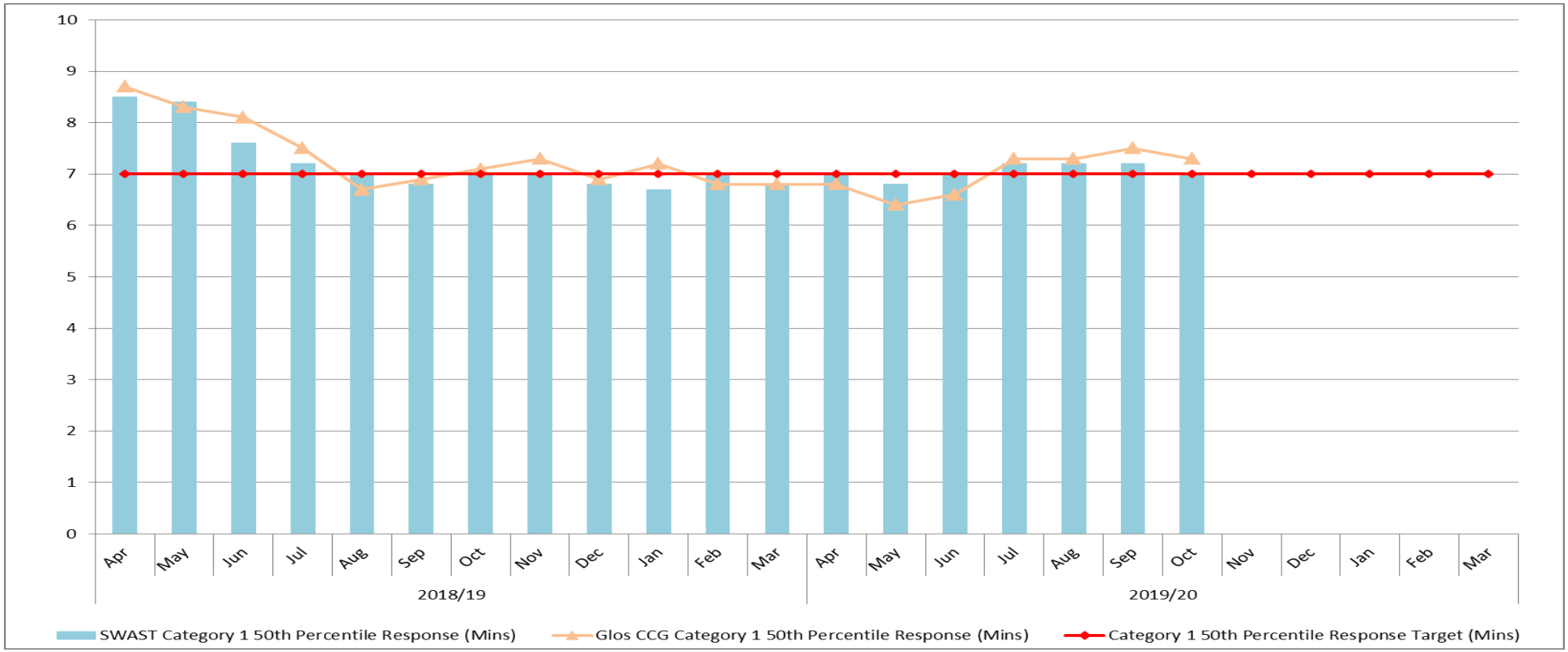
- Contract extension has been agreed/funded by the CCG 30th April 2020
- 4 specialities offering Advice &Guidance: Acute Medicine, Acute Paediatrics, Acute Respiratory and Dermatology
- 74% of GP practices have received a demonstration and have access to Cinapsis. 100% should have access by December 2019
- 588 calls have been made to date, with improved flow and patient experience

NHS111:

- Bristol CareUK call centre was awarded “Outstanding” by CQC in the recent inspection.
- GCCG are working with BNSSG, Somerset and NHSE/I to improve and streamline 999/ED validation.
- 60 seconds and abandonments targets performance remains volatile but recently there has been some improvement as “Back to basics” plan is implemented.

3.2 Unscheduled Care – Ambulance Category 1

Amber

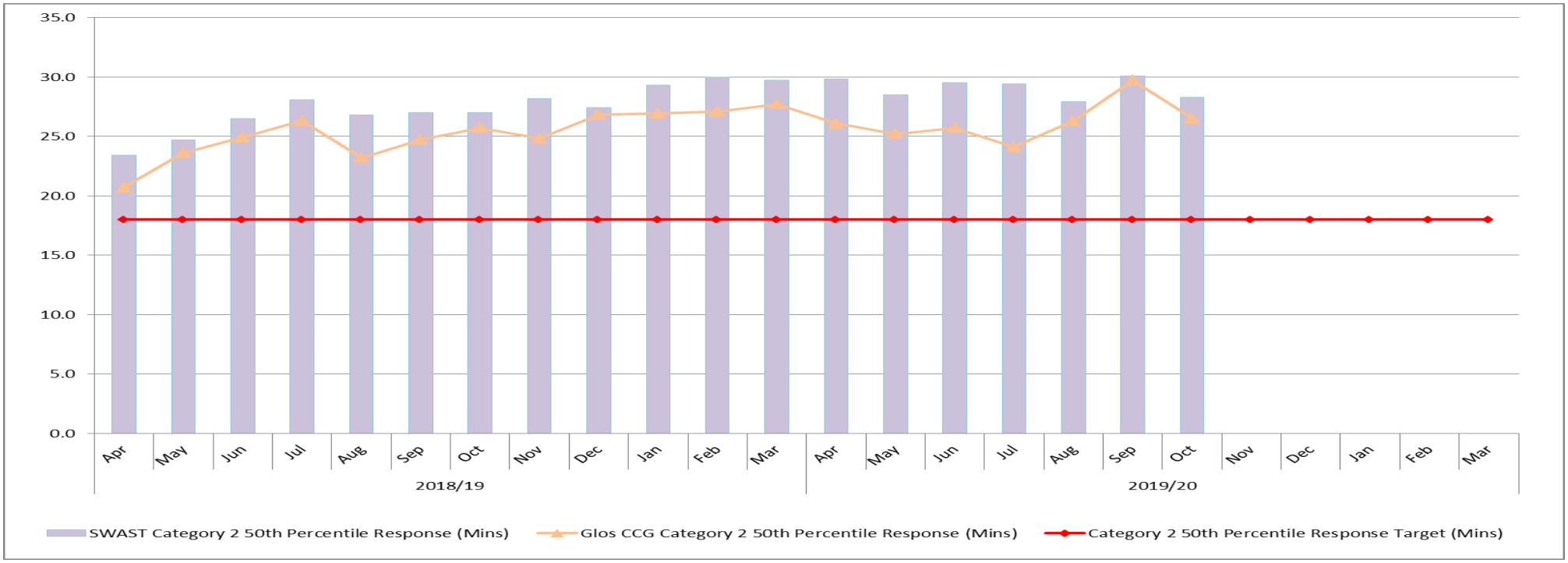


Gloucestershire performance in Category 1 for October 2019 remains within a 10% threshold of the 7 minute average response time target at 7.3 minutes. YTD performance across Gloucestershire is 7.0 minutes on average. SWAST Performance across all geographical areas (South West) was 7.0 minutes in October, meeting the 7 minute target across the whole region.

Handover delays have increased slightly at both GRH and CGH acute sites, the CCG is working with SWAST and GHFT to determine what actions can be implemented to return to the excellent performance seen earlier in the year.

3.2 Unscheduled Care – Ambulance Category 2

Amber



Category 2 performance again remains above the target of an average response time of 18 minutes in October 2019. This target has been missed consistently across the whole SWAST patch since the introduction of the ARP standards and remains a focus for improvement for South West commissioners in 2019/20.

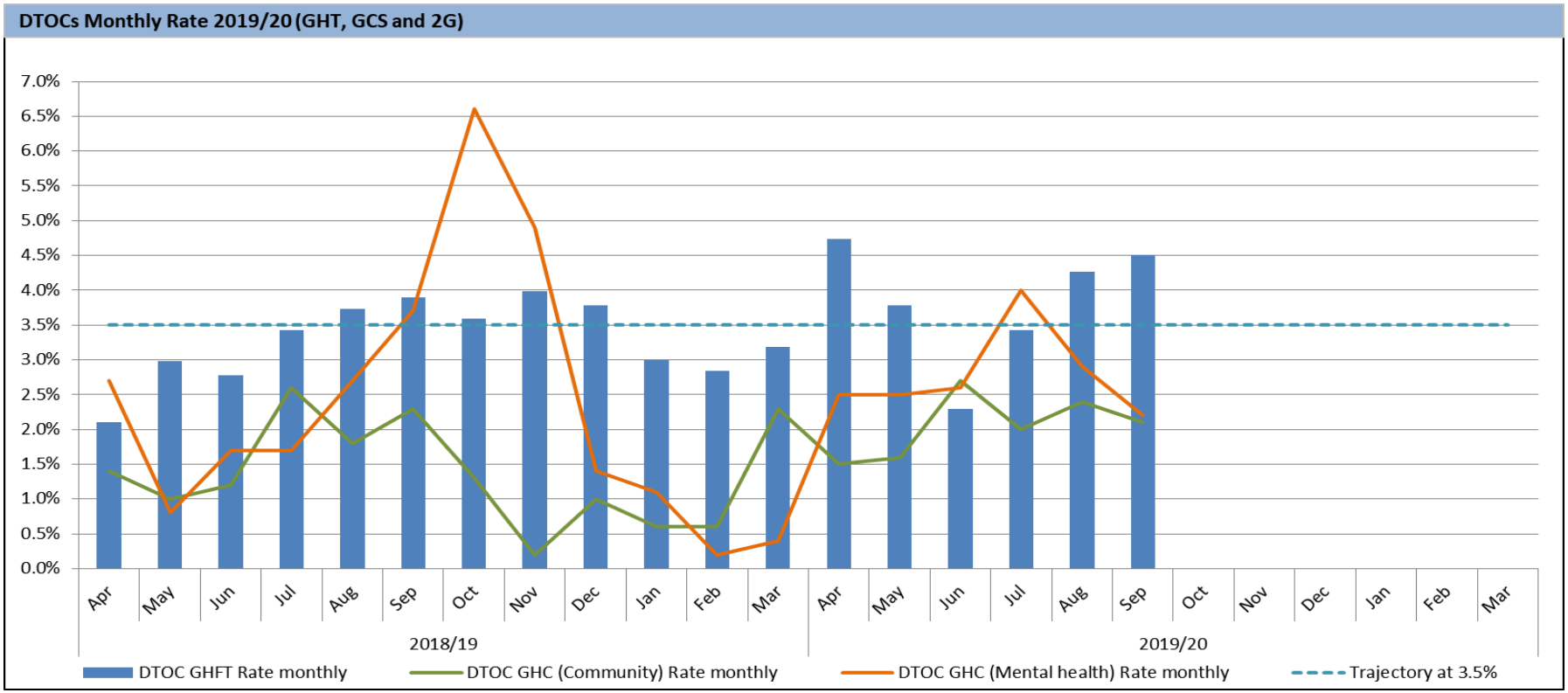
Increased demand on SWAST, particularly in Gloucestershire, has led to current over-performance against contract activity throughout the YTD.

A working group has been set up to assess demand management for SWAST incidents and define actions to reduce incidents requiring an ambulance response focussing on:

- 111 demand (validation of Category 3 and 4 calls)
- High Intensity Users
- Care home activity

3.21 Unscheduled Care – Delayed Transfers of Care

Green



Top Line Messages

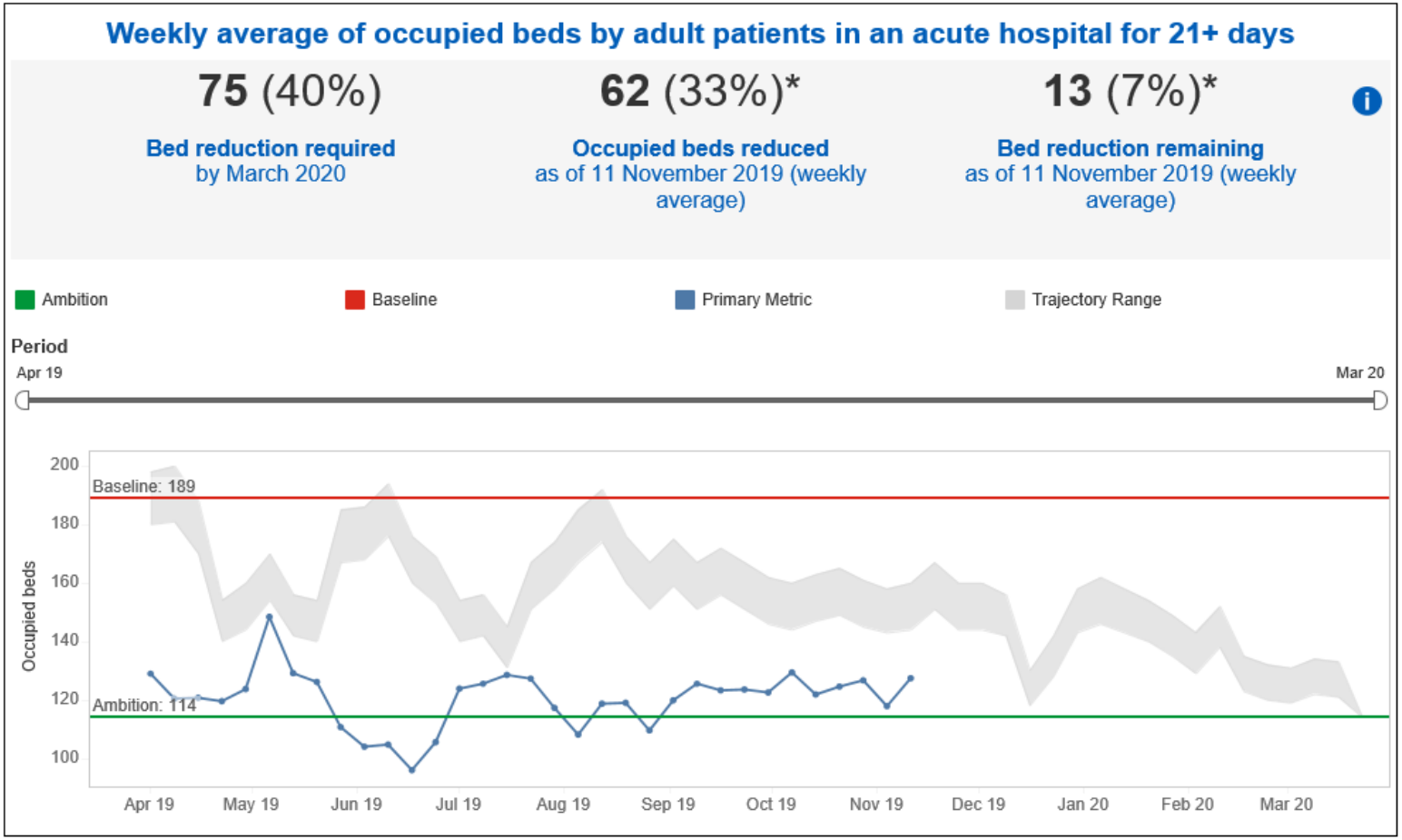
The DToC rate at GHFT has risen slightly in September, exceeding the 3.5% target with performance at 4.5%. GHC (mental health) and GHC (Community) DToCs remain under 3.5% in September.

The system has committed to a Transfer of Care Bureau – this is a Multiagency/disciplinary clinical team based in GHFT who will triage all referrals out of the acute hospital (7 days a week) to focus on home first, and reducing the number of patients placed into residential care/ care environments.

To support winter resilience, GHFT are in the process of planning a Gallery ward equivalent for Cheltenham for winter period. This will support medically fit patients to assist with flow elsewhere in the hospital when unavoidable delays occur.

3.21 Long Stay (>21 day LoS)

Green



Patients who have stays longer than 21 days are classed as “long stay or superstranded” patients in acute hospitals. They often experience avoidable delays and have worse outcomes, so a national target has been set to reduce these by 40% from a March 2018 baseline. Based on this data, GHFT have been set a target of reducing patients with stays of longer than 21 days in the hospital to no more than 114.

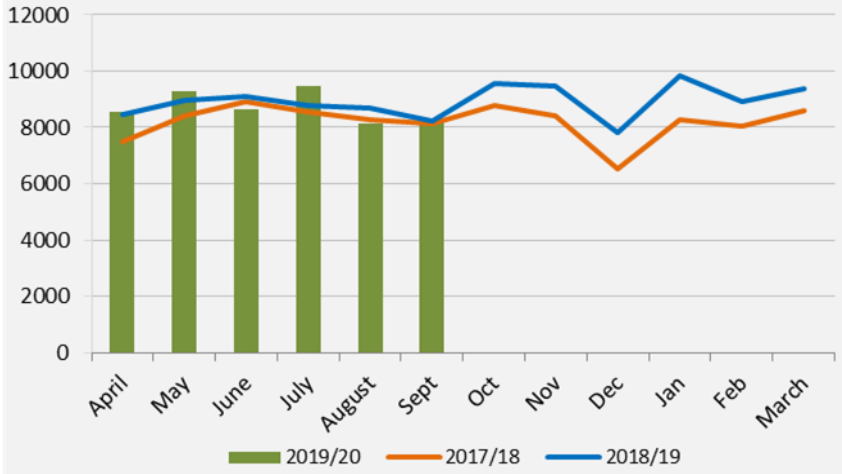
As of the 14th October 2019, the weekly average long stay patient figure was 123, equating to an 62 bed reduction and not meeting the ambition set by NHSE, but remaining below the organisation trajectory set for 2019/20.

3.3 System Overview - Planned Care:

Amber

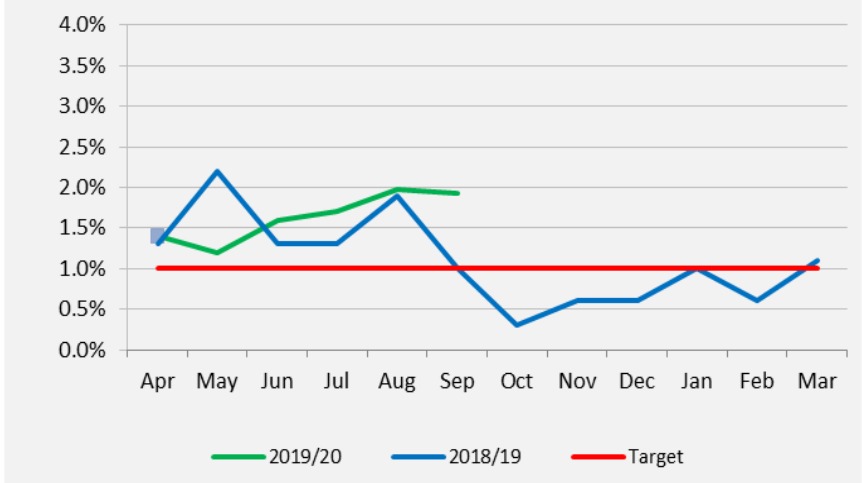
Referral Trends

E-referrals - GP Referred - 2017/18 to 2019/20



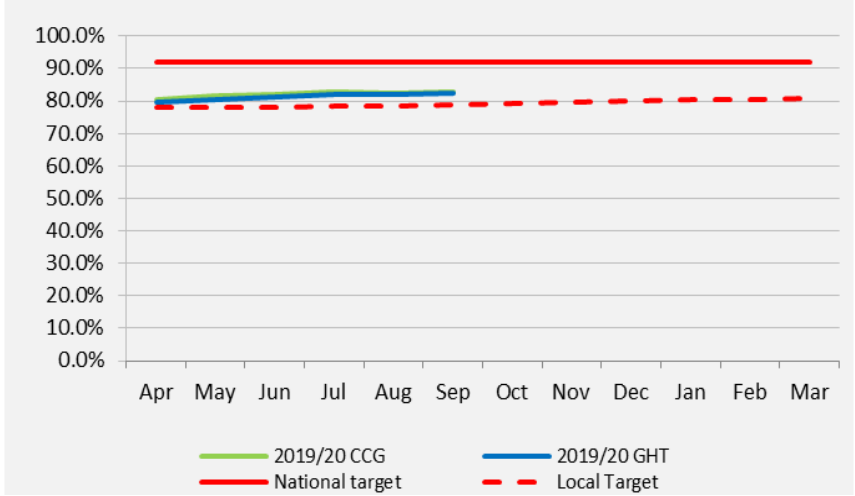
Diagnostics

CCG Diagnostic Tests - 2018/19 to 2019/20



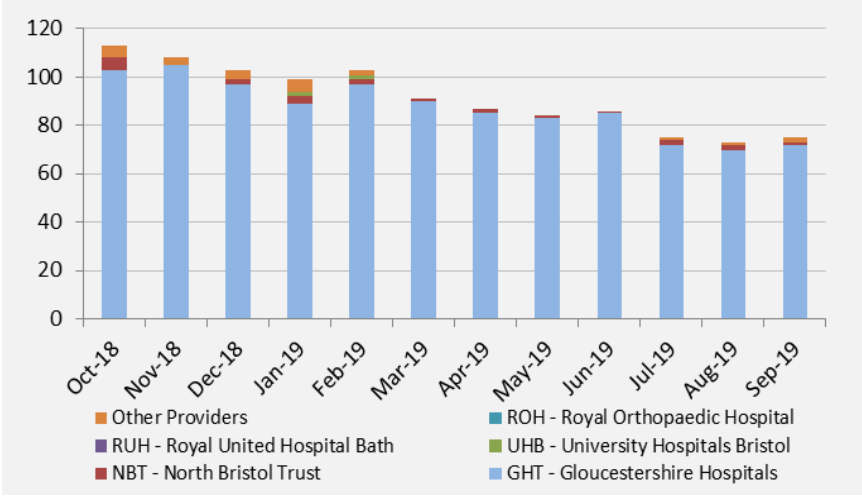
RTT >18 weeks

RTT Incomplete Pathways - Performance 2019/20



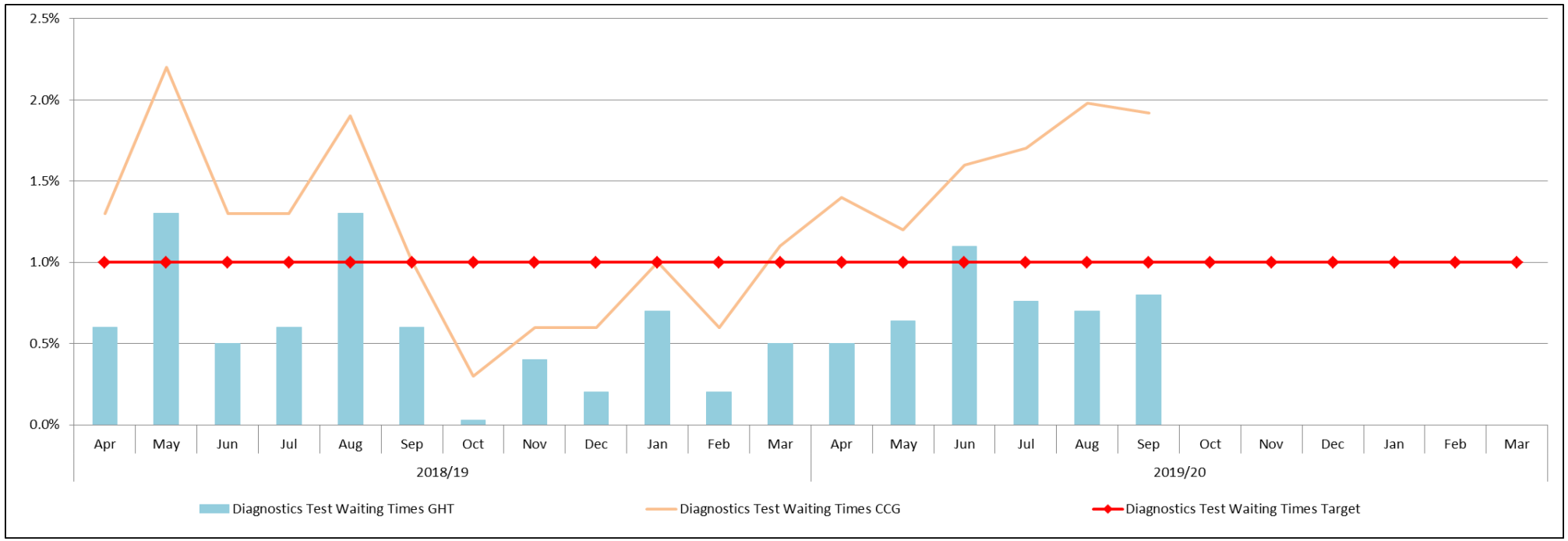
52 week waits (RTT)

RTT Incomplete Pathways - Number of Breaches ovr 52 Weeks



3.4 Planned Care – Diagnostics >6 weeks

Amber



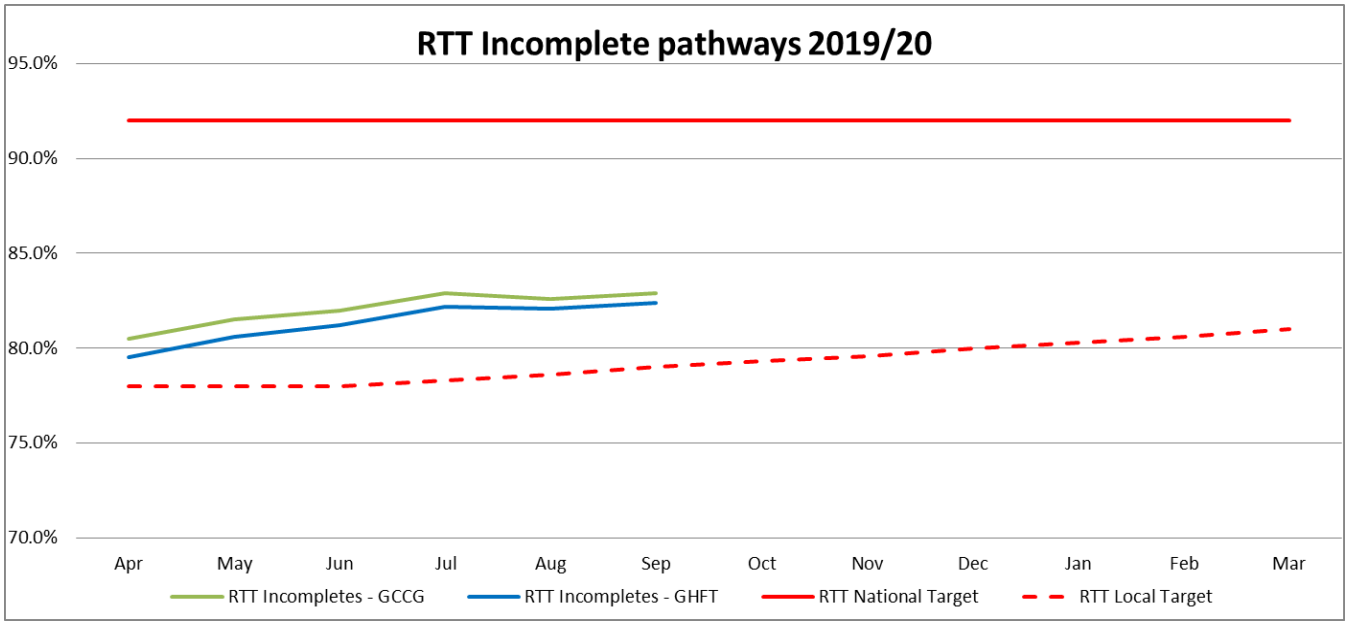
Top Line Messages:

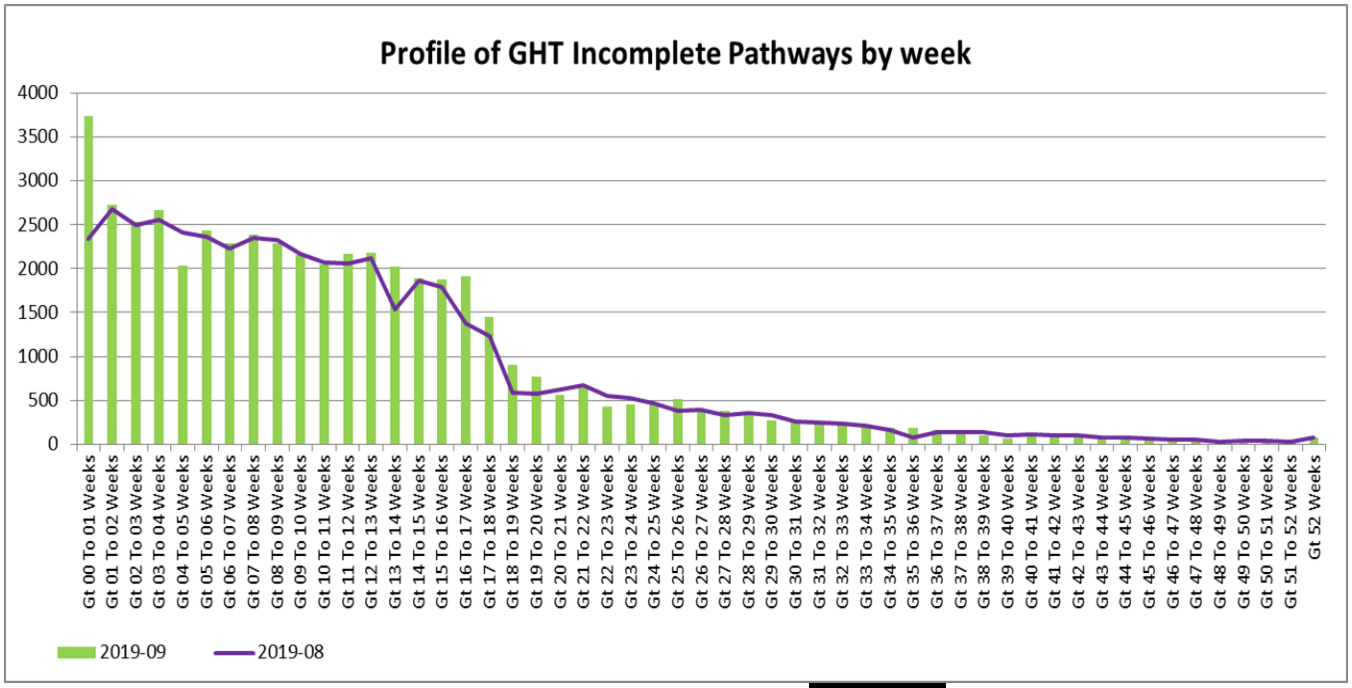
CCG Performance for September was 1.92% waiting more than 6 weeks for a diagnostic test, with 191 breaches for GCCG patients in September. The majority of breaches were in CT (GHFT) and echocardiography (GHC).

