

## Governing Body

Meeting to be held at 2pm on Thursday 30 January 2020  
in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

### AGENDA

No.	Item	Lead	Recommendation
1.	Apologies for absence	Chair	Information
2.	Declarations of interest	Chair	Information
3.	Minutes of the Meeting held on 28 November 2019	Chair	Approval
4.	Matters Arising	Chair	Discussion
<b>Standing Items and Update Reports</b>			
5.	Public Questions	Chair	Information
6.	Patient Story – <i>experience of using mental health services</i>	Bill Singh	Information
7.	Clinical Chair's Update Report	Chair	Information
8.	Accountable Officer's Update Report	Mary Hutton	Information
9.	Performance Report	Cath Leech	Discussion
10.	Governing Body Assurance Framework	Cath Leech	Discussion
11.	ICS Update Report	Mary Hutton	Discussion
12.	Quality Report	Marion Andrews-Evans	Discussion
<b>Strategic and operational items</b>			

13.	Fit for the Future – Outcome of Engagement Report	Becky Parish / Caroline Smith	Presentation / discussion
14.	Emergency Prevention Preparedness and Response (EPRR) Annual Assurance)	Marion Andrews Evans	Discussion & noting
<b>Items for Approval</b>			
15.	Primary Care Strategy Refresh: 2019 – 2024	Stephen Rudd/Helen Goodey	Approval
<b>Items to Note:</b>			
16.	Audit and Risk Committee Minutes <b>16.1</b> Audit and Risk Chair's Report and minutes of meeting held on 10 <sup>th</sup> September 2019  <b>16.2</b> Audit and Risk Chairs Report and minutes of meeting held on 29 <sup>th</sup> October 2019	Colin Greaves	Information
17.	Primary Care Commissioning Committee Minutes	Alan Elkin	Information
18.	Governance and Quality Committee Minutes	Julie Clatworthy	Information
19.	Any Other Business (AOB)	Chair	
<b>Date and time of next meeting:</b> Thursday 26 March 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 Governing Body Meeting Held in Public at 2:00 pm on 28 November 2019

#### Board Room, Sanger House

<b>Members Present:</b>		
Dr Andy Seymour	AS	Clinical Chair
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Mark Walkingshaw	MW	Deputy Accountable Chair
Colin Greaves	CG	Lay Member, Governance
Alan Elkin	AE	Lay Member, Patient and Public Experience
Dr Lawrence Fielder	LF	GP Liaison Lead – Forest of Dean
Peter Marriner	PM	Lay Member, Business
Becky Parish ( <i>Deputising for Dr Marion Andrews-Evans</i> )	BP	Associate Director, Engagement and Experience
Dr Will Miles	WM	GP Liaison Lead – Cheltenham Locality
Cath Leech	CL	Chief Finance Officer
Dr Sheena Yerburgh	SY	GP Liaison Lead – Stroud and Berkeley Vale
Julie Clatworthy	JC	Registered Nurse
Dr Alan Gwynn	AGw	GP Liaison Lead – South Cotswold Locality
Dr Lesley Jordan	LJ	Secondary Care Doctor
Dr Caroline Bennett	CB	GP Liaison Lead – North Cotswold
Ellen Rule	ER	Director of Transformation and Service Redesign
Kim Forey	KF	Director of Integration

<b>In Attendance:</b>		
Gerald Nyamhondoro	GN	Governance Officer (taking minutes)
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Lauren Peachey	LP	Governance Manager
Catlin Lord (Agenda Item 6)	CLd	Project Manager, Self-Management
John (Agenda Item 6)	J	Presenter of Patient Story

<b>1.</b>	<b>Apologies</b>
1.1	Apologies were noted from Mary Hutton, Margaret Willcox, Sarah Scott, Jo Davies, Helen Goodey, Dr Will Haynes and Dr Marion Andrews-Evans
<b>2.</b>	<b>Declarations of Interest</b>
2.1	The Chair advised that all members were required to declare relevant interests at every Governing Body meeting. The Chair further advised that it was in line with best practice to consider any potential interests. The GPs declared the general interest of GPs in the provision of primary care services. Members other than the GPs considered the interests of the GPs and concluded that there was no material conflict; therefore GPs would not be excluded from participating and contributing in the discussions.
<b>3.</b>	<b>Minutes of the Previous Meeting</b>
3.1	<p>Minutes of the meeting held on 26<sup>th</sup> September 2019:</p> <p>The minutes of the meeting held on Thursday 26<sup>th</sup> September 2019 were approved as an accurate record subject to:</p> <ul style="list-style-type: none"> <li>inserting the title of a member to read 'Dr Sheena Yerburgh' instead of 'Sheena Yerburgh';</li> </ul> <p>amending the third sentence of paragraph 13.1 to read ' CGi stated that the CCG had introduced a more advanced risk management and</p>

	assurance tool called 4Risk’.
<b>4.</b>	<b>Matters Arising</b>
4.1	<p><b>25/07/2019, Item 11.2.3 <u>Cancer Performance Overview.</u></b></p> <p>ER explained that there was a recovery plan in place to recover performance against the 62 day cancer standard. The Governing Body requested a detailed plan to be brought before members in a future Governing Body Development Session. <b>Item closed.</b></p>
4.2	<p><b>26/09/2019, Item 9.3.4 <u>Mental Health and Community Health Overview.</u></b></p> <p>LF raised the concern of the increased number of people residing outside of the county who accessed local services within Gloucestershire and he enquired as to how planning accommodated such an increase when mapping out the delivery of services. KF promised to investigate this further and return with further information to present to the Governing Body. <b>Item closed.</b></p>
4.3	<p><b>26/09/2019, Item 12.4 <u>Annual Public Health Report.</u></b></p> <p>AS referred to statistical evidence of the school readiness in the county and he enquired as to what measures were being taken to address the issue of poor performance. SS responded that her team was looking at ways of redressing the problem. <b>Item closed.</b></p>
	<i>The Chair directed that the meeting proceed to Agenda Item 6</i>
<b>6.</b>	<b>Patient Story</b>
6.1	<p>CLd outlined the role of advocacy for people living with long term health conditions and described the ‘Live Better to Feel Better’ programme as an effective tool for people living with long term conditions. John delivered the ‘Patient’s Story’ and presented a short film on managing long term health conditions.</p>

6.2	ER enquired as to how many people were receiving support from the 'Live Better to Feel Better' programme. CLd responded that the programme currently catered for 45 people and, in terms of outcomes, the programme had been transformative. BP enquired about the criteria used for selecting participants into the programme. CLd responded that the participants were brought into the programme through referrals. John described the GP surgeries as the main vehicle for supporting the 'Live Better to Feel Better'. John explained that the programme had 16 tutors.
6.3	AS suggested that the 'Live Better to Feel Better' programme could be embedded into other CCG projects and that information should be made available on the CCG bulletin board to get the 'Live Better to Feel Better' message out. <b>Action: CLd.</b>
	<i>Catlin Lord and John left the meeting at 2:30 pm. The Chair re-directed the meeting to Agenda Item 5.</i>
5.	<b>Public Questions</b>
5.1	<p>AS read out the public question and summarised the CCG response which had been sent to the member of the public who had raised the question.</p> <p><u>The question read:</u> 'How will the information from the evaluation of the NHS Workforce Race Equality Standard (WRES) be used by NHS Gloucestershire Clinical Commissioning Group? Are there any specific areas from this report that can be used to support and enhance the implementation of WRES?'</p> <p><u>The Response read:</u> 'The CCG publishes an annual report called An Open Culture: Engagement-Equality-Experience. The Annual Report for 2018 is available on the CCG's website, (see the links below). The reports include examples of good practice and demonstrate the local impact of patient and community voice as well as the work that the CCG is undertaking in relation to the Workforce Race Equality Standard'</p>

(WRES).

[Annual Report 2018](#) and appendix 1 [Health Profile](#)

The CCG is committed to:

- making best use of the range of talent and experience available within our workforce and potential workforce;
- supporting our workforce through learning and development, recruitment and succession planning;
- ensuring that our legal obligations are fulfilled.

We collect information about our workforce to enable us to monitor and investigate any disparities in outcomes for our different employee groups, and identify where we may need to act. This showed that for 2018:

- The CCG had 298.7 full time equivalent (FTE) employees.
- 49% of our staff worked full time while 50% worked part time
- 73.7% of our workforce were female
- 1.8% of our workforce described themselves as having a disability; 12% of our staff have not declared whether or not they have a disability
- 8.4% of our workforce declared that they were from ethnic minority groups; 8.4% of our staff had not specified their ethnicity
- 61.5% of our workforce were aged under 50
- 72.7% per cent of our workforce declared a religion or belief
- 79.6% of our workforce declared they are heterosexual; 0.8% per cent of our workforce declared that they are lesbian, gay or bisexual; 19.6% did not specify their sexual orientation
- No staff identified themselves as transgender
- The CCG does not monitor our staff on their marital or a civil partnership status, but may consider doing so in the future.

We have collated benchmarking data about our workforce to comply with the Workforce Race Equality Standard (WRES). This can be found on our website at <http://www.gloucestershireccg.nhs.uk/about-us/equality->

[diversity/reports](#)

The 2019 report will be published in the early part of 2020 and will include 2019 data on the staffing profile of the CCG specifically focusing on BAME staff.

The CCG has undertaken a range of initiatives to support our commitment to equality and diversity. A summary is given below:

- Participated in the Insight programme to allow board level opportunities for aspiring non-executive directors from a BAME background. This ran in 2018.
- The CCG was accredited as a Disability Confident Employer
- Reviewed our recruitment and selection processes to ensure that best practice has been adopted in terms of equality and diversity and evidenced this for disability confident employer accreditation
- Ran HR workshops for managers and staff that covered a wide spectrum of HR and employment issues including equality and diversity issues
- Evaluated staff survey data to ensure that we provide all staff, with equal opportunities to obtain training opportunities, career development and promotion. We have also looked into any reporting related to Bullying and Harassment and organised HR training in this area for managers and staff.
- In 2020 we will be running the 30/30 Challenge offering those Not in Education, Employment or Training (NEETS) with opportunities to come into the CCG and learn about how to start a career in the NHS. There is a specific focus on BAME young people and encouraging them to enter the NHS workforce (see AO report). We are working with GCC and local schools on this programme.

We have been working with our ICS partners to make E&D a priority. For 2020 E&D will be a key priority for the ICS. The Accountable Officer's report for the November Governing Body covers the broad range of work being undertaken on workforce and OD across the ICS.

<b>7.</b>	<b>Clinical Chair's Report</b>
7.1	AS presented the Clinical Chair's Report and stated that a new health centre in Stow-on-the-Wold opened on 28 <sup>th</sup> October 2019. AS added that the new centre brought fresh, modern, spacious facilities to the local community and the facility constituted seven GP consulting rooms, four nurse consulting rooms, two phlebotomy rooms, an area for minor procedures and a further two consulting rooms specifically for trainee GPs.
7.2	AS updated members on the Primary Care Commissioning Committee's approval of the Business Case supporting the development of a new surgery for the local community of Minchinhampton. The new building was large enough to hold a list size of up to 9,000 patients and host additional Primary Care roles which formed part of the NHS England 'Additional Reimbursable Roles' (ARRs) which included, but was not limited to, 'First Contact Physiotherapists' and 'Social Prescribers'. The building was expected to be opened in October 2021.
7.3	AS stated that 'Integrated Locality Partnership' (ILP) members were discussing and agreeing on priority areas of work which would contribute to the delivery of the NHS Long Term Plan (LTP). Members from each ILP participated along with local communities in discussions relating to the future of urgent care in Gloucestershire.
7.4	AS stated that the CCG continued to engage with PCNs and held regular meetings with Clinical Directors. AS added that most PCNs had brought on board clinical pharmacists. AS emphasised that Gloucestershire had one of the highest numbers of Clinical Pharmacists.
7.5	<p>AS further summarised as follows:</p> <ul style="list-style-type: none"> <li>• Gloucestershire's use of the Electronic Prescription Service was one of the highest in the country;</li> <li>• the CCG supported career development for GPs and a GP retention programme had been designed to offer support to 'out of practice' GPs returning to work;</li> </ul>

	<ul style="list-style-type: none"> <li>nurse coordinators, who formed part of the parachute nursing team, were being utilised to provide nursing support to cover unexpected short term gaps in general practice;</li> <li>the CCG was effectively contributing to positive developments in the area of 'Adverse Childhood Experiences' (ACEs), through the 'Health and Wellbeing Board'.</li> </ul>
7.8	<b>RESOLUTION: The Governing Body noted the contents of the Clinical Chair's report.</b>
8.	<b>Accountable Officer's Report</b>
8.1	MW presented the report and stated that the CCG and its partners had set up a 'Local Workforce Action Board' (LWAB) to work jointly on a workforce and organisational development strategy which supported integrated solutions and services to the local population. MW added that this required an optimal skill base and workforce, and the challenge faced was that local health services competed with other employers for the best talent. MW emphasised that not only did the CCG and its service delivery partners need to invest in talent; it also needed to retain the talent available. MW explained that a range of technological solutions had been implemented by the CCG and its partners to better plan the day-to-day workforce requirements. MW stated that the CCG had put in place programmes that supported a wider range of careers in the health services.
8.2	MW described the winter campaign programme as a programme structured to encourage the 'Accident & Emergency' (A&E) department to remain clear for more serious problems, rather than be inundated by minor incidents. AS stated that 'Cinapsis' could be an effective tool for acute services. MW concurred and added that at the time of presenting the report there was 87% coverage of Cinapsis with target coverage of 100%.
8.3	MW stated that the winter campaign employed, as its outreach tools, door-to-door campaigns, outdoor advertising, community publications and high impact video campaigns, amongst other methods. MW further stated that an evaluation mechanism would be put in place to ascertain

	the effectiveness of the outreach methods.
8.4	MW stated that the CCG, in conjunction with Gloucestershire Hospitals NHS Foundation Trust (GHFT), were developing dermatology services. MW also stated that clinicians in primary and secondary care were aiming to work together towards a virtual model of rapid diagnosis of skin conditions; particularly skin lesions. Funding from the Primary Care Training Hub would enable the CCG to provide training sessions to all clinicians within GP practices in Gloucestershire to support this vision.
8.5	MW explained that the Cinapsis dermatology module went 'live' on 16 <sup>th</sup> September 2019 to provide a combined Information Governance (IG) compliant solution for capturing images using smartphone technology. MW clarified that 'Dermatology Advice and Guidance' would continue to be available for GPs to use alongside Cinapsis, and it was hoped that the benefits of Cinapsis would gradually encourage GPs to make a transition to the new platform.
8.6	MW presented a list of meetings that had been attended by the Accountable Officer from September to November 2019.
8.7	<b><u>RESOLUTION:</u> The Governing Body noted the contents of the Accountable Officer's report.</b>
9.	<b>Finance and Performance Report</b>
9.1	<u>Operational Performance</u>
9.1.1	MW delivered the performance aspect of the report and stated that when measured against performance domains, 'Better Health', 'Leadership' and 'Sustainability' themes showed good performance whilst 'Better Care' continued to experience pressures and a lower level of performance.
9.1.2	MW further summarised as follows: <ul style="list-style-type: none"> <li>category 1 ambulance performance increased to 7.3 minutes in the</li> </ul>

	<p>month of September but the ‘Year to Date’ (YTD) performance remained within the 7-minute standard;</p> <ul style="list-style-type: none"> <li>• category 2 ambulance performance remained above the target of the average response time of 18 minutes in the month of October 2019;</li> <li>• in the month of October 2019 the Gloucestershire whole system performance, measured against the emergency department 4-hour standard, was 86.4%;</li> <li>• in the month of October 2019, YTD whole system performance was 90.5% against the 4 hour target, with GHFT YTD performance at 86.0%;</li> <li>• regarding NHS111 performance, Bristol CareUK call centre was awarded “Outstanding” performance by CQC in the recent inspection;</li> <li>• the CCG had been working with ‘Bristol, North Somerset and South Gloucestershire’ (BNSSG), Somerset and ‘NHS Improvement’ (NHSE/I) to improve and streamline 999/ED validation in unscheduled care;</li> <li>• the ‘Delayed Transfer of Care’ (DToC) rate at GHFT rose slightly in September and exceeded the 3.5% target, with performance at 4.5%;</li> <li>• ‘Gloucestershire Health and Care’ (GHC) ‘Delayed Transfer of Care’ (DToC) remained under 3.5% in September in both mental health and community health performance.</li> </ul>
9.1.3	<p>MW reassured members that the CCG had put in place strong clinical and non-clinical leadership across key areas. Recent developments included investment in GP Provider leads to support local delivery and Primary Care Networks (PCNs). MW added that the CCG effectively engaged with staff by way of ‘Joint Staff Consultative Committee’ (JSCC) and ‘Annual Staff Surveys’.</p>
9.2	<p><u>Cancer Performance Overview</u></p>
9.2.1	<p>ER presented the cancer performance update and summarised as follows:</p>

	<ul style="list-style-type: none"> <li>the September 2019 2-week wait performance was 92.8% for the CCG and 92.7% for GHFT;</li> <li>the 62-day performance had been consistent since 2016, with 2018/19 statistics showing an average of 74.5%;</li> <li>urology remained challenging and pressures also remained around the neurology pathway;</li> <li>GHFT established partnership working with Royal Devon and Exeter Cancer Service to share learning around 'Patient Tracking List' (PTL) management, escalation, and breach management.</li> </ul>
9.3	<u>Mental Health and Community Health Overview</u>
9.3.1	<p>KF delivered the mental health and community aspect of the report and stated that recovery performance in 'Improving Access to Psychological Therapies' (IAPT) was excellent throughout 2018/19, with the 50% target being met in each month, and this continued into the new financial year with September 2019 performance at 51%. KF further summarised as follows:</p> <ul style="list-style-type: none"> <li>referral quality in 'Continuing Health Care' (CHC) continued to be an area of concern;</li> <li>'Fast Track' activity remained high and review of patients remaining on 'Fast Track' longer than 12 weeks was being prioritised;</li> <li>the occupational therapy 18 week target performance was at 96.5%;</li> <li>podiatry performance had decreased to 66.1% in September 2019 compared to 75.2% in August 2019.</li> </ul>
9.3.2	<p>AE suggested that 'Fast Track' needed extra investment in the further education of personnel. KF concurred and stated that training programmes were being designed and being rolled out by the CCG, working together with its partners.</p>
9.4	<u>Financial Performance</u>

9.4.1	CL presented the financial performance aspect of the report and explained that the CCG set an in year plan of breakeven. This included savings of £17.3m derived from recurrent and non-recurrent mitigation measures.
9.4.2	CL stated that although the CCG planned an in year position of breakeven, overspends that have emerged in-year posed a financial risk to the breakeven position. The scale of the financial risk was high and the CCG had assessed the net financial risk as £3.5m. Pressures emanating from Continuing Health Care (CHC) and GHFT prescription drug pressures contributed to the risk. This, therefore, resulted in the need for dedicated management action to recover the financial position which had been worsened by prescribing pressures.
9.4.3	CL reiterated that further mitigations and controls needed to be progressed in order to deliver the planned breakeven position. CL added that even if such mitigations were realised, there was the need to focus on devising further saving schemes for the next financial year since some of the in-year mitigations were of non-recurrent nature and therefore could not be factored into year 2020/21.
<b>10.</b>	<b>Governing Body Assurance Framework (GBAF)</b>
10.1	CGi presented the GBAF and stated that there were no significant changes from the risk position previously reported. CGi explained that each directorate maintained a risk register which was updated on monthly basis and the register would be used to shape discussions on emerging and current risks that needed to be mitigated.
10.2	CGi explained that the 'Risk Register' (RR) and the GBAF were migrating from the conventional spreadsheets to a dedicated risk management platform called 4Risk. CGi presented, before the Governing Body, 24 risks and clarified that there was only one 'Red Risk' out of the 24 risks reported.
10.3	CGi emphasised that, in the future, risks would be presented in a different

	format via the 4Risk platform. CGi further emphasised that the significance of the 4Risk reporting format lay in that it produced reports that were precise and succinct, and therefore better articulated the risk position.
10.4	CG suggested that CGi further train members on 4Risk so that they would develop a deeper appreciation of the functionality of 4Risk, as this would enable them to effectively fulfil their oversight role. CGi stated that arrangements would be made for the required level of training. <b>ACTION: CGi and LP.</b>
<b>11.</b>	<b>Integrated Care System (ICS) Update</b>
11.1	ER presented the update on the ICS and stated that the report provided an insight into the progress being made in the ICS transformation programmes, measured against the system vision and priorities. ER stated that the ICS focused on integration through the 'Enabling Active Communities', 'Clinical Programme Approach' and 'Reducing Clinical Variation', programmes.
11.2	ER also emphasised that the ICS programme was being driven forward through introducing system enablers, namely 'Joint Digital Strategy', 'Primary Care Strategy', 'Joint Estates Strategy' and 'Joint Workforce Strategy'.
11.3	ER stated that the 'Enabling Active Communities' programme looked to build a new sense of personal responsibility and improved independence through supporting community capacity.
11.4	ER emphasised that the key priorities for 2019/20 would align to the refreshed Health & Wellbeing Strategy. This could be split across the four main work streams, namely supporting pathways, supporting people, supporting places and communities and supporting our workforce.
11.5	ER stated that the 'Clinical Programme Approach' aimed to reorganise the way care that would be delivered in ways which ensured

	Gloucestershire residents received the right care, in the right place, at the right time.
11.6	<p>ER stated that the 'Reducing Clinical Variation' programme elevated key issues of clinical variation at ICS level and promoted engagement with the public on the agreed priorities. ER further summarised that the key priorities would be:</p> <ul style="list-style-type: none"> <li>• to continue to use the successful 'Prescribing Improvement Plan' (PIP);</li> <li>• to focus on working with hospital colleagues to consider areas of medication choice and how medicines were supplied;</li> <li>• to develop a programme 'Medicines Optimisation' scheme in Care Homes;</li> <li>• to develop &amp; improve mechanisms to that would allow GPs to access specialist opinion/advice and guidance;</li> <li>• to support changes on how 'Outpatient Care' delivered services across the ICS.</li> </ul>
<b>12.</b>	<b>Quality Report</b>
12.1	BP presented the Quality Report and highlighted areas of strong performance and areas which required increased surveillance. BP addressed the issue of 'Never Events' and stated that, at GHFT, one patient was temporarily connected to 'air' rather than 'oxygen', and the second 'Never Event' related to wrong site surgery on varicose veins. BP reassured that these events were subsequently reviewed and new guidance was issued to ensure that such events would not reoccur.
12.2	BP described the themes identified from the CCG 'Quarter 2' (Q2) 'Patient Advice and Liaison Service' (PALS). BP explained that PALS have continued to receive many telephone calls, many of which were of a complex nature. BP added that PALS also utilised emails as a communication channel.
12.3	BP stated that in 2019/20, 78% of patients developed symptoms of

	<p>'Clostridium Difficile Infection' (CDI) for the first time and post infection reviews indicated that there were delays in the diagnosis and diarrhoea management was not consistently optimal. BP explained that, nevertheless, the overall number of cases of CDI reported at the time of presenting the report indicated that Gloucestershire CDIs was showing a downward trend compared to 2018/19 cases.</p>
12.4	<p>BP explained that in 2016 the Government planned to halve the number of Escherichia coli (E.coli) Infections by March 2021. The CCG showed some level of slippage in its performance with year 2017/18 exceeding the threshold by 19 cases and by 29 cases in year 2018/19. BP, however, explained that comparative figures showed that the CCG was performing relatively well.</p>
12.5	<p>BP stated that CareUK 111 Southwest had recently been inspected by the Care Quality Commission (CQC) and was rated as 'Outstanding'; and CareUK 111 was possibly the first 111 provider to be rated as 'Outstanding' in the country.</p>
12.6	<p><b><u>RESOLUTION:</u> The Governing Body noted the contents of the Quality report.</b></p>
13.	<p><b>Primary Care Commissioning Committee Minutes of the Meeting Held on 29 August 2019</b></p>
13.1	<p><b><u>RESOLUTION:</u> The Governing Body noted the contents of the Primary Care Commissioning Committee minutes.</b></p>
14.	<p><b>Quality &amp; Governance Committee Minutes of the Meeting Held on 8 August 2019</b></p>
14.1	<p><b><u>RESOLUTION:</u> The Governing Body noted the contents of the Quality &amp; Governance Committee minutes.</b></p>
	<p><b>Any Other Business</b></p>

	There was no other business raised.
	<b>The Governing Body meeting ended at 3.30pm</b>
	<p><b>Date and time of the next Governing Body meeting:</b></p> <p><b>The next Governing Body meeting would be held at 2:00pm on Thursday 30 January 2020, in the Board Room, Sanger House.</b></p>

## Agenda Item 4

### Governing Body Matters Arising – January 2020

Item	Description	Response	Action with	Due Date	Status
28.11.19 Item 6.3	<u>Patient Story</u> . AS suggested that the 'Live Better to Feel Better' programme could be embedded into other CCG projects and that information should be made available on the CCG bulletin board to get the 'Live Better to Feel Better' message out.		CLd	26 March	Open

<b>28.11.19 Item 10.4</b>	<u>Governing Body Assurance Framework</u> . CG suggested that CGi further train members on 4Risk so that they would develop a deeper appreciation of the functionality of 4Risk, as this would enable them to effectively fulfil their oversight role. CGi stated that arrangements would be made for the required level of training.	Arrangements being made to hold the training at a Governing Body Business Session.	CGi and LP	30 January 2020	Open

There are no public questions

'Patient Story' to be presented at the meeting.

**Agenda Item 7****Governing Body meeting**

<b>Meeting date</b>	<b>30 January 2020</b>
<b>Title</b>	<b>Clinical Chair's Report</b>
<b>Executive Summary</b>	This report provides a summary of key issues and updates arising during December 2019 and January 2020 for the Clinical Chair.
<b>Key Issues</b>	<p>Key topics for this report:</p> <ul style="list-style-type: none"> <li>• <b>Approval for a new premise for Locking Hill Surgery and Stroud Valleys Family Practice in Stroud;</b></li> <li>• <b>Primary Care Strategy progress;</b></li> <li>• <b>Improving access including our Community Pharmacy Consultation Service (CPCS) pilot and Cinapsis;</b></li> <li>• <b>Workforce development;</b></li> <li>• <b>Care Quality Commission and mergers;</b></li> <li>• <b>Gloucestershire Health and Wellbeing Board.</b></li> </ul> <p><b>Meetings December 2019 to January 2020.</b></p>
<b>Conflicts of Interest</b>	None.
<b>Risk Issues: Original Risk</b>	None.
<b>Financial Impact</b>	None.
<b>Legal Issues (including NHS Constitution)</b>	None.
<b>Impact on Health Inequalities</b>	None.
<b>Impact on Equality and Diversity</b>	
<b>Impact on Sustainable Development</b>	None.
<b>Patient and Public Involvement</b>	None.
<b>Recommendation</b>	This report is presented for information and Governing Body members are requested to note the contents.
<b>Author</b>	Andy Seymour
<b>Designation</b>	Clinical Chair

## Agenda Item 7

### Governing Body

30 January 2020

### Clinical Chair's Report

#### 1. Primary Care Infrastructure

- 1.1 Gloucestershire CCG continues to invest in primary care infrastructure. Having updated on a new health centre which opened in Stow and on the planned development of a new surgery for the people of Minchinhampton in my last report, this month I am proud to confirm that Primary Care Commissioning Committee members gave their support to the Business Case for the development of a new facility for Locking Hill Surgery and Stroud Valleys Family Practice both in Stroud.
- 1.2 The development will see the two existing practices, which are both part of Severn Health Primary Care Network, re-locate to a new site in King Street, Stroud with the new premises forming part of the revamped shopping centre in the town. The plans make provision for an additional 12 clinical rooms with provision for minor operations and GP training facilities and take account of anticipated combined list size growth of at least 15,161 patients over the next 10 years.
- 1.3 Local Authority planning permission has already been obtained for this development with the extensively refurbished and modernised building expected to be open in the Summer of 2021.