- Despite 28 CT breaches, GHFT performance remained good at 0.8%, reflecting consistent performance at the trust.
- Non-obstetric ultrasound remains an area of concern at GP Care where breaches of the 6 week target remained high at 50 in September. This is an improvement on performance in August (where then were 81 breaches) however the CCG continues to work with GP Care to improve performance for this test.
- GHC (formerly GCS) have indicated that their drop in performance around Echocardiography is the result of several clinic cancellations in July and August for the echocardiography scan for Heart failure patients. This has had an impact on August and September performance and is being resolved by operational leads.

3.4 RTT

Amber





Top Line Messages:

September 2019 data shows that GCCG incomplete pathways (>18 weeks) stands at 82.9% - exceeding the locally agreed planning target (for September the trajectory was to achieve 79%). GHFT performance for August was 82.4%. While significantly below the national target of 92%, GHFT performance against the RTT standard benchmarks similarly to other providers across the South West reflecting the continuing pressure of demand for consultant led treatment nationally.

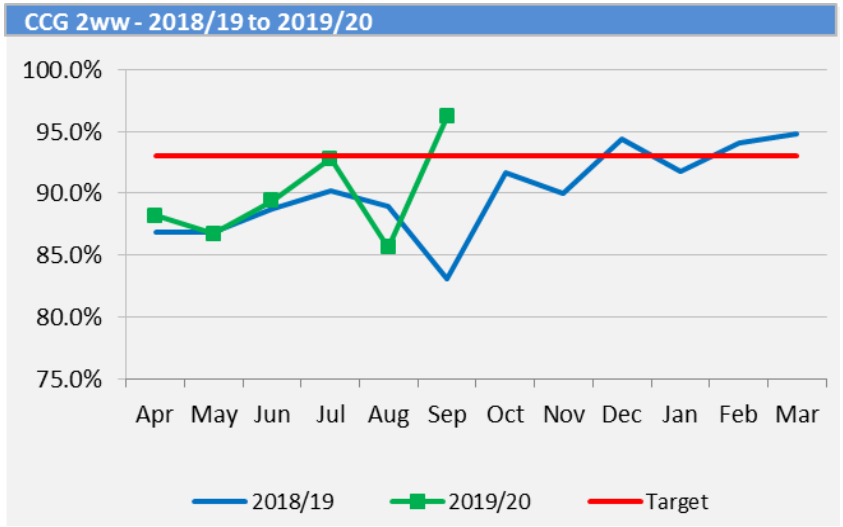
There were 75 fifty-two week incomplete waiters in September 2019, against the local trajectory of 80: 72 of these were at GHFT across a number of specialties, with the highest number of breaches recorded in Upper and Lower GI surgery, and ENT. A specialty level trajectory for 52 week breaches has been produced by the trust, to ensure that each service has a specific target to work to in ensuring the organisational trajectory is met.

The three remaining 52 week breaches were 1 in Plastic Surgery at North Bristol Trust and 2 at other providers.

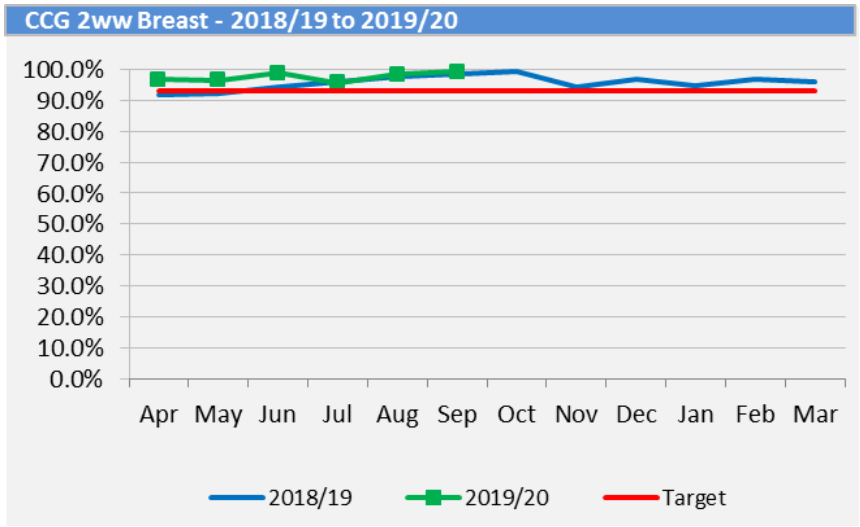
3.5 System Overview Cancer: September 2019

Amber

2WW (GP Ref'd)



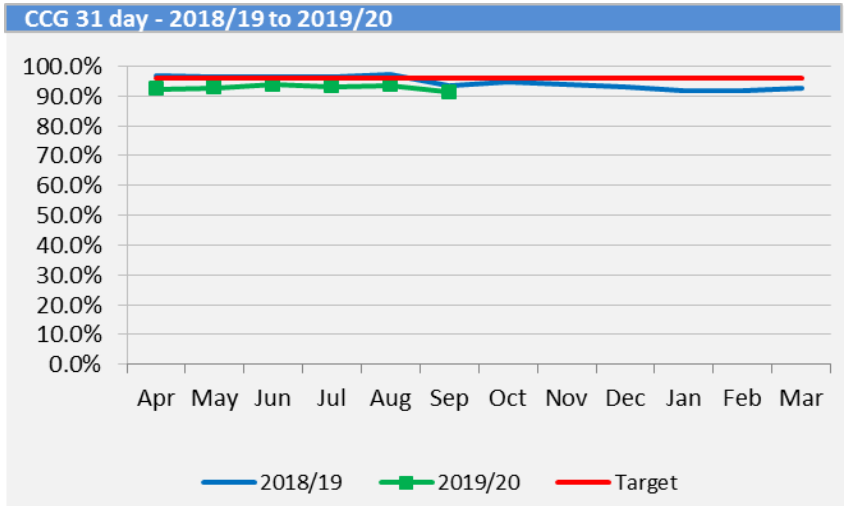
2WW (Breast)



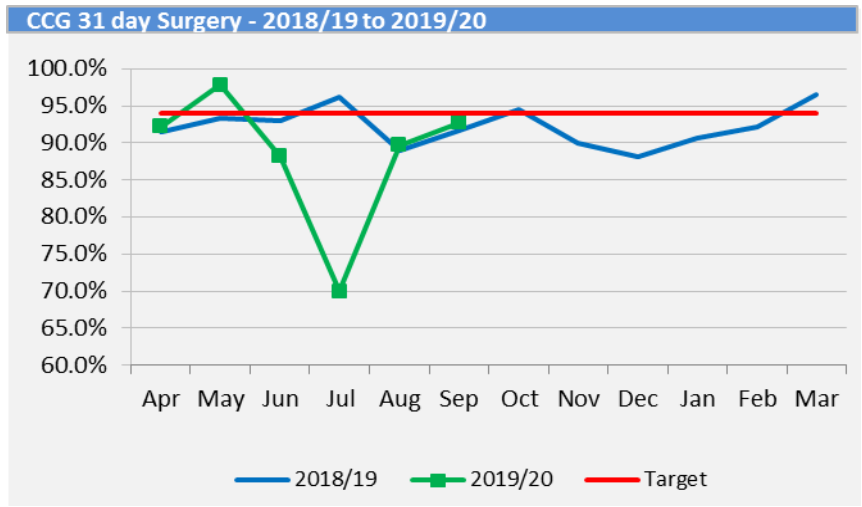
3.5 System Overview Cancer: September 2019

Amber

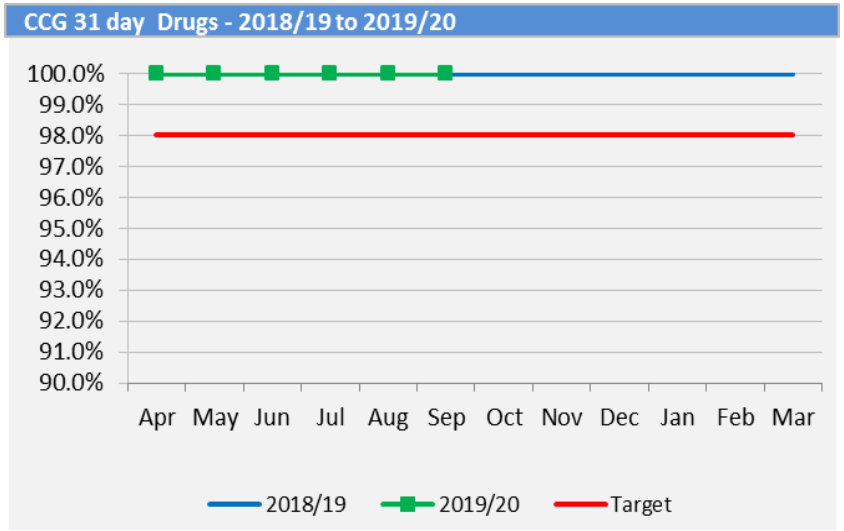
31 day



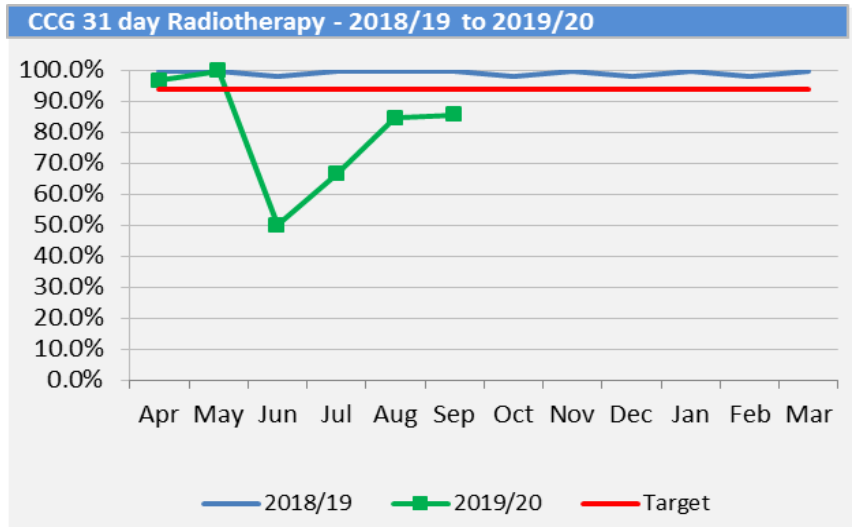
31 day subsequent treatm't: Surgery



31 day subsequent treatm't: Drugs



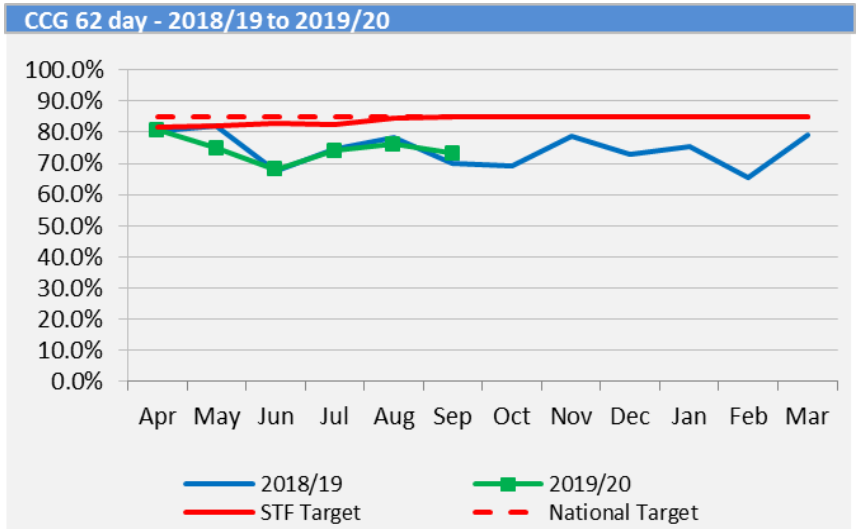
31 day subsequent treatm't: Radiotherapy



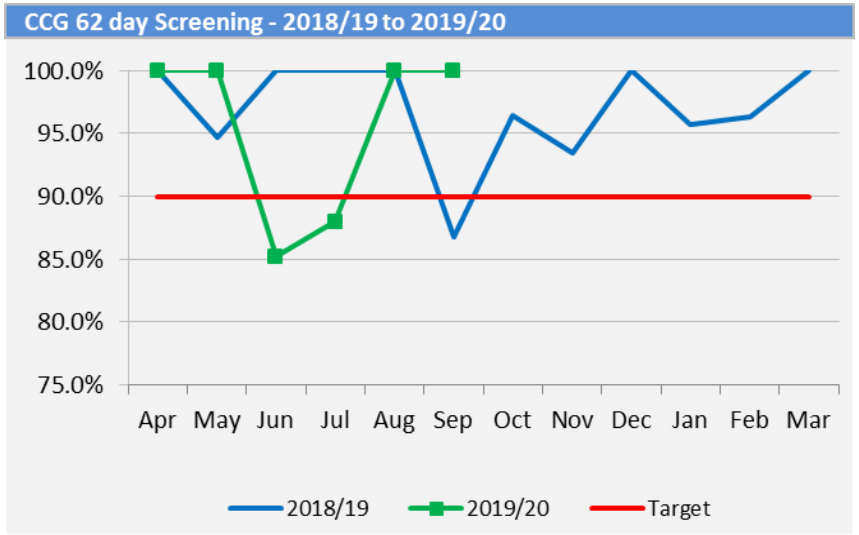
3.5 System Overview Cancer: September 2019

Red

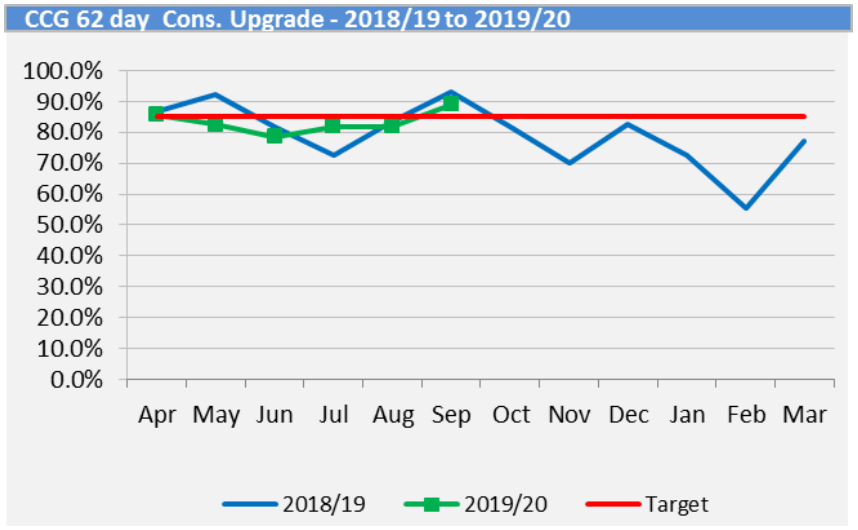
62 day: GP referral



62 day: Screening

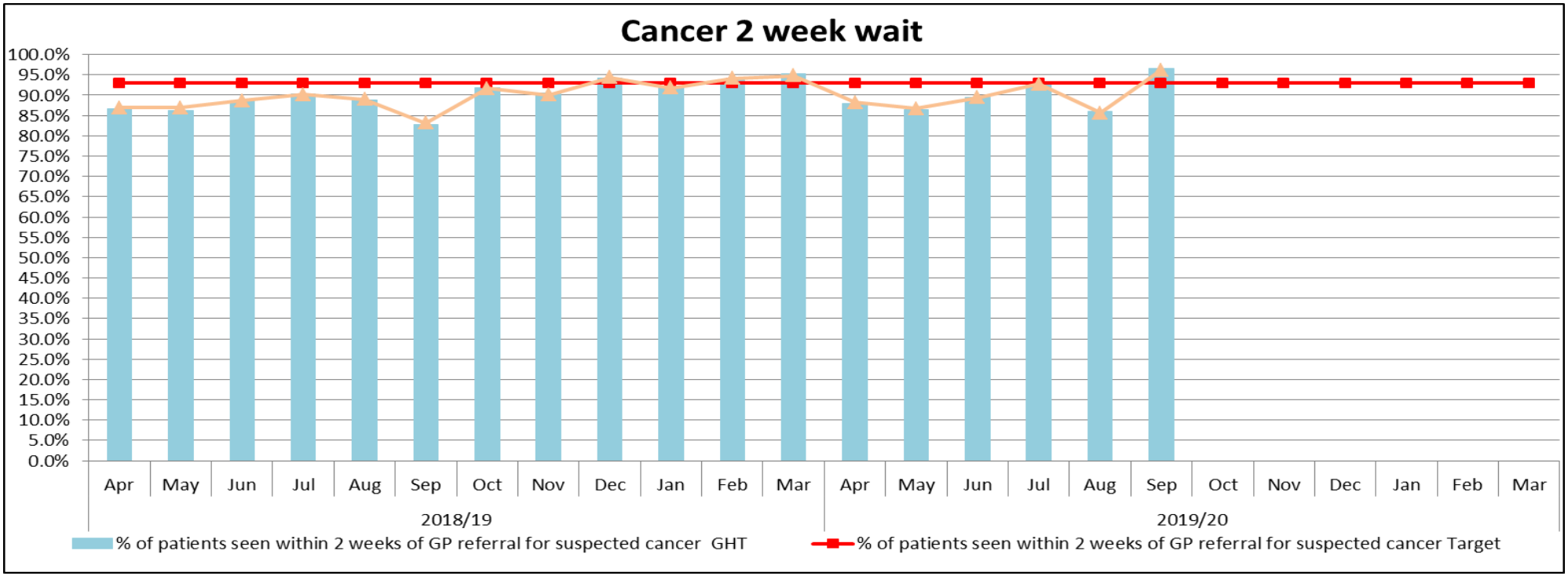


62 day: Consultant Upgrade



3.6 Cancer – 2 week waits

Amber

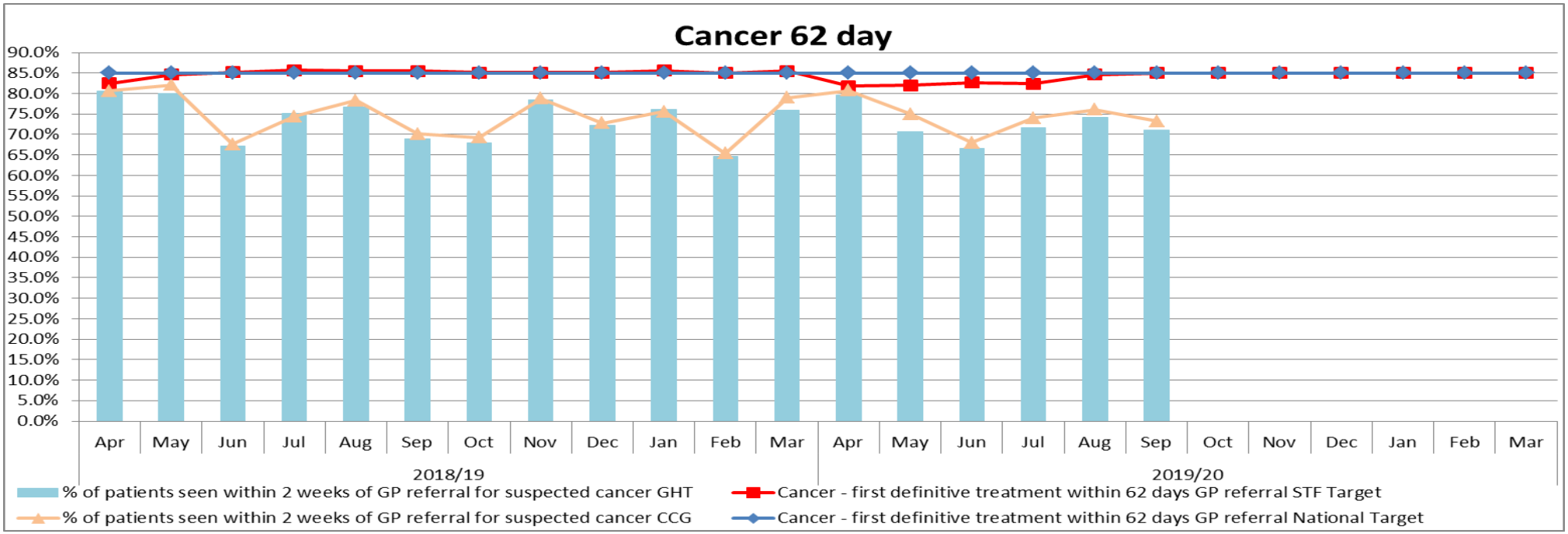


In September 2019, 2 week wait performance was 96.2% for GCCG and 96.5% for GHFT, achieving the 2ww standard with the best monthly performance seen for GCCG patients since pre-2016/17, and GHFT's best performance since cancer data recording on their system (Insight) was instigated (2013).

The only specialty not to meet the 93% standard in GHFT was Lower GI, which still achieved 91.4% of patients seen within 2 weeks of referral- a significant improvement on performance earlier in the year, and excellent performance in spite of significant demand for endoscopy services locally.

3.7 Cancer – 62 days

Red



September performance was 73.2% for GCCG, and was 71.1% at GHFT. There were 40 breaches, the majority in Urology (21 – 25% specialty performance).

62 day treatment performance has remained stable since 2016, with 2018/19 end of year performance averaging 74.5%. National performance has been dropping for the 62 day standard since the start of 2018/19; while GHFT has not significantly improved, stable performance against this target means Gloucestershire is performing similarly to the national average in terms of waits for treatments. GHFT have also made significant progress in reducing the number of patients on the list for treatment waiting more than 62 days, with time to treatement reducing across a number of specialties.

Urology remains the specialty impacting 62 day performance the most, with the majority of 62 day breaches in this specialty. In September 2019 there were 18 104 day breaches for first treatment for GCCG patients; 17 breaches accountable to GHFT and one breach accountable to Airedale. This comprised: 15 Urology (including Airedale patient), 1 Lower GI, 1 Haematology, and 1 Gynaecology.

3.7 Cancer – Actions and updates

Programme / Trust–wide actions to improve performance:

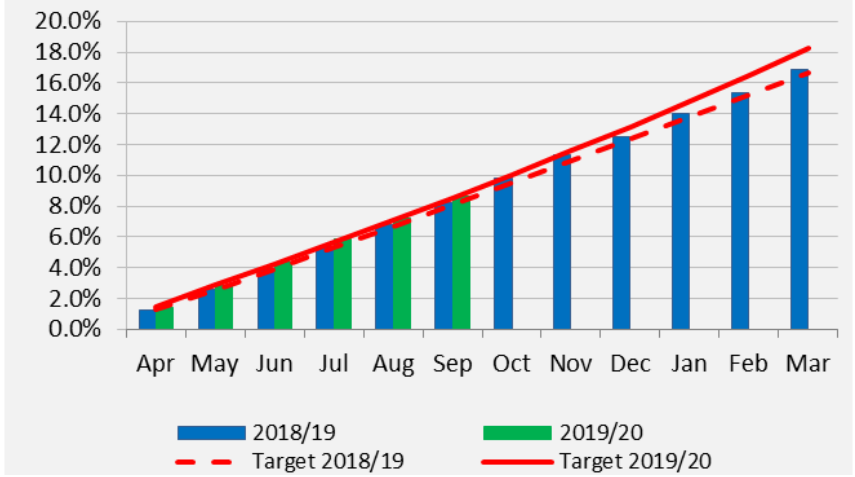
- 0-7 day booking being rolled out across specialties – Lung have now polling at 10 days, Breast at 85% booked in 0-7 days (August data);
- Dermatology referral pathway development project (to support how the system responds to significant variation in demand);
- Continuation of GLANSO lists for Endoscopy;
- Quality of referrals improvement project and further work to understand GP referral patterns.
- Demand and Capacity modelling across all specialties led by Deputy Cancer services manager.
- Pathway analysis conducted in conjunction with NHSI focussing on Lower GI now complete.
- Consultant triage of Urology referrals now implemented.
- Deep dive analysis into individual patient breaches to identify and understand the reasons for days lost in a patient pathway.
- GHFT have established partnership working with Royal Devon and Exeter Cancer Service to share learning around PTL management, escalation, and breach management.
- Splitting Upper GI MDT to two separate MDTs (Oesophogeal and Hepatobiliary and Pancreatic (HPB)) to allow focus on respective pathways.

3.8 System Overview: Mental Health - IAPT

Green

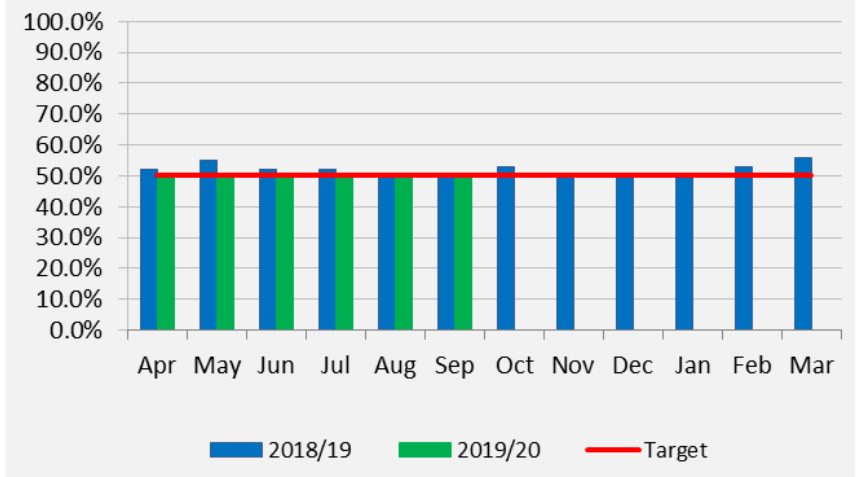
Access

IAPT Access - 2018/19 to 2019/20



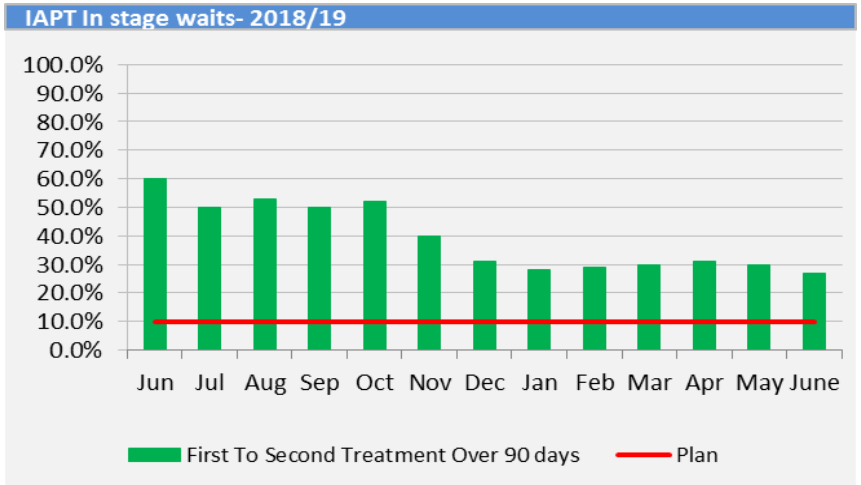
Recovery

IAPT Recovery - 2018/19 to 2019/20



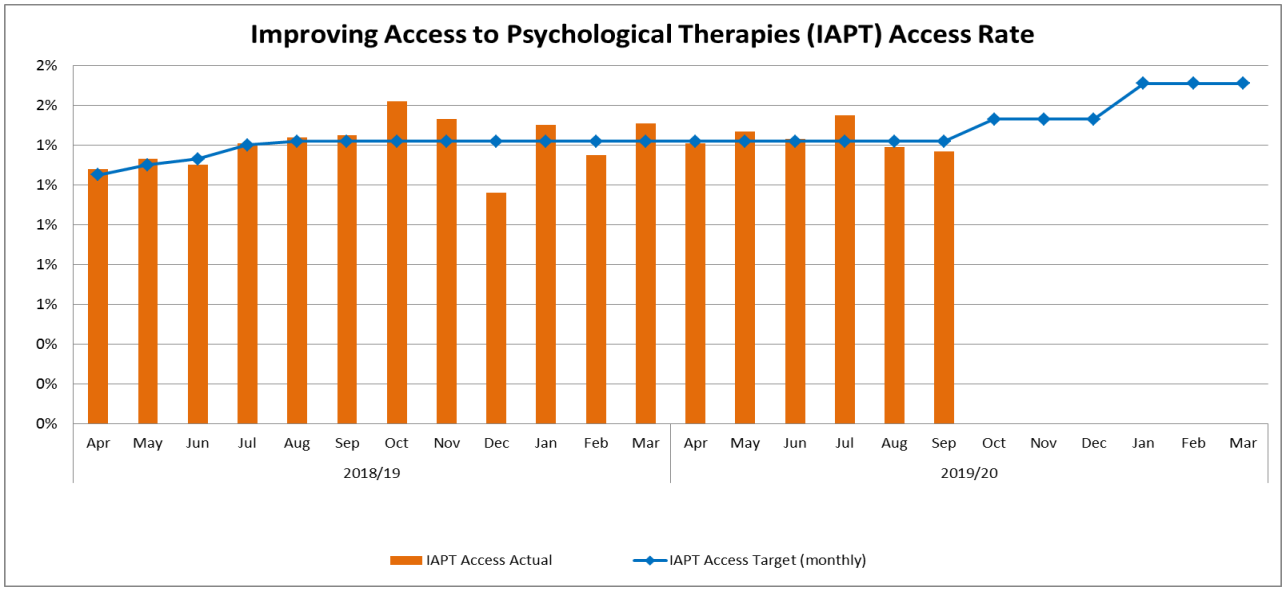
In-Stage Waits

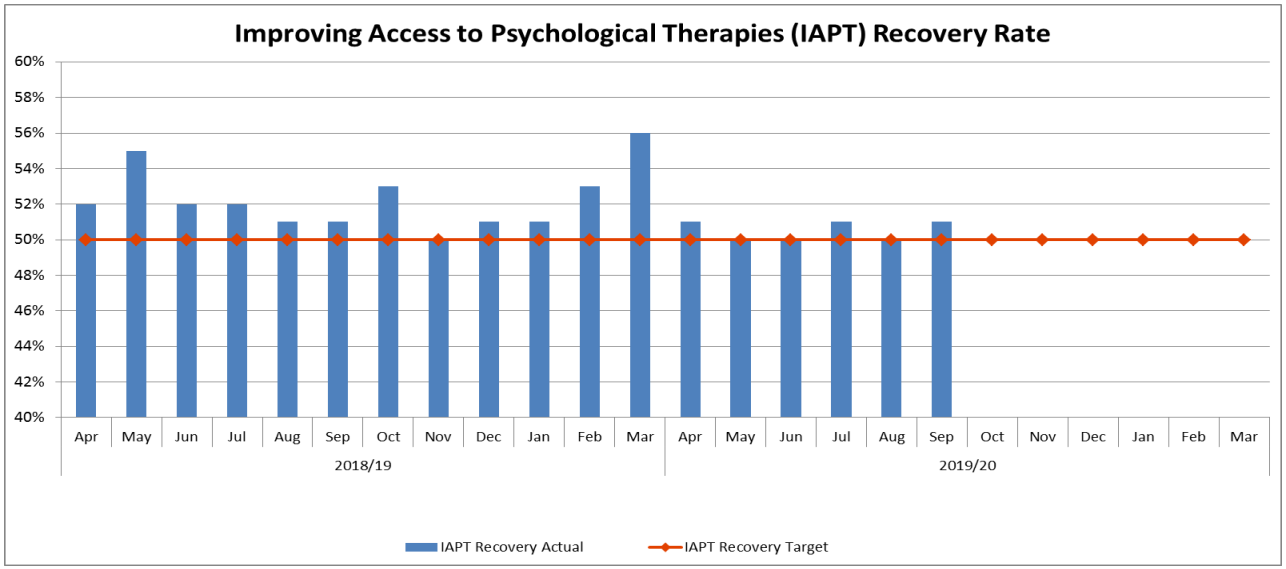
IAPT In stage waits- 2018/19



3.8 Mental Health - IAPT

Green



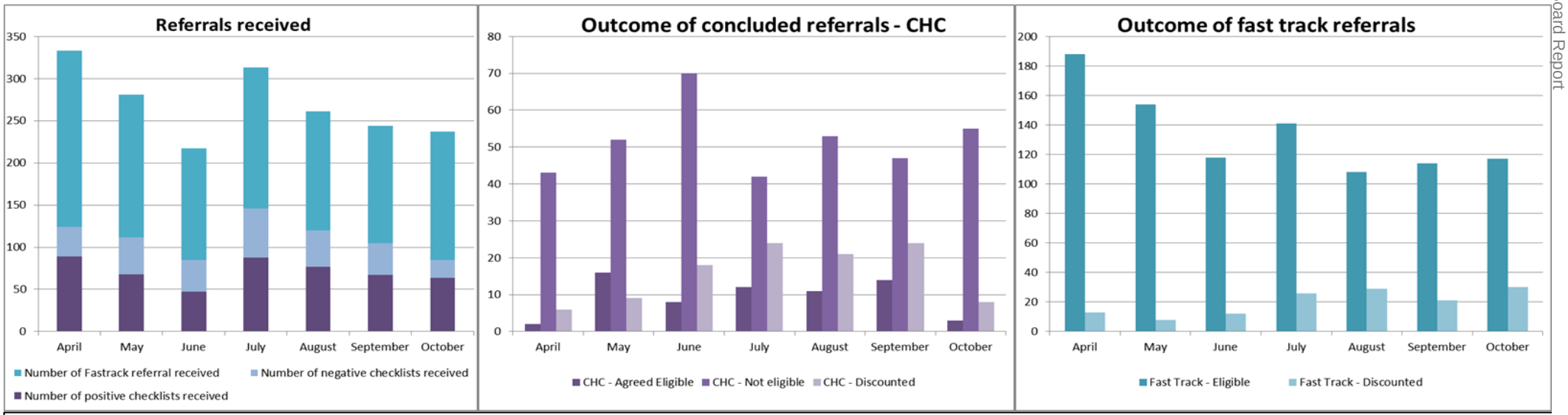


Recovery performance has been excellent throughout 2018/19, with the 50% target being met in each month, and this has continued into the new financial year with September 2019 performance at 51%.

The Access target has been held at 17% annually for the first half of 2019/20 to allow for the continued focus on reduction of in-stage waits (see below). While below the national access target of 19%, the service continues to meet the local trajectory cumulatively though September access was slightly below target at 1.37% of the estimated population with a low level mental depression or anxiety need accessing the service (against a target of 1.42%).

3.9 Continuing Health Care – Referrals

Amber



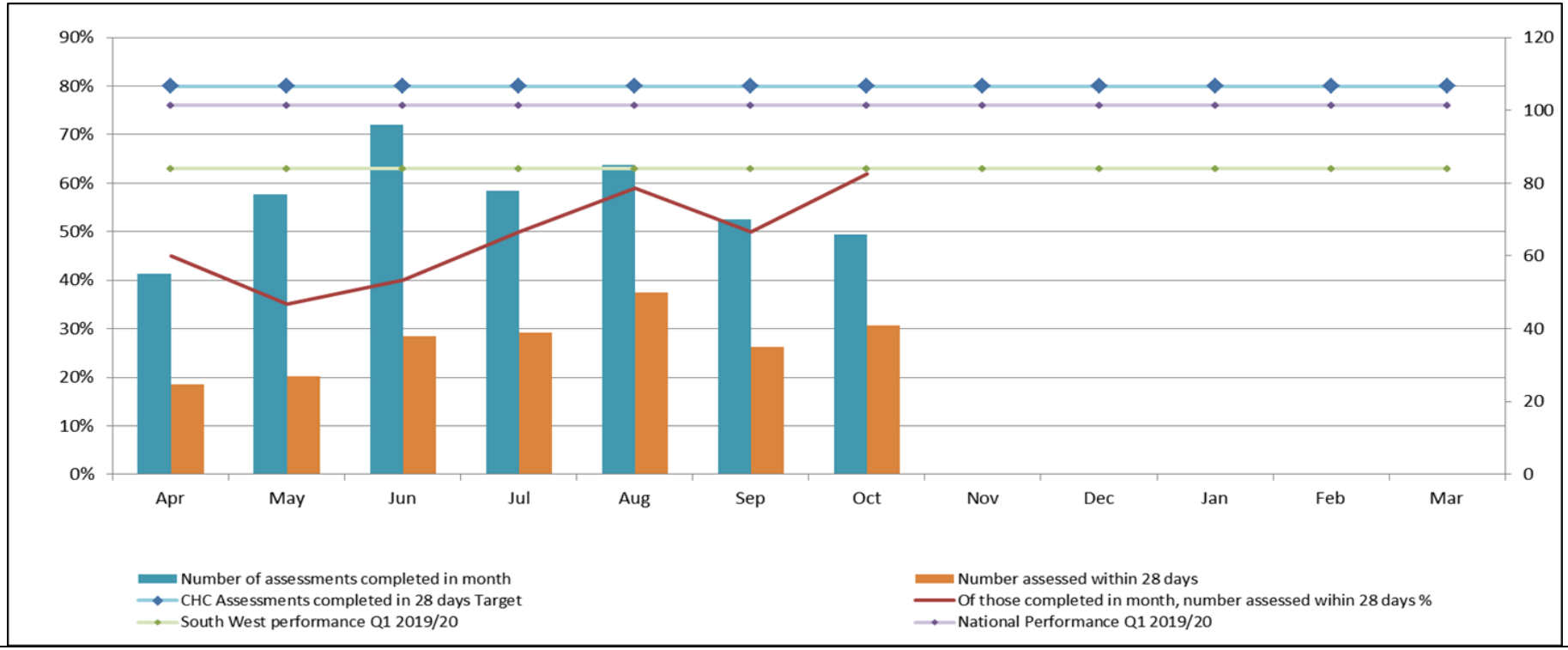
Positive checklist referrals have increased in 2019/20 to 71 per month on average (compared with the 2018/19 average (61/month)). Referral quality continues to be an area of concern, with an increase in both positive checklist (CHC) and Fastrack referrals that are discounted.

Fastrack activity has also remained high – and Gloucestershire is an outlier in the rate for Fastrack funding provided. This is being reviewed by the CHC team and a project is being established to consider the best way forward. Reviews of patients remaining on Fastrack longer than 12 weeks have been prioritised by the team – as of October 2019 there are 92 Fast Track patients who have been receiving funding for more than 12 weeks, these are to be reviewed by December 2019 and a new process will aim to ensure that Fast Track packages exceeding 12 weeks are routinely reviewed.

To date, 29% of Fast Track patients reviewed after 12 weeks remained eligible for full CHC funding (10/35 patients reviewed to date in 2019 were no longer eligible).

3.9 Continuing Health Care Assessments completed in 28 days

Red



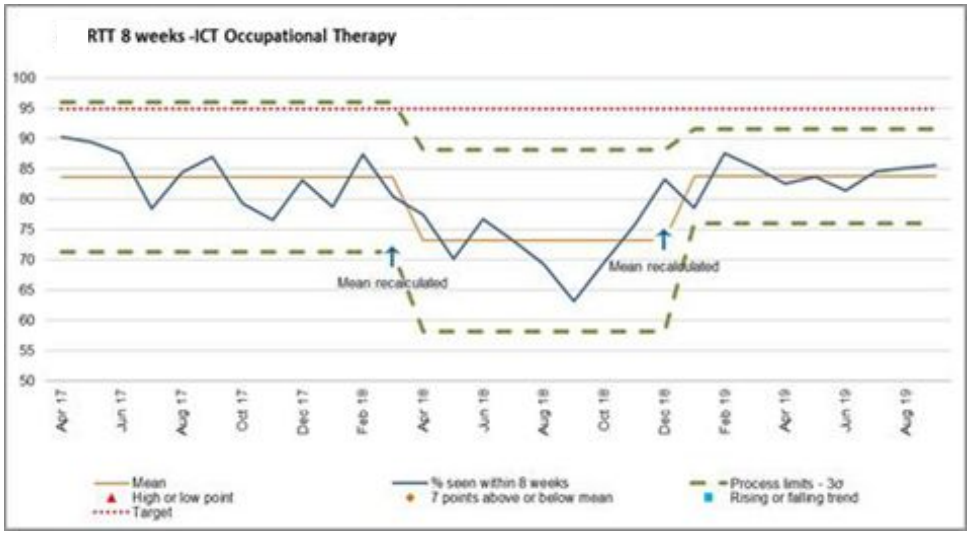
Top Line Messages:

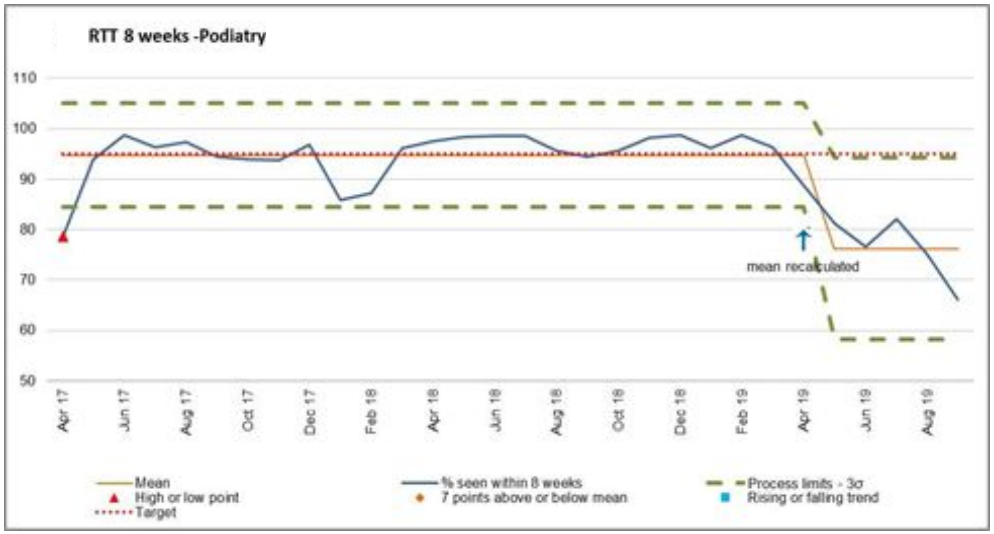
Performance remains significantly below the 80% target for assessments to be carried out within 28 days of referral, however October 2019 performance has improved to reach 62%. The average time waited for assessments completed in October 2019 was 26 days for standard CHC and 17 days for LD cases – a significant improvement on the long wait times seen earlier in the year.

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.
- LD agency staffing and focus on long waits for assessment and review.

3.9 Gloucestershire Health and Care – Community Services





Occupational Therapy:

- Occupational therapy performance has stabilised and improved from 2018/19 position. In September 62 out of 432 patients were seen outside the 8 week threshold.
- 18 week target performance was 96.5% (15 out of 432 patients seen outside the18 week threshold).
- An increase in referrals to the service and staff vacancy levels (particularly in Gloucester at more junior bands) have impacted the service's ability to deliver the 8 week target.

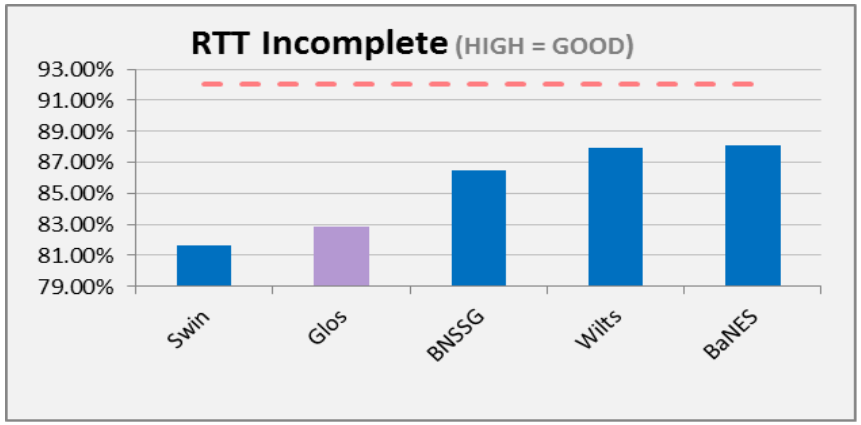
Podiatry:

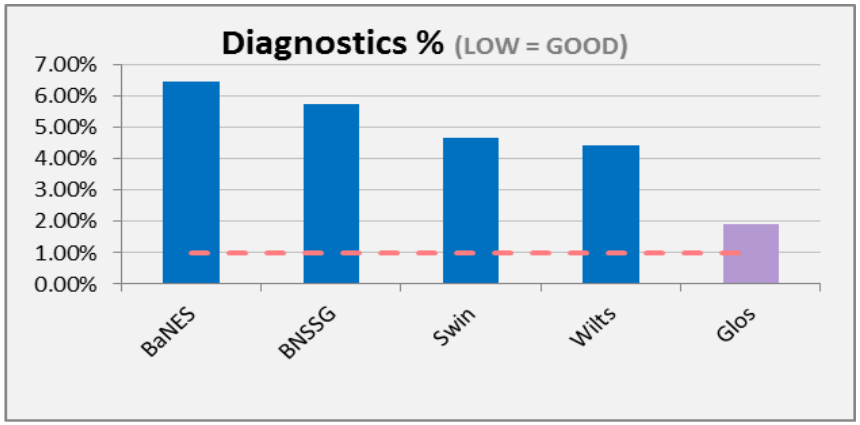
Podiatry performance has decreased to 66.1% in September compared to 75.2% in August.

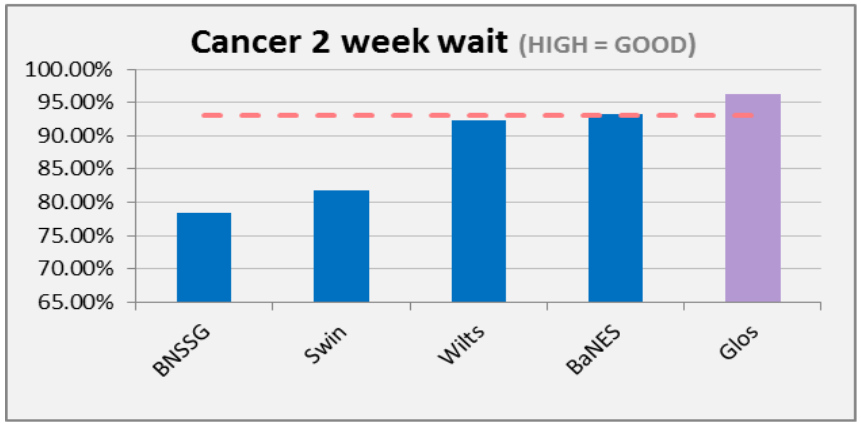
The current action plan has a focus on three main areas:

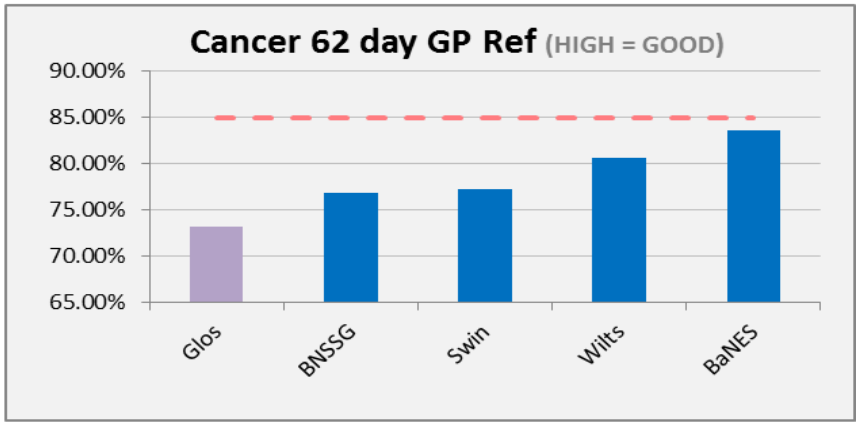
- SystmOne process review and redesign to improve data quality and performance reporting.
- Review and redesign care pathway by speciality level to improve efficiency.
- Redesigned workforce plan based on demand and capacity outcome findings.

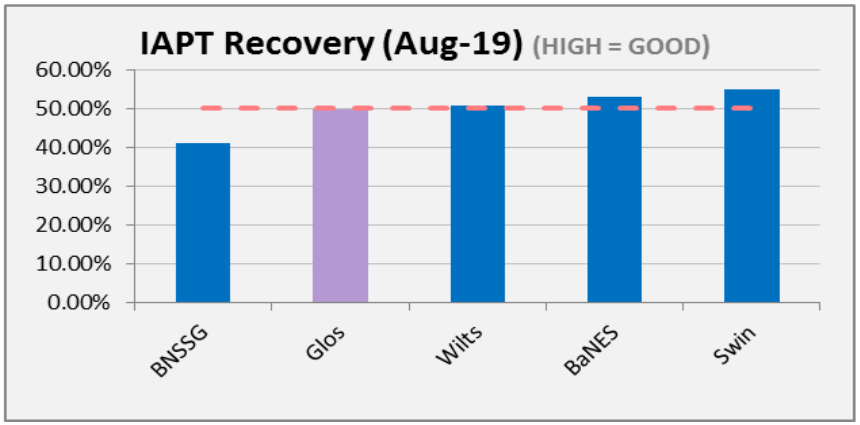
3.11 Regional Comparison – September 2019











Green

Indicator	Component Measure	Narrative
Staff and member practice engagement	OD Plan Staff Survey Turnover Vacancies Sickness PDP/Training	**Turnover Rate:** Turnover for Oct has decreased to 17.19% from 18.04% in Sept. Overall turnover has been constant throughout the last 12 months, but September saw turnover over 18%. **Staff in Post:** Staffing levels for Oct - headcount of 364. 2 equating to 299 FTEs. Over the last 12 months there have been 63 leavers (49.30 FTE) and 66 starters (49.30 FTE). **Leavers by Reason:** There were 63 leavers over the 12 month period, the main reason for leaving over the last 12 months – 24 leavers due to Promotion, 6 leavers due to retirement and 8 due to work life balance **Sickness Absence Rate:** short term absence has increased to 1.90%. Long term absence has decreased to 3.31%. Overall absence % FTE over 12 months has increased to 3.88% from 3.65% in Sept. **Sickness by Reason:** For Oct 2019 absence due to anxiety/stress is 34.33%, an increase from the figure of 21.25% in Sept. The overall cost of absence for Oct is £56,933 a total of 565 days lost (480.57 FTE) over 68 occurrences. This equates to 361 days (14 occurrences) long term sickness and 204 days (54 occurrences) short term sickness.