#### 2. Primary Care Strategy Progress

- 2.1 Within the GP Contract Framework released in January 2019, there was reference to seven service specifications to be delivered by Primary Care Networks as part of the Network Contract Directed Enhanced Service. The first five would be delivered from April 2020 and another two from April

2021. NHS England and NHS Improvement released a draft of the service specifications prior to Christmas with a consultation open for feedback from interested parties until 15<sup>th</sup> January.

- 2.2 The PCN Clinical Directors in Gloucestershire have written a letter to Gloucestershire CCG for onward sharing to NHS England and NHS Improvement to express their concerns about the specifications. Both our Accountable Officer and myself have sent a similar letter. Clearly the exact details of the national service specifications require negotiation which is not directly in our gift, however we have a duty to our member practices and patients to support the sustainability of primary care and to highlight concerns to our NHSE/I colleagues. To our knowledge from various sources including Clinical Director forums and the Local Medical Committees, the reaction to the draft service specifications in Gloucestershire are not dissimilar to those around the country.
- 2.3 Gloucestershire CCG continues to support Primary Care Networks and Primary Care Network Clinical Directors to utilise the Primary Care Network Development Support funding available to support their development and maturity.
- 2.4 For the Primary Care Network Development element of this funding, Primary Care Networks were encouraged to bid against a Primary Care network maturity roadmap to ensure that the funding would support the national direction for Primary Care Networks. Most Primary Care Networks had their bids approved by the Primary Care Commissioning Committee. We are working to support the remaining Primary Care Network that has not yet submitted a bid and a number of minor amendments to existing bids, to ensure they are in line with requirements so that all funding is utilised.
- 2.5 We are working closely with the Gloucestershire Clinical Fellow for Primary Care Network Development to develop the process for the Clinical Director element of this funding and to ensure the Primary Care Network Development Support funding meets the needs of our Primary Care Networks.

- 2.6 As reported previously Gloucestershire CCG is one of twelve CCGs in the country participating in NHSE/I Wave 2 Population Health Management (PHM) pilot. The PHM pilot is in progress and PCNs are developing their cohorts and solutions through the Action Learning Sets and Design to Action workshops.
- 2.7 Central PCN's proposed cohort is targeted at people who have six or more long term conditions, who live alone and who have depression. Meanwhile St Paul's proposed cohort is people who are housebound or are on the District Nurse register with 5 or more hospital visits living in deprived areas and in Peripheral PCN the proposed cohort is unidentified moderately frail people within the community at risk of falls and who live alone.

### 3. Improving Access

- 3.1 Gloucestershire's GP practices and Primary Care Networks continue to deliver Improved Access to all Gloucestershire registered patients meeting the core requirements and delivering over the nationally mandated 30 minutes per 1,000 population. The PCNs have a number of health care professionals employed through the innovation funding contributing to the delivery of the service.
- 3.2 In partnership with NHSEI, Gloucestershire CCG is also piloting the navigation and booking of some patients directly into a consultation with a community pharmacy. At the end of December 2019 two practices, Aspen in Gloucester and Locking Hill in Stroud, were actively referring patients to neighbouring pharmacies for one to one consultations. Another four practices are due to commence the pilot in January 2020. This equates to 71,028 registered patients in the county having access to community pharmacy via their GP practice.
- 3.3 Patients in Gloucestershire can also access appointments with community pharmacists via NHS 111 and by mid December 274 patients in Gloucestershire had an appointment booked for them in the community via this route.
- 3.4 Ninety nine percent of Gloucestershire's GP practices have now received a demonstration of and have access to Cinapsis, a digital platform which

supports clinical decision making by making it easier for primary care clinicians to speak with their Consultant colleagues. The services available on Cinapsis are Acute Medicine, Acute Paediatrics, Frailty Assessment Service, Respiratory Hot Clinic and Dermatology. You can view a local promotional video featuring Dr Chin Whybrew GP, Dr Hwyl Furn-Davies GP, Dr Chris Custard Consultant in Acute Medicine and a patient, Claire via the Gloucestershire CCG YouTube site.

#### 4. **Workforce development**

- 4.1 ICS workshops have been taking place to progress the conversation with relevant stakeholders in each of the professional groups which are part of the Additional Roles Reimbursement scheme for primary care. The initial Clinical Pharmacist Stakeholder workshop took place on the 10<sup>th</sup> of December 2019, which was well attended and well received with a follow up workshop planned for March 2020. The Physiotherapist ICS workshop took place on the 15<sup>th</sup> of January 2020 with a follow up workshop planned for Spring. Conversations with SWASFT and Health Education England have also commenced.
- 4.2 All of the good practice developed in Gloucestershire over the last few years around the New Roles in Primary Care will be highlighted at a Health Professionals in Primary Care Conference taking place at the end of this month, with the aim of creating further awareness for all PCNs in county to support their future employment models.
- 4.3 The Health Equalities Fellowship has been adapted to offer a broader spectrum of post-grad learning options, whilst the project focus remains Health Equalities. One GP has successfully completed the scheme and will be working in the Inner City PCN on a salaried basis. Another two GPs currently remain on the scheme, with adverts out for two additional new GP roles. A mirror programme for Practice Nurses is under development.
- 4.4 Work is currently underway to support early career GPs and Practice Nurses as part of the PCN New to Practice programme. This will enable staff to undertake development whilst settling into primary care. The offer will be similar to the Next Generation GP scheme and includes coaching or mentoring.

4.5 An offer has been made to practices on workforce planning and support from the Primary Care Training Hub. PCNs are beginning to engage with this offer and PCN based workforce planning group discussions will start in early Spring 2020.

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

5.1 There have been no new CQC reports issued since my last report. 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".

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

## 6. Gloucestershire Health and Wellbeing Board meetings

6.1 The Health and Wellbeing Board meets on five occasions throughout the year. The Board was previously chaired by Cllr Roger Wilson but due to his sad departure, I chaired the meeting as the Vice-Chair for the January meeting. The Health and Wellbeing Board includes representatives from across Gloucestershire's health, care and public sector agencies. The Board is well represented by the CCG with Dr Hein Le Roux, CCG Deputy Clinical Chair and Mary Hutton, Accountable Officer as members of the Board. At the meeting held on 21 January 2020 the following items were considered and discussed: Children's Health and Wellbeing Strategy and Child Friendly Gloucestershire, the NHS Long Term Plan, Report from the Gloucestershire Health and Wellbeing Board and Safer Gloucestershire development session held on 5 November 2019 and a refresh of the Joint Strategic Needs Assessment amongst other items. More information about the meeting can be found on Gloucestershire County Council's website using the link below:

<https://glostext.gloucestershire.gov.uk/documents/g9387/Agenda%20frontsheet%20Tuesday%2021-Jan-2020%2010.00%20Gloucestershire%20Health%20Wellbeing%20Board.pdf?T=0>

## 7. Meetings attended during December 2019 to January 2020

02 Dec	Practice Visit – Sixways Clinic, Cheltenham
03 Dec	Dorset CCG Executive Visit
05 Dec	ICS Executive Meeting
05 Dec	Topping Out Ceremony New Cinderford Health Centre
09 Dec	Practice Visit – Partners in Health, Gloucester
09 Dec	Visit to St James Inner City Farm
11 Dec	PCN Development Group Meeting
12 Dec	Clinical Directors Meeting
12 Dec	ICS Board Meeting
16 Dec	A&E Delivery Board Meeting
17 Dec	SW-CEO/Chairs: South Regional Meeting, London
19 Dec	Leadership Gloucestershire
19 Dec	LMC Negs Meeting
06 Jan	Practice Visit - Berkeley Place Surgery
09 Jan	ICS Executive Meeting
09 Jan	LMC Main Meeting
13 Jan	Practice Visit – Drybrook Surgery
14 Jan	Health Scrutiny Committee Meeting
14 Jan	Health Chairs Meeting
16 Jan	Clinical Directors Meeting
16 Jan	Clinical Council Meeting
20 Jan	Practice Visit – Beeches Green Surgery
20 Jan	Cinderford Artspace Visit

21 Jan Health & Wellbeing Board Meeting  
23 Jan ICS CEO's Meeting  
23 Jan ICS Board Meeting

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

**Agenda Item 8****Governing Body**

<b>Governing Body Meeting Date</b>	<b>Thursday 30 January 2020</b>
<b>Title</b>	<b>Accountable Officer's Report</b>
<b>Executive Summary</b>	This report provides an update on some of the key programmes and initiatives within the CCG during December 2019 and January 2020. 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.
<b>Key Issues</b>	<p>Key topics for this report:</p> <ul style="list-style-type: none"> <li>• <b>Winter Plans</b></li> <li>• <b>Outpatient re-design programme</b></li> <li>• <b>Contracting round timeline</b></li> <li>• <b>PTS update</b></li> <li>• <b>Escape Pain</b></li> <li>• <b>Long Term Pain</b></li> <li>• <b>Work based risk screening for staff - Gloucestershire's National Diabetes Prevention Programme (NDPP)</b></li> <li>• <b>Our Gloucestershire Moves programme</b></li> <li>• <b>Breathe Magic Intensive Therapy Programme</b></li> <li>• <b>CCG Graduate Trainee Scheme</b></li> <li>• <b>Proud to Care Gloucestershire</b></li> <li>• <b>Gloucestershire Care and Health NHS Foundation Trust (GHC)</b></li> </ul> <p><b>Meetings attended in December 2019 and January 2020.</b></p>
<b>Conflicts of Interest</b>	None.
<b>Risk Issues: Original Risk</b>	None.
<b>Financial Impact</b>	None.
<b>Legal Issues (including NHS Constitution)</b>	None.

<b>Impact on Health Inequalities</b>	None.
<b>Impact on Equality and Diversity</b>	None.
<b>Impact on Sustainable Development</b>	None.
<b>Patient and Public Involvement</b>	None.
<b>Recommendation</b>	This report is presented for information and Governing Body members are requested to note the contents.
<b>Author</b>	Mary Hutton
<b>Designation</b>	Accountable Officer

## Accountable Officer's Report

30 January 2020

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 28 November 2019.

### 1. Winter Plans

1.1 The A&E Delivery Board comprises representatives from health and care organisations across Gloucestershire, working collaboratively on plans to manage urgent care and emergency services. The changed governance structure has provided clear oversight and delivery of plans and schemes through the Urgent and Emergency Programme Group (UECPG).

1.2 Plans were completed for winter 2019/20 to ensure that organisations could respond effectively to increased demand for services during the winter months. The A&E Delivery Board monitors the development and implementation of the Winter Resilience plans which were submitted to NHS England and Improvement (NHSEI) for scrutiny. Initial feedback from NHSEI on 29<sup>th</sup> October was:

“Gloucestershire ICS have demonstrated understanding of demand and capacity across the system, which will further be enhanced by the full implementation of SHREWD supported by the region. The maturity of this system has shown great integrated services and will be holding an *ICS perfect week* in the coming weeks. Winter communications plans have been enhanced this year alongside national guidance to support with anticipated system demand. These are seen as an exemplar for the region. The system is rated amber-green.”

1.4 The Gloucestershire system has not had to declare OPEL level 4 to date. There have been challenging periods for all organisations but the system responded well and de-escalated quickly.

- 1.5 Ongoing performance is monitored and reviewed at the UECPG and Gloucestershire system partners are implementing, and evolving, plans to support the ongoing delivery of care to patients. A Winter debrief session will be scheduled before the end of March 2020.

## 2. **Outpatients Redesign**

- 2.1 Gloucestershire CCG has been shortlisted for an HSJ award (Best consultancy partnership with the NHS) for the outpatient transformation work we did with the consultancy firm Attain. The CCG is also presenting some of its successful outpatient transformation work to a Royal College of Physicians webinar in order to help disseminate the learning to the wider NHS.

- 2.2 The Gastroenterology/Hepatology referral assessment service has been such a success that we are now looking to implement the same solution in Gynaecology and Cardiology.

- 2.3 The number of Dermatology advice and guidance requests using Cinapsis continues to increase and we have received a significant number of very positive comments back from GPs on the speed of the service and the ease of use to capture images using the phone app.

- 2.4 We are now exploring the potential for using Cinapsis to provide a platform for high street Optometrists to seek advice and guidance from a hospital Ophthalmologist.

## 3 **Patient Transport Service**

- 3.1 Ezec Medical, the provider of the Non-Emergency Patient Transport Service (NEPTS), started operating across Gloucestershire, Wiltshire, Bath and North East Somerset and Swindon in June 2019.

- 3.2 Ezec undertake nearly 6000 journeys each month for Gloucestershire patients. Approximately 45% are for patients undergoing dialysis treatment at the three dialysis units in the county, 40% are for those

attending outpatient appointments and around 15% for discharges.

- 3.3 Since starting in June 2019, Ezeq have consistently improved performance across the full range of 14 key performance indicators (KPIs) set out in their contract. For patients, the most important performance measures relate to timeliness for which we have set three main KPIs. Ezeq has consistently improved since starting and now meet two out of three KPIs, with the third being only a few percent away from being achieved:
- Patients should not arrive after their booked arrival time - **90.27%**
  - Patients should not arrive more than one hour before their booked arrive time - **98.61%**
  - Patients should not wait more than 75 minutes after their agreed pick up time- **89.54%**.
- 3.4 All NEPTS journeys are important. However, we have placed special importance on 'End of Life' journeys for which we have set a challenging 'collection within 2 hour' KPI. The most recent performance shows this KPI is being fully met.
- 3.5 NEPTS is available to all eligible patients who have a medical or mobility need. Since 2018 we have commissioned the NHS run Patient Transport Advice Centre (PTAC) to undertake eligibility assessments and make bookings for Gloucestershire patients. PTAC ensures that the assessment process is fair and consistent.
- 3.6 PTAC receive around 1,500 calls from Gloucestershire patients each month, from which around 85% result in a NEPTS booking. For those patients found not to be eligible PTAC will signpost patients to other travel options such as public transport, or community transport providers.
- 3.7 Bookings made by healthcare professionals on behalf of patients (normally for discharge or transfer) are made on-line, but follow the same eligibility criteria.

#### 4. **Escape Pain**

- 4.1 ESCAPE-Pain is a well-established evidence based intervention for patients diagnosed with knee and/or hip Osteoarthritis (OA), delivered in a non-clinical setting by physiotherapists and level 3 trained exercise professionals. The provision for ESCAPE Pain in Gloucestershire commenced in late 2017 in Cheltenham with Gloucester following in early 2018. Such is the success of the programme that we now have a total of 6 venues with Tewkesbury, Forest of Dean, Cirencester and North Cots joining the initiative in 2019 and early 2020. The North Cots and Cirencester programmes have been made possible by funding from the CCG.
- 4.2 Data collected from the two longest established programmes in Gloucestershire show a marked improvement from participants in terms of pain, function and quality of life. There are also reported improvements in general physical and mental wellbeing and, in particular, a reduction in social isolation. One participant described the programme as “a life saver”. Other benefits include increased self-confidence, better and more effective medication management, delayed surgical interventions and better outcomes from surgery due to the “pre-hab” effect of physical exercise.
- 4.3 The ESCAPE Pain programme has been highly successful in Gloucestershire and demonstrates effective collaborative partnerships between our Providers, the CCG, the Academic Health Science Network and local leisure centres.

#### 5. **Long Term Pain**

- 5.1 Long-term pain is distressing and disabling. Many people describe little benefit from medical treatments for pain. In order to improve support for people with long term pain to live well with their condition, Gloucestershire's Living Well with Pain Programme have developed a pack of resources to be used in Primary Care.

The packs include:

- Videos of local clinicians and patients describing their

experiences when reducing their pain medicines.

- Patient self-management and medicines reduction resources.
- Local opioid tapering guidance.
- Template letters that can be used or adapted to invite patients for pain medicine reviews and for patients who don't attend their pain medicine review.
- Copies of the Pain Navigator Tool, a patient decision aid, which patients and their prescriber work through together to help understand what is important to the patient and to underpin shared decision making.

5.2 As well as reducing the number of new patients given medicines that are not helpful, we are developing strategies to support patients who have been on high doses of medicines for many years but with little benefit.

These include:

- A pilot to put a support worker in primary care to help patients who may be dependent or addicted to their medicines.
- Piloting a specialist pain Multi-disciplinary Team in primary care.

We will continue to explore new ways to support people to live well with their pain whether or not medical treatments have been helpful.

## 6. **Work based risk screening for staff - Gloucestershire's National Diabetes Prevention Programme (NDPP)**

6.1 Since transitioning to a new NDPP service provider (ICS Health and Wellbeing) in August 2019 there have been 1,061 referrals to the service. Since July 2017, there have been 4,375 referrals onto the diabetes prevention programme. In line with the NHS Long Term Plan to double the NDPP capacity support up to 200,000 people at risk per year by 2023/24 the NDPP project team have been working with Gloucestershire Hospitals NHS Foundation Trust (GHNFT) to pilot work-based diabetes risk screening for staff.

- 6.2 This diabetes risk screening will begin with the GHNFT Staff Advice & Support Hub Team engaging with staff members to complete a modified Diabetes Risk Screening Questionnaire (Diabetes UK). This engagement event will take place between 21<sup>st</sup> – 30<sup>th</sup> January; starting with Gloucester Royal Hospital (21<sup>st</sup> – 23<sup>rd</sup>) in the staff Atrium and then Cheltenham General Hospital (28<sup>th</sup> – 30<sup>th</sup>, space to be confirmed). The Gloucestershire Health and Care Diabetes Team, ICS Health & Wellbeing and CCG project team will support GHNFT during the staff engagement days.
- 6.3 Following the completion of the questionnaire staff members that are identified as moderate to high risk of developing Type 2 Diabetes will be able to book a free HbA1c (blood glucose) test with their Occupational Health Team. Those at a low risk of Type 2 Diabetes will be signposted by the Staff Advice Hub Team to services that can help to reduce their risk factors, *i.e.* the Healthy Lifestyle Service. All employees that have a HbA1c blood test will receive confirmation of their results and this will also be shared with their registered GP. Those employees with an HbA1c result of 42 – 47 mmol/mol are eligible for the local NDPP service, will be sent an invitation letter and signposted to ICS Health & Well to self-register for the work based prevention programme. For employees with an HbA1c test  $\geq$  48 mmol/mol will be advised to go to their GP for additional tests as this indicates Type 2 Diabetes.
- 6.4 This pilot project's aim is to increase referrals to the NDPP from those of a 'working age' that are at risk of Type 2 Diabetes in an attempt to achieve greater health improvement, reduce the rate in which people are developing Type 2 Diabetes and its complications.
7. **Our Gloucestershire Moves programme**
- 7.1 Our Gloucestershire Moves programme is getting a name change and relaunch. There will be a new website and increasing support for those trying to get active.

- 7.2 Over the past three years the CCG and Active Gloucestershire have been building the 'Gloucestershire Moves' programme in conjunction with other partners across Gloucestershire. The programme is focussed on increasing levels of physical activity in the county using behaviour change approaches based around three principles; individual interventions; tackling the barriers in the environment that prevent people from getting and staying active and building a social movement in which physical activity becomes the social norm.
- 7.3 In 2019, Active Gloucestershire conducted a significant piece of work across a wide range of ages, backgrounds and physical abilities to determine what this movement should be called and how it should be portrayed. The result is **We Can Move**, which can be seen at [wecanmove.net](http://wecanmove.net) and on social media channels Instagram, Twitter and Facebook. The website aims to do two things - help those who are looking to get active and give support to those who are trying to get others active. The research conducted by Active Gloucestershire also provided clear direction on what film and photography should convey. Feedback so far is very positive, and the following on social media is building.
- 7.4 In 2019 we had a brilliant year with a number of successes including the launch of our falls-proof strength and balance campaign, more than 10,000 people taking part in Beat the Street and over 60% of our primary schools now doing the Daily Mile. With the new brand now launched we will look to continue to grow and develop the We Can Move movement across Gloucestershire during 2020. You sign up to **We Can Move** news via the website, or if you would like brand guidelines or more background to the movement email [hello@wecanmove.net](mailto:hello@wecanmove.net)
8. **Breathe Magic Intensive Therapy programme**
- 8.1 A Breathe Magic Intensive Therapy programme is seeking young people aged between 7 and 18 affected by \*hemiplegia to take part when it returns to Gloucestershire next year. This is part of the Social Prescribing programme, and the CCG has teamed up with Breathe

Arts Health Research to offer a 10 day 'Magic Camp' during April 2020.

- 8.2 The innovative, award-winning clinical programme uses specially chosen magic tricks that combine occupational therapy and creativity to help children with hemiplegia to build strength and dexterity in their affected arm and hand. The aim is to significantly improve the young people's hand function, social interaction, confidence and independence over the course of the programme, which has been proven to work. Clinical research on the programme has shown that between 75% and 92% of children have clinically significant improvements in hand function after the Breathe Magic camp.
- 8.3 Taught by professional Magic Circle magicians and occupational therapists, the programme offers 60 hours of one to one therapy over a 10 day camp, where Breathe combine the learning of magic tricks with a focus on everyday activities such as cutting up food and crafts.
- 8.4 Seven local children were involved in the first phase of the programme in April 2019. The camp will return to Gloucestershire in April 2020 and will culminate in a special Magic Show involving the young people at the Parabola Arts Centre, Cheltenham Ladies College.
- 8.5 Families with young people affected by hemiplegia who may be interested in joining the 2020 programme can either register their interest directly on the Breathe website ([breatheahr.org/referral-form/](http://breatheahr.org/referral-form/)), or sign up to come to a taster day on 18th January to find out more.

## 9. **NHS Graduate Scheme – launching September 2020**

- 9.1 From September 2020, the CCG will be introducing a new Graduate Scheme aimed at both university graduates and existing CCG staff members. The scheme will be pitched at pay band 5 entry level and by the end of two years; staff will be aspiring to pay band 7 roles. There will be five places available. Support will be given by the CCG's HR provider (Commissioning Support Unit, ConsultOD team) as they have

been successfully delivering a Graduate Scheme for a number of years.

## 10. **Proud to Care (PTC) Gloucestershire**

10.1 The representation of Job Centre Plus (JCP) on the PTC Strategy & Development Group has enabled PTC Gloucestershire and the Joint Commissioning Partnership (JCP) to collaborate on several key projects supporting job seekers to enter the care sector. Attending JCP team meetings has enabled job coaches to have a better understanding of the opportunities available in adult social care in the county, leading to an increased sign posting from job coaches to PTC Glos.

10.2 In collaboration with JCP, PTC has recently coordinated Mentoring Circles, comprising of 4 x 2 hour sessions where Adult Social Care (ACS) employers act as mentors to the job seekers and ambassadors for the sector. The mentoring circles cover; building awareness of the sector, tailoring CV's for ASC roles, understanding Values Based Recruitment, developing interviewing skills, practice interviews with employers and goal setting. So far 2 mentoring circles have been held in Gloucester. In the second Gloucester mentoring circle 57% of attendees progressed to a work experience, training opportunity or job role related to Adult Social Care. Following their success two more are planned in January for Cheltenham and Cinderford.

10.3 In addition to mentoring circles PTC Glos have collaborated with JCP and Gloucester College to run a care specific Sector Based Work Academy (SBWA) in Gloucester. The SBWA is a 4 week programme where individuals learn more about the care sector, completing some elements of mandatory training along with employability qualifications. At the end of the programme attendees are guaranteed an interview with Adult Social Care employers. 75% of the SBWA participants progressed to the next step in Adult Social Care employers' recruitment process or were offered a role with an employer. As a result of the success of the Gloucester SBWA, a Cheltenham SBWA will be held in February.

## 11. **Gloucestershire Care and Health NHS Foundation Trust (GHC)**

- 11.1 On 1 October 2019 Gloucestershire Care and Health NHS Foundation Trust (GHC) was formed following the merger of Gloucestershire Care Services (Physical) and 2Gether Trust (Mental Health). This new provider of community health and care services is commissioned by Gloucestershire Clinical Commissioning Group, via the Integrated Commissioning Team. Within the contract there are jointly commissioned services that are provided on behalf of Adult and Children Social Care, Education, Public Health and Health.
- 11.2 There is significant work underway to align contract management, monitoring arrangements and meetings for a consistent and cohesive approach into the new contracting period, to achieve a standard approach and design principles as services develop, evolve or cease.
- 11.3 Alongside this there is a senior working group to review, revise where necessary, a large volume of existing KPIs to ensure the range, frequency and volume of national and local KPI, quality indicators and reporting requirements.
- 11.4 GHC has combined its Quality Committees and associated governance structures. GHC now has a combined safeguarding offer. Work to align Serious Incident approach will be complete by the end of January.

## 12. **Chief Nursing Officer – Silver Award to CCG staff member**

- 12.1 I am delighted that Claire Lambie, who works for the CCG has won the Chief Nursing Officer's Silver award for her outstanding contribution to nursing and improvements in patient care. Claire's unique role as the CCG's Chief Nurse Information lead was recognised at the CCG's Nurses Forum in January. There are only two nurses in England employed in such a role. The Chief Nursing Officer gave Claire Lambie one her CNO Silver awards in recognition of the role nurses have in

the digital revolution and the impact this work has on improving the quality and safety of care provided to patients.