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' was 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 The Patient Experience and Engagement team are currently gathering feedback as part of the engagement for Fit for the Future. An Outcome of Engagement Report will be produced by Christmas..

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 07

Amber

Income and Expenditure	YTD surplus	FOV surplus	YTD Running costs	FOV Running costs
In Year	£0k	£0k	£0k	£0k
Cumulative	(£12,524k)	(£21,470k)	£0k	£0k

Savings Programme	YTD Savings	% YTD Savings	FOT Savings	% FOT Savings
	£9,049k	92.7%	£16,281k	94.2%

Other Metrics	BPPC	Cash drawdown	FOT Capital
	97.67%	59.4%	£0k

NHS Gloucestershire Clinical Commissioning Group

5.0 Sustainability – Executive Summary

- Gloucestershire CCG set an in year plan of breakeven; this included savings of £17.3m this included a number of non recurrent measures to achieve the plan. The risk assessment for the initial plan was high risk.
- The CCG is currently forecasting to achieve it's planned in year position of breakeven. However, this is entirely dependent on in year actions to mitigate the overspends that have emerged in year. The scale of the financial risk is high and the CCG has assessed the net financial risk as £7.5m; this position has been reported to NHS England.
- The changes in risk relate to a number of key areas: CHC, placements, GHNHSFT drug pressures and primary care prescribing. Some mitigations have also been decreased following a review.
- The prescribing forecast has increased to £2.5m overspent with additional risks reported of c£0.7m based on the anticipated costs relating to a new NICE FAD.
- Further mitigations and controls are being progressed in order to deliver the reported breakeven position; the implications of each one are being assessed as a part of the process.
- As much of in-year mitigations are non recurrent in nature, the consequence will be an additional pressure in 2020/21; new savings will be needed to fill the funding gap. The impact of this issue is reflected in the early draft of the ICS five year system plan, currently in development.
- The CCG has a financial plan in place to recover the position, however, further dedicated management action is required to recover the financial position due to the worsening of the financial position for prescribing.
  The CCG will be undertaking a review of its position along with Gloucestershire system partners in the next month.
- Savings plans are showing some under delivery in year, there is mitigation in place for some through risk sharing agreements with providers, however, this does not cover all slippage. Further plans are currently in development to help mitigate the overall financial position.

5.1 Sustainability – Resource Limit

The CCG's confirmed allocation as at 30th October 2019 is £936.8m.

The following allocation transfers were actioned in October;

£'000	Rec/ Non Rec	Description
22	NR	Additional funding for NHS 111
348	NR	Better Care Fund Support
257	NR	Adult & Children's Palliative & End of Life care
20	NR	Digital Improving Access to Psychological Therapies Evaluation
67	NR	Individual Placement Support wave 2b transformation
375	NR	Community Mental Health Transformation
111	NR	Mental Health Liaison wave 2 transformation
2,036	NR	ICS Transformation funds
164	NR	Enhanced GP IT infrastructure and resilience
101	NR	Social prescribing networks
(1,221)	REC	Identification Rule exercise
2,280		**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. The current financial overspend reflects the pressure on drug budgets, which is now fully reported in the position with no potential risk. Within the block contract, emergency activity and expenditure remain above the planned level. Activity within an outpatient setting is also above planned levels, however elective activity and spend is below the planned levels.	↓	3,557.6
University Hospital Bristol NHSFT Monitoring, based on six months of data, shows continued underspends in the following areas: • non elective inpatient admissions in cardiology • drugs costs for Adalimumab and homecare drugs	↓	(461.3)
Oxford University Hospital NHSFT The position highlights a further improvement compared to the previous month, however there are still overspends within most areas of the contract including: • Elective activity for cardiology, clinical haematology, pancreatic surgery and trauma & orthopaedics (T&O) • Non elective in T&O, colorectal surgery and Hepatology	↑	600.0

5.2 Sustainability – Acute Contracts *(2 of 3)*

Acute NHS Contracts	Trend	Year end Forecast £'000
Great Western Hospital NHSFT This contract continues to show an underspend within key areas of: • Non elective activity in general surgery specialties however excess bed days for emergency admissions is at 5% compared to 3% last year. • Elective activity primarily within T&O • GWH's expectation is that Elective activity will recover by year-end therefore a potential risk has been flagged in anticipation , also the Referral to Treatment (RTT) recovery plan profile will deliver enough activity to ensure a stable waiting list position by 31 March 2020	➔➔	(150.0)
Winfield Hospital September activity continues to show an increased over-performance on the contract , primarily due to an increase in the case mix of referrals and work is ongoing to validate this. A risk has been included regarding the potential for this increase to be sustained for the remainder of the financial year which equates to £189k.	↓	657.3
Wye Valley Hospital The marginal favourable movement in the acute contract position is due to slippage in planned and emergency care which is being slightly offset by an increase in Podiatric day cases within the community contract. Overall the position is overspent relating to emergency non electives.	↑	143.0

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

Acute NHS Contracts	Trend	Year end Forecast £'000
Any Qualified Provider Contracts **Newmedica** – increase in activity above the planned level for the initial months of the year, however, activity for the last few months not increased over that seen in the initial months. Currently reporting a £405k overspend. **Oxford Fertility** – £322k overspend relates to an increase in the number of patients accessing treatment and some slippage in the planned savings.	↑	897.7

5.3 Sustainability – Community

Acute Contracts	Trend	Year end Forecast £'000
South Western Ambulance Services NHSFT The current year contract is a block contract but includes a "break glass" clause which is triggered when activity reaches a contract threshold in totality, across the commissioners who are party to the contract agreement. At the end of July, at which stage the first over-performance charge was triggered, this threshold has been met and this trend has been assumed to continue until September. However, thereafter, it is forecast that the contract performs to planned levels. There is risk around this forecast as it is predicated on a number of actions mitigating some of the demand being seen by the ambulance service. Mitigating actions include work with care homes on the management of patients and work with the NHS111 service. A risk of £250k is included within the CCG's overall risk analysis.	↓	438.1

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5.3 Sustainability – Community

Community	Trend	Year end Forecast £'000
Telecare continues to underspend due to a low take up in telehealth which continues the trend of previous years. Children's services is also reporting and a marginal underspend relating to hospice care which is currently below recent trends for quarter 1 & 2.	↓	(52.7)

5.4 Sustainability – Prescribing

Primary Care Prescribing	Trend	Year end Forecast £'000
The budget for prescribing is £86m which includes a £5m savings programme. The latest data from NHS Business Services Authority (NHS BSA) received relates to August. The prescribing costs when compared with the previous year, the cumulative position highlights a 1.71% increase in spend (10.57% increase in the month). This movement is due to approximately £600k worth of Lloyds pharmacy prescriptions not being submitted until August due to a national computer error therefore the previous months forecast was artificially low. An additional savings plan of £1m is currently in development by the medicines management team to accelerate savings . Risks to this position have been identified amounting to £0.7m which are included within the risk position reported to NHSE.	↓	2,500.0

NHS Gloucestershire Clinical Commissioning Group

5.5 Sustainability – Mental Health

Mental Health	Trend	Year end Forecast £'000
Mental Health Services The reported position reflects an adverse movement due to risks now being realised and included within the reported position. There are significant overspends within Learning Disabilities which are offset by a reduction in activity for Acquired Brain Injury (ABI) and projected costs within treasure seekers due to realignment of projects.	↑	112.4

5.6 Sustainability – Primary Care

Primary Care	Trend	Year end Forecast £'000
Delegated Co-Commissioning – During budget setting a pressure of £2.1m was identified and additional budget has been included over and above the ring-fenced delegated allocation. The total budget is £86.3m compared to an allocation of £84.2m – Maternity and sickness payments have reduced from previous months which is predominantly driving the underspend. – List size growth is above those levels initially built into budgets	↑	(79.6)
Other Primary Care – An underspend is forecast based on variances in a number of areas. – The most significant being a release of the Challenged practice provision.	↑	(1,296.8)

5.7 Sustainability – Continuing Health Care & Placements

Continuing Health Care (CHC)/Funded Nursing Care (FNC)/Placements	Trend	Year end Forecast £'000
This area includes costs based continuing health care including domiciliary care, placements, funded nursing care (FNC) and personal health budgets. The current forecast overspend is reported in the following areas • **Children's CHC**: has remained broadly consistent with last month's position. This area has reported a forecast overspend of £298.8k. • **CHC Nursing Home placements**: the forecast outturn has deteriorated marginally with a forecast breakeven position. Current activity information has informed the forecast for future months and an exercise has been undertaken to ensure consistency between the Council's brokerage team and the CCG's internal team. • **CHC/LD placements :** this is the primary element of the forecast overspend (£3,399k; a £360k improvement in the month). This is due to a switch of package to domiciliary care and further work on assessment of care costs across a number of eligible cases. Following on from the previous month a number of cases previously assessed as a risk have been found not eligible for support and have therefore reduced the risk that was identified. Overall risk in this area relating to cases yet to be assessed is now £687k (from £917k). • **Domiciliary Care**: costs have increased by £280k in this area; due to the above resultant change of payment approach. Consequentially a forecast overspend of £930k is reported in the current financial year. The CCG continues to work with the CSU to improve both the processes and forecasting between local authority and CCG on this area.	↑	4,715.1

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)
 	
• There has been a favourable movement in the recent months forecast that primarily relates to estimates received from the local authority in respect of
  • Older People and Physical Disability services (£590k forecast overspend; no change from last month)
  • Agency costs (£337k forecast overspend; no movement from previous month)
  • The movement relates to the removal of Community equipment overspends which are not coming to fruition.
	↑	1,057.1

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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 forecast outturn is highlighting areas of slippage (£1,006k), however, work is ongoing to mitigate financial risks associated with the savings plan. Those schemes which are deviating adversely from plan and where no mitigations can be applied include Commissioning Policies (£45k), Biosimilars (including Humira) (£641k), High Cost Placements (£300k) and other transactional savings (£144k). The slippage relating to Humira is as a result of a change in the national prices since setting the plan. Other opportunities are being worked on in terms of secondary care drugs and also the cost of continuining health care packages. With the support of the joint commissioning teams, work is continuing on high cost placements.

- eRS Advice and Guidance is currently expected to over deliver by £120k.

- 2019/20 is the baseline year for the NHS Long Term Plan. Work is progressing on the 5 year forecasts for the system-wide efficiency programmes to be included in the Strategic Planning Tool that accompanies the Long Term Plan narrative submission.

NHS Gloucestershire Clinical Commissioning Group

5.10 Sustainability - Savings forecast delivery

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Savings Programme 2019/20

Area	Planned Savings 2019/20 £	Forecast 2019/20 £	Variance 2019/20 £
Clinical Programme Approach (CPA)	1,914	1,914	-
Planned Care Programme	1,502	1,577	75
One Place / Urgent Care Programme	1,100	1,104	4
Community & Prevention Programme	1,801	1,501	(300)
Medicines Optimisation Programme - Primary Care	5,000	5,000	-
Medicines Optimisation Programme - Secondary Care	3,404	2,763	(641)
Other	2,566	2,422	(144)
Grand Total	**17,287**	**16,281**	**(1,006)**

Risk share and contract mitigations are in place to offset potential financial risks 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 94.2% after applying these risk mitigations to the 2019/20 plan.

5.11 Sustainability – Financial Risks & Mitigations overview

Risks

- Transforming Care/LD placements and CHC pressures (including backdated costs)
- Growth & demand pressures in acute contracts/AQP providers
- Drug costs in GHFT contract
- 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 (incl Cat M and NICE FAD issues)

Mitigations

- Slippage on developments – non-recurrently retained centrally
- System agreement on application of transformation funds
- Identify new savings schemes
- Balance sheet reviews
- 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.

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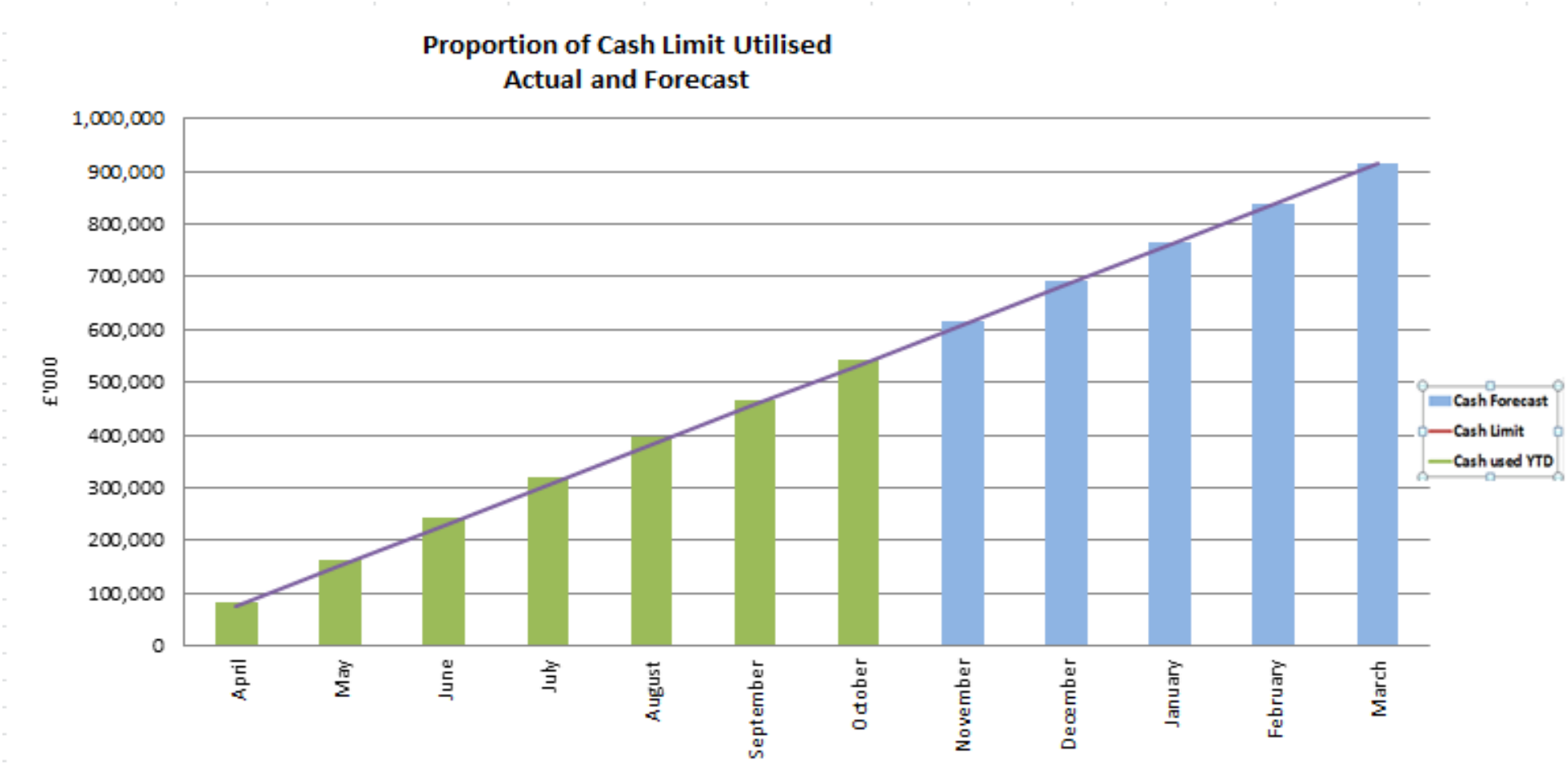
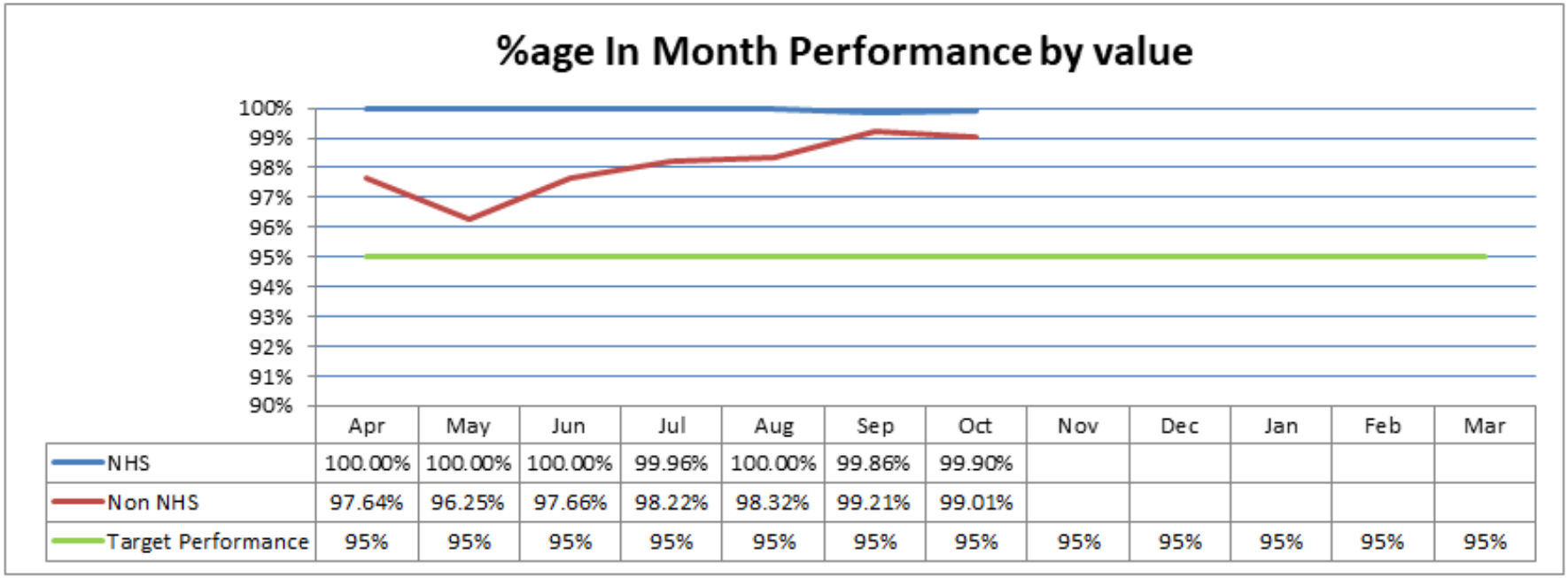
5.12 Sustainability – Cash Drawdown

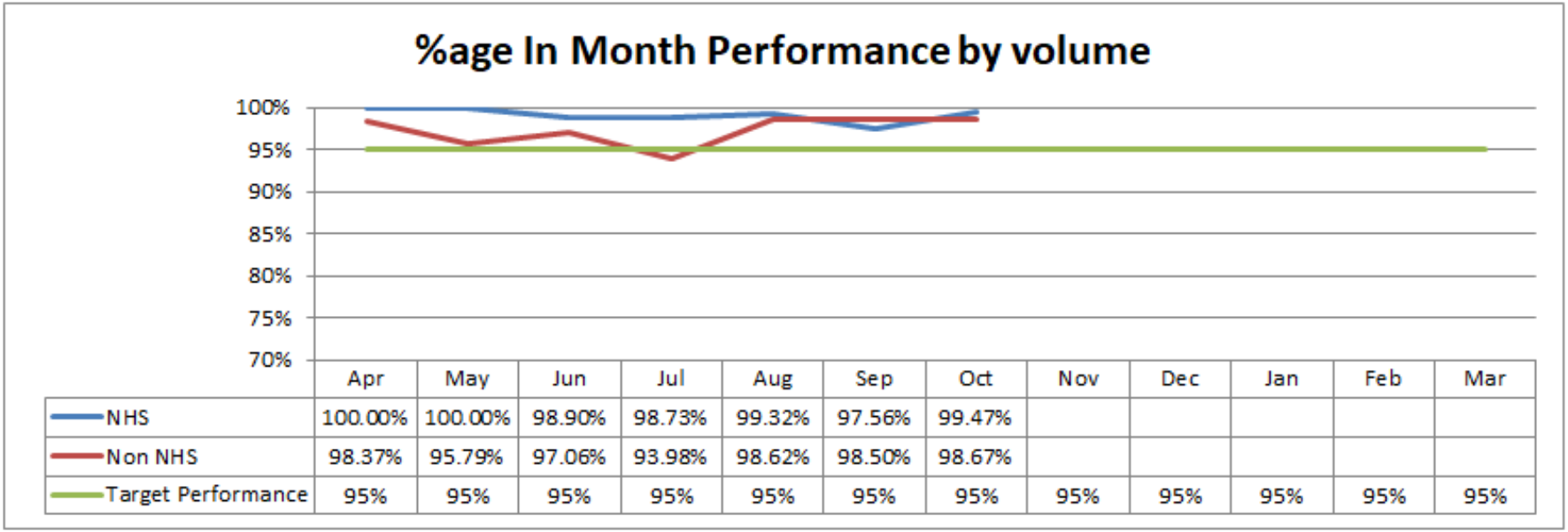


At the end of October £542.7m had been drawn down (59.4%) of the maximum cash drawdown available.
The cash balance at 30th October 2019 was £2.72m.

5.13 Sustainability – BPPC performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS	100.00%	100.00%	100.00%	99.96%	100.00%	99.86%	99.90%					
Non NHS	97.64%	96.25%	97.66%	98.22%	98.32%	99.21%	99.01%					
Target Performance	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS	100.00%	100.00%	98.90%	98.73%	99.32%	97.56%	99.47%					
Non NHS	98.37%	95.79%	97.06%	93.98%	98.62%	98.50%	98.67%					
Target Performance	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

5.14 Sustainability – I&E Position for Month 07 – October

Level 3 name	Level 4 name	Total Budget	YTD Budget	YTD Actual	YTD Variance	Total Forecast Variance	Prv Mth Forecast Variance
⊟ PROGRAMME	ACUTE	436,203,408	254,311,418	257,621,531	3,310,113	6,281,706	5,327,114
	COMMUNITY HEALTH SERVICES	86,788,464	50,428,896	50,367,484	(61,412)	(52,674)	(101,017)
	CONTINUING CARE	50,769,335	29,614,737	32,184,724	2,569,987	4,715,074	4,721,315
	MENTAL HEALTH	91,051,649	53,048,573	53,384,004	335,431	112,371	(35,303)
	OTHER	24,975,142	11,886,245	12,728,793	842,548	1,057,063	1,287,887
	PRIMARY CARE	200,358,221	115,820,783	116,288,543	467,761	1,126,579	657,233
	RESERVES	11,558,781	10,883,872	3,450,317	(7,433,555)	(13,240,118)	(11,857,229)
PROGRAMME Total		**901,705,000**	**525,994,524**	**526,025,397**	**30,873**	**1**	**(0)**
⊟ ADMIN	RESERVES	(892,095)	(479,313)	0	479,313	374,130	319,109
	CORPORATE	14,474,095	8,402,139	7,891,953	(510,185)	(374,130)	(319,109)
ADMIN Total		**13,582,000**	**7,922,826**	**7,891,953**	**(30,873)**	**(1)**	**(0)**
⊟ SURPLUS	SURPLUS	21,470,000	12,524,157	0	(12,524,157)	(21,470,000)	(21,470,000)
SURPLUS Total		**21,470,000**	**12,524,157**	**0**	**(12,524,157)**	**(21,470,000)**	**(21,470,000)**
Grand Total		**936,757,000**	**546,441,507**	**533,917,350**	**(12,524,157)**	**(21,470,000)**	**(21,470,000)**

NHS Gloucestershire Clinical Commissioning Group

5.15 Sustainability – Statement of Financial Position M07 - October

	Opening Position as at 1st April 2019	Closing Position as at 31st October 2019
	£000	£000
Non-current assets:		
Premises, Plant, Fixtures & Fittings	326	252
Total non-current assets	**326**	**252**
Current assets:		
Trade and other receivables	7,899	7,900
Cash and cash equivalents	9	2,723
Total current assets	**7,908**	**10,623**
Total assets	**8,234**	**10,875**
Current liabilities		
Payables	(50,642)	(45,578)
Provisions	(2,876)	(1,759)
Total current liabilities	**(53,518)**	**(47,337)**
Non-current assets plus/less net current assets/liabilities	**(45,284)**	**(36,462)**
Non-current liabilities		
Total non-current liabilities	**0**	**0**
Total Assets Employed:	**(45,284)**	**(36,462)**
Financed by taxpayers' equity:		
General fund	(45,284)	(36,462)
Total taxpayers' equity:	**(45,284)**	**(36,462)**

5.16 Sustainability – M07 reconciliation of I&E to cash

	Position as at 31st October 2019
	£000
YTD Surplus	12,524
Less YTD Resource Limit	(546,442)
Net Operating Expenditure	**(533,918)**
In year movements	
Depreciation	74
(increase)/Decrease in trade & Other Receivables	(0)
Increase/(Decrease) in trade & Other Payables	(4,993)
Utilisation of Provisions	(411)
Increase/(decrease) in provisions	(707)
Payments for PPE	(70)
Net Cash Inflow/(Outflow)	**(540,024)**
YTD Cash Drawdown	**542,739**
Net Movement in Cash	**2,714**
Opening Cash Cash at 1st April	**9**
Closing Cash at 31st October	**2,723**

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

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Agenda Item 10

Governing Body meeting

Meeting Date	**Thursday 28 November 2019**
Title	**Risk Management paper** **Governing Body Assurance Framework**
Executive Summary	The Audit and Risk Committee is responsible for assuring the Governing Body of the CCG's policies and processes for risk management. Additionally the committee reviews the identification and articulation of risks, risk mitigation plans and risk ratings. The committee provides feedback and comment with respect to how each directorate has identified, scored and managed its risk. The Quality and Governance Committee reviews clinical risks. Where there are issues with regard to how risks have been identified, managed and/or scored are reported to the A&G Committee. The Audit and Risk Committee review this report at its meeting on 10 September 2019. The committee approved the inclusion of new risks and noted that a schedule training programme is underway to implement 4Risk the new risk management software. A new 4Risk report format for the GBAF and CRR will be considered by the Audit and Risk Committee at its December meeting. Thereafter the GBAF will be submitted to the Governing Body meeting in January. 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 are reported to each meeting.
Key issues:	See narrative report.
Management of	None identified

11

Conflicts of Interest	
Risk Issues: **Original Risk** **Residual Risk**	The absence of a fit for purpose CRR 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)	See JR risk
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	Not applicable
Recommendation	• To note the report and progress work on 4Risk
Author	Christina Gradowski
Designation	Associate Director of Corporate Affairs
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

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Audit and Risk Committee

28 November 2019

Introduction

1.1 Each directorate has a risk register that is updated on a monthly basis and should be used as part of directorate meetings to shape discussions on emerging and current risks that need to be effectively managed / 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 receives a copy of the Assurance Framework which contains high level risks those rated 12 or more, at each of its meetings.

1.3 4Risk implementation

During July and August this year, the Corporate Governance Team attended two training sessions with RSM on 4Risk the new risk management system. There is a follow up training half day session with directorate risk leads. Each directorate was asked to nominate at least two staff members who would be the risk leads for the directorate. They have all been invited to the training that will be provided by RSM on 16 September at Sanger House.

1.4 The CCG will cease to use spreadsheets to record risks at the end of November 2019. Since September the Governance Manager has been supporting directorate risk leads to upload their risks onto the system. The Associate Director of Corporate Affairs has attended some of these sessions to inform the discussion of how risks should be articulated; namely a concise description of the risk with cause and impact detailed. The new risk reporting tool requires separation of controls and action plans linked to controls. This has meant that risk leads need to rethink the way that they articulate their directorate risks. During the

early part of November the Governance Team is working on inputting those risks not yet uploaded onto the system, training risk leads and running trial reports ready for the Audit and Risk Committee meeting in December.

The Audit and Risk Committee will be responsible for reviewing the new report format and providing feedback. It is intended that the new style GBAF will be ready for the January 2020 Governing Body meeting. In the meantime this report provides an overview of the risks

2 Risk Management strategy and procedures

The new risk management system requires a different approach to risk management, where each control is listed and risk mitigation relates to each of the controls. Additionally the system allows for greater clarity on the identification of risk, risk appetite and assurances. This will alter the risk management process currently operating within the CCG, which will be reflected in the newly created Risk Management Framework incorporating a risk strategy and policy. The CCG's Risk Policy will become obsolete. This will take some months to complete. By December the new framework will be in place.

Highest risks RED

There is one high rated Red risk F11 on this 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).

- K15 There are at least 8 care homes within Gloucestershire where all residents are placed by other authorities or CCGs. The CCG/Council is not in a position to monitor these homes due the placement being outside their contractual control. 2gether trust services are not involved in the care of these residents until crisis point resulting in a high use of resource. GCC is still responsible for the safeguarding of these individuals. This was originally rated as a 9 and has increased to a 12.
- T20 Risk that delayed implementation of changes to pathways through the Clinical Programme Approach fail to deliver the anticipated benefits; resulting in: transformation projects that may not deliver the expected outcomes for patients and the whole system. This risk has been reviewed and the risk scoring 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 has been reviewed and the actions have been updated. The risk remains unchanged at 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 and assurances have been updated and the risk score remains unchanged at 12 (Amber) down from an original risk rating of 16 (Red).

- C6 A&E target 4 hour wait. The actions and assurance have been updated and the risk score remains unchanged for most of the year, at 12 (Amber).
- 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), the risk was reviewed but 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 and assurances 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 was reappraised following on from a Governing Body Business Session where Public Health attended and where the cuts to services were discussed. This risk was reviewed in August and remains unchanged at 12 (Amber).
- Q20 Mortality review. The assurances have been updated, the actions remain 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 were updated for the July report, the risk has been reviewed and remains unchanged for the September report at 12 (Amber).

- 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).
- 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 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 risk remains unchanged at 12 (Amber).

3. Recommendation

3.1 The Governing Body is asked note the Risk Report and GBAF.

4. Appendices

Appendix 1 Governing Body Assurance Framework.

Governing Body Assurance Framework 25/06/2019 **Agenda Item 13.1**

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. 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	↓	A member of the CPG team is now leadning on specialised commissioning.
Date added 15.01.2019 **Directorate** **O22 Quality Directorate** Executive Sponsor Marion Andrews-Evans **Lead Committee** Audit & Risk Committee **Review Date** 31.03.2020	SWAST have 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.	1. SWASFT have reviewed rota's and opperating proceudres 2. SWAST have increased GP support in hubs 3. System wide QSG and workshops 4. Escaltion plans in plac	None	Review at Clinical Effectiveness Meetings	None	3x4=12	3x4=12	⟺	NHSE&I have now convened two single issue Quality Surveillance Groups and a urgent care system wide workshop. New hold times for 11 have been instigated to prevent SWAST from reaching Opel level 4. 111 provider is about to start Cat2 sense checks and we are working with partners to help reduce risks. The CCG & NHSE continue to monitor performance and patient safety and a further QSG is being organised by NHSE.N18
Date added 7/8/2019 **Directorate** K15 Integration **Executive Sponsor** Kim Forey **Lead Committee** Audit & Risk Committee **Review Date** 31.03.2020	There are at least 8 care homes within Gloucestershire where all residents are placed by other authorities or CCGs. The CCG/Council is not in a position to monitor these homes due the the placement being outside their contractual control. 2gether trust services are not involved in the care of these residents until crisis point resulting in a high use of resource. GCC is still responsible for the safeguarding of these individuals.	* ADASS Guidance * Care Act 2014 - Ordinary Residence * Frameworks and Contracts with Gloucestershire Providers	None	TBC	TBC	3x3=9	4x3=12	↑	Update 18/07/2019 GCC wrote to all neighbouring authorities on 17/01/19.
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 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 presented to UEC Programme Group with exception reports to A&EDB / ICS Board.	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. Introduction of UEC Programme Group to have multiagency oversight of progress against work streams. Improving System Flow Plan on a Page reviewed at UEC Programme Group.

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating	Current risk rating	Trend	Progress with actions
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	Performance Reports and dashboards, critical milestones reviewed, regular programme stocktake presented to UEC Programme Group with exception reports to A&EDB / ICS Board.	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. Introduction of UEC Programme Group to have multiagency oversight of progress against work streams.
Date added 01.04.2017 **Directorate** **C15 Commissioning Implementation** **Executive Sponsor** Mark Walkingshaw **Lead Manager** Christian Hamilton **Lead Committee** Audit & Risk Committee **Review date** 31.03.20	Failure to fully comply with all NHS constitution standards. **Due to:** Delivery of changes required to recover performance and address issues related to capacity and demand. **Resulting in:** Potential delays to patient care	Acute provider contracts, including AQP.	None	Reports to GB at Business Sessions; GB meetings	None	3x4=12	3x4=12	⟺	Progress with actions 1. Significant improvement in performance continues – including delivery of ED 4 hours standard, diagnostics, cancer 2 ww and DTOCs. 2. Further concentrated work on delivering recovery plan for cancer 62 day standard, and to reduce number of over 52 ww breaches. 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 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 and dashboards, critical milestones reviewed, regular programme stocktake presented to UEC Programme Group with exception reports to A&EDB / ICS Board.	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. Introduction of UEC Programme Group to have multiagency oversight of progress against work streams. ED Attendance & Hospital Admission Avoidance Plan on a Page reviewed at UEC Programme Group
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** **O20 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 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 aggregated contract 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**	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	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				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 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.

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating	Current risk rating	Trend	Progress with actions
Mark Walkingshaw / Cath Leech **Lead Manager** Christian Hamilton / Andrew Beard **Lead Committee** Audit Committee **Review date** 31.03.20	This will have an adverse impact on cash balances held by the CCG.					4x4=16	3x4=16	⟺	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 **Directorate** **K9 Integration** **Executive Sponsor** Kim Forey **Lead Manager** Miriam Street & Debbie Sanders **Lead Committee** Audit & Risk Committee **Review date** 31.03.2020	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 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.	Monthly perfromance reports reported to the Core Leadership team and to the Governing Body at the Business Sessions and formally as part one of the Governing Body meeting.	None	Governing Body Performance Reports; reports to the Audit and Risk Committee and performance monitoring by NHS England	None	4x4=16	3x4=12	↓	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. 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	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;	LHRF Business group are co-ordinating the planing arranegements and liaising with the LRF SCG. If no-deal by last	None	All providers have been asked to undertake risk assessments and develop contingency planns. Also they ahev been asked to contact their	None				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.

Risk details	Risk Description	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Original Risk rating	Current risk rating	Trend	Progress with actions
Directorate **Q23 Quality** **Executive Sponsor** Marion Evans Andrews **Lead Manager** Emergency Accountable Officer **Lead Committee** Audit Committee **Review date** **31.03.2020**	• 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	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.		suppliers to make sure they also have plans in place.		3x4=12	3x4=12	NEW	
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 wellbeing outcomes later in life	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

Agenda Item 11

Governing Body

Meeting Date	**Thursday 28th November 2019**
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.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	ICS programme risks are regularly reported to 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

Gloucestershire CCG Governing Body

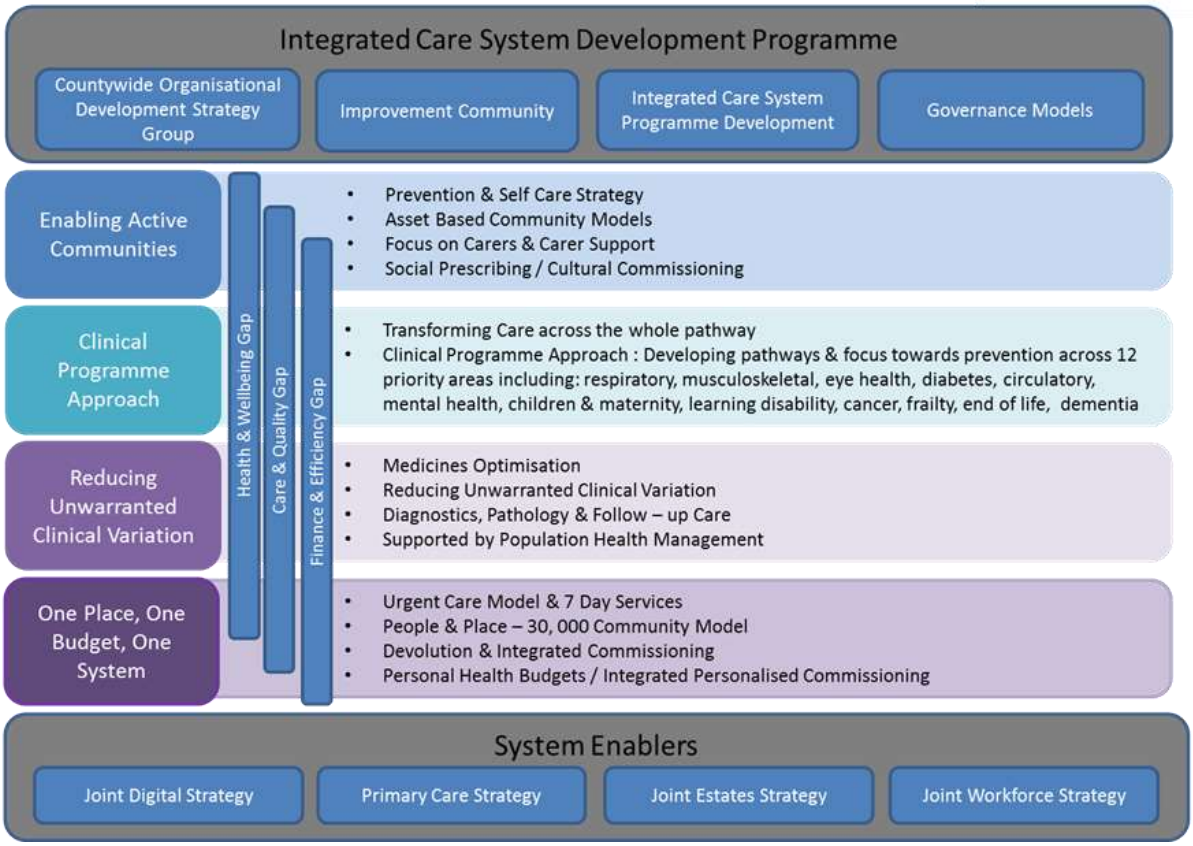
November 2019

One Gloucestershire ICS Lead Report

1. Introduction

The following report provides an update to CCG Governing Body 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. Priorities continue to be delivered across the main transformation programmes and we have relooked at how plans will be delivered. This will help with the changes required to deliver the Gloucestershire 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 ICS. One of the roles of the ICS is to improve the quality of Health and Care by working in a more joined up way as a system.



Gloucestershire's ICS Plan on a page

12.1

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 improve health and wellbeing. It recognises that a more efficient approach to preventing ill health is very important. This will improve the health of the population and maintain financial sustainability in our ICS .

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

Supporting Pathways

- The provider of the **Tier 2 Child weight management service** is in the final stage of developing a trial service for Gloucester and Forest of Dean. This includes establishing referral routes and developing ways of testing the programme.
- At the end of September the first joint Gloucester and Cheltenham **Blue Light change resistant drinkers** meeting took place. Members of the group are reaching the point of being successfully discharge and have been helped to find employment.
- **Postpartum contraception -** Delivery of 'contraceptive counselling' continues. The service has achieved a delivery rate of 100%; with 100% of women attending the service accepting contraceptives.

Supporting People

- Referrals to **Self-Management - Live Better, Feel Better** are increasing. An assessment of the service is underway and results show people taking part are able to manage their conditions better than before attending the service.
- A project has been developed which focuses on improving the quality of 'Stop Smoking' services.

Supporting Places & Communities

The **Community Wellbeing Service (CWS)** continues to make a positive impact to individuals, with 3,971 referrals made since the service began nearly 3 years ago. A successful workshop was held during October between CWS providers and district council colleagues. The workshop aimed to further develop how the CWS and Strengthening Local Communities project work together. An assessment of the service to date is currently underway.

We Can Move programme:

- The Active Youth Network provides opportunities for people to get together, equipping them with the tools to recognise and support those who may be experiencing mental health issues.
- 15 people have been upskilled through practical courses including safeguarding and the

'Inclusive Activities course' focuses on equipping people with the skills to work with disabled people and people with long-term health conditions more effectively in activities.

- Active Gloucestershire blog article exploring potential for a public transport, walking and cycling bridge across the River Severn generated considerable positive feedback.
- The Fall-Proof website has had 565 views in September, with over 500 people having received packs via community groups. As a result 83 champions / influencers have been identified. The programme looks at how people can improve strength and balance to help prevent them from falling.

Strengthening Local Communities

- In Cotswold the second Bourton Funstival took place on 21st September. Health champions and 'Dementia Friendly Bourton' were promoted at the event.

Supporting Workforce

- **Workplace Health and Wellbeing:** The distribution list for the workplace wellbeing newsletter continues to grow. The newsletter has received very positive feedback. Planning is underway to formally launch the newsletter in January 2020.

Focus on Community Wellbeing Service: Case Study

A couple in their 80s had been referred by the GP as both were feeling low and were struggling with everyday life. A home visit was carried out to establish their needs. The initial issue was that they were struggling financially and this was having an impact on many areas of their lives, not least their mental health. They didn't know where to get support and were concerned that things might deteriorate. On discussion it was suggested that a referral be made on their behalf to Age UK for support and a review around benefits and pensions.

Both agreed to this and a referral was made. Working with Age UK the couple were able to get their finances sorted and benefits/pensions reviewed. This resulted in a more positive mental attitude and they were more relaxed. On a follow-up visit they said that their wedding anniversary was imminent and they would love nothing more than a few days away. It was suggested that as the husband had been in the armed forces that they contact the British Legion to see if they were able to provide a short break or some financial support. The husband subsequently did this and they were able to provide a break at a hotelat the sea side. . The couple were able for the first time in a few years to have a break away and were delighted that they even had a room with a view. They were able to spend quality time together with few worries as their finances had been sorted as well.

On their return, a phone call was received saying how grateful they had been for the support, information and help they had received. if they had not come to us their lives would not have changed for the better and they would not be in such a positive place. The couple just wanted to thank the service. They also informed us that they had had the time of their lives while on holiday. It had all had such a positive impact on their mental health.

3. Clinical Programme Approach

The Clinical Programme Approach has been adopted across our local health care system to make sure services work together to redesign the way care is delivered in Gloucestershire. , By reorganising the way care is delivered and services that deliver this care we can make sure that people get the right care, in the right place, at the right time. During 2019/20 we have identified 4 clinical programmes which will be moved forward more quickly. These are Respiratory, Diabetes, Circulatory and Frailty & Dementia.

Respiratory:

Health Education England funding has been approved to continue to support education and training in 2019/20 across primary care, community and acute care. This includes developing bespoke training packages including diagnostics, management and preventative support for teams working in Primary Care.

A Chronic Obstructive Pulmonary Disease (COPD) Self-management plan is to be evaluated in the Hospital, community and 13 GP practices. The trial phase commenced in September 2019

The specification for Home Oxygen and its Assessment is being relooked at. . Changes to this process will mean a more joined up approach to help discharge patients from hospital. The design of an Integrated triage for community and outpatient referrals is underway.

Diabetes:

The new National Diabetes Prevention Programme (NDPP) provider, ICS Health and Wellbeing, started on 1 August 2019 is working well with nearly 400 referrals made to date. A letter is also being sent out to Clinical Directors of Primary Care Networks showing their referrals onto NDPP against their total patient population The CCG is waiting to hear about the start date to be an early implementer site for the HeLP online tool for people with type 2 diabetes.

The pathway for children with Type 1 diabetes going onto a Continuous Glucose Monitor is working with 50 children in receipt of this device. The device will help manage their diabetes and reduce its complications

Research into all major diabetes related amputations commenced on 8th September 2019. This is being undertaken by diabeteolgist and podiatrist and learning from the work will be fed back to those involved in the patients care to help improve the quality of care in the future

7 national sites have been chosen to trial a Low Calorie Diet Programme of which Gloucestershire is one. Virtual clinics (patients are not present in the surgery) are being held by one of our GP's. They are working well but it is too early to say if they are having longer term positive effects on patients' health and care.

The 10 Year Diabetes Strategy has been finalised and will be submitted for approval to Diabetes Clinical Programme Group in November 2019.

The CCG was successful in being awarded £40,500. This money will be used to look at how people with Diabetes can volunteer to work with other suffers in the community to help improve the uptake of

available education and support

Circulatory:

Joint GP and Hospital Consultant review of Cardiology referrals have been undertaken. This highlighted issues with both the quality and appropriateness of referrals. Meetings are planned with the Cardiology Leader to discuss options and next steps.

A Workshop was held in October with important stakeholders to develop the management of patients with palpitations as part of the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) palpitations pathway.

REACH-HF home-based rehabilitation programme for people with Heart Failure commenced with the first group of patients.

'Nature on Prescription' in partnership with Gloucestershire Wildlife Trust launched, with actions identified to try to increase referrals.

Meeting held with the Hospital to agree actions to increase referrals for cardiac rehab. Patient engagement has taken place to gather feedback on ways to increase uptake with a proposal for an on-line tool to be developed.

Frailty & Dementia:

From the data provided, there is an early suggestion that the care home trial that is being delivered by the Rapid response team is reducing the number of call outs to the Ambulance Service in targeted care homes.

We want to make sure that the person is at the centre of decision making. The Frailty and Dementia Group are drafting and testing assumptions about what individuals living with frailty want. The drafted principles have been agreed and are now being tested with different groups.

The Integrated Community Dementia Team has been operational since July 2019, with all of the additional Community Dementia Nurse and Dementia Advisor posts successfully recruited to. Early feedback suggests that families value the improved contact with dementia services and the staff value the shared base and joint approach to planning care

The Community Dementia Dog project has been extended to 12 months based on positive results following a review during the middle of the trial. The project has worked with Charlton Lane staff to help discharging people home using activities designed to improve outcomes for patients.

4. Reducing Clinical Variation

The Reducing Clinical Variation programme looks to elevate key issues of clinical variation to ICS level. This will include having conversations with the public around some of the harder priority decisions we will need to make. This includes building on a different approach with primary care, promoting 'Choosing Wisely' , thinking about how medicines can be used in a better way to reduce cost and waste, undertaking a review of diagnostic services and working to improve Outpatient services.

Key priorities for 2019/20 are

- We will continue to use the successful Prescribing Improvement Plan (PIP) to ensure that we continue to save money and improve benefits 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 Hospital colleagues to consider areas including medication choice and how medicines are supplied so that benefits are shared across the ICS.
- Continue to include Medicines Optimisation topics within the annual Primary Care offer to support primary care colleagues to maximise savings available from prescribing in a better way
- 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 scheme, specifically in residential homes.
- Develop & improve mechanisms to allow GPs to access specialist opinion/advice and guidance.
- Develop appropriate alternatives to Hospital outpatient services where there are opportunities to manage patients in a less specialist and lower cost setting.
- Support changes to how Outpatient Care in delivered across the ICS Improve how money is spent to commission services through changing and developing relevant policy.
- Referrals to Hospitals will be triaged and managed using improved procedures. A review of diagnostic services across the ICS will be undertaken to support programmes of change.

What we've achieved so far:

- Work within GP practices is progressing towards achievement of the 2019-2020 Prescribing Savings target through the updated Prescribing Improvement Plan and Primary Care agreement which have been combined for the first time this year.
- Our team of Prescribing Support Pharmacists Prescribing Support Technicians and Clinical Pharmacists are working with their allocated practices and provide support to help achieve prescribing savings for individual practices.
- Ongoing communication with the public around changes to medicines policies including the prescription of over the counter (OTC) medicines. OTC medicines information leaflet, relating to encouraging people to buy their own medications where possible, has been updated.
- GHNHSFT are looking at ways of improving outpatient services looking at 5 specialist areas. The specialties are dermatology, diabetes, neurology rheumatology and booking functions and patient communications. A bid has been submitted to Health Education England for some additional funding to provide on the ground support to deliver change.
- A meeting has taken place to discuss Public Involvement in Diagnostics and agree the purpose and attendance of a public involvement workshop for diagnostics. A plan for the aim of the workshop will be taken to the programme board and further work is needed on securing representation.

5a. 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 ICS 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,
- Live in healthy communities,
- Benefit from strong networks of community support
- Be able to access high quality care when needed.

New locality or Place led 'Models of Care' trials started in 2016/17. The trials were to 'test and learn' from this process including benefits, challenges and working across organisational boundaries. This led to the formation of 16 locality clusters/ Places across the county.

Key priorities for 2019/20 are

- Senior leaders from health and social care, locally elected government and non-professional representatives are working together to inform and support integration at Primary Care Network (PCN) level. This will help with 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 by working together. .
- 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 an approach which concentrates on their population which includes keeping people healthy (prevention) and public health. The agreed priorities will help to improve health and wellbeing for their population.
- Develop how teams made up of different health and social care staff will work together at a PCN level.

What we've achieved so far:

- ILP members participated in Place based workshops, with local people, focussed on urgent care in Gloucestershire throughout September and October.
- ILP Plans commenced for Forest of Dean and Stroud & Berkeley Vale, using a framework agreed by all ICS partners which made sure priorities fed into the NHS Long Term Plan. A workshop held in Tewksbury was very well attended and produced lots of good work. Participants in the workshop agreed that they would like to work together to create a Strategic ILP to include a common set of short, medium and longer term strategic priorities.

South Cotswolds Frailty Service

- Flu clinic training has started and leaflets have been ordered. The team have been undertaking a health promotion exercise in as many flu clinics as they are able to attend including offering the "Sit to Stand" challenge and information about the importance of strength and balance and nutrition as we age.
- End of Life Care: the frailty team are undertaking development to improve confidence and competence in recognising when End of Life planning is needed and starting Advance Care Plan conversations earlier.

- Supporting GP's in End of Life Quality Improvement.
- Process for improved joined up working with Cirencester Community Hospital has been reviewed and a new process developed and expected to start in November.
- Dementia lead at the Community and Mental Health Trust is providing monthly Question and Answer sessions and also helping the team to explore identifying people who are at the End of their Life and planning care for people with Dementia.

5b. Fit For The Future

Fit For The Future

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.

Our key deliverables for 2019/20 include;

- Continue to develop and refine the "Fit for the Future" 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 plans identified within the Emergency Department attendance (A&E) admission avoidance programme and length of stay management.
- To further develop and deliver plans which look at the journey patients take from the time they are admitted until discharge which will reduce bed occupancy of long stay patients by 25%:
- To further develop and deliver plans identified within the Community Admission Prevention programme.
- To further develop and deliver plans identified within the Find and Prevent programme.

Current progress

An independently chaired Engagement Hearing took place on the 24th October in public and live streamed; giving people an opportunity to share their ideas and views on developing urgent and specialist hospital care in Gloucestershire in the future. The Hearing was also an opportunity for individuals and groups to discuss their thoughts on what they think should be taken into account in arriving at the best solutions for services. A group of experienced doctors and other healthcare professionals made up the panel on the day.

Health leaders in Gloucestershire have 'paused' the current programme of public engagement in response to the Government's announcement that a General Election will be held on Thursday 12 December 2019. The pause, which is in line with NHS England guidance in relation to a Pre-Election

Period means that the Citizen's Jury and Solutions Appraisal Exercise, both scheduled to be held in December, will be rescheduled. New dates for the events will be published in due course.

Health partners in Gloucestershire would like to thank everyone who has taken the time to share their views and ideas as part of the public engagement programme that was launched in August. All feedback received is being collated into a comprehensive Engagement Report and this will be used to inform the development of potential solutions for the future local NHS services.

6. Enabling Programmes

Our vision for future Health and Social Care in Gloucestershire is supported by our enabling programmes. These are working to ensure that the ICS has the right capacity and capability to deliver on the clinical priorities which have been identified.

Joint IT Strategy: Local Digital Roadmap

- Funding has been offered by NHS England to appoint a Chief Clinical Information Officer to support Mental Health, Digital & Data Strategy and Regional Diagnostics Sharing.
- Cinapsis (an Advice and Guidance system), has now been rolled out to 47 practices across the county. This supports GPs and hospital consultants and other clinical staff communicating to support GPs with advice for patients on a quick turnaround.
- Joining Up Your Information (JUYI) is being viewed 240 times a day on average supporting the sharing of information across our health and care providers.
- 26.18% of patients are now registered for online primary care digital services.