13.1 A summary of the meetings I have attended during December and January are given below:

02 Dec	Practice Visit – Sixways Clinic, Cheltenham
03 Dec	Dorset CCG Executive Visit
05 Dec	ICS Executive Meeting
05 Dec	Priorities Committee
06 Dec	West of England AHSN Board, Bristol
11 Dec	Enabling Active Communities Meeting
11 Dec	Joint Commissioning Partnership Board (JCPB)
11 Dec	Gloucestershire Winter Meeting, NHSE/I
12 Dec	Clinical Directors Meeting
12 Dec	ICS Board Meeting
17 Dec	SW-CEO/Chairs: South Regional Meeting, London
18 Dec	Local Workforce Action Board (LWAB)
19 Dec	Leadership Gloucestershire
06 Jan	Practice Visit - Berkeley Place Surgery
09 Jan	ICS Executive Meeting
09 Jan	New Models of Care Board (NMOC)
14 Jan	Health Scrutiny Committee Meeting
15 Jan	Central Glos City Region Growth Board
16 Jan	Clinical Directors Meeting
20 Jan	Practice Visit – Beeches Green Surgery

20 Jan	Cinderford Artspace Visit
21 Jan	Health & Wellbeing Board Meeting
22 Jan	Joint Commissioning Partnership Executive (JCPE)
23 Jan	ICS CEO's Meeting
23 Jan	ICS Board Meeting

#### **14. Recommendation**

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

**Agenda Item 9**

**Governing Body**

<b>Paper by e-mail</b>	<b>30<sup>th</sup> January 2020</b>
<b>Title</b>	Finance and Performance Report
<b>Executive Summary</b>	<p>The bi-monthly finance and performance report has been submitted to the Governing Body covering a review of performance to date (as available).</p> <p>The Finance report within the paper gives the forecast outturn as at Month 9; this is breakeven with net risks of £3.5m and represents a high risk forecast.</p>
<b>Key Issues</b>	<p>This report covers the following key elements:</p> <p><b>1.0 Scorecard</b></p> <p><b>2.0 Executive Summary</b></p> <ul style="list-style-type: none"> <li>2.1 Leadership</li> <li>2.2 Better Care</li> <li>2.3 Sustainability</li> <li>2.4 Better Health</li> </ul> <p><b>3.0 Better Care</b></p> <ul style="list-style-type: none"> <li>3.1 Constitution updates reported by exception</li> </ul> <p><b>4.0 Leadership</b></p> <ul style="list-style-type: none"> <li>4.1 Measurement</li> </ul> <p><b>5.0 Sustainability</b></p> <ul style="list-style-type: none"> <li>5.1 Resource Limit</li> <li>5.2 Acute Contracts</li> <li>5.3 Community</li> <li>5.4 Prescribing</li> <li>5.5 Mental Health</li> <li>5.6 Primary Care</li> <li>5.7 CHC</li> <li>5.8 Other</li> <li>5.9 Savings Plan</li> <li>5.10 Savings forecast delivery</li> </ul>

	<p>5.11 Risks &amp; Mitigations  5.12 Cash drawdown  5.13 BPPC performance  5.14 Income &amp; Expenditure.</p>
<b>Risk Issues:  Original Risk  Residual Risk</b>	The key risks are detailed within the report
<b>Financial Impact</b>	<p>The CCG is forecasting a breakeven financial position for 2019/20, however, there remain net risks to this position of £3.5m and limited time to identify mitigations to this position. The CCG needs to continue to take all actions to identify mitigations to offset these to deliver the financial position.</p> <p>See slides 36-56</p>
<b>Legal Issues (including NHS Constitution)</b>	<p>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.</p> <p>The CCG has set an annual plan to achieve breakeven.</p>
<b>Impact on Health Inequalities</b>	N/a
<b>Impact on Equality and Diversity</b>	N/a
<b>Impact on Sustainable Development</b>	N/a
<b>Patient and Public Involvement</b>	N/a
<b>Recommendation</b>	<p>The Governing Body is asked to:</p> <ul style="list-style-type: none"> <li>• discuss and note the CCG's performance</li> </ul>

	<ul style="list-style-type: none"> <li>• discuss and note the CCG's financial forecast position including the net financial risks, any additional actions and the implications for the 2020/21 budget.</li> </ul>
<b>Author</b>	Katharine Doherty Andrew Beard
<b>Designation</b>	Performance Manager Deputy Chief Finance Officer
<b>Sponsoring Director (if not author)</b>	Mark Walkingshaw – Deputy Accountable Officer Cath Leech - Chief Finance Officer



# Gloucestershire Clinical Commissioning Group

# CCG Monthly Performance Report January 2020

# 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.

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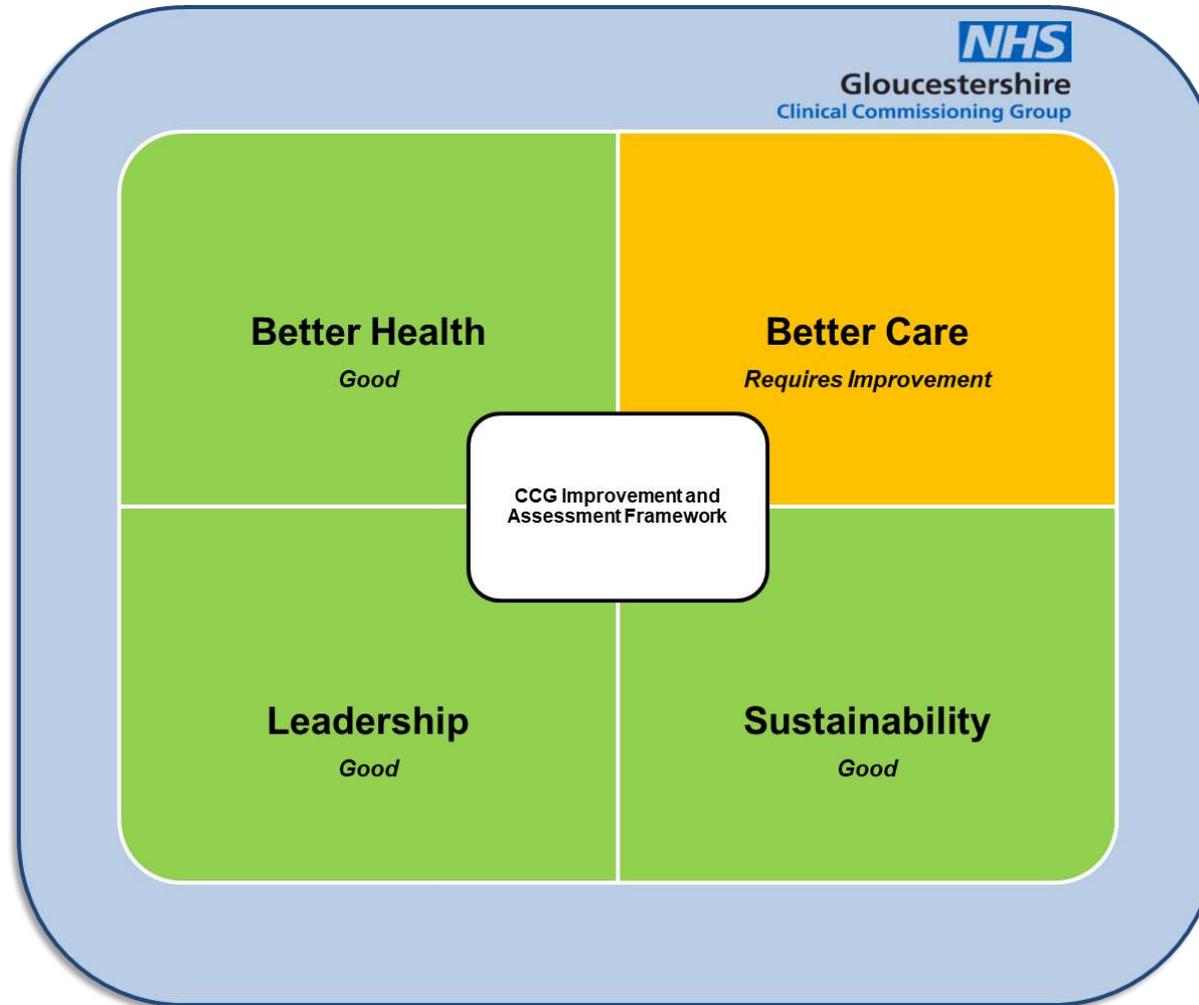
- 4.1 Measurement

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# 1.0 Scorecard: CCG Performance Overview

CCG IAF assessments for 2018/19 were published 11<sup>th</sup> 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 | <b>Staff engagement</b> : Robust culture and Leadership Sustainability (OD Plan)  |
| 2.1.2 | <b>Probity and Corporate Governance</b> : Full governance compliance  |
| 2.1.3 | <b>Effectiveness of working relationships in the local system</b> : Effectiveness of working relationships in the local system              |
| 2.1.4 | <b>Quality of CCG leadership</b> : Review of the effectiveness of culture, leadership sustainability and an oversight of quality assurance. |

## 2.2 Executive Summary – Better Care

Amber

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

## 2.3 Executive Summary - Sustainability

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 (%)	

# 3.0 Performance Dashboard

Amber

<b>Unscheduled Care</b>	4 Hour A&E Dec (System)	4 Hour A&E Dec (GHFT)	Category 1 Ambulance Dec 19 (Gloucestershire)	Category 1 Ambulance YEAR TO DATE (Gloucestershire)	Delayed Transfers of Care (DToC) Nov 19 (GHFT)
	<span style="color: red;">●</span> <b>83.4%</b>	<span style="color: red;">●</span> <b>76.2%</b>	<span style="color: yellow;">↑</span> <b>7.1 mins</b>	<span style="color: yellow;">↓</span> <b>7.1 mins</b>	<span style="color: green;">↑</span> <b>3.28%</b>

<b>Planned Care November 2019</b>	RTT Incomplete <18 weeks Gloucestershire	RTT Incomplete <18 weeks GHFT	RTT 52 week breaches Gloucestershire	RTT 52 week breaches GHFT	Diagnostics >6 weeks (Gloucestershire) (GHFT)	Diagnostics >6 weeks (YTD) (Gloucestershire) (GHFT)	
	<span style="color: green;">↓</span> <b>82.1%</b>	<span style="color: green;">↓</span> <b>81.5%</b>	<span style="color: green;">↑</span> <b>43</b>	<span style="color: green;">↑</span> <b>41</b>	<span style="color: yellow;">↓</span> <b>1.67%</b>	<span style="color: yellow;">↓</span> <b>1.1%</b>	<span style="color: yellow;">↓</span> <b>1.7%</b>

<b>Cancer Dashboard (November 2019)</b>	2 Week Waits	2 Week Waits Breast	31 Day 1 <sup>st</sup> Treatment	31 Day Waits Surgery	31 Day Waits Drugs	31 Day Waits Radiotherapy	62 Day GP Referral	62 Day Screening	62 Day Upgrade
	<span style="color: green;">●</span> <b>94.3%</b>	<span style="color: green;">↓</span> <b>96.0%</b>	<span style="color: yellow;">↓</span> <b>94.8%</b>	<span style="color: yellow;">●</span> <b>92.0%</b>	<span style="color: green;">●</span> <b>100%</b>	<span style="color: green;">↑</span> <b>93.0%</b>	<span style="color: red;">↓</span> <b>66.4%</b>	<span style="color: green;">●</span> <b>96.6%</b>	<span style="color: green;">↑</span> <b>93.8%</b>
	<b>GHFT Performance</b>	<span style="color: green;">●</span> <b>94.6%</b>	<span style="color: green;">↓</span> <b>96.0%</b>	<span style="color: yellow;">↓</span> <b>92.2%</b>	<span style="color: green;">●</span> <b>100%</b>	<span style="color: green;">●</span> <b>100%</b>	<span style="color: green;">↑</span> <b>93.8%</b>	<span style="color: red;">↑</span> <b>63.8%</b>	<span style="color: green;">●</span> <b>96.7%</b>

<b>IAPT (November 2019)</b>	Access (target 1.53%)	Recovery (target 50%)
	<span style="color: yellow;">↓</span> <b>1.44%</b>	<span style="color: green;">●</span> <b>50%</b>

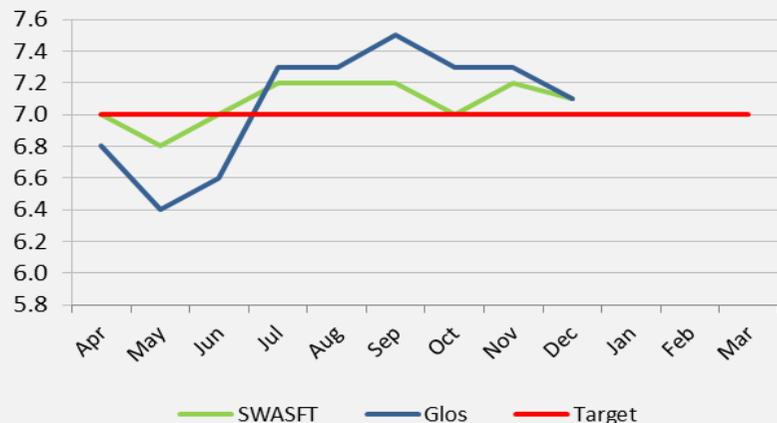
<b>Dementia Diagnosis (November 2019)</b>	Estimated Diagnosis Rate (Target 66.7%)
	<span style="color: green;">●</span> <b>67.8%</b>

*Arrow direction reflects performance from previous month*

# 3.1 System Overview Unscheduled Care

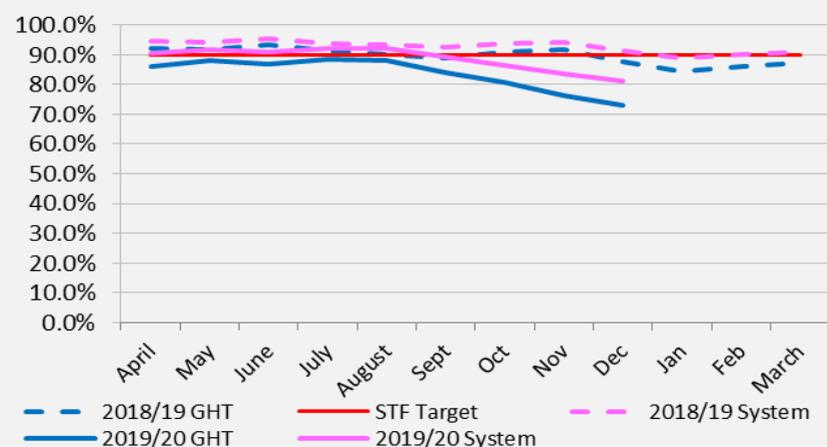
## Ambulance – Category 1

SWASFT Ambulance Cat. 1 Reponse 2019/20



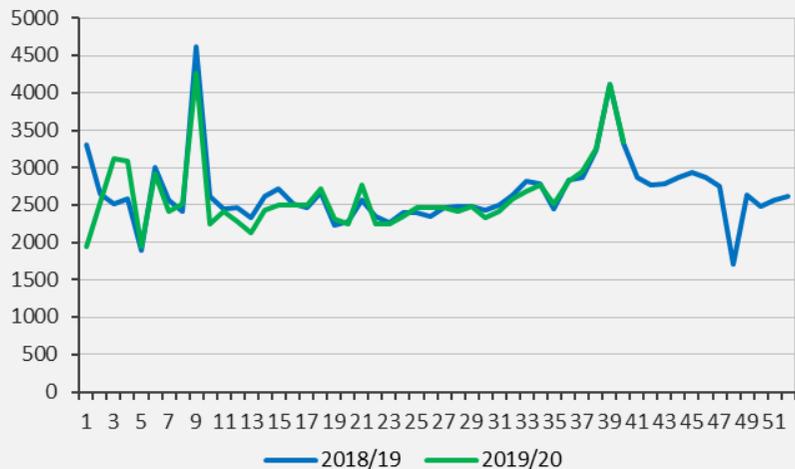
## System A&E 4 hr Performance

A&E 4 Hour - 2018/19 to 2019/20



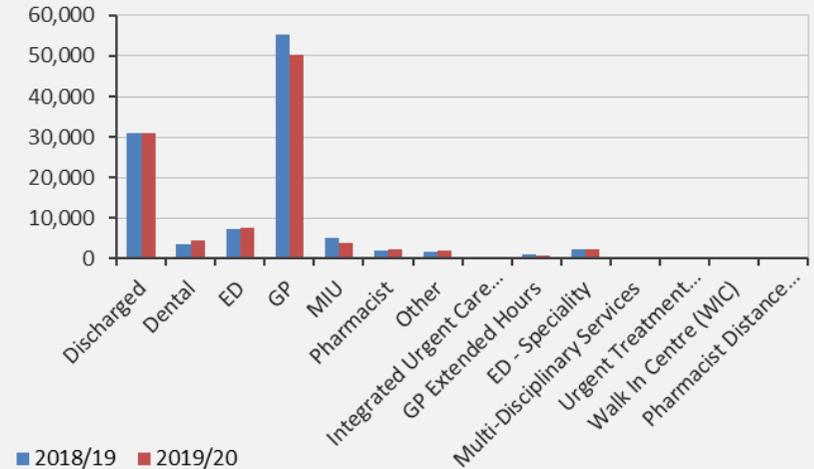
## 111 Call Volume

111 - Number of calls - 2018/19 to 2019/20 (YTD week 40)



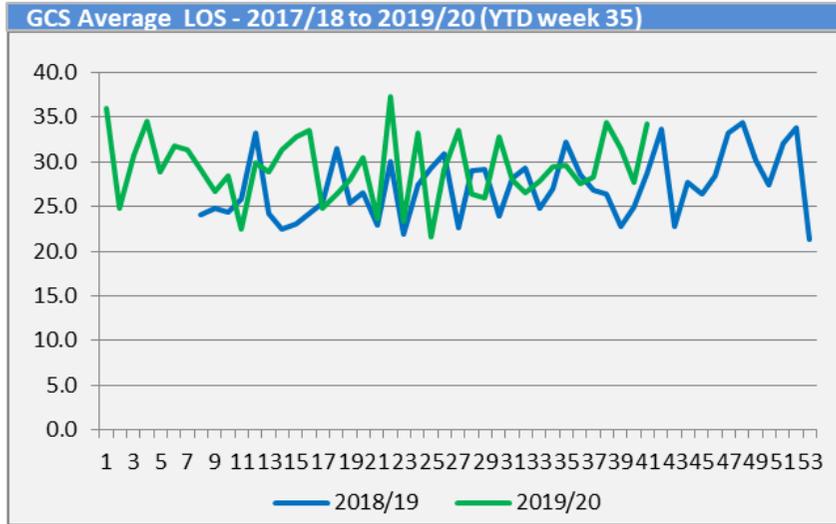
## 111 Disposition

111 Outcome of contact 2018/19 to 2019/20 (Week 40)

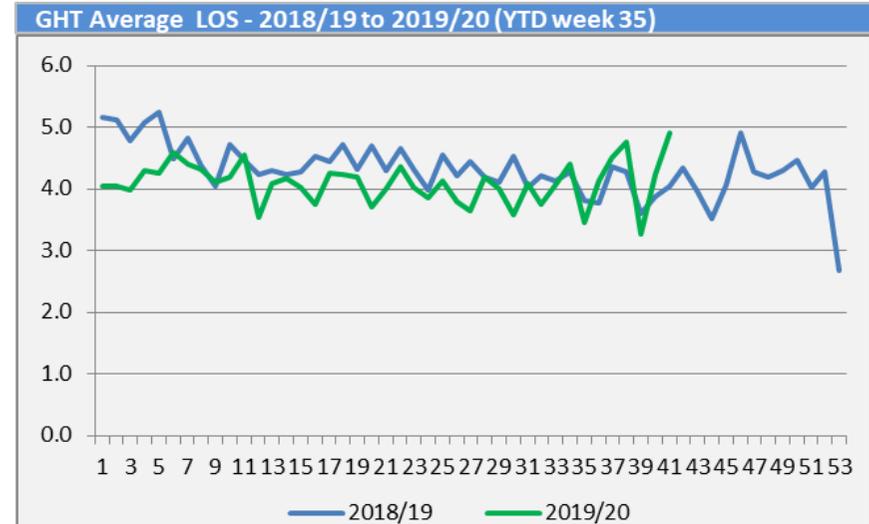


# 3.1 System Overview Unscheduled Care

## GCS average Length of Stay



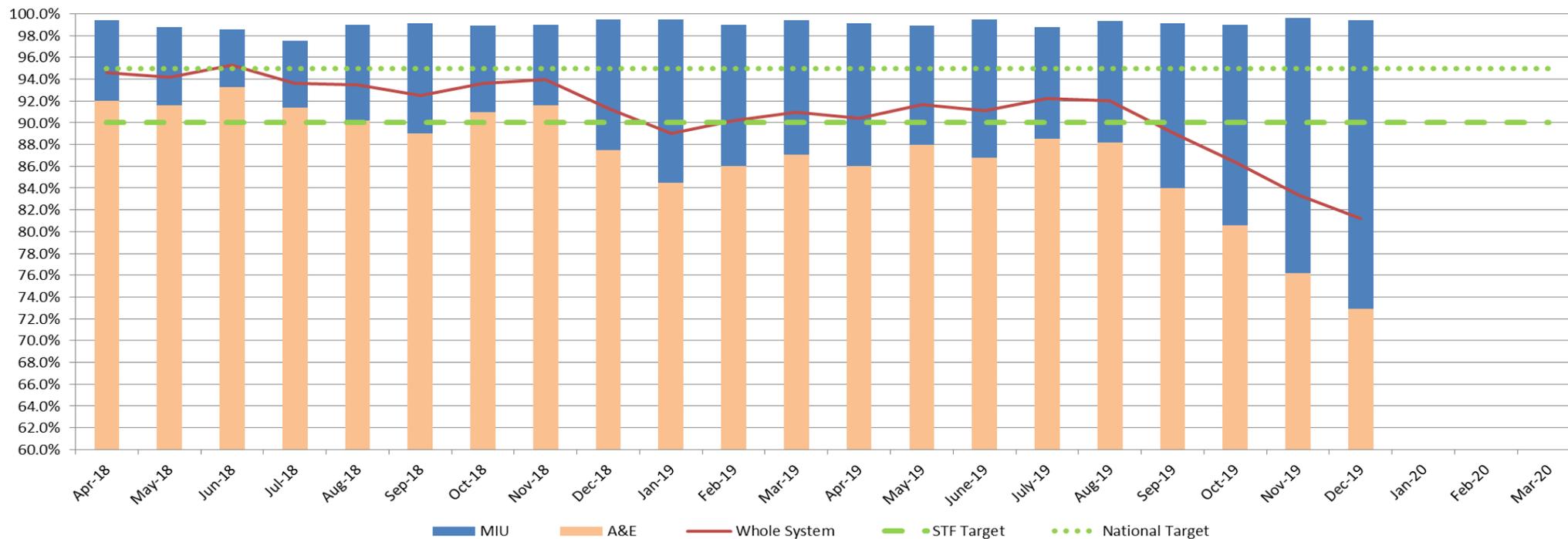
## GHFT average Length of Stay



NB: Weeks 1-7 missing from 2018/19 data due to quality concerns

# 3.1 Unscheduled Care – 4 hour A&E

Red



Gloucestershire whole system performance was 81.2% in December 2019, reflecting performance of 72.9% against the 4 hour target at GHFT and 99.4% across all MIU sites. YTD whole system performance is 88.7% against the 4 hour target, with GHFT YTD performance at 83.5%. The GRH site performance continues to drive the drop in performance seen across the system, however despite some peaks and troughs in activity, there has not been a significant rise in Emergency Department (ED) attendances in December.

There has been a national deterioration in performance against this standard. December performance ranks the Gloucestershire system as 49/119 (Acute trusts with Type 1 activity with their attributed Type 3 activity included).

A five point plan for ED front door to address performance has been agreed :

- Refocus of GP in ED (to back door);
- Enhancing ED streaming and redirection;
- Increasing access to directly bookable appointments, including at MIUs;
- Winter funding allocation for supporting Acute Medical Initial Assessment unit (AMIA) staffing to 11pm;
- Increased use of Cinapsis for medical referrals to ED.

## 3.1 Unscheduled Care updates

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### **Cinapsis (Hot advice from specialty consultants for medical emergency referrals):**

- Contract extension has been agreed/funded by the CCG for 7 months from 1st October 2019 to 30th April 2020 allowing time to fully test and evaluate the service.
- Roll out is complete and Cinapsis is now mandated for all medical referrals into ED from GP practices.
- Initial outcomes suggest patients are increasingly avoiding ED and being directed to assessment units in CGH and GRH; sometimes the following day, improving flow and patient experience.

### **NHS 111:**

- Care UK has received dedicated funding to improve clinical validation of ambulance disposition (Cat 3 and 4 calls) specifically for Gloucestershire and BNSSG patients. This should ensure validation of these calls reaches 95% and should have a significant impact on the number of calls with a 999 disposition outcome.
- December average time to call answer was 83 seconds, reflecting significant delays in answering calls on busy days (especially weekends). Care UK are continuing to focus on training and recruitment to improve staffing resilience to address performance.

### **Out of Hours (OOH):**

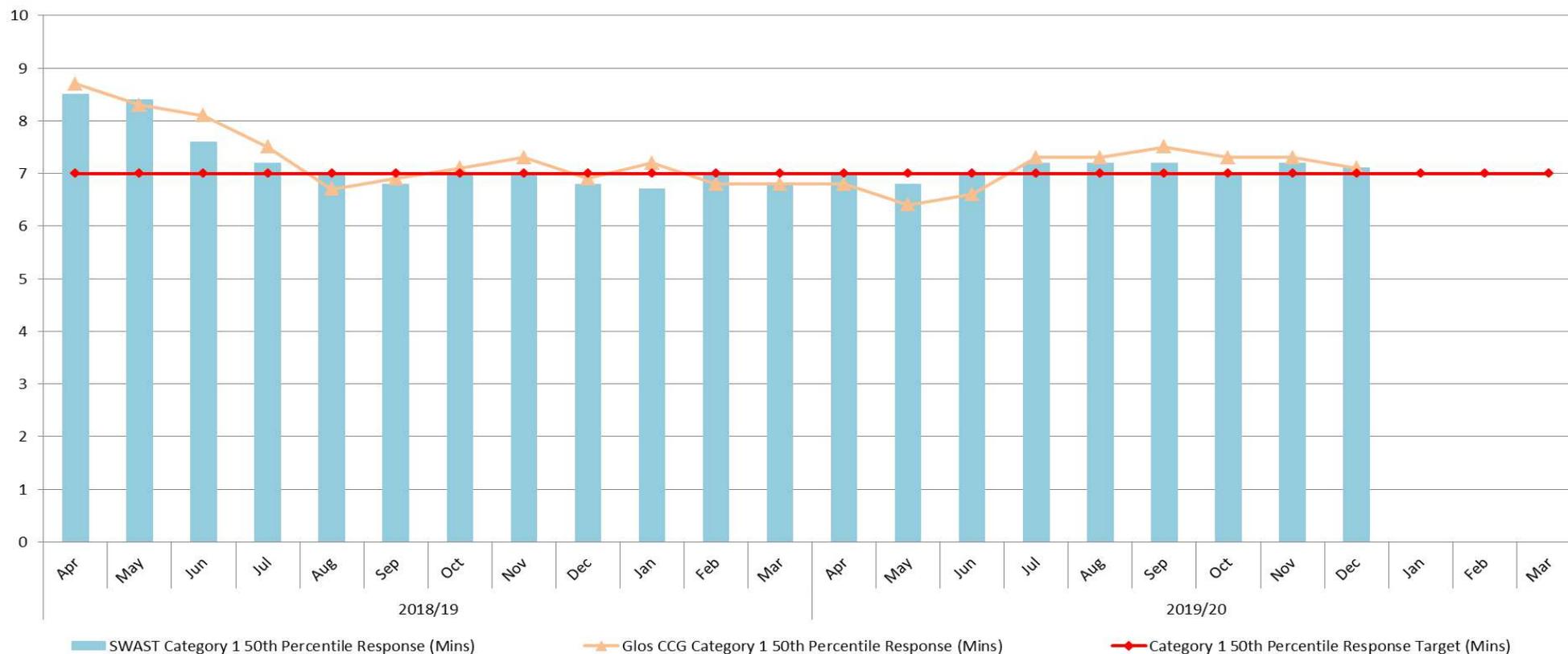
- Performance had been improving in recent months, however Christmas/ New Year shift fill has been challenging and performance is expected to have deteriorated over this period.
- Resilience plans are in place to ensure major acute sites are always covered by OOH.
- Patient pathway for NHS111 booked calls to ensure they attend OOH rather than ED is now in place, and there is work ongoing to ensure that where patients can be appropriately streamed to OOH they are spending minimal time in the ED.