Joint Workforce Strategy

The following 2019/20 Workforce Development Projects have been signed off by Health Education England and therefore supported with funding;

- Advancing Practice,
- Apprenticeship Hub supporting us to continue to provide excellent apprenticeships in health and care roles,
- Support to the clinical programmes (see section 3)
- Primary Care Network (PCN) Health Coaching Skills Training,
- Gloucestershire Improvement Community Programme,
- Outpatients and Upskilling Allied Healthcare Professionals in Ophthalmology Clinics.
- Cohorts 5 (CVD & Diabetes) and 6 (Respiratory & End of Life Care) of the ICS Leadership Development Programme are full and started in October.

Joint Estates Strategy

The ICS Estates Strategy is being developed which brings together updated organisational estates strategies of each partner organisation, as part of the long term plan. An updated Primary Care Infrastructure Plan with plans up 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 first ICS digital primary care priority is to have a main offer for all practices. It will test further digital improvements to establish the benefits for patients and GP practices. At the same time it will keep an eye to the future developments with 111 Online and the NHS App roll out.

The 2019-2024 Primary Care Strategy must demonstrate how the ICS will:

- How services will remain flexible sustainable
- improve integration and partnership working,
- detail priorities and how these will be achieved
- Describe how Primary Care Networks will be the focus as the key enabler to the strategy.

We continue to deliver over and above the national mandated target of 30 minutes for improved access. In October, we had a visit from the national Access Team from NHS England as part of their investigations to inform the Access Review. We coordinated this visit which included visits to practices in the Forest of Dean and Gloucester City and were pleased to be able to report back from the ground how Improved Access is working locally. Five practices in county have taken up the opportunity to develop admin staff to undertake some clinical tasks as part of their role – including phlebotomy, clinical correspondence and other activities to support GP workload. The new website (Footfall from Silicon Practice) supports Care Navigation and signposting to self-help and other services. It allows secure electronic communication between patients and practices and administrative functionality which should reduce telephone calls to practices. Currently 54 practices, out of Gloucestershire's 74 practices have accepted the FootFall solution.

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. The final output of public engagement has been completed and will be used it to inform our next steps in building the One Gloucestershire response to the NHS Long Term Plan.
- Further work has continued to seek additional transformational funding for the county to support being at the lead 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 group met in September and discussed the direction of the ICS including the Long Term Plan response and the Health and Wellbeing Strategy.

Focus on One Gloucestershire

As part of moving towards integrated care the ICS Board have reviewed the ICS priorities and have emphasised the following:

- **Improving mental health:** including improving dementia care and a renewed focus on mental health and wellbeing, additional support for regular users of health and care services. Ensuring that everyone has equal access to services no matter who they are or where they live. **Supporting Urgent & Emergency Care:** the Fit for the Future programme remains central to delivering our new model of care within Gloucestershire
- **Focusing on proactive care in partnership with local communities:** including building capacity in primary, community and VCSE (voluntary, community and social enterprise) care, reducing demand for acute services and improving end of life care
- **Improving population health:** including rapid delivery of place based integrated working through Integrated Locality Partnerships and a focus on wellbeing and prevention and self-care. Increasingly we will work to influence the wider factors of health including loneliness and isolation whilst also improving or use and application of population health management.
- Focus on **enabling conditions** including
    - fostering a culture of engagement and co-creation

- continuing existing enabling programmes of workforce, estates and digital
- ensuring effective governance that facilitates shared decision making

As we evolve our response to the NHS Long Term plan we have reviewed our transformation programmes and prioritised our focus since the publication of the 2016/17 Sustainability & Transformation Plan. The priorities are felt to be of increasing importance within our existing programme structure therefore they are being given more focus and resource over time.

8. Recommendations

This report is provided for information and CCG Governing Body Members are invited to note the contents.

Mary Hutton
ICS Lead, One Gloucestershire ICS

12.1

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Governing Body

Meeting Date	**Thursday 28 November 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)	

NHS Gloucestershire Clinical Commissioning Group

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. Full details of provider performance are reported to the Quality and Governance Committee

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 of Serious Incidents, split by category, are provided to Quality and Governance Committee.

2.3

Gloucestershire Hospitals NHF FT						
Never Event	1	0	1	1	1	1
Serious Incidents	6	5	5	7	9	3
	7	**5**	**6**	**8**	**10**	**4**

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2.4

Gloucestershire Health and Care NHSFT	
Never Event	**0**
Serious Incidents	**1**
	1

2.5

Legacy reporting for 2g and GCS

Gloucestershire Care Service NHS Trust						
Never Event	0	0	0	0	0	1
Serious Incidents	3	1	5	2	5	0
	3	**1**	**5**	**2**	**5**	**1**

2gether NHS FT						
Never Event	0	0	0	0	0	0
Serious Incidents	7	3	10	5	4	12
	7	**3**	**10**	**5**	**5**	**12**

2.6 **Never Events**

Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

In Quarter Two and Three (October) three Never Events have occurred:

- In GCS, an upper left adult tooth extracted instead of upper left baby tooth.
- In GHFT, one patient was temporarily connected to ‘air’ rather than ‘oxygen’. The other Never Event relates to wrong site surgery on varicose veins

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3 Patient Advice and Liaison Service (PALS) Activity

3.1 GCCG Patient Advice and Liaison Service (PALS)

The table below gives a breakdown of the types of enquiries the CCG PALS team has responded to up to end Q2 2019.

Type	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20
Advice or Information	111 (PC 27)	1 (PC 12)	110 (PC 22)	38 (PC8)	38 (PC 11)	21(PC 8)
Comment	11		11 (PC 4)	0	1	0
Compliment	4	2	2	2	2	4
Concern	*97* (PC 23)	110 (PC 14)	75 (PC 22)	72 (PC)	50 (PC 10)	35 (PC6)
Complaint about GCCG	2	5	7	5	7	12
Complaint about provider	22	18	18 (PC 5)	35	33 (PC 7)	33 (PC2)
NHSE complaint responses copied to GCCG PALS	1	0	0	1	10*	15*
Other	32 (PC 4)	52 (PC 5)	34 (PC 4)	67 (PC 9)	74 (PC 6)	87 (PC15)
Clinical Variation (Gluten Free)	0	2	0	1	1	1
Total contacts	**280**	**288**	**257 (PC 57)**	**221**	**216 (PC 34)**	**208 (PC46)**

	**** NHSE complaint investigations & responses copied to GCCG PALS:*** *NHSE are now consistently sharing complaints for logging only.*
3.2	**Themes identified from GCCG PALS Contacts Q2 19/20** PALS have continued to receive many telephone calls, many of which have been of a complex nature. This is consistently themed throughout all Quarters. PALS email contact had been included within the letter Marybrook patients had received about the future of the practice. In total five contacts by email had been received which were responded to directly by the Primary Care team. In Q2 there have been a total of six contacts relating to Aspen Medical Centre. • One contact – compliment made to their Patient Advocate • Two contacts - NHSE complaints team • Three contacts - under other requesting information leaflets and medical records
3.3	**GCCG Complaints** There has been a relatively high number of GCCG complaints recorded during Q2. This breaks down as follows: 4 x commissioning (autism pathway, IFR/IVF, wheelchair provision – joint with GHaCNHSFT and a joint primary care/GCCG) and 8 x CHC complaints (retrospective funding, fast track and outcome of local resolution meetings).
3.4	**Announcement on future changes to the Friends and Family Test FFT** NHSE shared news of changes to the FFT in July 2019. These are based on the findings from the project NHSE ran between June 2018 and March of this year, in which GCCG participated. The recommendations were accepted, almost in their entirety, and NHSE have detailed the new processes in revised guidance published in early September 2019 https://www.england.nhs.uk/fft/fft-guidance/

	The changes NHSE mean that from next April 2020: • All providers will use a new FFT mandatory question and six new response options; • NHSE will have removed mandatory timescales where some services are currently required to seek feedback from users within a specific period, which affects emergency departments, inpatients and maternity, to allow more local flexibility and enable people to give feedback at any time, in line with other services; • NHSE will have greater emphasis on use of the FFT feedback to drive improvement; • NHSE will be well advanced in exploring new, more flexible, arrangements for ambulance services where the FFT has proved difficult to implement in practice. NHSE have published a set of Frequently Asked Questions about the changes. https://www.england.nhs.uk/fft/friends-and-family-test-development-project-2018-19/faqs/
3.5	**Fresh FFT case studies** NHS has published a refreshed set of FFT case studies on our website. You can find them at: https://www.england.nhs.uk/fft/friends-and-family-test-development-project-2018-19/case-studies/
3.6	**Engagement** **NHS Long Term Plan / Operating Plan / One Gloucestershire: One Place and Centres of Excellence** Earlier this year, the CCG Engagement Team worked with Integrated Care System (ICS) partners, including Healthwatch Gloucestershire, to gather feedback from people who live and work in Gloucestershire and the surrounding area to inform the development of local delivery and transformation plans. Engagement events, ranging from Information Bus Drop Ins to targeted discussions with local groups and stakeholders such as young carers or District Councilors, took place from mid-March to mid-May 2019. We asked ***'what matters to you… and why'*** about a range of topics such as 'starting well/living well/ageing well' or 'GP services', 'Urgent advice' etc.

	The Outcome of Engagement Report, and the Healthwatch Report are now available on the One Gloucestershire website at: www.onegloucestershire.net
3.7	***Fit for the Future*** **(FFTF) engagement: Developing urgent and hospital care in Gloucestershire** The feedback from the LTP engagement has fed into the FFTF current engagement and consultation (as required) during 2019/20. One Gloucestershire NHS partners have 'paused' the current programme of staff and public engagement Fit for the Future in response to the Government's announcement that a General Election will be held on Thursday 12 December 2019. The pause, which is in line with NHS England guidance in relation to the Pre-Election Period (PEP), means that the Citizens' Jury and Solutions Appraisal Exercise, both scheduled to be held in December 2019. The NHS partners of One Gloucestershire would like to thank everyone who has taken the time to share their views and ideas since the engagement programme got underway in August 2019. All feedback received is being collated into a comprehensive Engagement Report and will be used to inform the development of potential solutions for future local NHS services.
4	**Infection Control**
4.1	**Methicillin-Resistant Sstaphylococcus Aureus (MRSA) Bacteremia** From 1 April 2018 to 31 March 2019 there were fourteen incidences, eight cases attributed to community acquisition and six cases to hospital acquisition. Six of the cases are linked to intravenous drug misuse. A review group was formed, led by GCC Public Health Protection consultant with countywide representation from health providers. Implementation of an action plan is progressing well and on-going. 1 April 2019 – 30 August 2019 there has been three MRSA Bacteremia cases in Gloucestershire. One case had a hospital onset and two cases a community onset.

4.2	**Clostridium difficile Infections (CDI)** The threshold set by NHS Improvement (NHSI) for Gloucestershire for 2019/20 is 194 cases which equates to 16 or less cases per month. Overall the number cases of CDI being reported in 2019/20 in Gloucestershire is showing a downward trend compared to 2018/19 with a total of 101 cases between April and end September 2019. There are new reporting categories in place, namely Hospital Onset Healthcare Associated (HO-HA), Community Onset Healthcare Associated (CO-HA), Community Onset Indeterminate Associated (CO-IA) and Community Onset Community Associated (CO-CA).
4.3	**Community Onset Prevention Programme** In 2019/20 78% of patients first developed symptoms of CDI in the community. Post Infection Reviews indicate there are delays in community clinicians sending stool samples when a patient presents with diarrhoea and diarrhoea management is not consistently optimal. Delays in diagnosing CDI risks patients developing a more severe form of the illness and requiring longer treatment. A 'think CDI' campaign is in progress raising awareness to consider CDI particularly in high risk patients when presenting with diarrhoea. Key high risk factors are over 65 years of age, recent treatment with antibiotics or hospital admission. This work promotes early identification of CDI through prompt stool testing, optimising the treatment of patients with CDI and ensuring patients in the community have the information to prevent spread of infection.
4.4	A monthly Assurance Panel chaired by the CCG reviews all the monthly CDI cases reported as hospital onset. The meeting routinely reviews the outcomes of action plans and lessons learnt from Post Infection Reviews (PIR). The panel further overseas the CDI reduction strategy. Under this strategy is an action plan for each Trust as well as collaborative actions undertaken to reduce CDI. An example of an action is the development of an educational initiative to

	improve diarrhoea management. It will include sampling, isolation, and avoiding the use of loperamide when CDI suspected to be offered along the pathway from GP through to hospital services.
4.5	**Gram Negative Bloodstream Infections (GNBIs) Escherichia coli (E.coli) Infections** The national ambition, announced by the Government in 2016, is to halve the number of healthcare-associated Gram-negative bacteraemia by March 2021. In 17/18, the threshold was exceeded by 19 cases. In 18/19, the threshold was exceeded by 29 cases. Despite this increase we have been informed by NHSE that we have the lowest rate of E.Coli in the south west region. The Quality Premium for 17/19 (two years) includes an annual threshold target of 257 incidences of E.coli Bloodstream infections in Gloucestershire. April 2019 – August 2019, One hundred and thirty E.coli bacteraemia cases were reported of which twenty-four cases (18%) with hospital onset and one hundred and six cases (82%) with a community onset. A countywide UTI reduction plan is in place and reviewed quarterly. Further planned work for 2019/20 is to extend the action plan to include other causes of Gram Negative Blood Stream Infections.
5	**Provider Updates**
5.1	**Gloucestershire Hospitals NHS Foundation Trust** **Inspection Reports** The Trust had a recent joint inspection by CQC, HSE and Environment Agency of their arrangements for ionising radiation. Whilst the CQC noted that patient's safety was protected and staff were kind and caring, regretfully the inspection team identified that the Trust were in breach of three aspects of regulation 6. The key focus of these breaches was in relation to policies, procedures and protocols and QA programmes. The Trust have been issued with an

	improvement notice and developed an action plan which will be monitored via CQRG. HSE have also issued a "notification of contravention". We have been assured by the Trust that recovery actions have been taken.
5.2	**GHC NHS Foundation Trust** On the 1st October 2019 GCS and 2G successfully merged. The CCG have now combined the Clinical Quality Review Group meeting to reflect the integration of services and the associated quality agenda within the trust. During Quarter 3, the Nursing, Therapies & Quality Senior Team within GHC will develop a revised harmonised format for the Quality Report to bring together the physical and mental health indicators of the predecessor organisations, taking note of NHS England guidance with regard to mandated content and structure of the final report. Medical staffing within Mental Health and LD services remains a significant concern. Whilst most posts are filled with locums there are 3 consultant posts that remain vacant. The executive team at GHC have now added additional scrutiny and focus to this issue and progress with recruitment will be provided to the CCG via the CQRG meetings. The CCG remain concerned with the staffing position in relation to the new Trailblazer service. It is unclear how these posts will be backfilled and there is a risk that staff will be deployed from core services that are already experiencing significant capacity issues. GHC have been asked to provide a comprehensive update to the CCG that clarifies the position. Pressure Ulcers has been a priority focus within GCS and the improvement work will continue within GHC. Whilst significant improvements have been made a focus on robust initial assessments of skin integrity and risk factors is still required across services. The CCG quality lead has raised concerns that the number of preventable

pressure ulcers developing within GHC care remains at a concerning level. The GHC Director of Nursing has committed to working with the CCG to accelerate this aspect of the work.

5.3 **CareUK 111**

CareUK 111 Southwest has recently been inspected by the CQC and was rated as 'Outstanding'.

Ratings	
Overall rating for this service	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

CareUK believe they are the first 111 provider to be rated as 'Outstanding'.

The full inspection report can be read online at:
https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ2441.pdf

Particularly noteworthy comments about CareUK 111 include:

- a well-embedded culture of high quality sustainable care
- a strong focus on continuous learning, quality improvement and risk management from complaints and incidents and performance management which included joint working and shared governance with partner organisations
- a strong focus on staff wellbeing.
- a strong focus on continuous learning and improvement at all levels of the organisation
- the service routinely reviewed the effectiveness and appropriateness of the care it provided.

The CCG has written to CareUK to congratulate them on their

	achievement.
5.4	**Care UK Out of Hours Service (OOH)** The OOH Services was inspected by CQC and the report has been published. The organisation received a 'Requires Improvement' rating. The CCG is working with the organisation to agree the improvement plan and will monitor implementation.
6	**Quality Team Activity**
6.1	**Practice Nurse Development** In September and October GCCG funded 5 immunisation update sessions for practice nurses in county. These sessions were very well attended and evaluated. Further training dates are being planned for spring. GCCG is also developing a Non-Medical Prescribing (NMP)Update session, scheduled for March 2020 to ensure NMP's in county are up-to-date with current guidance and the day will also feature specific updates in relation to frailty, diabetes and respiratory care.
6.2	**Gloucestershire Dietitian's Network Event** Gloucestershire NHS Community Dietitian's Network, a collaboration of the 6 dietitians working across GHC and GCCG came together on 6th November to host an educational event for 50 nurses working in GP practices and community nursing teams in Gloucestershire. This was the first event of its kind in Gloucestershire and Professor Jane Melton, Professional Lead for Allied Health Professionals- One Gloucestershire Integrated Care System, gave the opening address and described the event as 'a fabulous, pioneering and visionary training day…… a great example of actions taken to ensure the best, holistic care and collaborative nutritional practice'. The feedback from the event showed that that all attendees increased their confidence in providing nutrition and dietary advice to their service users, and would increase the frequency that they do this.

NHS
Gloucestershire
Clinical Commissioning Group

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

Minutes of the meeting held at 9.45am on 29 August 2019
Boardroom, Sanger House

Present:		
Alan Elkin (Chair)	AE	Lay Member - Patient and Public Engagement
Mark Walkingshaw	MW	Deputy Accountable Officer
Dr Andy Seymour	AS	Clinical Lead
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Julie Clatworthy	JC	Registered Nurse
Colin Greaves	CG	Lay Member – Governance
Cath Leech	CL	Chief Financial Officer
Helen Edwards *(Deputising for Helen Goodey)*	HE	Associate Director of Primary Care and Locality Development
Becky Parish	BP	Associate Director, Engagement and Experience
In Attendance:		
Declan McLaughlin *(item 5)*	DMc	Senior Primary Care Project Manager
Jo White *(item 5)*	JWh	Programme Director
Zaheera Nanabawa *(item 5)*	ZN	Programme Manager – Primary Care Workforce
Bronwyn Barnes *(item 5)*	BB	Programme Manager, Primary Care, Localities & Variation
Jeanette Giles *(item 5)*	JG	Head of Primary Care Contracting
Karl Gluck *(item 7)*	KG	Lead Commissioner, Mental Health, Autism and Advocacy
Fiona Robertson	FR	Associate Director for Digital Transformation, CSU
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Lauren Peachey	LP	Governance Manager (minutes)

1.	**Apologies**
1.1	Apologies were received from Cllr Roger Wilson, Helen Goodey, Andrew Hughes, and Jo Davies
1.2	It was confirmed that the meeting was quorate.
2.	**Declarations of Interest**
2.1	JC had been involved in producing the NICE Quality Standards on co-existing mental illnesses and declared that this was relevant to item 7: The Locally Enhanced Service (LES) for Serious Mental Illness. It was agreed that this was professional interest and represented no financial gain and therefore AE confirmed that JC could continue to take part in discussions during PCCC. The committee noted AS's declaration of interest with regards to item 7: The LES for Serious Mental Illness and 8: Primary Care Quality Report.
3.	**Minutes of the Meeting held on 27 June 2019**
3.1	The minutes of the meeting held on Thursday 27 June 2019 were approved subject to the following amendment: Section 5.9: with regard to GHAC, CG requested that this section was re-worded to reflect that the population had outgrown the premises.
4.	**Matters Arising**
4.1	**Item 4.9, 31.01.19, Nurse Training** This matter would be covered during agenda item 6: Primary Care Workforce. *Item to be closed* **Item 6.14, 26.06.19, Learning Disabilities Health Checks** Communications were to be arranged for Gloucestershire residents regarding the benefits of attending Annual Health

	Checks. JG updated the committee that this had been discussed with the GCCG Communications Team. Item to be closed **Item 8.7, 26.06.19, Review of GP Education** JC highlighted that there was some private training provision which was not available to all GPs including locums which was the issue that prompted the review of GP education. JC had raised the concern that some GPs may have been excluded from accessing certain training. Furthermore it was emphasised that the quality of the private training being offered could not be scrutinised. HE advised that the Primary Care Training hub would need to be fully staffed to ensure sufficient capacity to fully address this review. It was agreed that a detailed update would be taken to the PCCC in February 2020. **ACTION: Review of GP Education to go on the February 2020 PCCC Agenda. This was to cover both quality and access to GP education.**
	AS joined the committee at 09:51
5.	**<u>Primary Care Strategy Refresh</u>**
5.1	HE introduced the draft refresh of the Primary Care Strategy (PCS). HE requested that comments be fed back to the Primary Care Team. HE began the presentation by summarising some of the key achievements over recent years as follows: • there were new buildings for over 50,000 patients in several areas across Gloucestershire; • there had been in excess of 113,000 extra improved access appointments; • there were 14 PCNs and 20 Clinical Directors; • the Complex Care at Home Service provided proactive preventative services in the Forest of Dean, Cheltenham and Gloucester; • there were 1,413 registered patients per qualified

	permanent GP compared to a national average of 1,728; • Gloucestershire CCG (GCCG) was well regarded by Primary Care colleagues; • 87% of patients in Gloucestershire who responded to the GP patient survey rated their experience as 'good'. HE acknowledged that although GPs in the county were supportive of the work that has been undertaken, there was a continued underlying concern that there were not enough GPs in the county to undertake the volume of work that was being seen. AE highlighted the value of having the presentations available prior to the committee meeting.
	Primary Care at Scale: Partnerships and Integration
5.2	BB presented on 'Primary Care at Scale: Partnerships and Integration' beginning with an overview of the Primary Care Networks (PCNs). BB emphasised that it was widely recognised that PCNs represented opportunities for the wider system and residents of Gloucestershire. BB highlighted that PCNs were supportive of the NHSE aspirations for PCNs including bringing care closer to home, stabilising the GP partnership model and bringing new roles into Primary Care.
5.3	BB drew the committee's attention to the following key points with regards to the PCNs in Gloucestershire: • the PCNs would work towards seven service specifications; five of which would commence from April 2020; • the sizes of the PCNs varied between approximately 30,000 and 63,500 patients and there were between one and eleven practices per network; • the facilitation of the PCNs had been supported by the prior cluster arrangements which had been in place since 2016; • PCNs, which officially commenced on the 1st July 2019, covered 100% of the county;

5.4	GCCG was supporting Clinical Directors with their facilitated meetings which were taking place on a six-weekly basis. In addition to this support they were also being offered a reimbursement scheme that related to a number of new roles which were being put in place.
5.5	BB continued the presentation by explaining that across the county there was a variance in the level of maturity within PCNs. There was reasonable expectation that this would be the case. A PCN Development Programme was planned which supported the development of the PCNs as well as providing support to the Clinical Directors. The GCCG was working with the Clinical Directors to identify what the development needs were and had been utilising an NHSE provided maturity matrix.
5.6	BB informed the committee that there was senior-level sign up to Integrated Locality Partnerships (ILPs) from all member organisations. In five of the six ILPs there was an Operational and Strategic Partnership of leaders of health, social care and local government.
5.7	GCCG was successful in a bid to join Wave 2 of the NHSE Population Health Management (PHM) programme which represented a key aspect of PCN and system development.
5.8	With regards to the variance in PCN maturity, JC enquired as to whether there was anything more that GCCG could be doing to further support their development, and bring them in line with the more developed PCNs? BB responded that the PCN development programme offered an opportunity to support the less mature PCNs where needed. BB emphasised the collaborative approach underpinning the PCN development. HE added that the NHSE requirement was for PCNs to assess themselves against the maturity matrix. PCNs were informed of this requirement during September 2019. HE further informed the committee that the six-weekly PCN Clinical Directors meeting which was chaired by AS, the clinical lead for the GCCG, was well attended. Approximately half of the agenda was dedicated to updates from Clinical Directors and information exchange which

	ensured areas requiring support were identified.
5.9	AS informed the committee that Jeremy Welch had accepted the position of ICS Liaison Lead and therefore will not be continuing in his role on the Governing Body.
5.10	CG acknowledged that ILPs were in their early stages of development and noted that the names of the ILPs leads had not yet been made available. HE advised that the information on the ILPs leads and members could be provided and this could include work streams and ILP priorities. Emily Beardshall, Deputy ICS Director, has been working with the ILPs to ensure there was understanding on the Long Term Plan (LTP) and the work programme fit with the ICS agenda.
5.11	CL commented that it was necessary to consider how to adapt the way the CCG contracts with organisations going forward. The contractual arrangements were relevant to the Governing Body and linked into PCCC. CG further queried how we could get oversight of the progress. CL responded that lines of communication were evolving and needed clarifying as part of the governance arrangements. AS added that the ILPs reported into ICS and then the ICS reported into the Governing Body. AE noted that it was important that all partners were kept informed of the developments.
	Improving Access (IA)
5.12	JWh presented on Improving Access (IA) and began by summarising the background of the Improving Access programme. Improved access delivered 113,000 additional appointments for practices that were delivering through the IA contract from August 2018 to July 2019. JW noted that, due to NHSE reporting criteria, slightly less than this figure was reported to NHSE.
5.13	JWh noted that most of the IA appointments were seen by GPs. JWh continued by explaining that this was largely due to the NHSE requirement that GP face to face appointments

	were available. The remainder of the IA appointments were able to be provided by other clinicians such as paramedics, phlebotomists, practice nurses, advanced nurse practitioners, urgent care practitioners, and advanced physiotherapy practitioners. JWh highlighted that this range of staff enabled people to be seen by the most appropriate clinician for their needs, without the need of an initial GP appointment.
5.14	Patient satisfaction was very good for IA. JWh reported that 90% of Gloucestershire patients who had an IA appointment and responded to the questionnaire were satisfied with their appointment, and 96% would recommend the IA service to a friend or family member. Information about IA was available on GP surgery websites and leaflets in the waiting areas.
5.15	NHSE was undertaking an access review which included IA and Extended Hours. The intention of this review was to amalgamate these services into one contract provided by PCNs. JW highlighted that this work was in progress in Gloucestershire. This involved pulling together two funding streams and similar service specifications. The access review highlighted PCNs responsibility to consider how their patients may access services outside of core hours. The objective of the review was to improve patient access both within and outside of core hours and reduce variation in patient experience. In terms of reducing fragmentation JWh noted that PCNs were working together to look at access to services. Two practices in Gloucestershire were selected for the NHSE IA review.
5.16	JW concluded the IA presentation by summarising that, in the National GP Patient Survey published in July 2019, 87% of Gloucestershire patients rated their overall experience as “good” compared to 83% nationally.
5.17	MAE emphasised that in the long run it was important to

	consider how the model could incorporate more nurses as the high proportion of GPs in the model was costly. MAE further highlighted that in many practices significant numbers of daily appointments were already being managed by Advanced Nurse Practitioners. AE agreed with MAE and further added that this was an area which could add pressure to GPs which was why Gloucestershire needed to increase the diversity of the response to patients in order to respond to the need appropriately.
	Population Health Management
5.18	CL presented on Population Management (PHM). PHM was a data driven approach to analyse and improve planning and care at a population level. This supported the decision making process when deciding, which intervention would have the greatest impact. CL described the three key elements of PHM: • Infrastructure: to include IT and Information Governance and data structures; • Intelligence: including analysis and data presentation; • Interventions: including proactive clinical and non-clinical interventions. It was noted that Gloucestershire was already working in this way however this PHM programme supported a more structured approach.
5.19	Gloucestershire already had a significant amount of the infrastructure in place however there was work to be completed on ICS level infrastructure. There was a place to `land the data` however there was a longer term piece of work to determine where the best place to `land the data` would be. In terms of information governance, the commissioning data warehouse supported a pseudonymised data set. This meant that there was no patient identifiable information available. It was highlighted that pseudonymisation enabled

	richer analyses of the information.
5.20	Over the last year there had been an investment in analyst training across the community. This training was supporting the analysts to map disease prevalence using Quality Outcomes Framework (QOF) data and mapping tools. Sollis, an existing tool, was being used to stratify the Gloucestershire population. Alongside this there was an Integrated Locality Reporting (ILR) tool being developed for Primary Care. In terms of interventions, CL noted that some existing interventions including Multi-Disciplinary Teams (MDTs), Complex Care at Home and South Cotswolds Frailty were taking the same approach.
5.21	CL concluded the presentation by reiterating that Gloucestershire was part of the Wave 2 PHM programme which would apply additional structure to the approach which was already being utilised. It was expected that the work was going to result in a road map for the linked data set and Information Governance would be supported to a greater degree in terms of how this was developed.
5.22	AE acknowledged the importance of the PHM programme particularly considering the areas of population deprivation in the county. AE highlighted that it was necessary to grow and develop skills to deal with the interventions. AE added that the interventions highlighted in the report did not appear to address the future in line with what we know about the impact of smoking and obesity. CL responded that the tools that were in place were being used to support a number of interventions. Wave 2 of the PHM programme focussed on identifying growing trends and was to link in to the Long Term Plan (LTP). CL highlighted that we understood the themes and could use this programme to provide further oversight.
5.23	JC noted that this represented an opportunity to join up, for example, the disease specific pathways. There were a number of areas which could be managed differently when

	managed with big data. CL noted that the information included in the presentation was focussed on the Primary Care Strategy. Some capabilities may not be developed in Gloucestershire alone and this may be progressed as part of a regional response. CL noted that this work was going to be further developed. FR added that working with OPTUM highlighted that there were gaps in skills and capability around machine learning and AI.
5.24	CG highlighted that, at a strategic level, this was a Gloucestershire system issue and further queried whether Gloucestershire had the skills in the numbers that were needed. CG further emphasised that it was essential to ensure that a whole system approach was taken to manage this matter. CL responded that there was a PHM Steering Group chaired jointly by Sarah Scott, Director of Public Health, and herself. This was well attended by multiple organisations. There was an analyst working group with the heads of analytics from each of these organisations. PHM was being driven as part of the CCG's core agenda and GCC was also significantly involved. CG queried how the high level data could be driven down to an individual level. CL replied that there were two work streams. One to consider the wider population health management, and an approach which may take the data specific to individuals and identify their key issues. CG queried how this would work from an information governance perspective. CL noted that patients could only be re-identified by those who were directly involved with their care and not by anyone at the CCG.
	<u>Digitally Enabled</u>
5.25	FR presented on the Digital Transformation programme and began by explaining the progress to date in terms of digital maturity in Primary Care. It was noted that Gloucestershire had progressed from a largely paper based service to

	providing a mostly digital service. FR noted that there was still a lot of progress to be made prior to developing a more transformational way of working. FR highlighted that paper referrals to the acute sector were switched off in June 2018. FR continued by highlighting that the Long Term Plan stated that "every patient has the right to be offered digital first Primary Care by 2023/24" which would enable patients to be able to access advice, support and treatment digitally. Over the last three years significant progress towards this had been made in Gloucestershire.
5.26	The NHS app had been implemented across Gloucestershire although FR noted that it had not yet been widely advertised. This was going to be advertised in line with a national communications campaign in the Autumn of 2019. Further to this an online symptom checker and triage tool, called Dr Link, was being trialled along with a tool called Footfall which supported patients in interacting with online services.
5.27	FR highlighted that Gloucestershire's use of the Electronic Prescription Service was one of the highest in the country. In this service a prescription could be sent directly to a patient's nominated pharmacy of their choice and thereby remove the necessity to attend the GP practice. The Digital Programme supported PCNs to offer extended hours appointments which required access to patient records across multiple systems within the PCN. FR noted that there had been challenges regarding systems interoperating. All practices in Gloucestershire had both public Wi-Fi and practice Wi-Fi and this supported clinicians to work more flexibly across practices.
5.28	FR summarised that there were a number of digital themes which were supported within the Primary Care Digital Strategy including offering digital support to enable clinicians to more easily direct patients to the right service; and increasing the types of referrals that could be made

	electronically. In addition to this, improving information sharing was being progressed. FR noted that there was also work around how best to support practices with reporting which included work around data quality and coding.
5.29	A road map had been developed within the strategy which had taken into account national guidance. The road map had been based on six work-streams. FR summarised some of the key projects, which were underway under each of the work-streams.
5.30	MW emphasised that although the digital programme was supported there was some concern over the level of investment that was required. CL advised that the detail was being worked on. FR noted that the capital budget for Primary Care had been reduced for the current financial year. FR further added that funding from the digital element of NHSE Estates and Technology Transformation Fund had temporarily ceased to be available, resulting in a need to re-prioritise projects.
	Estates
5.31	DMc presented on Estates and began by summarising the completed and approved schemes which derived from the Primary Care Infrastructure Plan from 2016. DMc highlighted that the 2016/21 version of the Primary Care Infrastructure Plan was an amalgam of the projects inherited from previous organisations and new GCCG aspirations. DMc noted that there were some priorities outstanding and summarised the progress with and challenges around these priorities.
5.32	DMc reiterated that the Primary Care Infrastructure Plan had been refreshed. It was highlighted that consideration had been given to flexibility within new premises developments and this included multi-use rooms and ensuring rooms could be

	booked and used by community and mental health partners.
5.33	In terms of new priorities for 2021/26 DMc summarised the premises proposals for each of the ILPs. It was emphasised that the work being undertaken was focused on the county as a whole. Funding had been secured for two proposals one in Gloucester City and one in Wotton-under Edge. To conclude the presentation, DMc bought the attention of the committee to each of the premises proposals and the estimated delivery year and capital cost.
5.34	**<u>RESOLUTION</u>: The committee noted the Primary Care Strategy Refresh presentations.**
	Karl Gluck arrived at 11:14
6.	**<u>Primary Care Workforce</u>**
6.1	ZN began the presentation on Primary Care Workforce by briefing the committee on the baseline workforce position for GPs and Practice Nurses in Gloucestershire. The number of GPs had increased although it was recognised that a growing number of GPs sought part time work or preferred to work in portfolio roles which resulted in the total of Whole Time Equivalents (WTEs) decreasing. In contrast to this, the WTE of Practice Nurses had increased.
6.2	There were concerns in the county with regards to the number of GPs not being considered enough, however ZN highlighted that in terms of benchmarking, Gloucestershire had come second in the region (low being good) for the number of patients per qualified permanent GP and it was noted that this was very positive.
6.3	There had been work to promote information around the PCNs and how this may impact the system. ZN had engaged with Proud to Care who were working with care homes and social care colleagues. Primary Care was represented at the Workforce Steering Group, OD Steering Group and Local Workforce Action Board (LWAB).

6.4	ZN noted that there was a Primary Care Pharmacy education programme and highlighted that the pathway was complex. There were plans to establish a social prescribing e-learning platform.
6.5	Advanced Physiotherapist Practitioners continued to play a key part within certain networks in the county. ZN emphasised that effective working relationships with partner organisations had supported the success of the Advanced Physiotherapist Practitioners in Gloucestershire. ZN highlighted that there were challenges in getting access to diagnostics and ICE. The committee was assured this had been raised as an issue to the One Gloucestershire Diagnostics Board. .
6.6	In terms of recruitment and retention, an Early Career GP Lead was employed on an initial 12 month basis for one session per week. The lead would focus on supporting F1 and F2 GPs, in particular, when they were deciding which area of medicine they were keen to pursue.
6.7	ZN attended an International GP recruitment event in June 2019 and suggested that international recruitment may be hindered by Gloucestershire's lack of an international airport. It had been recognised that GPs were hearing about moving to the UK through word of mouth rather than the International GP Recruitment scheme, a trend seen across the whole system.
6.8	The Annual Workforce Survey was underway and this was supporting a robust representation of the workforce and supporting workforce planning. Part of the Annual Workforce Survey included questions around whether the GP practice was taking on learners and finding out reasons why not if that were the case.
6.9	There were ten GP retainers in the county and the requests for GP retainers were increasing. The CCG contributed

	funding towards this scheme in which eligible GPs may request to work for between one and four sessions per week. ZN highlighted that there were a number of GPs who were looking to work in Cheltenham and North Cotswolds and not where there were workforce gaps in the county such as Gloucester City. The newly qualified GP scheme had been running for two years. Four host practices took part in the scheme in 2019/20. ZN highlighted that this scheme was considered a success with six out of eight GPs who participated in this scheme remaining in the practices in which they were placed.
6.10	ZN concluded the presentation by summarising that the next steps were to roll out the Primary Care Workforce Website, and exploring how funding from the Primary Care Training Hub would enable PCNs to meet the expected challenges that lay ahead.
6.11	MAE updated on Practice Nurses. A new Clinical Development and Education matron had commenced in post and they would be focussing on training analysis. There were nurse coordinators in post for each locality in the county. They provided support and also looked at education and training needs. The nurse coordinators that formed part of the parachute nursing team were being well utilised to provide nursing support to cover unexpected short term gaps.
6.12	There was one qualified registered Nursing Associate in primary care in Gloucestershire and two trainees were due to begin in post. MAE noted that this was an area of great opportunity for Primary Care with Nurse Associates able to undertake a wide range of tasks.
6.13	MW emphasised the need to work in a planned and responsible way when it came to workforce planning and consider effects on the wider workforce across the system.

	JS highlighted that, in terms of supervision, clinical governance needed to be built in to the process.
6.14	**RESOLUTION: The committee noted the Primary Care Workforce Presentation**
7.	**LES for Serious Mental Illness (SMI) Physical Health Checks**
	KG presented on the LES for Serious Mental Illness (SMI). The paper was taken as read and KG highlighted the following key points: • compared to the rest of the population those with a mental health issue die on average 20 years earlier from health issues which could been prevented; there was a requirement to reach a minimum of 60% of people on GPs SMI registers having an annual health check; • there was CQUIN in place with the 2gether NHS Foundation Trust to undertake annual health checks for their patients who were on the Care Programme Approach; • there was a cohort of people with a SMI who were not known to 2gether and would thus not be part of a Care Programme Approach; • the LES has been supported by the Enhanced Services Group and the Local Medical Committee (LMC); • The budget for this was c£150k which had been approved by the priorities committee during the financial year 2019/20.
7.2	AE noted that there was a specific mention of Cardio Vascular Disease (CVD) as one of the conditions which supported the need and requirement for an annual health check. KG responded that a range of other conditions were included such as diabetes. The requirement for the SMI annual Health Checks also included offering appropriate interventions. AE queried what the budget of £150k would achieve. KG

	responded that the target population was approximately 3000 people. The aim was to have a programme in which practices would contact people on a regular basis and they would undertake the required six health checks and deliver interventions. It was acknowledged that part of the programme would focus on data quality improvement. MW agreed that data quality would need to be improved and noted that Gloucestershire looked like an outlier because there was data that was not joined up. JC further added that care planning also needed to be joined up. CG queried whether the funding was recurrent and noted that the minutes of the Priorities Committee specified £280k but did not specify if it was recurrent. CL advised that the initial £280k was reduced to £150k and confirmed that the funding was recurrent.
7.3	**RESOLUTION: The LES for Serious Mental Illness (SMI) Physical Health Checks was approved.**
7.4	*KG left the room at 11:35*
8.	**Primary Care Quality Report**
8.1	The report was taken as read and MAE noted that more serious incidents were being reported and it was accepted that this was a reflection of improved reporting. MAE further explained that the reporting of serious incidents supported learning.
8.2	With regards to the changes in the National Friends and Family Test BP noted that the revised guidance from NHSE had not yet been received. CCG PALs had received a number of enquiries regarding The Aspen Medical Practice. BP informed the committee that GCCG had been working with the Patient Participation Group (PPG) and there were reports of changes to the practice telephone system, which was having a positive impact.

8.3	AE enquired about what effect the revised National Friends and Family test may have on Primary Care and BP noted that this would remain unclear until the revised guidance was available. BP further added that it was expected that some of the revisions may include modifying some questions and the frequency of the questions being asked.
8.4	MAE bought to the committee's attention the prescribing figures and highlighted that the £5m saving noted within the report, had since been agreed at £6m due to Category M drug price changes. It was noted that the impact of Brexit on the ordering of drugs remained unclear. MAE noted that the first edition of the Practice Nurse Newsletter had been distributed. **ACTION: The Practice Nurse Newsletter to be circulated to PCCC members. MAE.**
8.5	AE noted that it was positive that there had been an increase in NHSE complaint responses copied to GCCG PALS and BP acknowledged that this showed an improvement in regular communication. AE queried the reasons behind the improving PALS relationship with MPs. BP suggested that this may be due to an increase in complex clients taking a large amount of time to manage in Primary Care, PALS and the MPs offices. With regards to the Engagement Team supporting a number of teams within the CCG with surveys; AE requested that additional detail be included in the next Primary Care Quality report around this to further understand the diversity of work that was undertaken by the team. **ACTION: BP to include additional detail around the support undertaken by the Patient Engagement Team in the next report.**
8.6	**<u>RESOLUTION</u>: The committee noted the Primary care Quality Report.**

9.	**Primary Care Delegated Financial Report**
9.1	CL informed the committee of the current financial position and noted that there was an underspend which in part related to the Data Protection Officer (DPO). However costs for this were due to be incurred and the contract was being put in place. In addition to this, seniority payments were also underspent however CL noted that this area was likely to change.
9.2	CL explained that there had been a small overspend of £15k which reflected the risks associated with dispensing and prescribing and volatility around sickness and maternity payments. CL noted that there was a variance on APMS and GMS contracts which reflected issues around the Marybrook contract. CG noted that the variance in the APMS contracts was a concern. CL advised that much of the variance would be resolved following the Marybrook procurement. CG further enquired if the additional funds that had been invested into Marybrook in the short term, were reflected within this budget line. CL advised this would be brought through as and when required.
10.	**Any Other Business**
10.1	There was no other business raised.
	The meeting closed at 11:51
11.	**Date and time of next meeting**
	The next PCCC will be held on Thursday 31st October 2019 at 9.45am in the Boardroom, Sanger House.

NHS Gloucestershire Clinical Commissioning Group

Quality and Governance Committee (Q&GC)

Minutes of the meeting held on Thursday 8 August 2019 at 9.30am, in the Boardroom, Sanger House

Present:		
Julie Clatworthy	JC	Chair - Registered Nurse
Marion Andrews-Evans	MAE	Executive Nurse & Quality Lead
Mark Walkingshaw (10:30 – 11:15)	MW	Deputy Accountable Officer and Director of Commissioning Implementation
Alan Elkin	AE	Lay Member, PPE
Peter Marriner	PM	Lay Member - Business
Dr Will Miles	WM	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)*
Dr Caroline Bennett	CB	GP Liaison Lead *(Quality Lead GHFT)*
Cath Leech	CL	Chief Finance Officer
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Teresa Middleton	TM	Deputy Director of Quality
Lesley Jordan	LJ	Secondary Care Specialist

In Attendance:		
Lauren Peachey	LPe	Governance Manager (minutes)
Liz Ponting *(Items 5.1 and 10.1)*	LP	Senior Medicines Optimisation Pharmacist
Christian Hamilton *(Item 10.3 and 10.5)*	CH	Head of Planned Care
Pauline Edwards *(Item 6)*	PE	Designated Nurse for Children in Care

Dr Imelda Bennett *(Item 6)*	IB	Designated Doctor for Gloucestershire CCG
Annette Blackstock	AB	Designated Nurse Safeguarding Children and Safeguarding Adult Manager

1.	**Apologies**
1.1	Apologies were received from Andy Seymour and Mary Hutton. It was noted that JC attendance would be delayed due to a serious incident resulting in the M5 being closed. CB was to chair the meeting until JC arrived.
1.2	The meeting began at 9:35 am. It was confirmed that the meeting was quorate.
2.	**Declarations of Interest**
2.1	There were no declarations of interest.
3.	**Minutes of the Meeting held on Thursday 13 June 2019**
3.1	The minutes of the meeting held on 13th June 2019 were agreed on the condition that the following amendments were made: Section 5.3.5 • LF requested that the occurrence of the Legionella outbreak should specify that it was in Gloucester. Section 5.4.19 • The Eating Disorder Clinic began on the 8th August. In addition to the amendments CGi also advised the committee that confidential aspects of the minutes on 13th June 2019 were recorded in italics to distinguish them from the non-confidential minutes. These confidential matters were removed from the minutes prior to being sent to the Governing Body. This ensured the confidential matters were still recorded.
4.	**Matters Arising and Actions**

4.1	**QGC Item 5.1 18/10/18, Children's Services** ***Update 25/7/2019*** Children's services continue to implement their OFSTED action plan. Front line social work services remain very challenging. The CCG has undertaken a review of the health input to MASH which will be reported to CCG Core Team in early August. The challenge for children's social care is putting additional workload on the public health service and the CiC team. ***Update 08/08/2019*** MAE updated that there was a Children's Services Improvement Board during the week commencing 29th July 2019. MASH had received a letter from the previous monitoring visit from OFSTED which remained critical of the Children's Services and informed them that they were still not making the progress that they were required to. There was another monitoring visit planned for the first week of September 2019. Further to this a full OFSTED inspection was planned for January 2020 and it was likely that the service would remain in special measures. MASH operated on a system called 'liquid logic model' and MAE noted that the quality of output relied on quality of information input which went into the model. The service was running on a high amount of frontline agency staff and it was reported that this was having a negative impact on the quality of information being put into the system. JS attended a safeguarding meeting and was advised that there had been 39 safeguarding meetings where health representatives were not present. AB investigated this problem and confirmed that there were 20 safeguarding meetings where health representatives were not present. The absent health professionals were predominately school nurses and health visitors. LF queried what barriers needed to be removed to improve the situation. MAE emphasised that children's social work was a challenging area resulting in a high number of agency staff. The area lacked clarity in decision making which had resulted in staff feeling unsupported. Figures from independent monthly audits showed that 40% - 45% of children's records were deemed 'inadequate' and this was the lowest rating. The local authority had invested an additional £8m on Children's Services and a large amount of this was to fund frontline agency staff. GPs advised that they were not receiving the feedback they needed

	regarding: • section 47 assessments; • whether the child was being put register; • why the investigation was taking place. MAE had been informed that information could not be shared with the GPs due to confidentiality reasons however the board established that this was not accurate. MAE advised that this issue was being worked through. PM highlighted that there was a need to continue considering what more needed to be done to ensure the quality and safety of the children being seen by Children's Services. It was important that doctors were made aware of when a child had been stepped down from a child protection plan. MAE has held conversations with the Chair of the Improvement Board with regards to relationship building with partners and working collectively. LF queried if the issues relating to children's services were on the CCG Risk Register? It was agreed that this should be included in the Risk Register. CGi advised that a 'Part II: Confidential' Risk Register was also going to be made available to committee members in addition to the public facing Risk Register. **Item to remain Open.**
4.2	**QGC Item 10.1.3, 14/2/19, Data Security and Information Governance Update** ***Update 13/06/2019*** CL stated that practices now had DPOs. The requirement was that the CCG make arrangements for the service during 2019/20. CL had been in conversation with the CSU providing a service for GPs. CL confirmed that she would link in Helen Edwards. ***Update 08/08/2019*** CGi confirmed that the CSU was going to provide this service and negotiations were underway with regards to the cost.

	Item to be closed.
4.3	**QGC Item 5.1.3, 13/06/19, Clinical Effectiveness (TAs)** MAE stated that seven TAs had gone through the Clinical Effectiveness Committee and were reported through the minutes. The following deviations needed to be added to the Risk Register: • Early Pregnancy Audit (EPA) and Ectopic pregnancy NG154. • ADHD NG87 and QS39 ***Update 08/08/2019*** CGi informed the committee that above items had been added to the Risk Register. **Item to be closed.**
4.4	**QGC Item 5.3.3, 13/06/19, Mental Capacity Act (MCA)** LF explained that NHSE guidelines were designed to cover patients who were very dependent on support especially in a community environment and at the moment there was not enough dedicated support in this area. It was important to implement the Act properly and relevant training should be offered. CGi explained that the ongoing audit would focus on this and she would email Kim Forey and Mary Hutton with further details as well as forward the training pathway to CH and her team. ***Update 08/08/2019*** CGi advised the committee that Simon Thomason had accepted the invite to present on the MCA at the October Q&GC. **Item to be closed.**
4.4	**QGC Item 5.7.5, 13/06/19, Care Homes Report** CGi advised that the CCG would become the responsible officer for the health aspect of LPS (e.g. CHC) and she added that there was a large backlog of cases. MAE added there were significant risks in care homes and BWlx wanted to meet to discuss the risks. CGi explained that Simon Thomason would finalise the MCA policy in August and also do an update on Liberty Protection Safeguards. There would be a

	meeting with MAE and CGi with internal to discuss the CCG as the responsible authority for CHC. ***Update 08/08/2019*** Simon Thomason accepted an invite to present at the Quality and Governance Committee in October 2019. **Item to be closed.**
4.5	**QGC Item 5.7.4, 13/06/19, LeDer Report** CH confirmed she had been part of the LeDeR panel and the CCG involved had received legal advice. JC stated there needed to be an open culture showing accountability and transparency. Quality reviews needed to be in place to ensure information was not omitted. It was important that those board members could view the reports. JC advised that NICE were reviewing quality standard criteria. ***Update 11/07/2019*** The LeDeR Report was with Graphic designers, minor tweaking to pictures with the report required and then it would be uploaded to the CCG website and formally published at the August LD Partnership Board for stakeholders to access. ***Update 08/08/2019*** MAE had received the LeDeR Report and she was making some changes prior to sign off. **Item to remain Open.**
4.6	**QGC Item 5.7.3, 13/06/19, Nursing and Residential Care Homes, Adults** MAE advised that clear explanations and rationale needed to be decided twice a year regarding funding requests. CL commented that better planning needed to go into the bid to NHSE **ACTION: DMc was asked to speak with CL about the funding options.**

	Update 08/08/2019 CGi advised that this has been funded. **Item to be closed.**
4.7	**QGC Item 5.1.10, 13/06/19, Safeguarding Conference** MAE updated the committee about the Conference held on 1st May 2019 attended by over 150 people. **ACTION: CGi was asked to distribute videos of the event for the members to view.** ***Update 08/08/2019*** CGi advised that this had been completed. **Item to be closed.**
4.8	**QGC Item 5.1.23, 13/06/19, GP Training** CB recommended a meeting dedicated to discuss GP training and poor information sharing between Educational Trust and GCare. **ACTION: MAE was asked to contact Zaheera Nanabawa and ask her to raise this.** ***Update 08/08/2019*** MAE advised that she had a discussion with Zaheera Nanabawa regarding the matter. MAE explained to members that Zaheera was looking at this as part of the Primary Care Strategy. **Item to be closed.**
4.9	**QGC Item 5.1.28, 13/06/19, Infection Control** MAE stated there had been a national trend regarding an increase in E.coli. LF enquired whether UTI septicaemia was related. MAE stated she did not know. **ACTION: MAE and JS were requested to get accurate data regarding the above mentioned problem.**

	Update 08/08/2019 MAE advised that data was included in the Quality Report. **Item to be closed.**
4.10	**QGC Item 5.4.19, 13/06/19, Referral Form, ED Services** LF had serious concerns that the referral form was not fit for purpose and he had spoken to the EDC about this but they were refusing to engage. 2g and LMC needed to confirm that the referral form should be changed and 2GL had contacted the clinic to say the form was unacceptable. JC asked if this issue needed to be on the Risk register. ***Update 08/08/2019*** LF was asked to update during agenda item 5.5: 2G Quality Report **Item to be closed.**
4.11	**QGC Item 7.3, 13/06/19, PCNs** BP explained that the public did not appear to understand the concept of PCNs assumed they would not see the same GP. Now that the feedback had been concluded BP would be looking at changes, in particular centres of excellence and the urgent care offer. The next phase would be a citizen's panel and engagement process. The analysis was ongoing and there would be a final report completed. **ACTION: BP was asked to forward all the specific themes regarding the areas of the survey to the clinical programme groups and their localities.** ***Update 08/08/2019*** It was noted that this action had been completed. **Item to be closed.**
4.12	*JC joined the meeting at 10:05*

5.0	**County Wide Quality Report**
5.0.1	The committee took the report as read and MAE confirmed that under clinical effectiveness the TA and guidance for implementation was due to be published on 28th August 2019. This indicated a significant cost of approximately £1.7m. MAE had discussed the cost with CL and TM. It was noted that GPs would need to be made aware of this and clear guidance would be made available. MAE suggested that it would be beneficial to have the DOACs presentation that went to the Clinical Reference Group at the Q&GC in October 2019. **ACTION: The presentation that went to Clinical Reference Group on DOACs to be brought before the Q&GC in October. Action for MAE.**
5.0.2	**RESOLUTION: The committee noted the County Wide Quality report.**
5.1	**Appendix 1.1 - Gosport Report**
5.1.1	The committee took the report as read and LP highlighted some of the key points of the Gosport Report. JC noted that there was a good level of detail within the report. With regards to the risk mitigation information within the report of the report, PM queried if a twice yearly review of medication was sufficient? LP responded that the risk mitigation was a separate piece of work being undertaken by the Pain Programme. It was then discussed that there was increasing awareness of the issues associated with high dosage opioid prescribing.
5.1.2	The Pain Programme had done a formulary and the Care Home Support Team had given feedback that this was part of the Pain Programme. MAE advised that funding had been put into a training programme for Care Home Support Teams. WM acknowledged that there should be a focus on education although it should be made clear that pressure was coming in from the media and CQC. In relation to opioid prescribing CB highlighted the GMC case which had recently been published. JC noted that opioid usage should be consistently monitored and it was queried whether this was being done in a systematic way? WM stated that this was included as part of the Primary Care Offer and MAE further added that GP surgery prescribing is monitored.