### **Other:**

- “Comfort call backs” for hospital discharges have received NHSE funding to assist in preventing readmission/ re-attendance at ED.

## 3.2 Unscheduled Care – Ambulance Category 1

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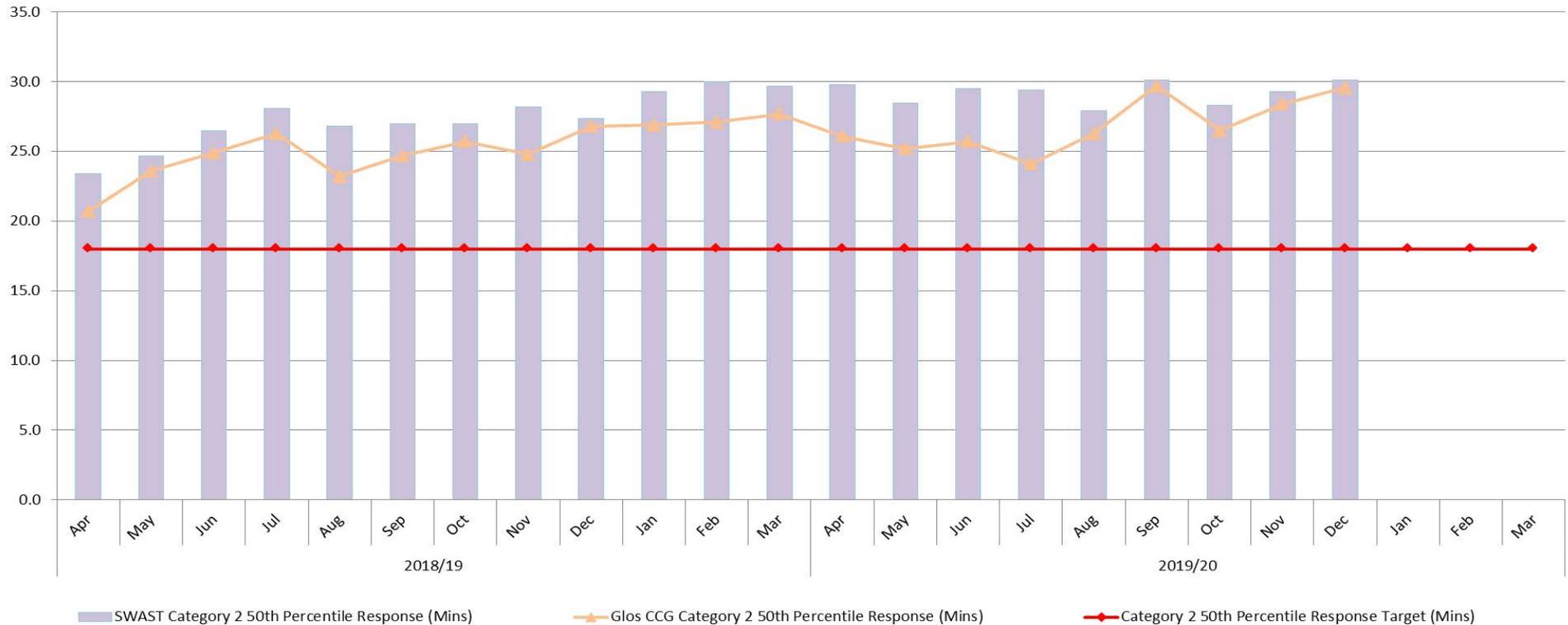


Gloucestershire performance in Category 1 for December 2019 remains just above the 7 minute mark for Gloucestershire on average, with performance at 7.1 minutes. YTD performance across Gloucestershire is 7.1 minutes on average. SWAST Performance across all geographical areas (South West) was 7.1 minutes in December, with yearly average also 7.1 minutes..

Handover delays have increased significantly at both GRH and CGH acute sites with the numbers doubling from those seen at the start of the financial year. SWAST has introduced a Hospital Acute Liaison Officer (HALO) post at GHFT (and all other trusts across the South West) to assist with queue management in the ED over the winter period, and to combat handover delays.

## 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 December 2019 with average time to response rising to nearly 30 minutes in Gloucestershire (and above 30 minutes over the whole SWAST region).

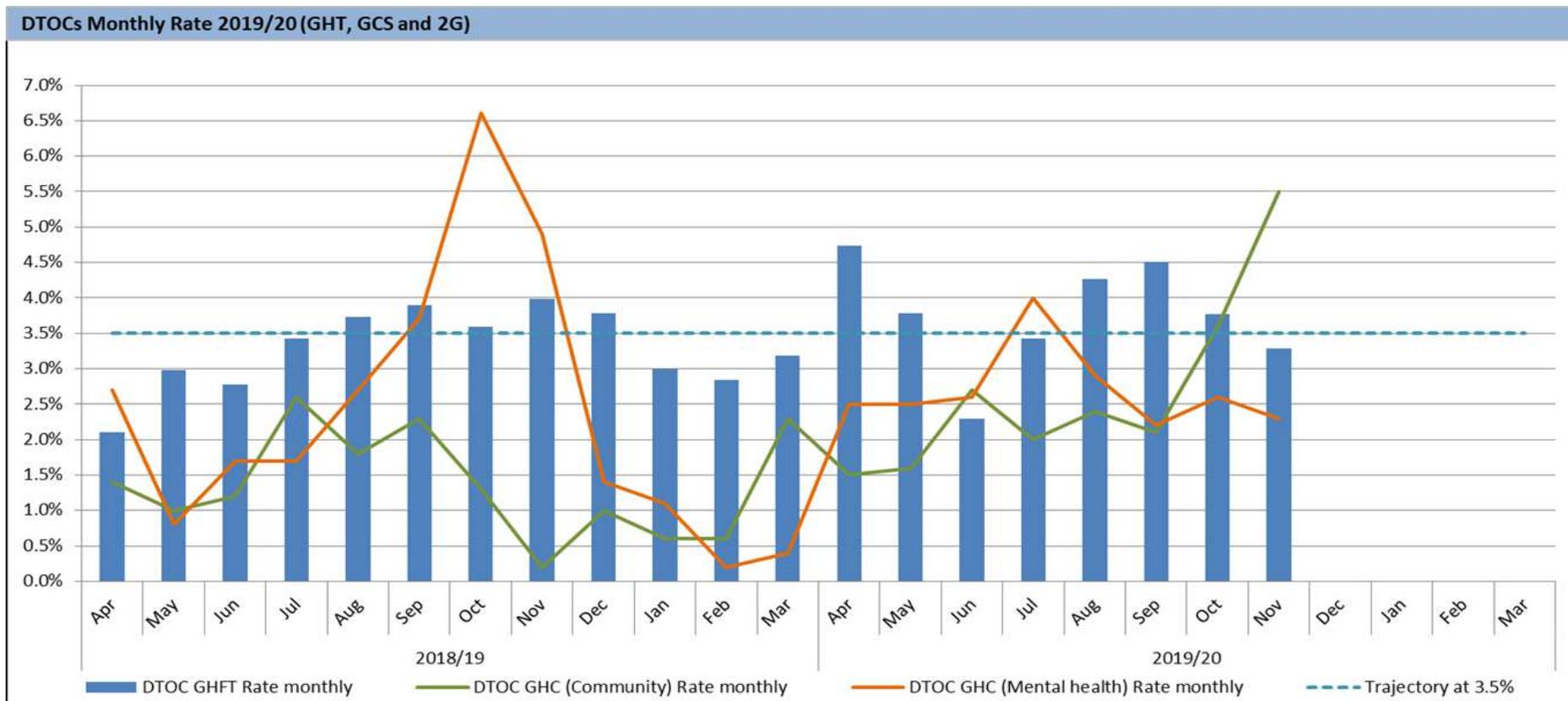
Increased demand on SWAST is putting financial pressure on the CCG as all areas in the South West now are over performing against the 2019/20 contracted plan.

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

# 3.2 Delayed Transfers of Care (DToC)

Green



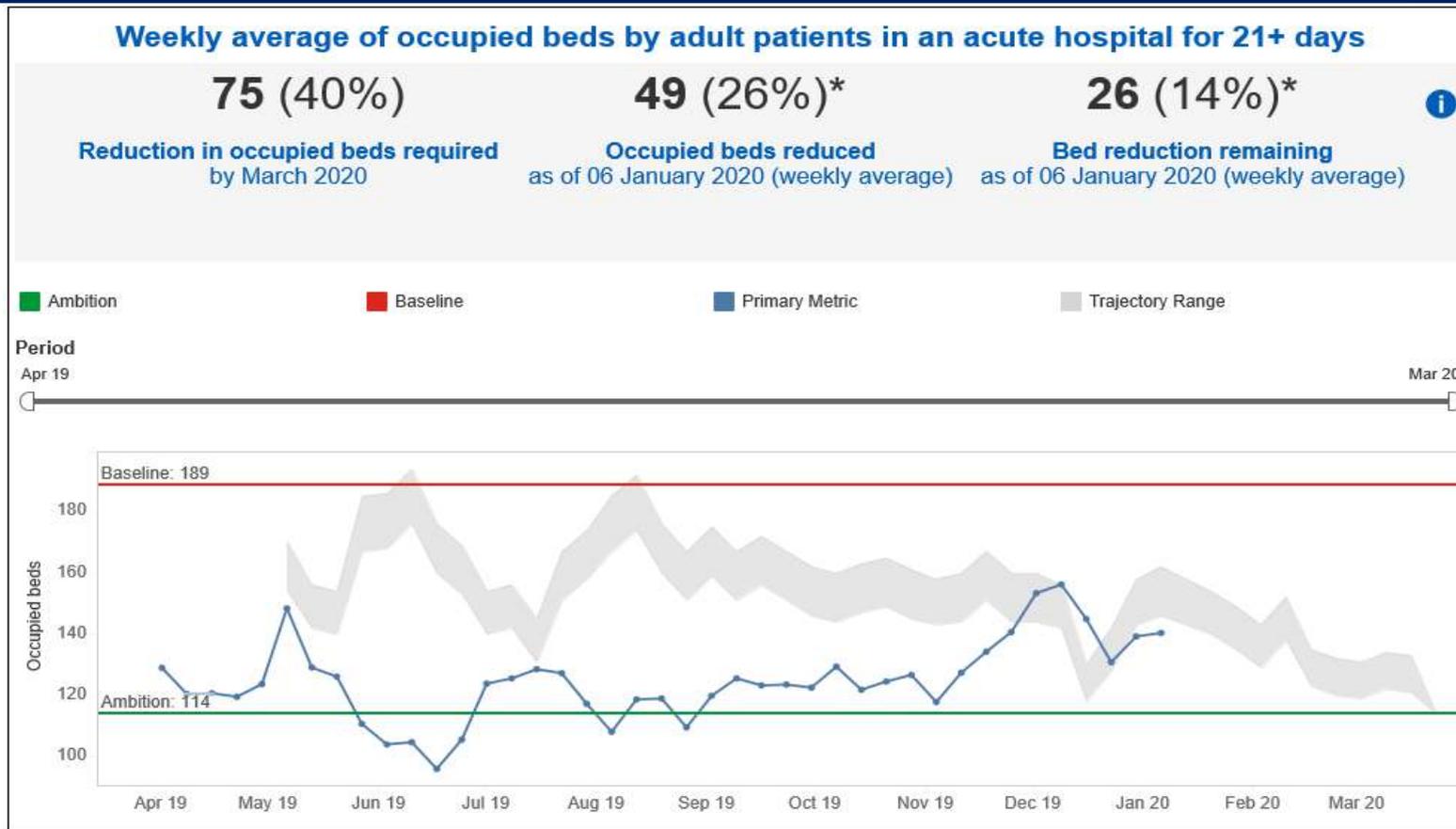
The DToC rate at GHFT has reduced in November 2019 to 3.28%, meeting the 3.5% national target and with an average daily delay of 28. This figure may be artificially low due to the exclusion of closed wards (due to infection control) from reporting.

GHC (Community) DToCs have risen (to 5.5% in November) as a result of a change in reporting, leading to a more accurate account of DToCs in community hospitals (see slide 31).

Work continues in the acute to embed the SAFER bundle (Senior Review, All patients, Flow, Early Discharge, Review) and positive risk taking to improve swift and effective discharge in GHFT acute hospitals. A refresh of the system choice policy is also underway to ensure it can be effectively used to support discharge from all hospitals across the system.

## 3.2 Long Stay (>21 day LoS)

Amber



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.

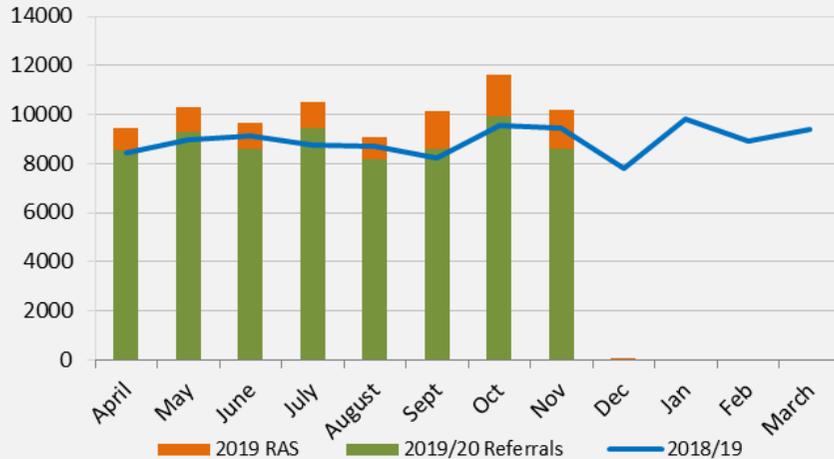
As of the 6<sup>th</sup> January 2019, the weekly average long stay patient figure was 140, which is below the expected trajectory for GHFT and is an improvement on recent weeks. Nationally, patients remaining in acute hospitals more than 21 days has increased in the past two weeks especially so this represents good practice at GHFT, where early review of patients (at 14 days across the board) and embedding positive risk taking have been introduced.

# 3.3 System Overview - Planned Care:

Amber

## Referral Trends

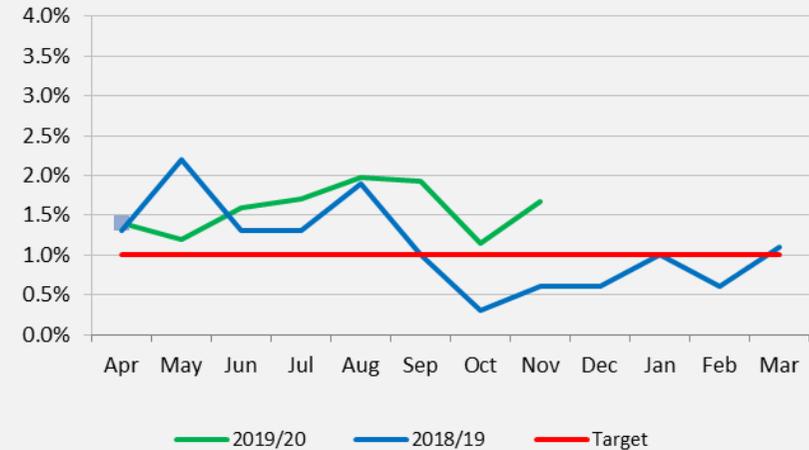
E-referrals - GP Referred - 2018/19 to 2019/20



NB: Referral Assessment Service (RAS) activity now included

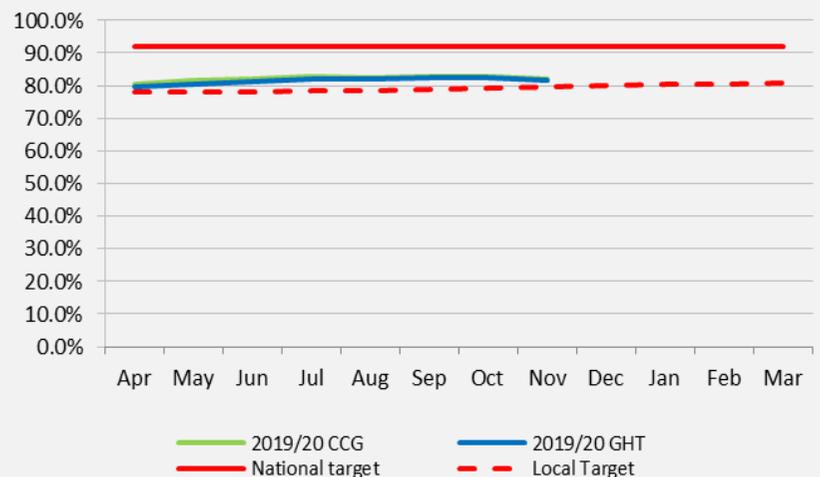
## Diagnostics

CCG Diagnostic Tests - 2018/19 to 2019/20



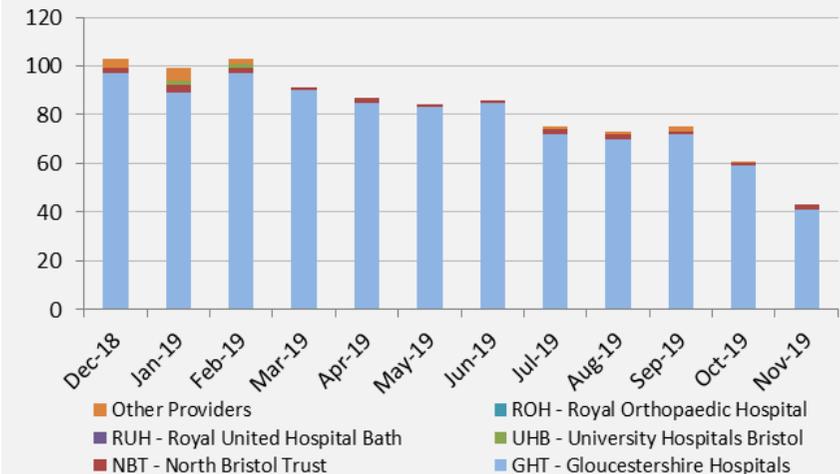
## RTT >18 weeks

RTT Incomplete Pathways - Performance 2019/20



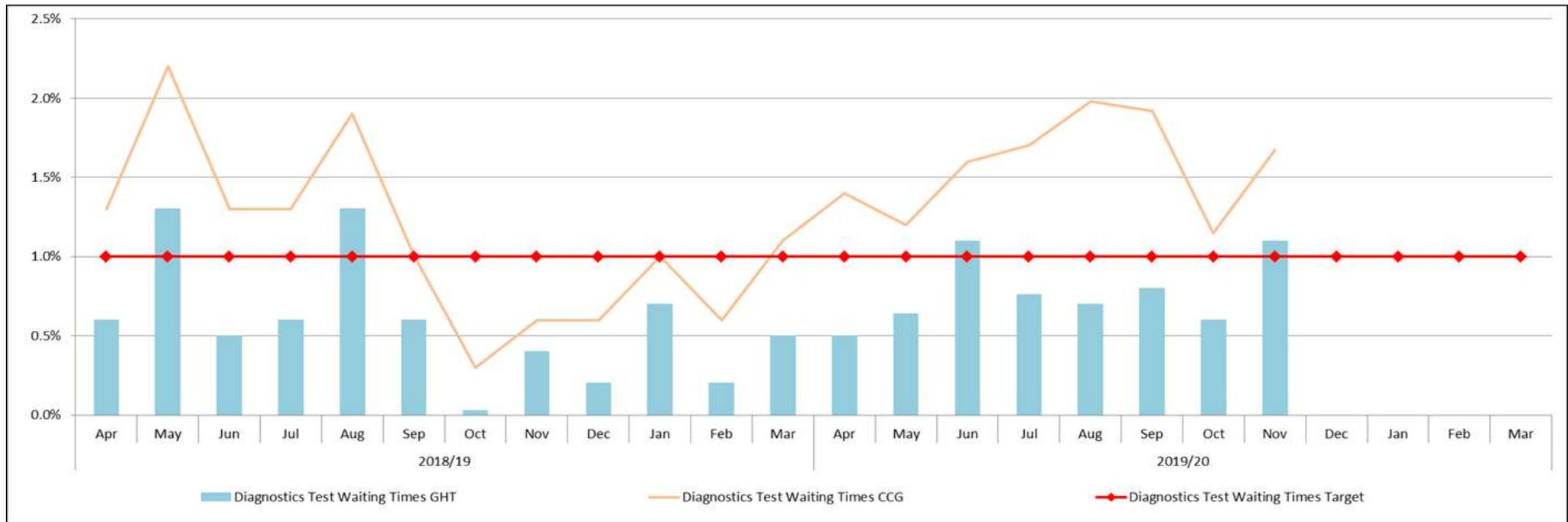
## 52 week waits (RTT)

RTT Incomplete Pathways - Number of Breaches over 52 Weeks



## 3.4 Planned Care – Diagnostics >6 weeks

Amber



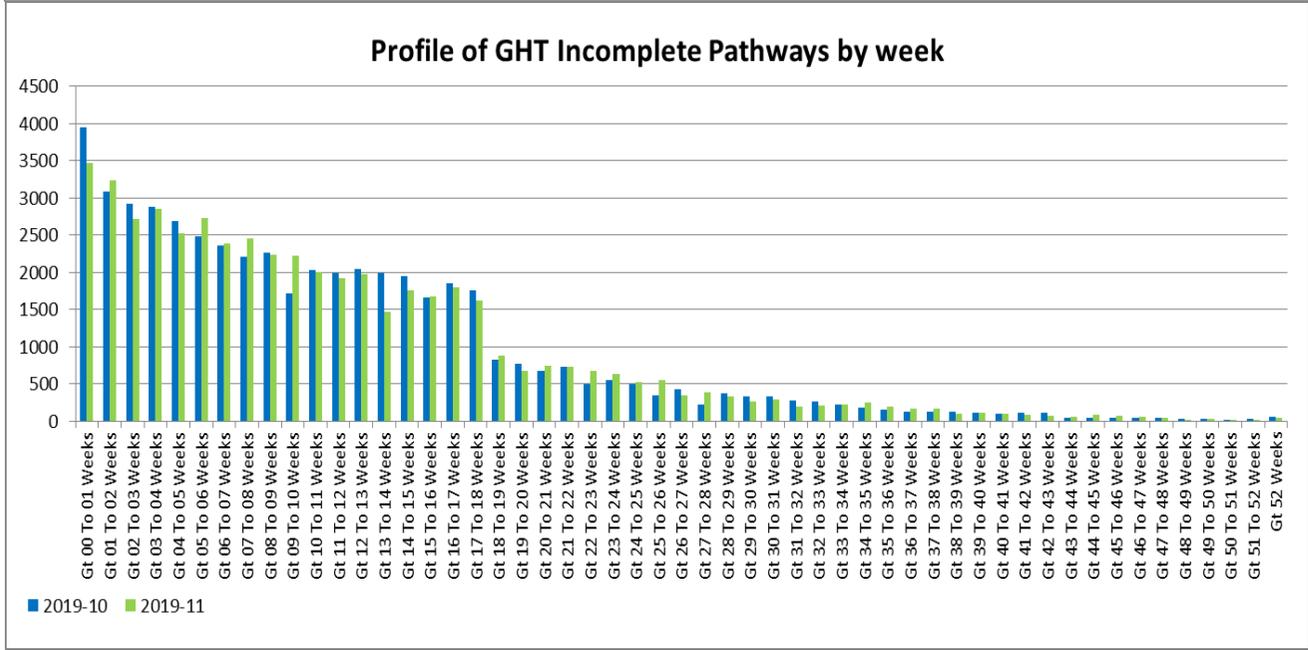
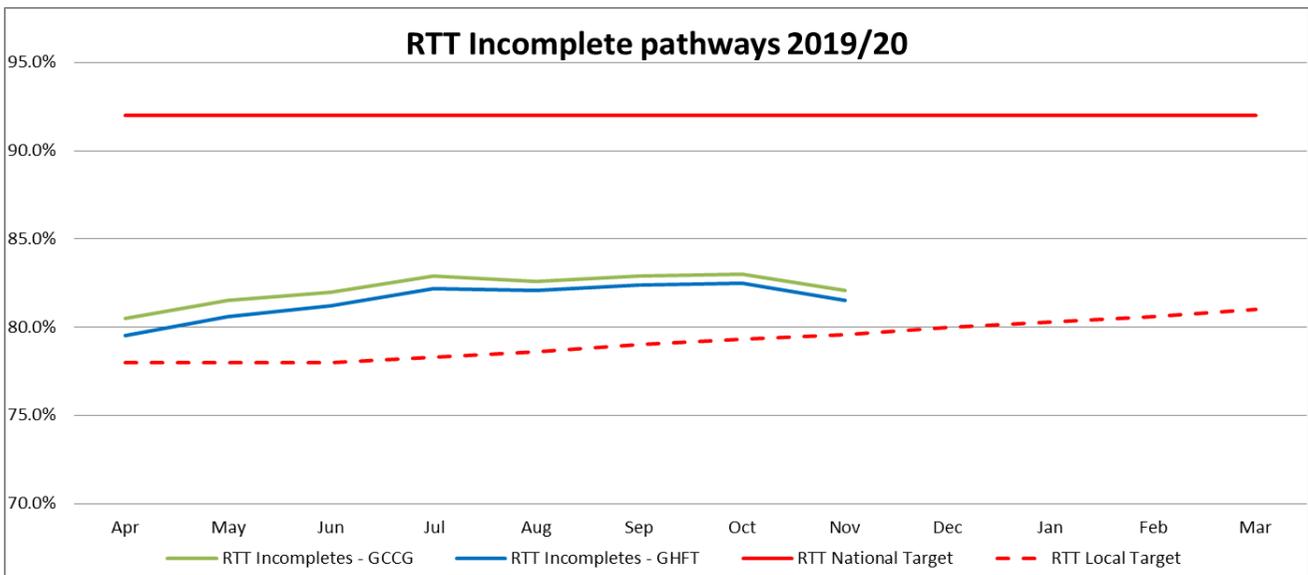
CCG Performance for November was 1.67%, which while still relatively consistent remains above the standard for no more than 1% of patients to be waiting over 6 weeks for a diagnostic test. The performance has declined slightly from October (at 1.15%), primarily as a result of GHFT also missing the diagnostic standard, with their performance at 1.1% for November. There were 165 over 6 week breaches in November 2019 for GCCG patients of which 87 were at GHT (increase of 40 from October when GHFT had only 47 breaches).