5.1.3	JC enquired as to what education and training was planned for nursing home staff? The committee were advised by JS that the training programme had been recently reviewed. This review had originated from feedback received from GPs that the high use of agency staff in nursing homes had resulted in inconsistencies in up to date knowledge and it was suggested that this was recorded as a risk. **ACTION: CGi to discuss the risk related to high usage of agency staff in care homes.**
5.1.4	JC queried action item number 7 for Change Grow Live (CGL) which was to "develop a procedure for revalidation of nurses and pharmacists" with a due date of July 2019. JC highlighted that revalidation was already a standard requirement and was also a CQC requirement. It was said that the CGL contract was commissioned by the Gloucestershire County Council.
5.1.5	**<u>RESOLUTION</u>: The Committee noted the Gosport report.**
5.0.3	The next item to be discussed in the County-Wide Quality Report was the Multi-Agency Safeguarding Hub (MASH). MAE informed the committee that the MASH was inspected by OFSTED as part of Children's Services. All safeguarding referrals initially went to the MASH where they would process the referral and make decisions on the next steps. There had been an issue around health contribution at the multi-agency meetings.
5.0.4	Since 2015 the CCG had funded one band four administrator and one band seven nurse. GCS had funded a temporary band seven nurse to support the volume of work of which the nurses had reported was extremely challenging. There was a request for additional resource from the CCG and this prompted the review of the health contribution for MASH. The report was completed and was due to be presented to Core Group and was to be recorded in the core minutes.
5.0.5	AB had visited Hampshire MASH who received an 'Outstanding' OFSTED rating. AB reported that, in Hampshire, referrals instigated a prompt ten minute strategic discussion. It was noted that Gloucestershire's case discussions lasted for up to one hour in which the impact was seen in nurses being away from their desks for this length of time.

5.0.6	**Serious Case Reviews (SCR) and Safeguarding Adult Reviews (SAR)** It was noted that this section also covered 'Agenda Item 6: Safeguarding'. AB informed the committee that of the Serious Case Reviews for children, three had been completed. The key points were noted as follows: • one of these would be unpublished due to the length of time the criminal procedures were taking as part of the review; • another case review had a significant impact because of the subject matter and the impact on the children; • the other case review was going through to NSPCC anonymous and the learning form this would still be captured. It was noted that the learning would also be captured from the case reviews that were not published.
5.0.7	The length of time that reviews took was an issue and this was frequently due to time taken for criminal processes. Publication of the reviews depended on these processes being completed and often the views of the members of family. Publication should mention work that had been progressed. A number of cases were still due to be published. Publication mentioned work happening as a result of the cases.
5.0.8	With regards to the Serious Case Reviews of children it was stressed that some serious incidents and injuries were presenting frequently and MAE stated that this included cases for non-mobile children who should not have the injuries they were reported to have sustained. The next steps were to look at robustness and rigour around children in need plans and to ensure the continuing recognition of the wider aspect of domestic abuse. MAE added that there were a low number of adult safeguarding case reviews.
5.0.9	*MW joined the meeting at 10:30*
5.0.10	The committee had a discussion on serious case reviews, safeguarding and out of county referrals. AE queried quality assurance monitoring mechanisms for out of county referrals and asked what could we have

	done to ensure responsibilities for out of county were met? MAE stated that she challenged the processes at the CQRG meeting. The CCG was meant to be informed of the children's placements. AE noted that CQC inspections should not be relied on for a full view of quality within a service. MAE responded that this measure of assurance was still valuable. MAE noted that there had been seven serious incidents reported in Primary Care and highlighted that this increased number reflected an improvement in the quality of reporting.
5.0.11	**GCCG Patient Advice and Liaison Service (PALS)** With regards to the demands placed, through complaints on the PALS team, MAE advised that there were up to five individuals who were very demanding and occupied a lot of PALS time. AE enquired if there were policies in place to mitigate such PAL pressures. MAE advised that there was a vexatious complaint policy which was implemented as required. CGi noted that it was important to remain mindful that these frequent and challenging callers may have had enduring mental health conditions which affect their behaviour. JC highlighted the importance of ensuring that the CCG supported the members of staff who dealt with these challenging callers. MAE confirmed that they received support.
5.0.12	PM noted that 30% of the 'types of enquiries the CCG PALS team has responded to' had been classified as 'other'. PM requested that this could occasionally be broken down further. JC suggested that this would be useful to have sight of every 6 months and the committee agreed with this. **ACTION: MAE to discuss with Rachel Price that the 'types of enquiries the CCG PALS team has responded to' would be shown with additional detail every 6 months.**
5.0.13	JC drew the attention of the committee to the Clinical Learning and Development Matron information in the report. JS advised that the

	Clinical Learning and Development Matron, Helen Acock, was going to commence their post during August 2019. The Clinical Learning and Development Matron would be working with JS on the practice nurse strategy and understanding the new support model for practice nurses in Gloucestershire. The Clinical Learning and Development Matron would take a focus on understanding training and education needs. A restructured team had been set up with nurse coordinators and part of this restructuring included a 'Parachute Practice Nurse' service which provided peer support and mentorship to Gloucestershire GP surgeries which were in crisis. This service had been running since June 2019 and initial feedback had been positive.
5.0.14	**Infection Control Update**
5.0.15	JC raised a query around the GHFT infection control data and questioned its reliability. AE asked about the category named 'CO-HA' and why it was counted as community onset. There had been discussions about attributing these to the hospital. MAE advised that the metrics employed to benchmark had changed since the previous year and this was why the numbers for GHFT were higher than expected. These figures included cases of Clostridium Difficile Infections (CDI) based on infections arising within four weeks of being in hospital. Based on this we would expect GHFT to have no more than nine to ten cases of CDI per month. At the time of the report it was showing around seven cases per month.
5.0.16	MAE stated that Gloucestershire had been represented as having a high level of CDI rates. Upon investigation by TM it was confirmed that this representation was incorrect. TM continued to explain that this misrepresentation was due to a misleading method of counting the CDI rates. GHFT have demonstrated a reduction in CDI cases over the last year. TM noted that in June GHFT were at 43 cases of CDI against a target of 48. MAE noted that GHFT were under the threshold and were reporting improvements. The way NHSE examined the data had resulted in misleading data. The Infection Control Update showed the month on month data and MAE suggested that it would be useful to show this in graph format.
5.0.17	TM advised that there was an assurance audit which was undertaken on a monthly basis with the Assistant Director of Infection Control. Every CDI case was scrutinised at a monthly meeting which the Public Health Consultant from Public Health South West attended. It was

	highlighted that improvements were being seen although additional questions could be raised with regards to the cleaning of GHFT.
5.0.18	JS advised the committee that on the next quality assurance visit JS would be joining the Infection Control Nurse on a visit to the ED and one of the assessment wards with regards to cleanliness; this visit had stemmed from patient complaints. There had been concerns around the cleanliness in the Emergency Department, corridors and the holding areas. JS confirmed that although there had been a change in contract for domestic cleaning this had not resulted in reduced cleaning hours. JC reminded the committee Q&GC members could pay visits to GHFT as stated in the Terms of Reference.
5.0.19	With regard to MRSA incidences MAE advised that the majority of cases arose from intravenous drug misuse although there were some hospital acquired cases which MAE noted were a cause for concern. Public Health was undertaking work around the MRSA issue including improving needle exchange systems to attempt to reduce the MRSA rate. CGi advised that it had recently been decided that Katie Hopwood from Public Health was to attend future Quality and Governance Committees.
5.0.20	*CB left the meeting at 11:00*
6.	**Safeguarding**
6.1	**Annual Health Report for Children in Care**
6.1.2	PE advised that although the numbers of children in care had continued to rise it had recently stabilised. This was consistent with the national picture and was not just seen in Gloucestershire. PE emphasised that the specialist services were extremely dedicated to providing a high quality service.
6.1.3	*CB re-joined the meeting at 11:05*
6.1.4	The main challenge being seen in Children in Care was capacity; this was due to staff sickness. The lack of capacity resulted in significant challenges in meeting statutory obligations and there had been a high number of children waiting a long time for access to mental health support.

	Hadwen Surgery had an Initial Assessment Service which worked well however there had been an issue with getting paperwork to the surgery in a timely manner. This issue was being actively worked on.
6.1.5	IB noted that it was expected that the merger between 2gether NHS Foundation Trust and Gloucestershire Care Services would result in service developments and specialist combined paediatric CYPs clinics for children in care. JC noted that workforce issues had arisen previously and queried whether the sickness absence in the team was due to the work? IB responded that the work was challenging and the long term absence of the team doctor would have also had an impact on the team.
6.1.6	IB responded that the capacity was an issue and this was due to the level of staff sickness. This meant the staffing budget had already been used and there was no additional funding available to obtain additional staff cover. It was highlighted that this was a very specialist service and locums were rarely available. IB highlighted that doctors with the right skills were sparse and was therefore focussed on retention of the existing staff. IB noted that there was an increase of complexity of issues being experienced by the children which also had an effect on capacity. MAE said that there were additional clinics throughout the summer being held. AE noted that the children in care were especially vulnerable and we therefore needed to ensure the needs of these children were being met.
6.1.7	MAE highlighted that there were consistency issues with front line children's social work. Often the only consistent person the child would see would be the nurse and they would state that they do not know who their social worker is. The team was set up to complete health checks on the children however they had also been heavily involved in managing the case load.
6.1.8	AE iterated that due to issues with children's social care we were not getting to children as soon as we could. It was emphasised that it was important to ensure strong health representation regarding this. We

	only have an approximation of the numbers of children in care as the placing authorities were not communicating this information. AE queried what we were doing to obtain the relevant information from the authorities? PE advised that they were being written to and reminded of their statutory duties. We are dependent on being told about children being placed or moved and will not be able to obtain this information by other means.
6.1.9	LF requested that the risk identified regarding the referral to private mental health services was elaborated on and asked who funded this? IB advised that there was a budget available from social care. IB explained a concern that there was no assessment of the children's needs and she did not know how social care came to their decisions to fund specific private mental health services. LF enquired if this issue could be rectified? IB highlighted that there were no clinical governance arrangements with regards to this and it had been escalated. JC thanked IB and PE for their continuing hard work on this area.
6.1.10	**Childhood Obesity** IB noted that another area of concern was around the numbers of childhood obesity for children in care; in particular obesity rates in the Special Guardianship Orders (SGO). More children were being diverted to SGOs because it was a faster process compared to going through the adoption process. It was understood that these children would have the same issues whether they were adopted or placed with a family member and they would still require support. PM enquired about the percentage of the Referral Health Assessments completed on time in 2018/19. PM queried whether this was accurate? IB confirmed that this is an accurate measure and they were reaching 100% on assessments taken place within target timescales.
6.1.11	**RESOLUTION: The committee noted the Safeguarding report.**
	There was a break at 1 hour 45 (11:15) for ten minutes
5.2	**CEG minutes from 23 May 2019**

5.2.1.	JC noted that under item 15 it had been recorded that the GCCG continued to deviate from NICE Guidance 126. JC raised a concern that the guidance was being deviated from and queried whether this could be resolved? LP advised that this was an agreed deviation and it was confirmed that this was on the risk register.
5.2.2	**RESOLUTION: The CEG from 23 May 2019 minutes were accepted.**
5.3	**Effective Clinical Commissioning Policies (ECCP) Working Party Minutes from 11 June 2019**
5.3.1	JC directed the group to discuss item number 10.1 Update on Effective Clinical Commissioning Policies.
10	**Update on Effective Clinical Commissioning Policies**
10.1	**Non-medical Prescribing Policy**
10.1.1	JC acknowledged that she was pleased to see that this policy had been produced; particularly considering the increasing number of non-medical prescribers (NMPs). LF queried who accepts the responsibility of the prescriptions? TM confirmed that NMPs were responsible for their own prescribing. JC bought the attention of the committee to of section 3.7 of the policy where it specified newly qualified NMPs may benefit from frequent meetings with their clinical supervisor e.g. quarterly. JC suggested that this may not be frequent enough for a newly qualified NMP and it was discussed that an NMP would be in regular contact with their supervisor and queries would be raised on an ad-hoc basis. It was agreed that the policy wording would be updated to reflect this. LF queried what the role of the Primary Care Network (PCN) was in employing these NMPs? MAE gave details of an example of the South Cotswolds Frailty Nursing Service which was employed by Phoenix Surgery and worked on behalf of all South Cotswolds practices. JC suggested that the Royal College of Nursing should be included under item 5.5 in the Non-Medical Prescribing Policy.
	RESOLUTION: The Non-Medical Prescribing Policy was approved on the condition that the aforementioned changes were made.

5.4	**GHFT Quality Report**
5.4.0.1	JS advised the committee that since the GHFT Quality Report was written another never event had occurred at the end of July. A patient was briefly connected to an air outlet instead of oxygen. It was clarified that no harm was done to the patient; this incident was detected and resolved very quickly. JS was now having bi-monthly Quality Alert meetings at Gloucester Royal Hospital (GRH) ahead of the SERG meetings. A key focus of these meetings was around delayed discharge summaries. A new junior doctor commenced post during the first week of August and part of the induction had focussed on discharge summaries. JS said that she was confident that by the end of August this would have been bought up in line with other trusts. In terms of ED performance there had been a high amount of A&E attendances over the summer; particularly at GRH where there had been around 300 patients per day through the ED. The trust had been looking at flow and how to ensure the most effective use of the assessment areas. At GHFT a lot of work had been underway for winter planning. JS and MAE attended a joint inspection with CQC, HSE and the Environment Agency with regards to the GHFTs arrangements for ionising radiation and the inspection team identified that the Trust were in breach of three aspects of regulation 6. There were no concerns of harm to staff or patients and GHFT were working on rectifying the issues. LF queried when assurance that the CQC's six 'must do's' had been completed would be available? JS responded that these had been completed and now the 'should do's' were being worked on. In terms of learning from deaths CB informed the group that the process of reviewing deaths to be included in the learning report did not appear to be systematic and CB had challenged this with GHFT.
5.4.0.2	WM noted that there was more work to be done on the quality of discharge and in terms of the quality of discharge reports. WM observed that the future management plan of this was not clear. JS noted that the need was to develop timely discharge summaries.

	Coupled with this was to make progress around the overall quality of work that ward staff were involved in. There was a review of the role with the Onward Care Team including support matrons assisting the ward staff on pulling together the discharge planning. They were intended to take on the responsibility for contacting community services when required. There had been a change in the role of the matrons at the Trust. There was a new uniform which was a bold purple colour to ensure they were visible. This was considered as a positive move and the next step was to look at where the Onward Care Team would fit in with this.
5.4.0.3	CB updated the committee on an issue with DVT scans and CB noted that the committee was already aware of this issue. This was brought to light by GPs and LMPs and then raised with GHFT. There had been a change in the threshold for doing DVT scans which resulted in some people who should have had a scan being rejected and not having a scan over a period of four months. This was investigated and there was a review of approximately 200 cases where a scan may not have been done under the new criteria where it should have been done. The early indication was that 10% of these cases should have been scanned but were not under the criteria. These were approximate figures as the final report was not yet available. JC noted that this was a concern with their internal governance arrangements.
5.4.0.4	**Safe Staffing** JC noted that there was a persistent staffing issue. There had been recruitment drives at GHFT and training has been increased. JS advised that there had been a high number of applicants into certain areas however turnover in some areas was high; such as in the medical wards. Areas such as Critical Care, Cardiology, and Surgery were managing to recruit and retain their team however this was not being seen across other wards. This was high on the agenda within the divisional chief nurses and a senior nurse had been recruited into a six month secondment to focus on staff retention. Recruitment into band five and band six roles were particularly challenging due to a lack of applicants. MAE noted that the work was very physically demanding and JC

	acknowledged the impact the staffing issues had on the whole team.
10	**Update on Effective Clinical Commissioning Policies**
10.3	**Ear Wax (Micro-suction) Policy**
10.3.1	CH highlighted that this policy outlined the criteria for microsuction. Two examples of why individuals may require microsuction included: • Irrigation has not been successful on two occasions; • Irrigation may be contra-indicated due to a previous surgery. As there were a number of providers offering the procedure it was deemed appropriate to produce a policy stating the criteria for microsuction. This had been included in to the community microsuction service specification. For microsuction to be funded the policy must be adhered to. JC noted that this was a 'catch-all' policy however the service specification would be useful to read in conjunction with it. JC suggested it would be prudent to include some information which refers to the professional responsibility and governance arrangements for the service including qualification and training requirements. CH advised that this was included within the hospital contract and the hospitals service specification. CH advised that ear wax procedures formed part of a larger service specification and would not have its own specification. LF observed that the policy specified two attempts of irrigation which GPs has previously been steered away from this. CH advised that in this context irrigation was funded for primary care by a separate arrangement. It was discussed that there was exclusion criteria for irrigation and microsuction. CH advised that it was unknown what the rate of failure for the first attempt or the success rate of second rate of second attempt irrigation.
10.3.2	**RESOLUTION: The Ear-Wax (Micro-suction) Policy was approved on the condition that the aforementioned changes were made.**
10.4	**NICE Guidance: Hearing Loss in Adults**

10.4.1	The NICE guidance was to be considered as part of the Ear Wax (Microsuction) Policy. JC recognised that there was a deviation from the NICE guidance on the risk register. JC noted that we had continued to remain aware of the effectiveness of our processes and the impact on the patients. JC queried how this was reviewed as there was no CPG specifically for this? CH advised that bilateral hearing aids were not fitted so we would not monitor this. In terms of patient outcomes the evidence was provided by NICE. CGi confirmed that this had been summarised on the corporate risk register. JC highlighted the importance of keeping track of deviations from the NICE guidance. PM observed that there had been reports in the media around the links between the loss of hearing in the elderly and dementia. There was a brief discussion around this connection and CH highlighted the prioritising and de-prioritisation of funds when the funds are finite. PM acknowledged that we need to ensure we were making fully informed decisions.
10.5	**Dermatology two-week wait referral triage proposal**
10.5.1	The proposal was taken as read and CH explained that the pathway has been developed with the GHFT. A key factor which had been considered was whether images were of sufficient quality to rule out cancer. CH stated this had been through the GHFT governance processes and had been approved. It was acknowledged that the images need to be of good quality and would be taken by someone who could be trained to use the equipment. WM queried whether this had been supported by the LMC? CH advised that this had been supported by the LMC at a meeting attended by CH. CH offered to further confirm this. JC noted that the support could have been either for the clinical procedure or financial support but not necessarily both.

	LF raised a point as to whether the consulting team had robust and documented evidence to ensure this was in line with national cancer guidelines. CB queried the provision for the consultant to look at an image and then direct people to a more appropriate speciality in the first instance or there could be a direct referral process. CH advised this option was available. PM queried the information presented in the proposal and CH explained that it represented the current referral rate and the referral rate for the previous year. JC noted that as this was a shared risk it was important for clarity on responsibilities. JC recommended to CH that the clinical governance agreement was included and raised the point that this would also support the audit trail and the rationale for deviating from the NICE guidance. The justification for changing the pathway was by using technology to change the pathway however not the clinical responsibilities and this would need to be clearly documented. JC highlighted that a clinical audit programme should be included in the next steps and CH agreed to include this.
10.5.2	**RESOLUTION: The Dermatology two-week wait referral triage proposal was agreed subject to the aforementioned changed being made.**
5.4.1	**GHFT CQRG minutes on 18 July 2019**
5.4.1.1	JC requested that additional information could be provided on the issue regarding videofluroscopy and noted that this had an impact on stroke patients at The Vale CH. It was highlighted that the waiting list for patients requiring videofluroscopy had continued to increase whilst the issue was being resolved. JS advised that this issue was being monitored and offered to provide an update for the Q&GC in October 2019. **ACTION: JS to provide an update at the Q&GC in October.** *Note: Dr K Helier, Stroke Consultant and diagnostics lead at GHFT has confirmed this issue is now resolved 03/10/2019*

5.4.1.2	**RESOLUTION: The minutes were accepted.**
5.5	**2G Quality Report**
5.5.0	The report was taken as read. LF drew the attention of the committee to the section of the report which referred to the workforce issues and advised that these issues were included on the 2g Risk Register. Staff retention was considered as paramount within the organisation. LF assured the committee that the patient care was not being negatively impacted by these workforce issues. A 2g complex care team had been involved in assessing St Andrews, with regards to their out of county placements, and had reported that they were satisfied with their findings. There had been a death which was under police investigation. LF emphasised the importance of capturing the learning from this. LF had requested to have sight on the Warrington Safeguarding Adult Review Report which had been issued on the 5th July 2019. LF expected to have received this prior to the Q&GC in October 2019. In addition to the report LF had undertaken a visit to Alexandra Wellbeing House. Alexandra Wellbeing House provided a temporary safe-haven for individuals experiencing non-psychotic mental health issues. There had been concerns raised due to a lack of overnight supervision at the wellbeing house. LF had been given assurance on the safety of the house and was advised that the referrals were thoroughly reviewed prior to accepting them to ensure the safety of the individuals staying at the house and of the staff. PM queried the date on the report which stated '2009' and it was confirmed that this was the correct date. A bespoke Eating Disorder Clinic had been set up for those with a very low BMI.
5.5.1	**2G CQRC Minutes from 18 April 2019**
5.5.1.1	LF noted that the minutes were from April 2019 and had already been

	seen by the committee. It was confirmed that these were the most recent agreed minutes.
5.5.1.2	**RESOLUTION: The 2G CQRC minutes were accepted.**
5.6	**GCS Quality Report**
5.6.0	The report was taken as read and WM advised that the committee was to be kept informed on the progress of the investigation into the serious incident. A Quality Improvement Programme for catheter management had commenced. It was flagged that the GCS Quality Report stated that some patients in the community had clinically unnecessary catheters however WM advised that a recent study indicated very few clinically unnecessary long term catheters in the community. JC requested that we kept track of the progress on this. WM advised that progress on this was to be included in future reports. MAE noted that catheter management and pressure ulcers were a high priority and should remain as such. AE commented on whether pressure ulcers were properly owned in GCS.
5.6.0.2	WM highlighted that Referral to Treatment (RTT) was a challenge in some areas; particularly within MSK physiotherapy and Speech and Language. The challenges stemmed from recruitment issues the volume of referrals for MSK physiotherapy. JC noted that this issue had been ongoing for a long period of time and highlighted the importance of looking how we are manage this with the existing staffing level. PM asked whether the patients who should be receiving video fluoroscopy were being referred to another service for their examination and it was discussed that they were not.
5.6.0.1	**RESOLUTION: The GCS Quality Report was accepted.**
5.6.1	**GCS CQRG Minutes from 16 July 2019**
5.6.1.1	WM advised that under section 8.1.1. Care services wanted to flag that they were not compliant with current NICE guidance regarding 24 hour access to pregnancy advisory services.

5.6.1.2	**RESOLUTION: The GCS CQRG minutes were accepted.**
5.7	**Primary Care CQRG Minutes from 7 February 2019**
5.7.0	It was noted that these minutes were from February 2019 and CGi highlighted that these were the most recent set of approved minutes. Committee members were assured that PCCC had scrutinised the Primary Care Quality Report.
5.7.0.2	**RESOLUTION: The Primary Care CQRG minutes were accepted.**
5.8	**Care Homes Report**
5.8.0	MAE advised there was a county wide Children's Care Home Quality Review Group. There will be CCG representation at this group.
5.8.0.1	**RESOLUTION: The Care Homes report was accepted.**
5.8.1	**Care Homes CQRG Minutes**
5.8.1.1	**RESOLUTION: The Care Homes CQRG minutes were accepted.**
7.	**The Dean Neurological Centre**
7.1	MAE informed members that The Dean Neurological Centre had received an additional £1m of resource to address the CQC issues.
7.2	An Operations Director and a Clinical Director had been employed to address the issues which were being seen by The Dean Neurological Centre. MAE noted that these directors would bring a wealth of experience. It was expected that these directors would be in post for a minimum of six months. Hannah Williams was undertaking weekly visits at The Dean Neurological Centre for CCG assurance. JC requested that an update on The Dean Neurological Centre would be provided at the Q&GC in October 2019. **ACTION: MAE/HW to provide an update on The Dean Neurological Centre to be provided at the Q&GC in October 2019**

8.	**Patient Safety Strategy**
8.1	JC noted that the Patient Safety Strategy was clear and concise which highlighted the changes that would be seen. A revised process needs to be included in the next steps. MAE had met with Dr Henrietta Hughes, the National Freedom to Speak Up Guardian, whose role had been expanded to cover Primary Care.
8.2	**RESOLUTION: The committee noted the Patient Safety Strategy.**
9.	**Risk Register**
9.1	The Risk Register was taken as read and CGi highlighted that this had also been presented at the Governing Body. CGi advised the committee that there was a confidential risk register in addition to the public risk register which was discussed at the confidential Governing Body meetings.
9.2	**RESOLUTION: The committee noted the Risk Register.**
11.	**HR Update**
11.1	CGi provided an overview of the HR Dashboard and advised the committee that there were 301 FTEs employed by the CCG. There had been an increase in staff leaving the CCG to pursue opportunities in other organisations. CGi advised that the foremost reason for sickness absence at the CCG had been recorded as stress and anxiety. The committee was informed that focus groups had been undertaken to obtain further information and the results had indicated that the stress and anxiety was not work related.
12	**Terms of Reference**
12.1	JC noted that the Terms of Reference should be looked at in conjunction with the annual self-assessment of which some committee members were still due to return. It was agreed that this would be

	included on the agenda for the Q&GC in October. **ACTION: The Terms of Reference to go on the agenda for October 2019**
13.	**Data Security & Information Governance Minutes on the 15 May 2019**
13.1	MAE noted that there was a senior doctor and a senior nurse within the Joining Up Your Information (JUYI) team. MAE was assured that the clinical aspects of the JUYI project had been thoroughly considered.
13.2	**RESOLUTION: The Data Security & Information Governance minutes were accepted.**
14.	**Health & Safety Report**
14.1	JC requested that for the next Health and Safety report there would be an enhanced level of detail included. MAE advised that there was an annual Site Health and Safety Inspection and Risk Assessment which would be made available at the Q&GC in December 2019. MAE highlighted that the CCG Health and Safety rating had increased from the previous year. **ACTION: The annual Health and Safety report to be included on the agenda for the Q&GC in December.**
14.2	**RESOLUTION: The Health & Safety Report was accepted.**
15.	**Briefing on Listeria Outbreak**
15.1	MAE informed the committee that the briefing on the Listeria outbreak had been to Core Group. The briefing was provided to the Q&GC for information.
15.2	**RESOLUTION: The briefing on the Listeria outbreak was noted.**
16.	**Any Other Business**
16.1	There was no other business raised.
	The meeting closed at 13:05 pm.

	Date of Next Meeting: Thursday 10th October 2019, 9:30 am in the Boardroom, Sanger House.

This is Verbal Discussion