Tests with performance failing to meet the 1% standard were Gastroscopy (6.0% - 36 breaches), Flexi Sigmoidoscopy (4.8% - 12 breaches), Colonoscopy (2.6% - 9 breaches), Cystoscopy (2.4% - 1 breach), Peripheral Neurophysiology (2.4% - 3 breaches), MRI (20 breaches), CT (30 breaches), NOUS (1.2% - 45 breaches), and Echocardiography (1.5% - 9 breaches). However, several of the tests were only just over the 1% standard. Gastroscopy performance was a significant deterioration from previous months, with the majority of the breaches at GHFT. Weekend lists and backlog clearance have now been completed so performance is expected to improve in December.

GHC (formerly GCS) performance in Echocardiography has improved from previous months, with no reported breaches in November 2019.

# 3.4 Referral to Treatment (RTT)

Governing Body Part 1 -30/01/20



November 2019 data shows that GCCG incomplete pathways (>18 weeks) stands at 82.1% - exceeding the locally agreed planning target (for November the trajectory was to achieve 79.6%). GHFT performance for November was 82.5%, showing consistent performance above their recovery trajectory for the year. There has been some planned elective cancellation to assist with winter pressures at GHFT; therefore the continued maintenance of the RTT position is positive, along with continued reduction in the delayed to follow up patient numbers.

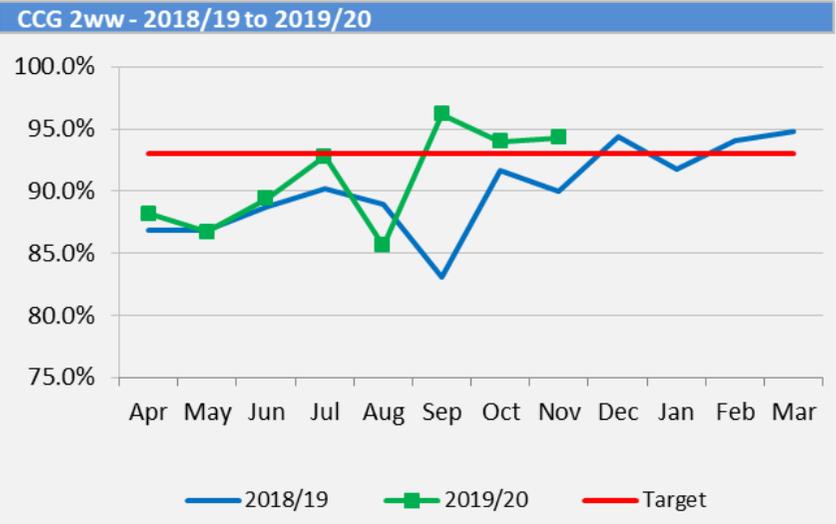
There were 43 fifty-two week incomplete waiters in November 2019 (against a local target of 67): 41 of these were at GHFT across a number of specialties, with the highest number of breaches recorded in Upper and Lower GI surgery and ENT. The two remaining 52 week breaches were at North Bristol Trust in plastic surgery.

Additional funding has been allocated by NHSE to support clearance of the 52 week backlog. GHFT is using this funding to provide additional resource in endoscopy/gastroscopy to free up surgeons time for operations. Additionally, some procedures are being outsourced to “Any Qualified Provider” (AQPs) help free up capacity at GHFT.

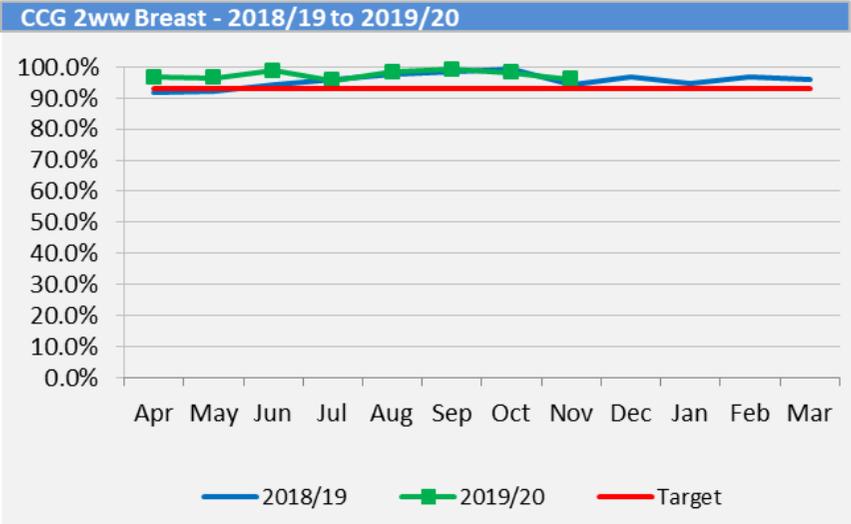
# 3.5 2ww Overview Cancer: November 2019

Green

## 2WW (GP Ref'd)



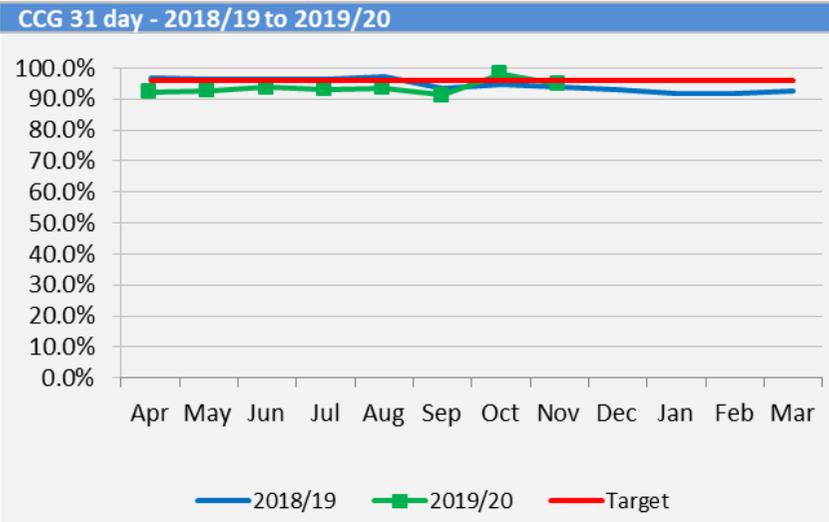
## 2WW (Breast)



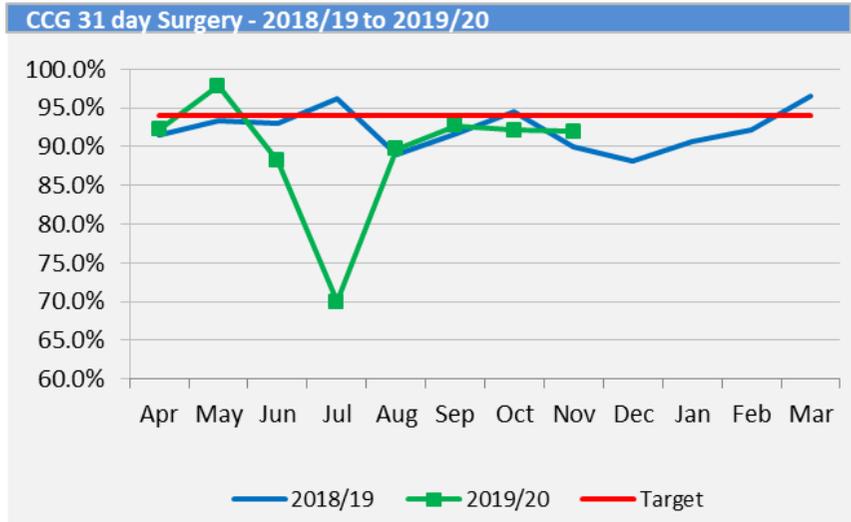
# 3.5 System Overview Cancer: November 2019

Amber

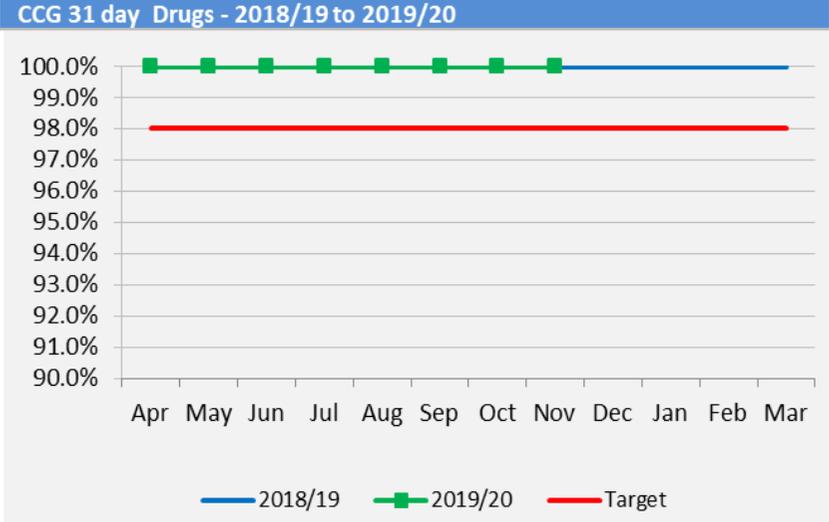
## 31 day



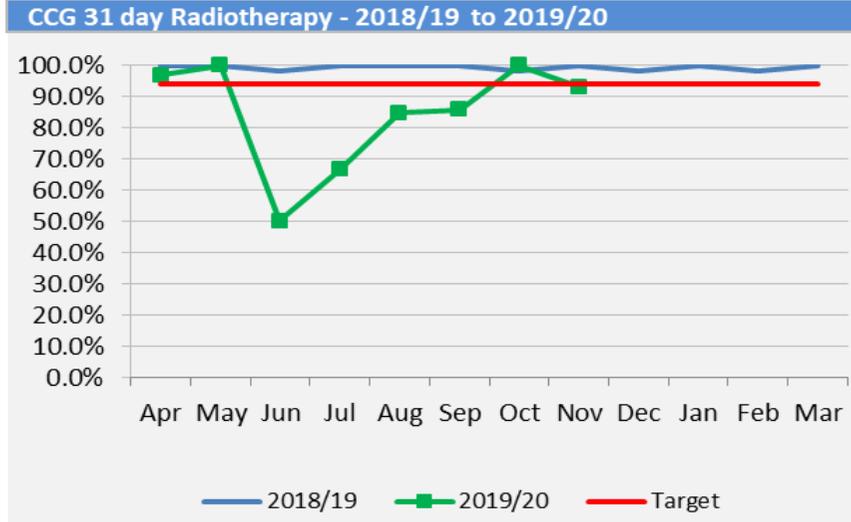
## 31 day subsequent treatm't: Surgery



## 31 day subsequent treatm't: Drugs



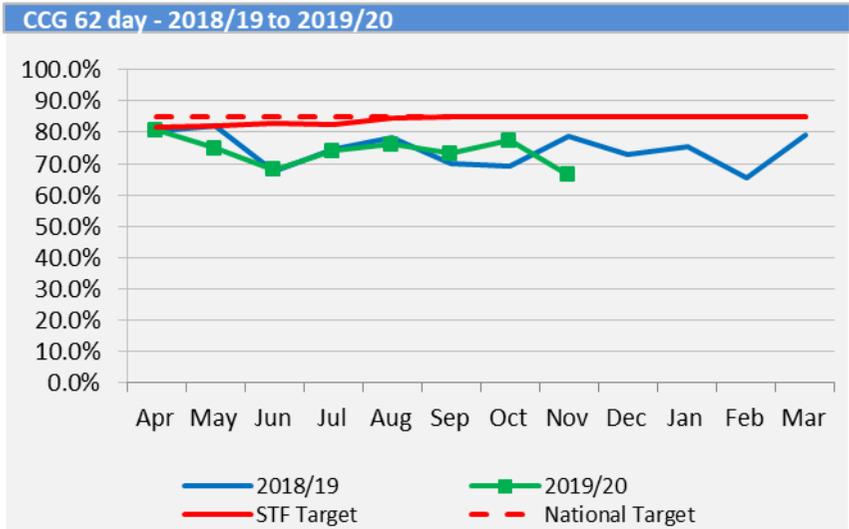
## 31 day subsequent treatm't: Radiotherapy



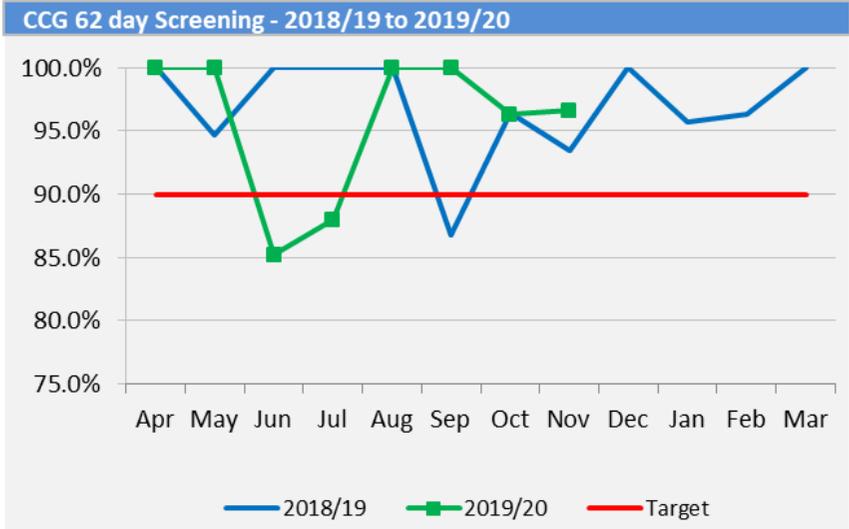
# 3.5 System Overview Cancer: November 2019

Red

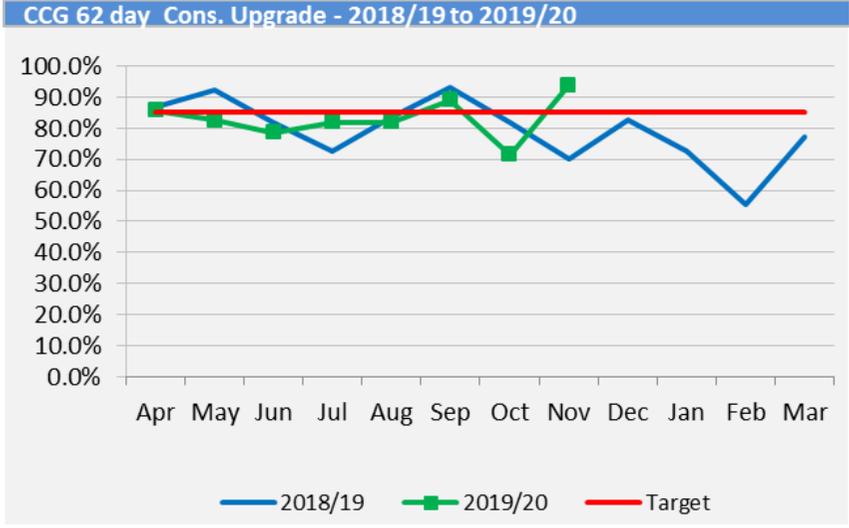
## 62 day: GP referral



## 62 day: Screening

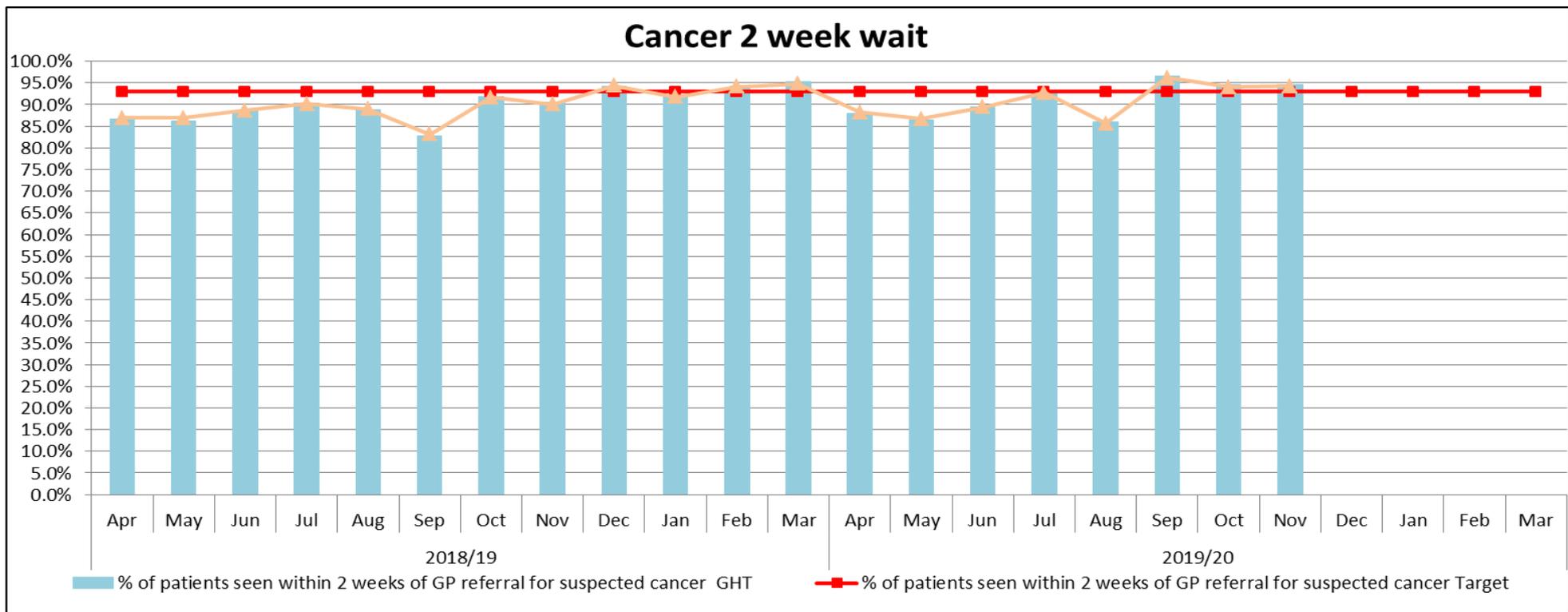


## 62 day: Consultant Upgrade



# 3.6 Cancer – 2 week waits

Amber



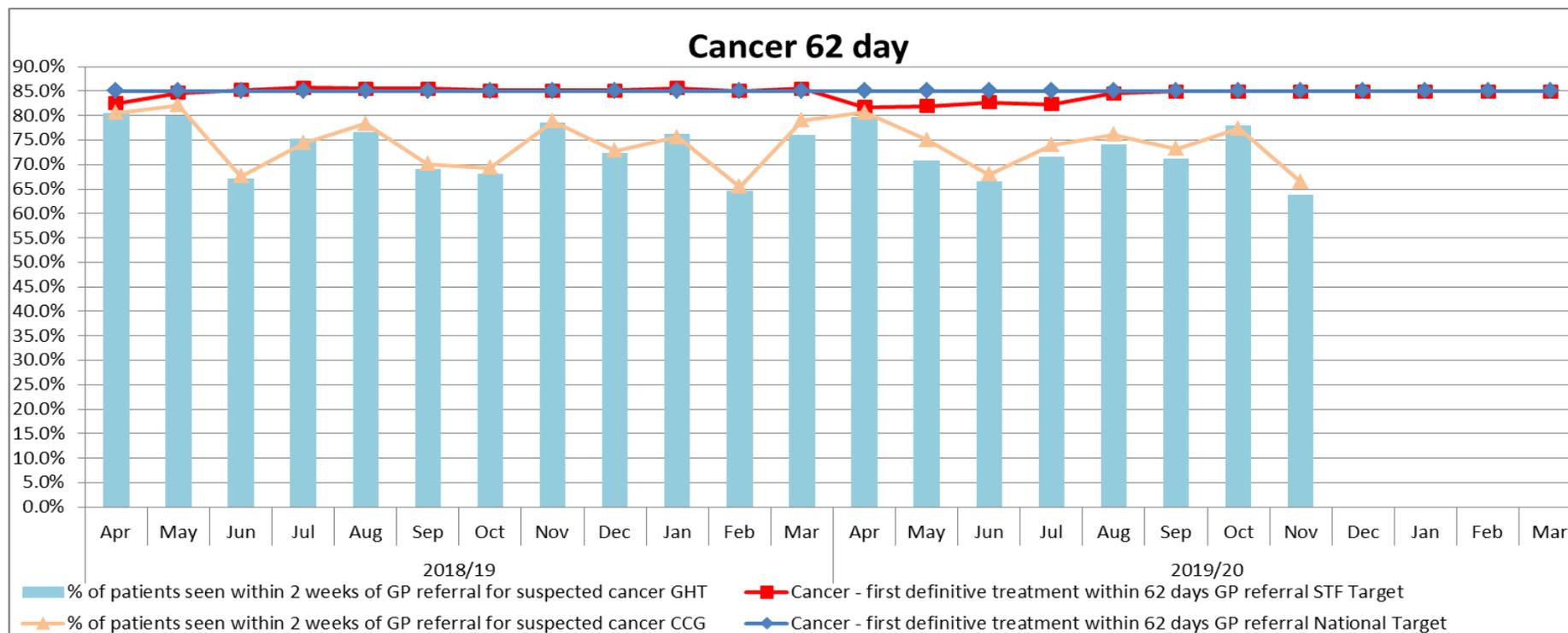
In November 2019, 2 week wait performance continued to be excellent with 94.4% seen within 2 weeks for all GCCG patients, and 94.6% for those seen at GHFT. This achieves the 93% 2ww standard for the third month running, with December performance also expected to meet the target (unvalidated).

Lower GI performance dropped slightly from previous months, however remains much improved on performance seen prior to the straight to test pathway was embedded in the colorectal specialty. There were 2 breaches in 2 week waits for sarcoma patients (out of county referrals) which led to this specialty missing the 2ww target for the CCG, and out of county breaches also contributed to Upper GI performance just missing the 93% standard for GCCG patients (at 92.9%). Actions to support continued delivery of this target include:

- 0-7 day booking being rolled out across specialties – now working on Gastroenterology 0-7 day booking;
- Dermatology referral pathway development project (to support how the system responds to significant variation in demand);
- Continuation of GLANSO lists (additional theatre slots) for Endoscopy

## 3.7 Cancer – 62 days

Red



CCG performance declined from the October position, with November at 66.4% (77.4% in August), failing to reach the target of 85%. There were 41 breaches for CCG patients of which there were 3 in Gynaecology (57.1%), 3 in Haematology (57.1%), 2 in Lower GI (81.8%), 1 in Lung (85.7%), 1 in Other (0.0%), 1 in Sarcoma (50.0%), 3 in Skin (81.3%), 2 in Upper GI (84.6%), 25 in Urology (26.5%).

### 104 breaches

In November 2019 there were 19 104 day breaches for first treatment for GCCG patients; 15 in the Urology specialty, 1 in Skin, 1 Lower GI, 1 Gynaecological, and 1 Haematological cancer patient. GHFT have advised that their backlog of long waiting patients is reducing, though there are still capacity issues within Urology which impacts the ability to fully clear the backlog. They have also highlighted improvements in Upper and Lower GI patient waiting lists, although Head and Neck and Gynaecology waiting lists still remain challenging for delivery of the 62 week target.

## 3.7 Cancer – Actions and updates

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### Programme / Trust –wide actions to improve performance:

GHFT continues to see the impact of Urology specialty breaches on 62 day performance in particular. The majority of breaches, particularly those over 104 days for patient treatment continue to be in Urology, which is a known issue nationally. GHFT are implementing a RAPID Urology pathway to improve time taken in each step of the pathway which will help to improve both the long waits in the specialty and adherence to the 62 day standard for total treatments.

### Additional actions:

- Lead cancer nurse post now in operation following retirement of previous post holder.
- Upgrade to Infoflex (cancer patient administration system) now operational.
- Recruitment of radiology and pathology pathway coordinators instigated.
- Continued review of primary care referrals by the referral improvement project team to identify patterns and reduce variation.
- Deep dive analysis into individual patient breaches underway at GHFT 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 Patient Treatment List (PTL) management, escalation, and breach management.
- Meeting held between Radiology and Endoscopy departments at GHFT to explore implementation of a straight to CT pathway following an endoscopy where suspicion of oesophageal cancer results.

### Faster Diagnosis Standard:

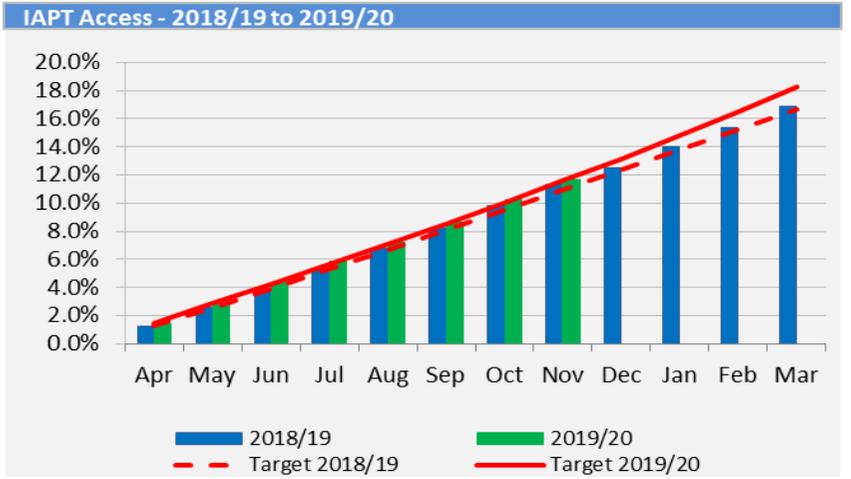
Reporting to 28 day (referral to diagnosis) targets is due to commence nationally from March 2020, reflecting the countrywide focus on improving faster diagnosis.

Shadow reporting of this standard is currently being carried out, ahead of full implementation for 2020/21.

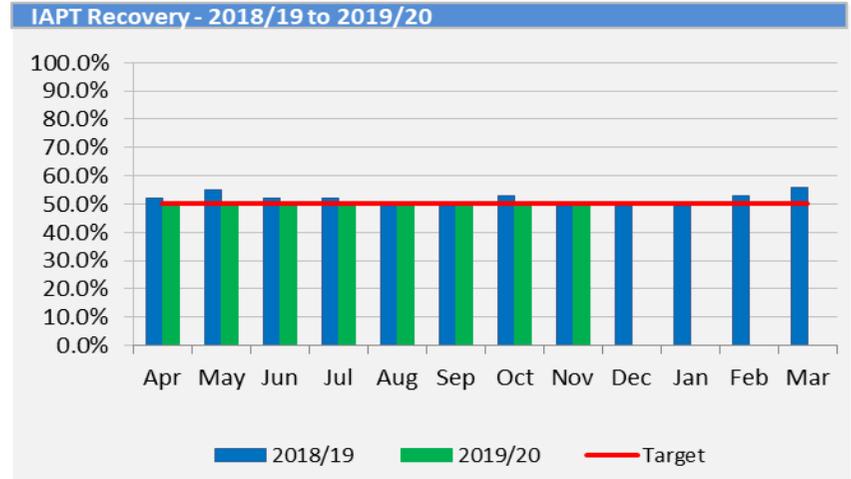
# 3.8 System Overview: Mental Health - IAPT

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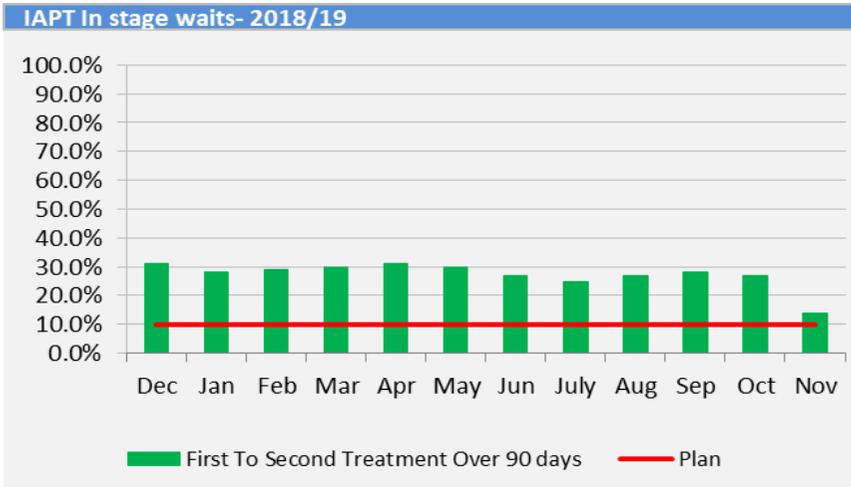
## Access



## Recovery



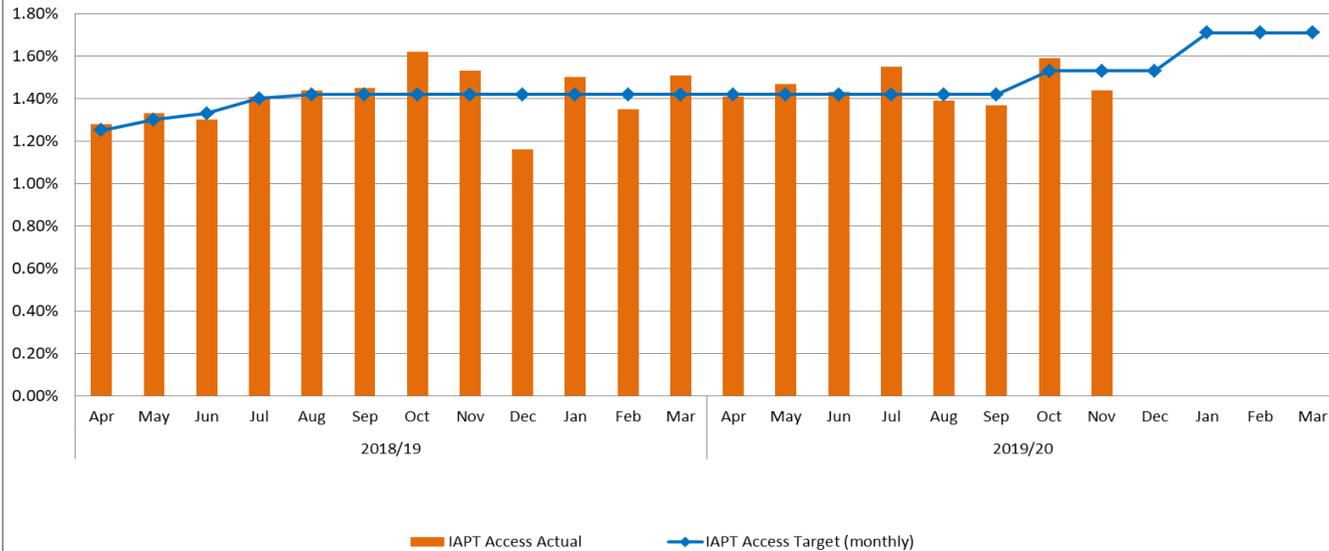
## In-Stage Waits



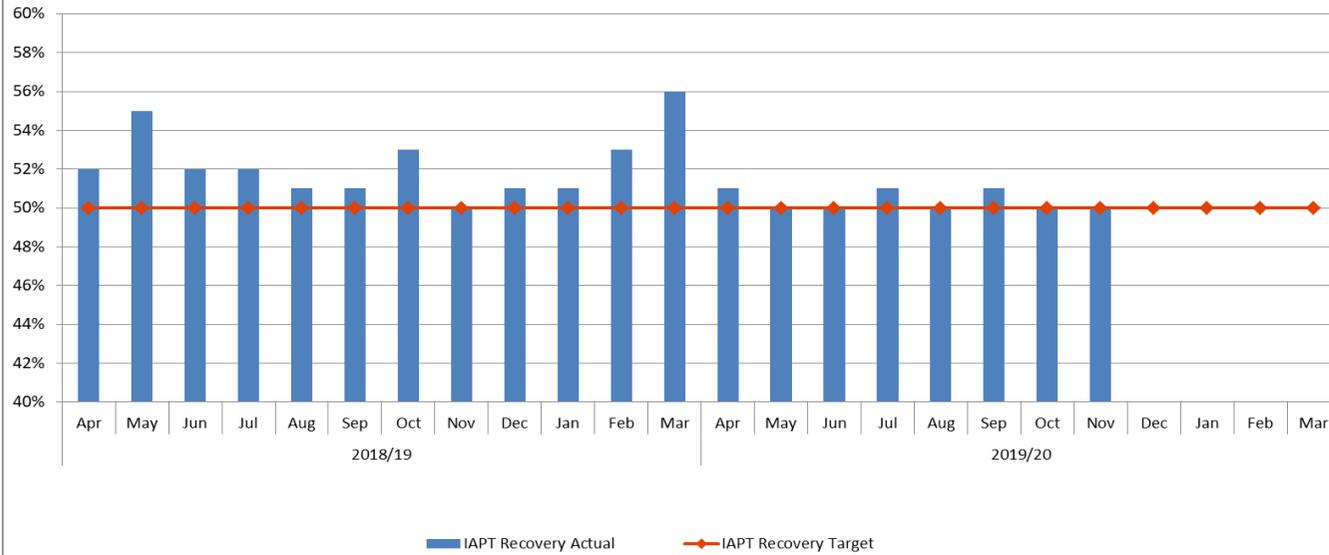
# 3.8 Mental Health - IAPT

Green

Improving Access to Psychological Therapies (IAPT) Access Rate



Improving Access to Psychological Therapies (IAPT) Recovery Rate

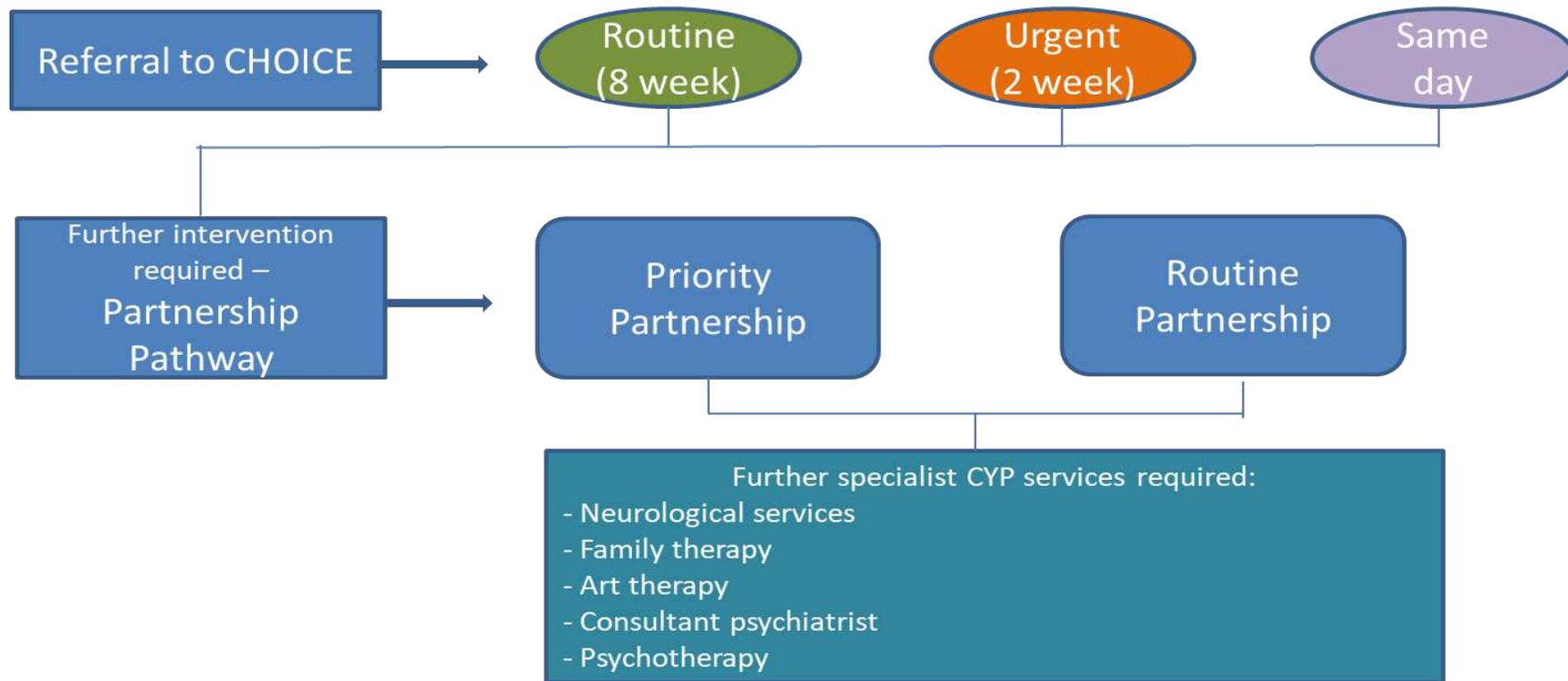


Recovery performance has been excellent throughout 2018/19, with the 50% target being met in each month; latest performance for November 2019 is 50%.

The Access target had 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). From October onwards, the access trajectory will increase by the equivalent of 1% annually, to reach 18% cumulatively (or 4.5% for Q3). While below the national access target of 19%, the service has met the local trajectory cumulatively though to September (at 17%) and is on track to meet the Q3 target despite performance against the access target dropping slightly in November to 1.42%.

November has seen a significant reduction in those patients waiting more than 90 days for a second appointment, with the backlog expected to reduce further by the end of the financial year.

# CYPS – Referral and waiting times



The average waiting time for a CHOICE initial assessment (first contact) is currently 9 weeks (though urgent cases are seen more quickly).

The waiting time for a Partnership first treatment (second contact) appointment has also increased over the past 12 months due to staff being attracted to work in the Trailblazer programme, increase in demand and complexity and staffing challenges at middle grade nursing nationally. Average waiting times rose to over 12 months, but this has now come down significantly to around 9 months (current wait time of 39 weeks). Waiting times for both assessment and treatment are predicted to reduce as new staff are inducted and maternity leave ends (see slide 28).

# CYPS – Waiting times



Demand and Capacity modelling forecast indicates:

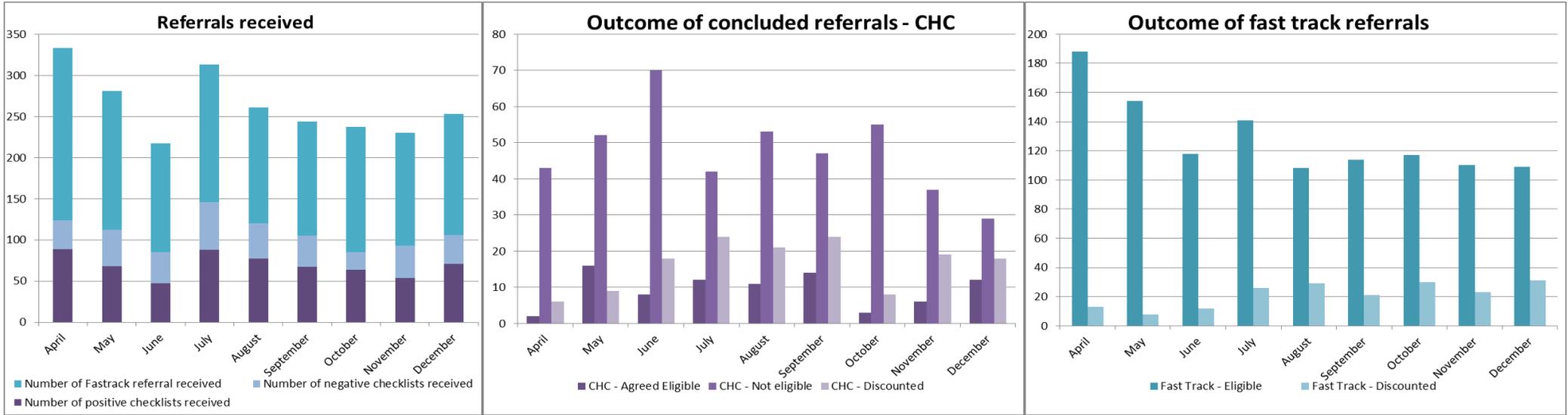
- By March 2020 there should be no patients waiting over 18 weeks;
- Recovery of waiting times to between 4 to 6 weeks for referral to treatment may be achieved by September 2020.

This assumes that demand is stable for the service, and that all planned staff recruitment/ retention strategies are successful.

All children and young people presenting with high risk needs are seen as a priority and are treated in a timely manner. Children requiring an urgent appointment are usually seen within the same day. There is an escalation process in place that families are informed about if their child's symptoms worsen.

# 3.9 Continuing Health Care (CHC) – Referrals

Amber



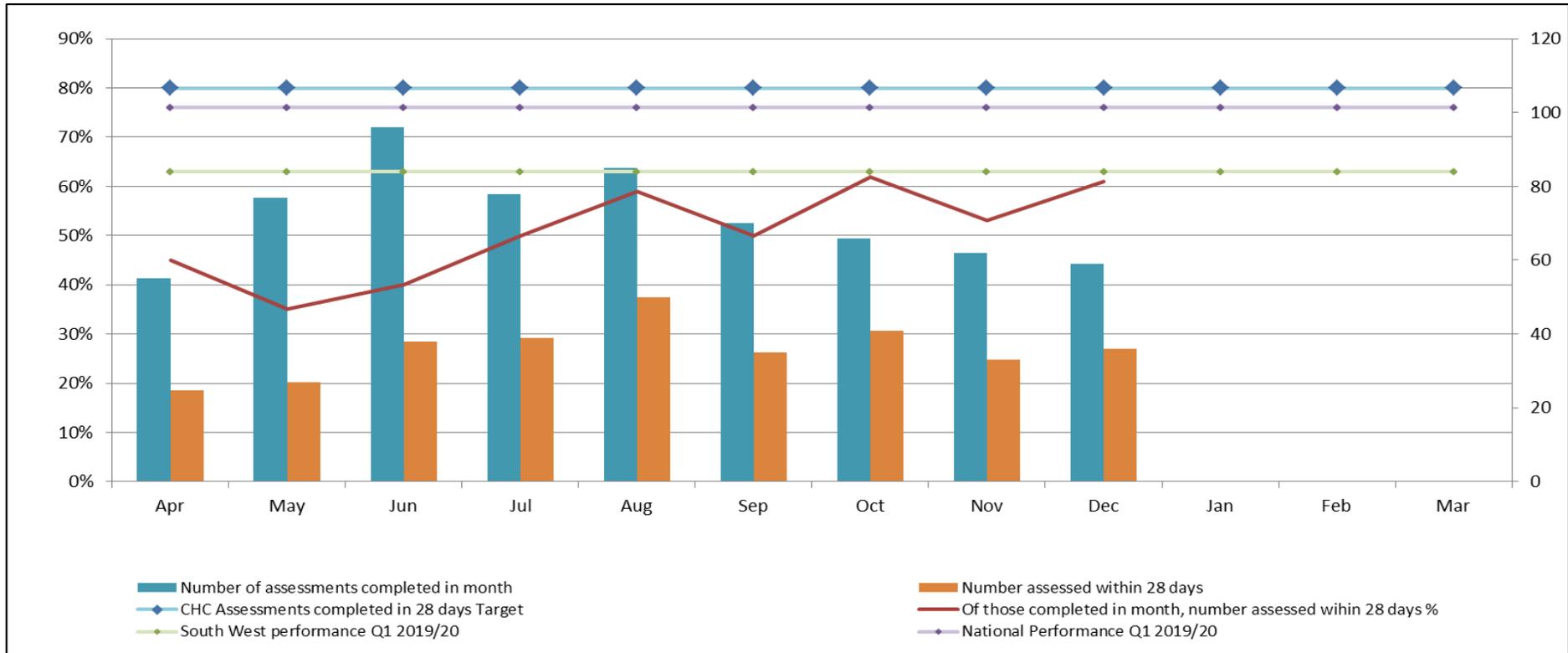
Referral numbers continue to average above 2018/19 figures, though numbers appear to have stabilised and have remained consistent since August 2019. The CHC team are still 100% compliant against the location of assessment standard (where CHC assessments are not carried out in acute hospitals apart from in exceptional circumstances).

Referral quality continues to be an area of concern, with an increase in both positive checklist (CHC) and Fast track referrals that are discounted.

Fast track activity has remained high: Gloucestershire is an outlier in the rate for Fast track funding provided. Reviews of patients remaining on Fast track longer than 12 weeks have been prioritised by the team – especially as many patients receiving Fast Track funding for more than 12 weeks are found not to be eligible for CHC funding and have stabilised. To date, 77.7% Fast Track patients reviewed after 12 weeks were found to be no longer eligible for Fast Track funding or full CHC funding (some may convert to Funded Nursing Care).

### 3.9 Continuing Health Care Assessments completed in 28 days

Amber

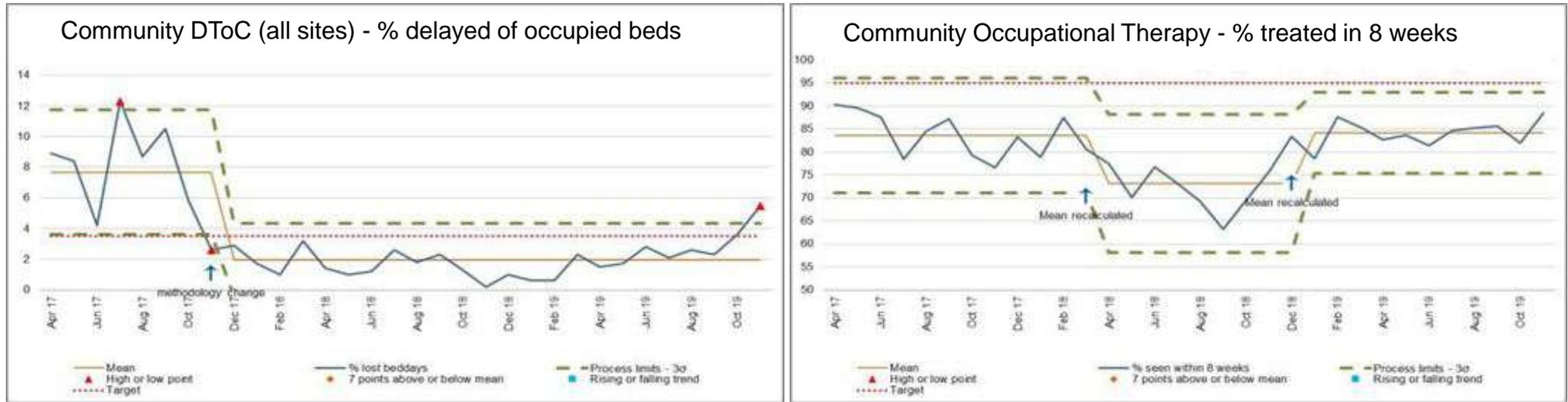


Performance remains below the 80% target for assessments to be carried out within 28 days of referral; however performance has been improving throughout 2019/20 and latest target compliance is 61% (December 2019). This contributes to a much improved quarterly average performance, rising close to the regional average which is the internal target for the CHC team for 2019/20. The team continue to work towards reducing the backlog of people waiting for assessment or review.

Actions to support performance include:

- Local authority assessor and agency staff in place to support backlog reduction.
- Improved communication and contact between brokerage and care homes.
- Additional learning disability agency nurse assessors and focus on long waits for assessment and review.

## 3.9 Gloucestershire Health and Care – Community Services



### Delayed Transfers of Care

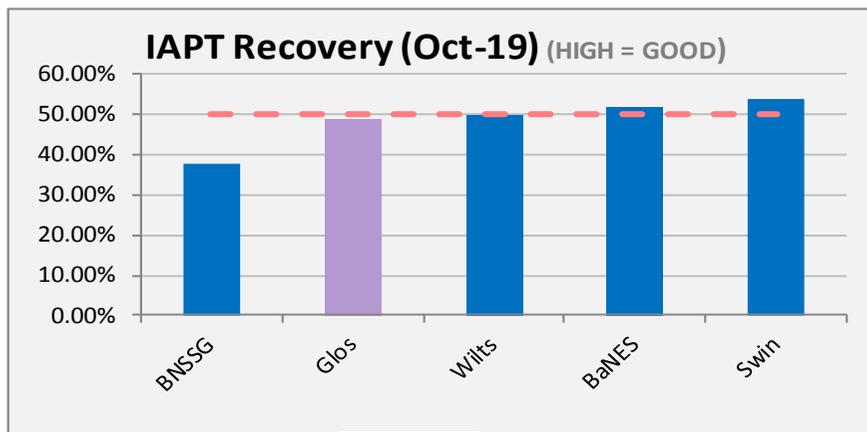
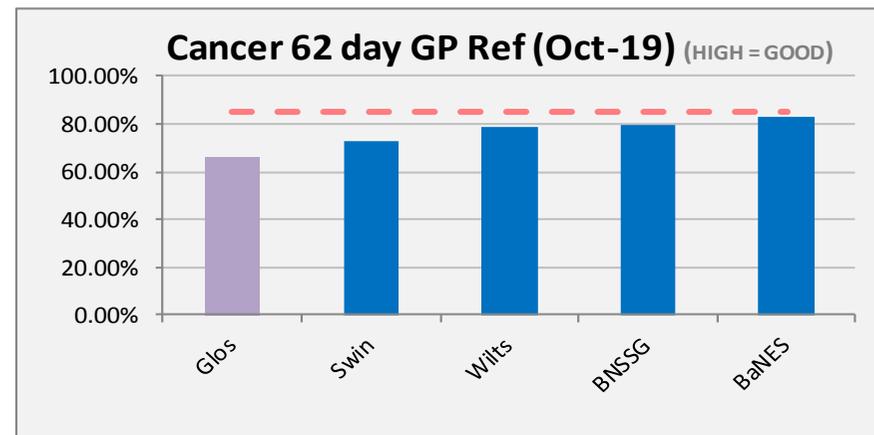
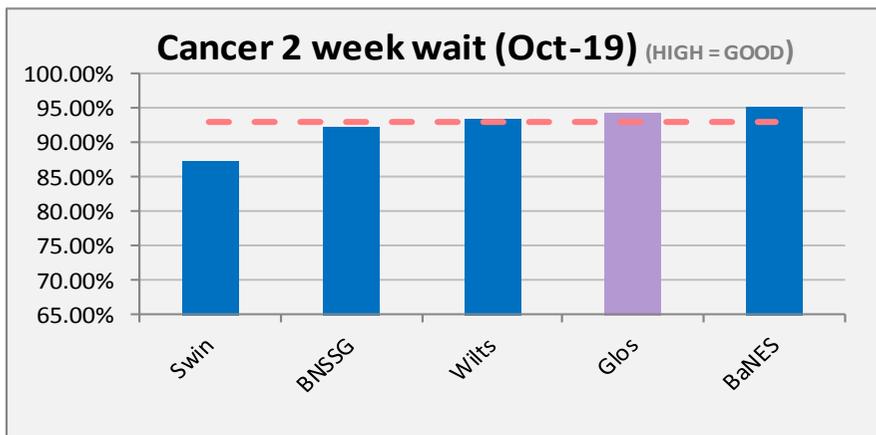
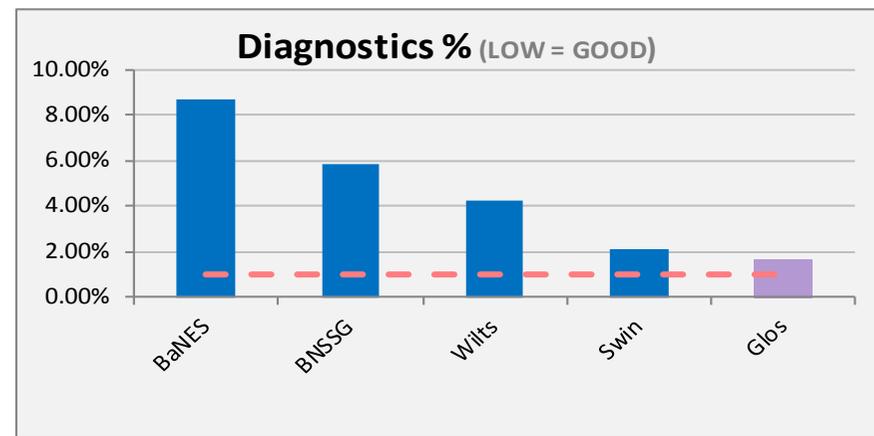
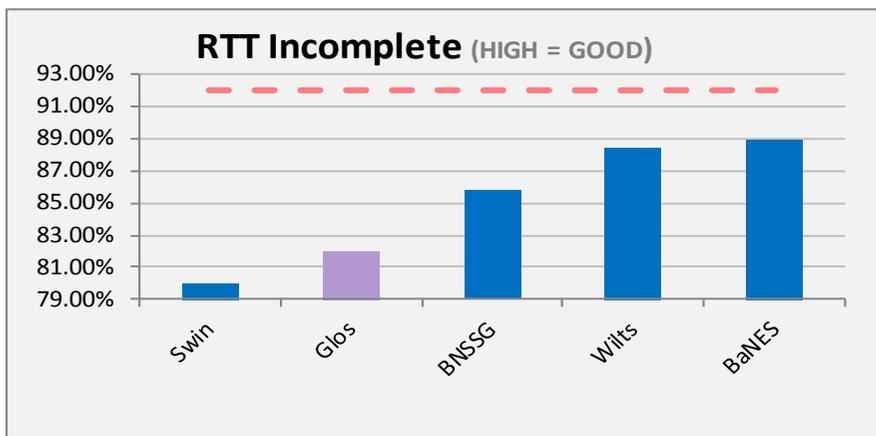
- DToC rates have risen at GHC, reflecting more accurate and robust reporting against this target. In particular Stroud and Forest of Dean hospitals reported delays in excess of 3.5% due to the presence of a dedicated discharge coordinator ensuring all delays are accurately recorded and reported.
- DToCs are monitored and escalated as appropriate both internally and externally with other partner organisations, with all stays of over 30 days reviewed. GHC is currently moving to review of all patients after 21 days to improve length of stay and DToC positions.

### Occupational therapy (OT)

In the first 8 months of 2019/20, the OT service saw 65.7% of people within 4 weeks of referral. 95% of people seen year to date were seen within 13-14 weeks. When the activity in the referral centre is included, November performance increases to 93.3%.

- Staff vacancies (especially more junior positions, in particular localities) have impacted the services ability to meet the 8 week target. To improve this, the service has secured staff on temporary contracts and is recruiting additional locums.

# 3.11 Regional Comparison – November 2019



Green

Indicator	Component Measure	Narrative
<b>Staff and member practice engagement</b>	OD Plan Staff Survey Turnover Vacancies Sickness PDP/Training	<p><b>Turnover Rate:</b> The report highlights that turnover for December 2019 was 16.63% and remains stable since November which recorded the same figure it was 17.19% in October and is on a downward trajectory.</p> <p><b>Staff in Post:</b> Staffing levels for Dec - 299 FTE equating to a total headcount of 364.</p> <p><b>Starters and leavers.</b> There was only 1 new starter in December and 3 leavers. Over the past 12 months there have been 61 leavers (47.38 FTEs) and 62 starters (52.19 FTEs)/</p> <p><b>Leavers by Reason:</b> There were 61 leavers over the 12 month period, the main reason for leaving over the last 12 months – 23 leavers due to Promotion, 6 leavers due to retirement and 8 due to work life balance.</p> <p><b>Sickness Absence Rate:</b></p>

Green

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

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

# 5.0 Sustainability - Month 09

Amber

Income and Expenditure	YTD surplus	FOV surplus	YTD Running costs	FOV Running costs
In Year	● £0k	● £0k	● £0k	● £0k
Cumulative	● (£16,102k)	● (£21,470k)	● (£71k)	● £0k

Savings Programme	YTD Savings	% YTD Savings	FOT Savings	% FOT Savings
	● £12,781k	● 89.4%	● £15,480k	● 89.6%

Other Metrics	BPPC	Cash drawdown	FOT Capital
	● 97.92%	● 76.3%	● £0k

## 5.0 Sustainability – Executive Summary

- Gloucestershire CCG set an in year plan of breakeven; this included savings of £17.3m and a number of non recurrent financial measures to achieve the plan. The risk assessment for the initial plan was high risk.
- The CCG, following a number of conversations with NHSEI is reporting an in year breakeven financial position; this follows a very detailed review of all commitments and potential additional allocations. This is entirely dependent on ongoing in year actions to mitigate the overspends that have emerged.
- The CCG assesses monthly the overall financial position to determine whether adequate mitigations exist to manage within a nil net risk position. However, pressures are continuing to emerge which, at this stage are unable to be offset by mitigations. This has resulted in the CCG revising net risk to £3.5m (Nov 19: £7.5m net risk).
- The main overspends within the position relate to : CHC and placements (primarily learning disabilities), primary care prescribing and drugs excluded from tariff. Some mitigations have also reduced following review.
- The prescribing forecast continues to be £3.5m overspent with additional risks reported of c£0.25m 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 latest draft of the ICS five year system plan submitted in mid-January 2020.
- Gloucestershire ICS has jointly reviewed its forecast outturn for 2019/20 and is continuing to report achievement against control total across the system, however, risks to achievement have been highlighted to Boards and NHSEI.
- Savings plans are showing under delivery in year, there are some mitigations in place for some through risk sharing agreements with providers, however, this does not cover all slippage. Further plans are continuing to be developed to help mitigate the overall financial position.

## 5.1 Sustainability – Resource Limit

The CCG's confirmed allocation as at 31<sup>st</sup> December 2019 is £937.6m.

The following allocation transfers were actioned in December,

£'000	Rec/ Non Rec	Description
731	Non Rec	MH Trailblazer in schools/CYPS 4 week wait (final instalment)
125	Non Rec	Community MH (final instalment)
111	Non Rec	Additional Elective Winter Funding
57	Non Rec	Diabetes Transformation - MDFT/SE (3 <sup>rd</sup> instalment of 4)
55	Non Rec	MH Winter Funds
59	Non Rec	NHS111 Clinical revalidation
609	Non Rec	System Winter Funding (first instalment)
91	Non Rec	Q2 Flash Glucose sensor reimbursement
7	Non Rec	GP appointment booking enablement
20	Non Rec	MOCH – Medicines Optimisation in Care Homes (3 <sup>rd</sup> instalment of 4)
(405)	Rec	Transfers to specialised commissioners (UH Bristol & BBT)
<b>1,460</b>		<b>Total change in month</b>

## 5.2 Sustainability – Acute Contracts (1 of 3)

<b>Acute NHS Contracts</b> <b>Key</b>  Indicates a favourable movement in the month  Indicates an adverse movement in the month	Trend	Year end Forecast £'000
<p><b><u>Gloucestershire Hospitals NHS Trust (GHNHSFT)</u></b></p> <p>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 overspend reflects continuing pressures on the drugs budget, this has decreased by £186k this month. This is now fully included in the overall position with no additional potential risk identified.</p> <p>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.</p>	↑	3,689.7
<p><b><u>University Hospital Bristol NHSFT</u></b></p> <p>Monitoring, based on eight months of data, shows continued underspends in the following areas:</p> <ul style="list-style-type: none"> <li>• non elective inpatient admissions in cardiology</li> <li>• drugs costs for Adalimumab and homecare drugs</li> </ul>	↓	(474.5)
<p><b><u>Oxford University Hospital NHSFT</u></b></p> <p>The position has remained consistent with the previous month with overspends within most areas of the contract including:</p> <ul style="list-style-type: none"> <li>• Elective activity for cardiology, general surgery, obstetrics and clinical haematology, pancreatic surgery and trauma &amp; orthopaedics (T&amp;O)</li> <li>• Non elective in cardiology, T&amp;O, colorectal surgery and Hepatology</li> </ul>	↔	700.0

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

Acute NHS Contracts	Trend	Year end Forecast £'000
<p><b><u>Great Western Hospital NHSFT</u></b>                      The position continues to show an underspend with a further improvement to the position. Underspends are within key areas of:</p> <ul style="list-style-type: none"> <li>• Under-performance in non-elective activity continues in general surgery.</li> <li>• Elective activity primarily within T&amp;O</li> <li>• The forecast anticipates the underspend will not continue and breakeven is forecast for the remaining months of the year.</li> </ul>	↑	(400.0)
<p><b><u>Winfield Hospital</u></b>                      November activity continues to show a continued increase in both the volume and the complexity of referrals. A risk has been included regarding the potential for this increase to be sustained for the remainder of the financial year.</p>	↓	911.3
<p><b><u>Wye Valley Hospital</u></b>                      The community contract is showing underspends within podiatry but this is being offset by day case overspends and increases in community hospital medical inpatients. The Acute contract is also overspending within most areas including planned care and emergency care activity.</p>	↔	181.0

## 5.2 Sustainability – Acute Contracts (3 of 3)

Acute NHS Contracts	Trend	Year end Forecast £'000
<p><b><u>Non Contract Activity (NCA)</u></b></p> <p>The forecast is based on an average rolling cost for the last 3 years and activity for the first 6 months is £348k higher than last financial year mainly due to critical care for several providers such as:</p> <ul style="list-style-type: none"> <li>• Imperial College London</li> <li>• Isle of Wight</li> <li>• Hillingdon</li> <li>• Hull</li> <li>• Weston Area Health</li> </ul> <p>Recent increases in Critical Care costs have driven the increase in the forecast outturn in the current month.</p>	↓	500.0
<p><b><u>Any Qualified Provider Contracts</u></b></p> <p><b>Newmedica</b> – substantial increase in activity above the planned level for the initial months of the year, and activity is still increasing. Currently reporting a £554k overspend.</p> <p><b>Oxford Fertility</b> – £337k overspend relates to an increase in the number of patients accessing treatment and some slippage in the planned savings.</p> <p><b>Care UK</b> - £103k overspend relates to recent increases in the activity general surgery, trauma &amp; orthopaedics and gastroenterology specialties</p>	↓	1,218.0

## 5.3 Sustainability – Community

Acute Contracts	Trend	Year end Forecast £'000
<p><b>South Western Ambulance Services NHSFT</b></p> <p>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.</p> <p>The forecast is based on the calculation of the break glass charge as at the end of November. This has been assumed to continue in December and, thereafter, it is forecast that the contract performs to planned levels</p> <p>Although recent months has highlighted a decreasing trend in over-performance 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 £120k is included within the CCG’s overall risk analysis for the last three months of the financial year.</p>		<b>379.0</b>

## 5.3 Sustainability – Community

Community	Trend	Year end Forecast £'000
<p>Telecare continues to underspend due to a low take up in telehealth which continues the trend of previous years.</p> <p>The main change within the month is the receipt of income from the Home Office relating to the increased numbers of Syrian Refugees registered with in-county practices and will offset additional costs of healthcare. This income was previously accounted for within the CCG's mitigations schedule but was higher than anticipated.</p>	↑	(167.8)

## 5.4 Sustainability – Prescribing

Primary Care Prescribing	Trend	Year end Forecast £'000
<p>The budget for prescribing is £86m which includes a £5m savings programme. The reported forecast is consistent with the previous month.</p> <p>The latest data from NHS Business Services Authority (NHS BSA) received relates to October. The prescribing costs when compared with the previous year, the cumulative position shows a 2.85% increase in spend (4.36% increase in the month).</p> <p>Risks to this position have been identified amounting to £0.25m which are included within the risk position reported to NHSEI.</p>		<p>3,500.0</p>

## 5.5 Sustainability – Mental Health

Mental Health	Trend	Year end Forecast £'000
<p><b><u>Mental Health Services</u></b></p> <p>The reported position is broadly consistent with the previously reported position. There continues to be significant overspends within learning disabilities which are marginally offset by a reduction in costs for acquired brain injury (ABI) placements.</p>		<b>512.1</b>

## 5.6 Sustainability – Primary Care

Primary Care	Trend	Year end Forecast £'000
<p><b><u>Delegated Co-Commissioning</u></b></p> <ul style="list-style-type: none"> <li>– 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</li> <li>– Maternity and sickness payments have reduced from previous months which is predominantly driving the underspend; these payments are highly variable and difficult to predict.</li> <li>– List size growth is above those levels initially built into budgets but has slowed in the most recent quarter</li> </ul>	↔	(278.4)
<p><b><u>Other Primary Care</u></b></p> <ul style="list-style-type: none"> <li>– These budgets are showing an underspend based on variances in a number of areas.</li> <li>– Specifically, the recharge of the costs of flu vaccinations to NHSE has been higher than anticipated within the original budget</li> <li>– The costs of Improved Access schemes in the current financial year have highlighted some slippage.</li> <li>– The underspend has reduced slightly from that reported in the previous month. This is mainly as a result of increased costs on the central drug budget (ie those not designated to practices).</li> </ul>	↓	(745.6)

# 5.7 Sustainability – Continuing Health Care & Placements

<u>Continuing Health Care (CHC) / Funded Nursing Care (FNC) / Placements</u>	Trend	Year end Forecast £'000
<p>This area includes costs based continuing health care including domiciliary care, placements, funded nursing care (FNC) and personal health budgets. The current forecast overspend, which has deteriorated slightly in the month, is reported in the following areas</p> <ul style="list-style-type: none"> <li>• <b>Children’s CHC:</b> has remained broadly consistent with last month’s position. The forecast overspend is £269k.</li> <li>• <b>CHC Nursing Home placements:</b> the forecast outturn has improved from the previous month to a forecast underspend of £230k. 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.</li> <li>• <b>CHC/LD placements :</b> this is the main element of the forecast overspend (£3,399k); there is no change from the previous month). The overall risk in this area relating to cases yet to be assessed is now £884k (from £721k last month).</li> <li>• <b>Domiciliary Care:</b> costs have increased during the month to an overspend of £1,111k.</li> </ul>		<p>4,809.8</p>

## 5.8 Sustainability – Other

Other	Trend	Year end Forecast £'000
<ul style="list-style-type: none"> <li>• This area includes budgets for:               <ul style="list-style-type: none"> <li>• Void Properties</li> <li>• Patient Transport</li> <li>• NHS 111</li> <li>• Joining Up Your Care (JUWI)</li> <li>• Integrated Better Care Fund (iBCF)</li> </ul> </li> <li>• The forecast primarily relates to estimates received from the local authority in respect of               <ul style="list-style-type: none"> <li>• Placement costs for Older People and Physical Disability services (£790k forecast overspend; no movement from last month)</li> <li>• Agency costs for childrens placements (£311.8k forecast overspend; consistent with previous month)</li> </ul> </li> </ul>		1,220.2

## 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 showing areas of slippage (£1,807k), however, work is ongoing to mitigate financial risks associated with the savings plan. Those schemes which are deviating adversely from plan and where no contract mitigations can be applied include:
  - Medicines optimisation (£1,300k). Whilst there is good progress being made in a number of schemes, other schemes have slipped or not yet started, plans are currently in development to accelerate progress in these latter areas
  - Commissioning policies (£145k): slippage in implementation
  - Biosimilars & secondary care medicines (including Humira) (£663k). Slippage relating to Humira is as a result of a change in the national prices since setting the plan, other opportunities are being worked for secondary care drugs
  - High cost placements (£450k). Work is continuing in this area, however, savings have been slower to realise than anticipated.
- eRS Advice and Guidance is currently expected to over deliver by £191k. The Straight To Test colonoscopy Pathway implemented in 2018/19 continues to deliver additional savings in 2019/20; savings for the year to date currently stand at £253k.
- Attention is now focused on progressing the 2020/21 efficiency plan for the system and organisations as part of the Operational Plan. This also includes an alignment of savings plans across the system.

## 5.10 Sustainability - Savings forecast delivery

### NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP Savings Programme 2019/20

Area	Planned Savings 2019/20 £	Forecast Before Mitigations 2019/20 £	Forecast After Mitigations 2019/20 £	Variance 2019/20 £
Clinical Programme Approach (CPA)	1,914	1,459	1,914	-
Planned Care Programme	1,502	1,131	1,593	91
One Place / Urgent Care Programme	1,100	809	1,104	4
Community & Prevention Programme	1,801	1,191	1,351	(450)
Medicines Optimisation Programme - Primary Care	5,000	3,700	3,700	(1,300)
Medicines Optimisation Programme - Secondary Care	3,404	2,491	2,741	(663)
Other	2,566	3,077	3,077	511
<b>Grand Total</b>	<b>17,287</b>	<b>13,859</b>	<b>15,480</b>	<b>(1,807)</b>

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 89.6% after applying these risk mitigations to the 2019/20 plan.

## 5.11 Sustainability – Financial Risks & Mitigations overview

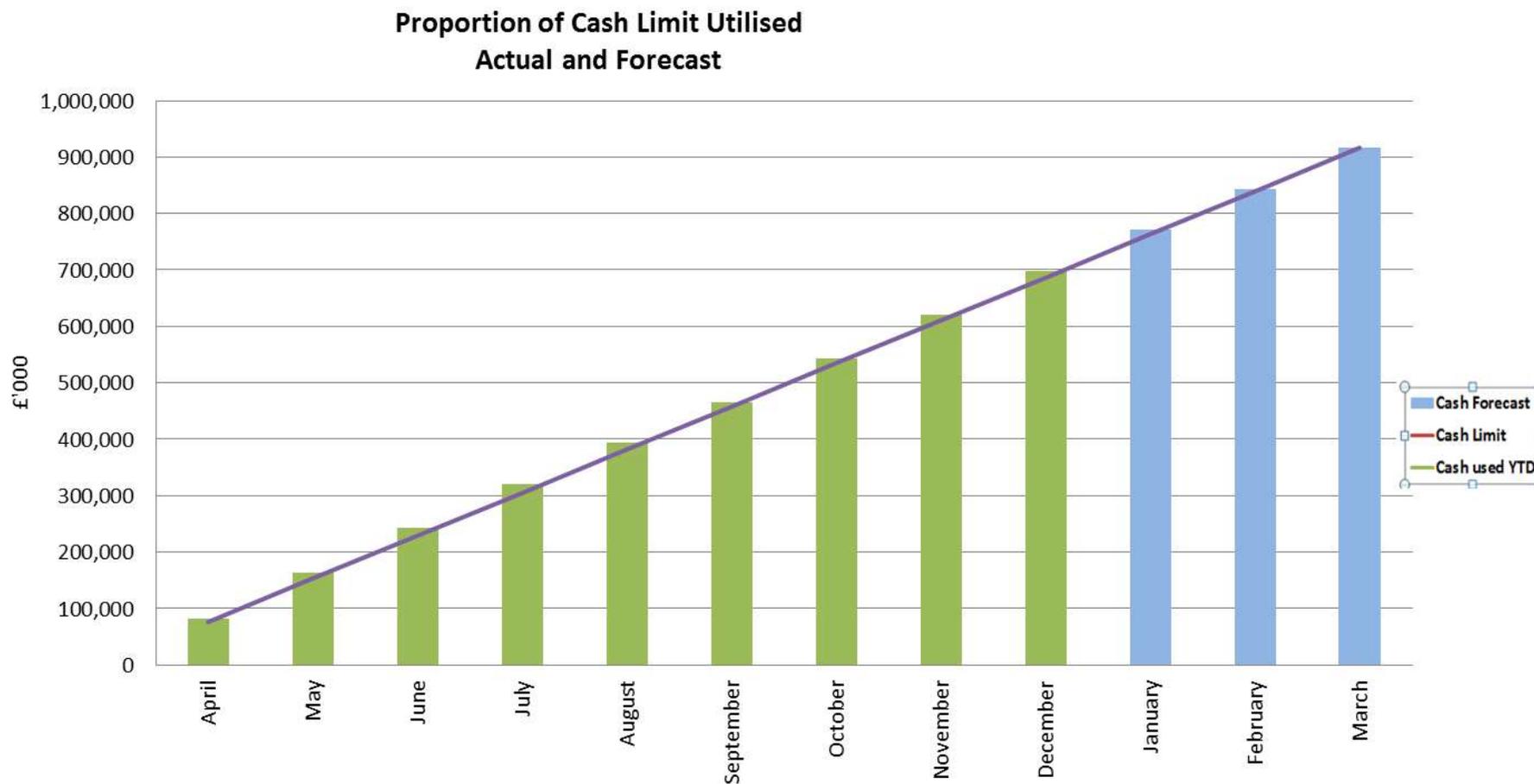
### Risks

- 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

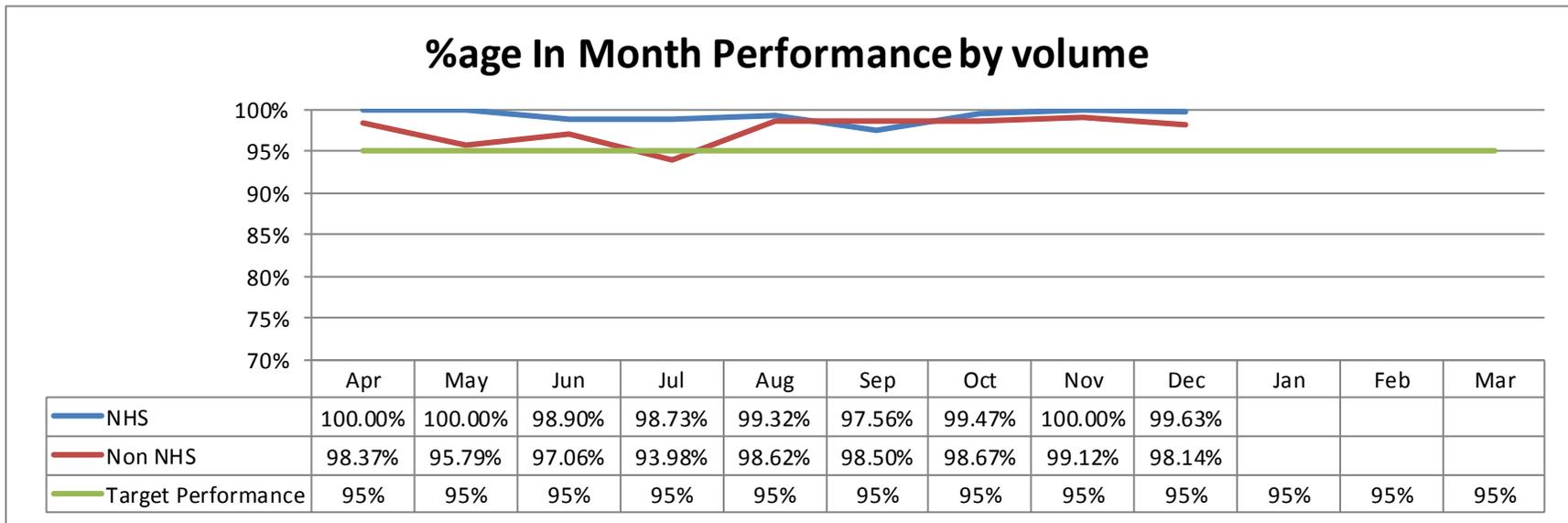
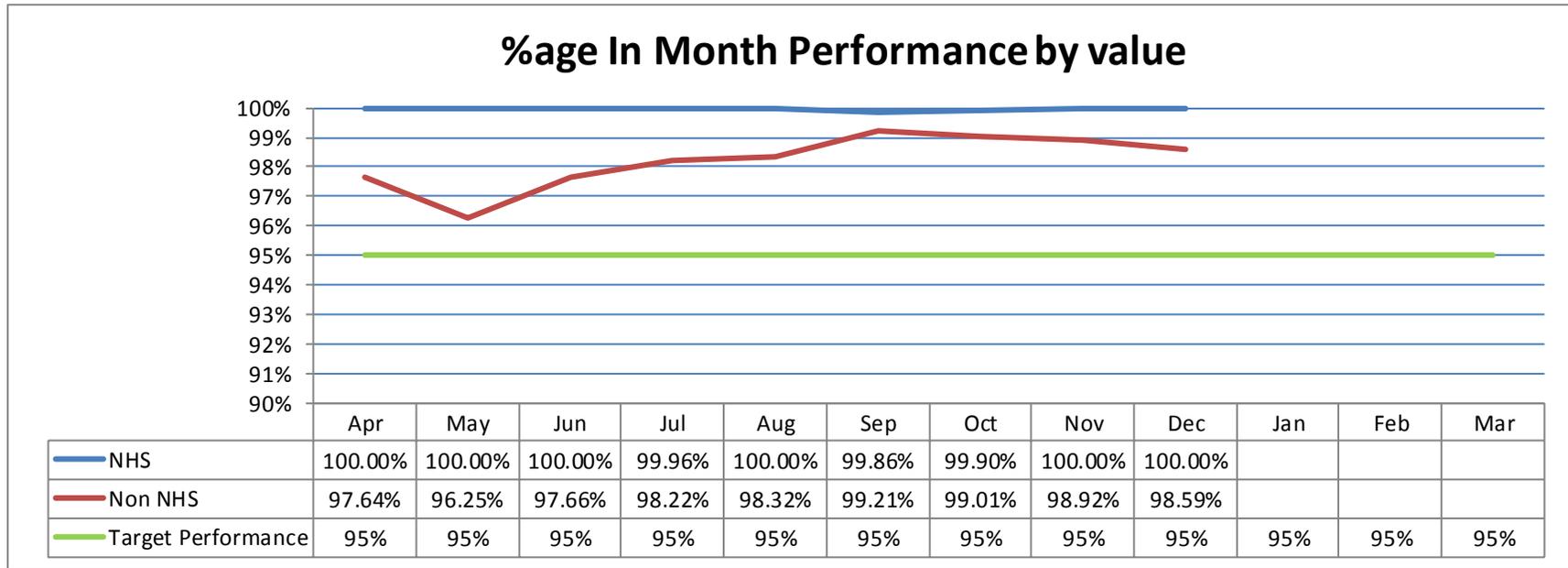
- Slippage on developments – non-recurrently retained centrally
- System agreement on application of transformation funds
- Identify new savings schemes
- Balance sheet reviews
- No controllable expenditure to be committed if no identified funding source
- All commitments against new allocations identified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

# 5.12 Sustainability – Cash Drawdown



At the end of December £698.0m had been drawn down (76.3%) of the maximum cash drawdown available.  
 The cash balance at 31<sup>st</sup> December 2019 was £6.40m.

# 5.13 Sustainability – BPPC performance



## 5.14 Sustainability – I&E Position for Month 09 – December

Level 3 name	Level 4 name	Total Budget	YTD Budget	YTD Actual	YTD Variance	Total Forecast Variance	Prv Mth Forecast Variance
<input checked="" type="checkbox"/> PROGRAMME	ACUTE	434,992,408	326,121,811	331,527,002	5,405,191	7,108,252	6,772,374
	COMMUNITY HEALTH SERVICES	86,788,464	64,977,636	64,766,621	(211,016)	(167,786)	(42,259)
	CONTINUING CARE	50,769,335	38,076,060	41,382,373	3,306,313	4,809,846	4,706,309
	MENTAL HEALTH	91,113,032	68,307,607	68,711,888	404,281	512,056	498,113
	OTHER	25,885,421	17,795,499	18,766,348	970,849	1,220,195	1,220,195
	PRIMARY CARE	201,300,897	150,033,103	151,304,415	1,271,312	2,475,998	2,339,380
	RESERVES	11,657,444	11,568,435	492,304	(11,076,131)	(15,958,561)	(15,494,113)
<b>PROGRAMME Total</b>		<b>902,507,000</b>	<b>676,880,152</b>	<b>676,950,951</b>	<b>70,799</b>	<b>0</b>	<b>0</b>
<input checked="" type="checkbox"/> ADMIN	RESERVES	(856,349)	(607,064)	0	607,064	541,003	426,552
	CORPORATE	14,438,349	10,793,554	10,115,691	(677,863)	(541,003)	(426,553)
<b>ADMIN Total</b>		<b>13,582,000</b>	<b>10,186,490</b>	<b>10,115,691</b>	<b>(70,799)</b>	<b>(0)</b>	<b>(1)</b>
<input checked="" type="checkbox"/> SURPLUS	SURPLUS	21,470,000	16,102,487	0	(16,102,487)	(21,470,000)	(21,470,000)
<b>SURPLUS Total</b>		<b>21,470,000</b>	<b>16,102,487</b>	<b>0</b>	<b>(16,102,487)</b>	<b>(21,470,000)</b>	<b>(21,470,000)</b>
<b>Grand Total</b>		<b>937,559,000</b>	<b>703,169,129</b>	<b>687,066,642</b>	<b>(16,102,487)</b>	<b>(21,470,000)</b>	<b>(21,470,000)</b>

## 5.15 Sustainability – Statement of Financial Position M09

	Opening Position as at 1st April 2019	Closing Position as at 31st December 2019
	£000	£000
<b>Non-current assets:</b>		
Premises, Plant, Fixtures & Fittings	326	231
<b>Total non-current assets</b>	<b>326</b>	<b>231</b>
<b>Current assets:</b>		
Trade and other receivables	7,899	8,223
Cash and cash equivalents	9	6,401
<b>Total current assets</b>	<b>7,908</b>	<b>14,624</b>
<b>Total assets</b>	<b>8,234</b>	<b>14,855</b>
<b>Current liabilities</b>		
Payables	(50,642)	(47,054)
Provisions	(2,876)	(1,715)
<b>Total current liabilities</b>	<b>(53,518)</b>	<b>(48,769)</b>
<b>Non-current assets plus/less net current assets/liabilities</b>	<b>(45,284)</b>	<b>(33,914)</b>
<b>Non-current liabilities</b>		
<b>Total non-current liabilities</b>	<b>0</b>	<b>0</b>
<b>Total Assets Employed:</b>	<b>(45,284)</b>	<b>(33,914)</b>
<b>Financed by taxpayers' equity:</b>		
General fund	(45,284)	(33,914)
<b>Total taxpayers' equity:</b>	<b>(45,284)</b>	<b>(33,914)</b>

## 5.16 Sustainability – M09 reconciliation of I&E to cash

	Position as at 31st December 2019
	£000
YTD Surplus	16,102
Less YTD Resource Limit	(703,169)
<b>Net Operating Expenditure</b>	<b>(687,067)</b>
<b>In year movements</b>	
Depreciation	95
(increase)/Decrease in trade & Other Receivables	(323)
Increase/(Decrease) in trade & Other Payables	(3,517)
Utilisation of Provisions	(455)
Increase/(decrease) in provisions	(707)
Payments for PPE	(70)
<b>Net Cash Inflow/(Outflow)</b>	<b>(692,044)</b>
<b>YTD Cash Drawdown</b>	<b>698,436</b>
<b>Net Movement in Cash</b>	<b>6,392</b>
<b>Opening Cash Cash at 1st April</b>	<b>9</b>
<b>Closing Cash at 31st December</b>	<b>6,401</b>

**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](mailto:GLCCG.GCCGperformance@nhs.net)**

## Agenda Item 10

### Governing Body meeting

<b>Meeting Date</b>	<b>Thursday 30 January 2020</b>
<b>Title</b>	<b>Governing Body Assurance Framework</b>
<b>Executive Summary</b>	<p>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&amp;G Committee. 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.</p> <p>In December 2019 a demonstration of the 4Risk system was given to the Audit and Risk Committee along with reports of the risks uploaded onto the system. The Committee reviewed the system and risks and recommended the following; that risk leads</p> <ul style="list-style-type: none"> <li>• Update their directorate risks on the new system ensuring that the risk explanation is clear and concise with cause and effect indicators</li> <li>• That the language used in the risk description, controls and actions is contemporary</li> <li>• That the action plans provide the latest information on the risk mitigation plans</li> <li>• That assurances of the controls are identified and detailed in the reports.</li> </ul> <p>This information was communicated to risk leads and they were asked to up-date their directorate risk registers, reflecting the feedback from the A&amp;R</p>

	Committee. The current GBAF report is dated 24 January 2020.
<b>Key issues:</b>	<p>All risk leads have updated their risk registers. The Governance Team has run a series of reports on the risk and additional training and support has been provided to risk leads. The current GBAF shows the following key issues:</p> <ul style="list-style-type: none"> <li>• Total of 17</li> <li>• 3 current Red risks</li> <li>• 13 current Amber risks (12)</li> </ul> <p>A more detailed narrative report will be produced for the March Governing Body meeting.</p>
<b>Management of Conflicts of Interest</b>	None identified
<b>Risk Issues:</b>	The absence of a fit for purpose GBAF could result in risks not being identified, acted upon and reported and gaps in control / assurances not being identified and addressed.
<b>Original Risk</b>	12 (3x4)
<b>Residual Risk</b>	4 (1x4)
<b>Financial Impact</b>	See finance risks
<b>Legal Issues (including NHS Constitution)</b>	There are legal risks on the CRR but rated low amber / yellow.
<b>Impact on Health Inequalities</b>	None
<b>Impact on Equality and Diversity</b>	None
<b>Impact on Sustainable Development</b>	None
<b>Patient and Public Involvement</b>	Not applicable
<b>Recommendation</b>	<ul style="list-style-type: none"> <li>• To note the report and progress work on 4Risk</li> </ul>
<b>Author</b>	Christina Gradowski
<b>Designation</b>	Associate Director of Corporate Affairs
<b>Sponsoring</b>	Cath Leech

<b>Director (if not author)</b>	Chief Finance Officer
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## Governing Body Assurance Framework

<b>Report Date</b>	24 Jan 2020
<b>Risk Status</b>	Open
<b>Risk Registers</b>	Commissioning Directorate, Corporate Governance & HR Team, Finance & Information Directorate , Integration Directorate, Primary Care & Locality Development, Quality Directorate, Transformation & Service Redesign Directorate
<b>Risk Level</b>	
<b>Control Status</b>	Existing
<b>Action Status</b>	Outstanding

1.Commission high quality, innovative services											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Primary Care & Locality Development	PCLD 1	<p>There is a risk to the quality, resilience and sustainability of Primary Care</p> <p><b>Risk Owner:</b> Helen Goodey <b>Risk Lead:</b> Jo White <b>Last Updated:</b> 22 Jan 2020 <b>Latest Review Date:</b> 22 Jan 2020 <b>Latest Review By:</b> Cherri Webb <b>Last Review Comments:</b> The PC team has reviewed this risk and confirm that it remains a valid risk.</p>	<p><b>Cause</b> - GP practices running at maximum capacity and certain practices not being financially viable - An ageing primary care workforce</p> <p><b>Effect</b> - Inadequate and/or unsustainable primary care provision for the residents of Gloucestershire - Poor patient experience</p>	I = 4 L = 3 12	AMPS contract for urgent primary care in place for 10 years from May 2018.		I = 4 L = 3 12	Implementation of Primary Care Strategy (PCS) and General Practice Forward View (GPFV). <b>Person Responsible:</b> Jo White <b>To be implemented by:</b> 31 Mar 2020		I = 4 L = 1 4	
					General Practice Forward View (GPFV)/Primary Care Network (PCN) Development Group	GPFV/PCN Development group to have oversight of Primary Care Strategy (PCS) implementation plan					
					Quarterly returns to NHSE.						
					Regular reporting into PCOG and PCCC						
					Reporting into New Models of Care (NMOC) Board and Integrated Care System (ICS) Board	Monthly reports to NMOC and ICS Board. Reports to Governing Body and Primary Care Commissioning Committee (PCCC).			PCN Development using national and local support mechanisms <b>Person Responsible:</b> Jo White <b>To be implemented by:</b> 31 Mar 2020		
					Subject of KLOE quarterly.				Implement General Practice Resilience Programme. <b>Person Responsible:</b> Jo White <b>To be implemented by:</b> 31 Mar 2020		
					Working proactively with practices to facilitate solutions for identified resilience issues.				Support PCN based resilience and transformation work to secure general practice and then build upon that foundation for new models of care. Develop Primary Care Networks in light of Long Term Plan and new PCN contract launched 31st January 2019. <b>Person Responsible:</b> Helen Edwards <b>To be implemented by:</b> 31 Mar 2020		

Governing Body Assurance Framework



3.Transform services to meet the future needs of the population, through the most effective use of resources											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Commissioning Directorate	CD 2	<p>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 14/21 days.</p> <p><b>Risk Owner:</b> Sharon Nicholson <b>Risk Lead:</b> Julia Doyle <b>Last Updated:</b> 13 Jan 2020 <b>Latest Review Date:</b> 07 Jan 2020 <b>Latest Review By:</b> Julia Doyle</p> <p><b>Last Review Comments:</b> We have suggested increasing the likelihood due to protracted 'winter' pressures.</p>	<p><b>Cause</b> Operational pressures.</p> <p><b>Effect</b> Poor patient experience.</p>	I = 4 L = 4 16	A&EDB, UEC Programme Group, weekly partnership meeting		Partial Assurance Date: 09 Aug 2019 Assurance By: Lauren Peachey	I = 4 L = 4 16	<p>Oversight of delivery of these work streams to be undertaken by UEC Programme Group as agreed June 2019.</p> <p><b>Person Responsible:</b> Julia Doyle <b>To be implemented by:</b> 08 Mar 2020</p>	<p><b>07 Jan 2020</b> Associate Director of Commissioning has developed a performance monitoring system for all programmes reporting into A&amp;EDB.</p> <p><b>03 Dec 2019</b> Update 09/0/19 Introduction of UEC Programme Group to have multiagency oversight of progress against work streams.</p> <p>Improving System Flow Plan on a Page reviewed at UEC Programme Group.</p>	I = 4 L = 1 4
					System Escalation Calls based on agreed Operational Escalation Levels (OPEL) Framework levels and agreed organisational actions	Escalation call gives assurance to system partners that all effort is being undertaken to support patient flow	Partial Assurance Date: 07 Jan 2020 Assurance By: Julia Doyle				
					<p>A&amp;EDB/ICS Board to receive reports on all work streams identified from UEC Summit including Top 3 priorities plus plans on a page for ED Attendance &amp; Hospital Admission Avoidance, Improving Patient Flow and Living Well Ageing Well.</p> <p><b>Person Responsible:</b> Julia Doyle <b>To be implemented by:</b> 08 Mar 2020</p>						
<p>Task and finish groups will be set up by exception to unblock any potential delays in progress.</p> <p><b>Person Responsible:</b> Julia Doyle <b>To be implemented by:</b> 08 Mar 2020</p>			<p><b>07 Jan 2020</b> Task and finish groups are set up with system partners, as appropriate, to unblock system flow.</p>								

3.Transform services to meet the future needs of the population, through the most effective use of resources											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Commissioning Directorate	CD 3	Non-delivery of the Constitution standard for maximum wait of 4 hours within the emergency department. <b>Risk Owner:</b> Maria Metherall <b>Risk Lead:</b> Julia Doyle <b>Last Updated:</b> 23 Jan 2020 <b>Latest Review Date:</b> 23 Jan 2020 <b>Latest Review By:</b> Lauren Peachey <b>Last Review Comments:</b> Risk score has increased from 12 to 16	<b>Cause</b> - Operational pressures - Increased demand <b>Effect</b> - Negative patient experience/outcomes - Reputational damage	I = 4 L = 4 16	A&EDB & UEC Programme Group, OPEL Escalation process		Partial Assurance Date: 09 Aug 2019 Assurance By: Lauren Peachey	I = 4 L = 4 16	GHT delivery against agreed 4 hr recovery plan <b>Person Responsible:</b> Maria Metherall <b>To be implemented by:</b> 28 Feb 2020	14 Jan 2020 Plan updated incorporating internal and system action to secure delivery.	I = 4 L = 2 8
					GCCG Escalation Plan, Gloucestershire Urgent & Emergency Care Sustainability Plan.	Descriptions of systems actions identified in plans.	Partial Assurance Date: 13 Jan 2020 Assurance By: Julia Doyle		Task and finish groups will be set up by exception to unblock any potential delays in progress. <b>Person Responsible:</b> Julia Doyle <b>To be implemented by:</b> 08 Mar 2020	14 Jan 2020 Increase in risk rating due to deteriorating performance picture. 13 Jan 2020 System calls have increased to facilitate flow	
									Oversight of delivery of these work streams to be undertaken by UEC Programme Group as agreed June 2019. <b>Person Responsible:</b> Julia Doyle <b>To be implemented by:</b> 08 Mar 2020	13 Jan 2020 Plan for monitoring key workstreams has been developed 03 Dec 2019 09/08/19: Introduction of UEC Programme Group to have multiagency oversight of progress against work streams.	
									A&EDB/ICS Board to receive reports on all work streams identified from UEC Summit including Top 3 priorities plus plans on a page for ED Attendance & Hospital Admission Avoidance, Improving Patient Flow and Living Well Ageing Well. <b>Person Responsible:</b> Julia Doyle <b>To be implemented by:</b> 08 Mar 2020	13 Jan 2020 Plan for monitoring key workstreams has been developed 03 Dec 2019 09/08/19 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 SHREWD will enable early and accurate identification of which parts of the system are under pressure, improving the flow of patients across all pathways and reducing the time spent on future conference calls to discuss capacity management. <b>Person Responsible:</b> Julia Doyle <b>To be implemented by:</b> 08 Mar 2020	13 Jan 2020 Review of SHREWD impact during 'winter' period to be undertaken as part of Debrief session.		

Governing Body Assurance Framework



3.Transform services to meet the future needs of the population, through the most effective use of resources												
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority	
Finance & Information Directorate	F&ID 4	Local Digital Roadmap Unable to Be Delivered <b>Risk Owner:</b> Cath Leech <b>Risk Lead:</b> Tim Clarke <b>Last Updated:</b> 15 Jan 2020 <b>Latest Review Date:</b> 15 Jan 2020 <b>Latest Review By:</b> Alex Webb <b>Last Review Comments:</b> Change in persons responsible for the risk. No other updates at this time. AWebb 15.01.20	<b>Cause</b> Financial and workforce resources may not be available to deliver the required scope of the programme and projects within the STP. <b>Effect</b> Roadmap not completed and impact on delivery and services	I = 4 L = 3 12	Digital Executive Steering Group		Positive Assurance Date: 13 Jan 2020 Assurance By: Tim Clarke	I = 4 L = 3 12	Potential risk to delivery to be escalated to the ICS Digital Executive Steering Group with options to mitigate risk <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 31 Mar 2020	15 Jan 2020 Risk escalated and approach agreed, to then review resourcing requirements following agreement of financial envelope for Roadmap delivery and further understanding of national funding. 23 Oct 2019 On going dialogue with Countywide IM&T Group.	I = 4 L = 1 4	
					ICS Digital Delivery Group	Reporting to ICS Digital Executive Steering Group and each organisation	Positive Assurance Date: 23 Oct 2019 Assurance By: Alex Webb					
					Strategy refresh including review of resourcing requirements of each organisation <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 31 Mar 2020							15 Jan 2020 ICS Digital Strategy developed and agreed by ICS Executive Steering Group. Now each organisation will put through own governance, before coming to ICS Board for sign off. 23 Oct 2019 Strategy refresh commenced to review resourcing over the next few years.
					Baseline activities and resources across the Digital, Data, and Technology areas. <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 31 Mar 2020							15 Jan 2020 Draft of prioritise roadmap has been created as part of Digital Strategy. Awaiting outcome of financial planning to confirm. Resource profiling is underway. 23 Oct 2019 Digital Workforce Group initiated
Secure national funding when available <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 31 Mar 2020			15 Jan 2020 Ongoing action. In 2019/20 funding has been secured from national funds for GPIT, HSLI (towards document sharing, EPR implementation and MDTs in acute) and ePMA . Further bids are awaiting outcomes such as eRostering. 23 Oct 2019 Bidding for national funds in progress.									

3.Transform services to meet the future needs of the population, through the most effective use of resources											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Finance & Information Directorate	F&ID 5	Increased risk of cyber attacks <b>Risk Owner:</b> Cath Leech <b>Risk Lead:</b> Tim Clarke <b>Last Updated:</b> 15 Jan 2020 <b>Latest Review Date:</b> 15 Jan 2020 <b>Latest Review By:</b> Alex Webb <b>Last Review Comments:</b> Change or persons responsible for risk. No other updates at this time. AWebb 15.01.2020	<b>Cause</b> - Cyber Attacks are becoming more sophisticated and common place. CCG systems are at a greater risk of being compromised. <b>Effect</b> - Data accessed, lost or corrupted, causing system wide failure.	I = 4 L = 3 12	CCG Policies designed to reduce the probability of attacks	The CCG has policies in place to reduce the probability and contracts with the CSU and CITs which include cyber security advice and services.	Positive Assurance Date: 23 Oct 2019 Assurance By: Alex Webb	I = 4 L = 3 12	Cyber Security plan and status across the ICS reported into ICS Digital Delivery Group <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 04 Feb 2020	<b>23 Oct 2019</b> GPIT Cyber Security PID and Windows 10 PID submitted to NHSE for approval  <b>15 Jan 2020</b> GHC have completed board level GCHQ Certified SIRO Training with the Director of Finance and Technology senior management from Templar.  Templar training has also been delivered to the Hospital Trust Executive CIO and his senior technology team. The Executive CIO will then be delivering this training to the wider Trust Executive team and CCG Governing Group in February. <b>10 Dec 2019</b> Cyber security training has been arranged for the 20th February 2020.	I = 4 L = 1 4
					Contracts with CSU & CITs to provide cyber security advice and services	Monthly reports to the LDR Infrastructure Group and CCG Infrastructure Group.  NHS Digital on-going assurance.	Positive Assurance Date: 23 Oct 2019 Assurance By: Alex Webb		Free NHS Digital Board level Cyber Security is being proposed to understand and support Executives to fulfil their Board level cyber security responsibilities. <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 28 Feb 2020		
									Mandated and proactive assessments to highlight areas to improve cyber security measures (ongoing through Cyber Essentials + and DPSR audits and accreditation) <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 31 Mar 2020		

Governing Body Assurance Framework



3.Transform services to meet the future needs of the population, through the most effective use of resources												
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority	
									Additional Network improvements underway following GPIT & Acute central funding awards. Business cases for investment in security measures are in development <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 31 Mar 2020	<b>15 Jan 2020</b> Moving forward with BT proposal for a secure gateway. Anti-Virus solution renewal has happened ahead of moving to a countywide solution in 2021. Vulnerability scanning completed for CCG, GHFT and GCS. Security Information & Event Management dashboards are complete. Asset discovery complete for GHFT, CCG & GPs. <b>23 Oct 2019</b> New Anti-Virus software installed and deployment started.		
									Internal and external assessments undertaken <b>Person Responsible:</b> Tim Clarke <b>To be implemented by:</b> 31 Mar 2020	<b>15 Jan 2020</b> Cyber Audit remediation is Amber, some slippage expected due to complexity in Domain Admin. <b>15 Jan 2020</b> Dionach have undertaken assessments of organisations in the ICS. Further NHS Digital assessments are being booked in.		
Quality Directorate	QD 11	SWAST have identified a risk in the SW to patients due to call stacking. <b>Risk Owner:</b> Marion Andrews-Evans <b>Risk Lead:</b> Rob Mauler <b>Last Updated:</b> 23 Jan 2020 <b>Latest Review Date:</b> 23 Jan 2020 <b>Latest Review By:</b> Rob Mauler <b>Last Review Comments:</b> SWAST reduced risk score on 22/01/20	<b>Cause</b> - Ambulance demand increases to levels where SWAST are unable to respond within appropriate timescales. <b>Effect</b> - Patients may wait longer for an ambulance - Patients may be exposed to increase risk of harm	I = 4 L = 4 16	Escallion plans in place		I = 4 L = 3 12	Recurrent additional investment to support staffing <b>Person Responsible:</b> Rob Mauler <b>To be implemented by:</b> 31 Mar 2020		I = 4 L = 3 12		
					SWASFT have increased GP support in hubs							
					SWASFT have reviewed rota and operating procedures							
								Increase hold times for clinical validation in 111 <b>Person Responsible:</b> Rob Mauler <b>To be implemented by:</b> 31 Mar 2020				
								New and additional resources <b>Person Responsible:</b> Rob Mauler <b>To be implemented by:</b> 31 Mar 2020				
								System wide work to review 111 clinical validation <b>Person Responsible:</b> Rob Mauler <b>To be implemented by:</b> 31 Mar 2020				

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

Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Transformation & Service Redesign Directorate	TSR 2	(T11) Risk of financial cuts to services provided by public health. This includes, and is not limited to, public health campaigns, smoking cessation services etc. <b>Risk Owner:</b> Ellen Rule <b>Risk Lead:</b> Emma Savage <b>Last Updated:</b> 17 Jan 2020 <b>Latest Review Date:</b> 22 Jan 2020 <b>Latest Review By:</b> Ryan Brunson <b>Last Review Comments:</b> Assurance control added by Ryan on 22/01 and provided by Emma Savage.	<b>Cause</b> Cuts to Council budgets each year (including Public Health) and increasing demand for services each year. <b>Effect</b> Some reduction in service provision i.e. Public Health Nurses  Short term funding for Independent Domestic Abuse Advisors in Emergency Department	I = 3 L = 4 12	Regular joint meetings and agreement of joint work plans with links to H&WB Board.	Assurance from Governing Body	Partial  Assurance Date: 22 Jan 2020  Assurance By: Ryan Brunson	I = 3 L = 4 12	Meetings are currently underway to identify and model impact. CCG currently working with GCC to identify opportunities to joint commission, pool resources and mitigate risk. <b>Person Responsible:</b> Emma Savage <b>To be implemented by:</b> 31 Mar 2020	<b>18 Sep 2019</b> 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.	I = 2 L = 2 4
									A review of Public Health core offer due to take place in spring 2019. <b>Person Responsible:</b> Emma Savage <b>To be implemented by:</b> 31 Mar 2020		
									Any reductions to Public Health budget discussed at JCPE meetings. <b>Person Responsible:</b> Emma Savage <b>To be implemented by:</b> 31 Mar 2020		
									Public Health budget ring fence was removed in 2016. GCC is now responsible for Public Health budget. <b>Person Responsible:</b> Emma Savage <b>To be implemented by:</b> 31 Mar 2020		

Governing Body Assurance Framework



3.Transform services to meet the future needs of the population, through the most effective use of resources											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Transformation & Service Redesign Directorate	TSR 3	(T20) There is a risk risk that delayed implementation of changes to pathways through the Clinical Programme Approach fail to deliver the anticipated benefits <b>Risk Owner:</b> Ellen Rule <b>Risk Lead:</b> Kelly Matthews <b>Last Updated:</b> 27 Nov 2019 <b>Latest Review Date:</b> <b>Latest Review By:</b> <b>Last Review Comments:</b>	<b>Cause</b> The potential causes of delayed implementation are numerous because of the complexity of some of the changes and the fact that, often, it requires multi agency, system-wide working to deliver the changes. <b>Effect</b> The effect depends on the anticipated benefits. This could be failing to achieve financial savings, quality standards, patient satisfaction or clinical outcomes.	I = 4 L = 3 12	Robust project management planning by the Transformation Team supported by the PMO, Information & BI Teams.	Progress of pathway changes reported through to CPB on a bi-monthly basis along with the benefits realised from pathway transformation.		I = 4 L = 3 12	1. All projects to have clear baseline monitoring with agreed KPIs so pathways. 2. Monthly monitoring with focus on schemes/changes at risk of non-delivery with agreement on remedial action. 3. Dashboard development to aid project manager reporting. <b>Person Responsible:</b> Kelly Matthews <b>To be implemented by:</b> 30 Dec 2019	<b>18 Sep 2019</b> 1. KPIs developed with baselines developed. 2. Ongoing monitoring of each scheme with a view to assessing optimum pathways and benefits realisation from changes to pathways through transformation. 3. Dashboards developed 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.	I = 2 L = 2 4

3.Transform services to meet the future needs of the population, through the most effective use of resources											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Transformation & Service Redesign Directorate	TSR 5	(T10) Risk that delayed implementation of Savings Projects and/or failure of projects to deliver anticipated benefits, resulting in under-delivery on planned savings targets.  <b>Risk Owner:</b> Ellen Rule <b>Risk Lead:</b> Kelly Matthews <b>Last Updated:</b> 27 Nov 2019 <b>Latest Review Date:</b> <b>Latest Review By:</b> <b>Last Review Comments:</b>	<b>Cause</b> The potential causes of delayed implementation are numerous because of the complexity of some of the changes and the fact that, often, it requires multi agency, system-wide working to deliver the changes.  <b>Effect</b> Under delivery of planned savings targets	I = 4 L = 3 12	Robust project management planning and reporting between the PMO & BI Teams.	Budgets approved by the Governing Body. Monthly performance reporting to CCG Governing Body and quarterly reporting to the CCG's Audit Committee.		I = 4 L = 3 12	1. All projects to have clear baseline monitoring with agreed KPIs so pathways. 2. Monthly monitoring with focus on schemes/changes at risk of non-delivery with agreement on remedial action. 3. Dashboard development to aid project manager reporting. <b>Person Responsible:</b> Kelly Matthews <b>To be implemented by:</b> 31 Mar 2020	<b>15 Nov 2019</b> 1. KPIs developed with baselines developed. 2. Ongoing monitoring of each scheme with a view to assessing optimum pathways and benefits realisation from changes to pathways through transformation. 3. Dashboards developed 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.	I = 2 L = 2 4

Governing Body Assurance Framework



5. Work with our partners and staff to promote both the physical and mental health and wellbeing of patients, carers, staff and the public											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Quality Directorate	QD 3	<p>Risk to financial performance if prescribing costs are in excess of the agreed budget.</p> <p><b>Risk Owner:</b> Marion Andrews-Evans</p> <p><b>Risk Lead:</b> Teresa Middleton</p> <p><b>Last Updated:</b> 10 Dec 2019</p> <p><b>Latest Review Date:</b> 03 Dec 2019</p> <p><b>Latest Review By:</b> Lauren Peachey</p> <p><b>Last Review Comments:</b> Prescribing savings plan for 2019/20 is a total of £5m. This is made up from £4.5m from primary care prescribing and £0.5m from secondary care prescribing partnership working. There are plans (upwards of 23 individual plans) in place to deliver this savings target, which are monitored through the Medicines Optimisation Programme Group which regularly reports to core team. The latest available M2 prescribing data indicates positive early implementation progress.</p>	<p><b>Cause</b> Unexpected national price increases to generic medicines which have been specified by NHSE/DoH as a result of community pharmacy contract national negotiations.</p> <p><b>Effect</b> Potential overspend of prescribing budget of which there are limited mitigating actions that can be undertaken. This is due to the short time period of communication between NHSE/DoH and CCG's.</p>	I = 4 L = 3 12	The primary care prescribing budget has been agreed and will be monitored.		Partial Assurance Date: 28 Nov 2019 Assurance By: Lauren Peachey	I = 4 L = 3 12	<p>Robust monitoring and engagement with overspending GP practices. CCG Medicines Management and CCG GP Leads will visit these practices.</p> <p><b>Person Responsible:</b> Cate White</p> <p><b>To be implemented by:</b> 31 Mar 2020</p>		I = 4 L = 1 4

6.Deliver strong leadership as commissioners ensuring good governance and financial sustainability											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Commissioning Directorate	CD 1	Risk of legal challenge to procurement decision <b>Risk Owner:</b> David Porter <b>Risk Lead:</b> David Porter <b>Last Updated:</b> 06 Jan 2020 <b>Latest Review Date:</b> <b>Latest Review By:</b> <b>Last Review Comments:</b>	<b>Cause</b> Challenge from bidders based on perceived: - Tender process - Financial assessment - Technical/quality assessment - Award criteria - Selection criteria - Conflicts of Interest <b>Effect</b> - Reputational damage - Financial consequences - Operational disruption of services	I = 4 L = 3 12	Compliance with UK and EU Public Contracts Legislation		Positive Assurance Date: 02 Oct 2019 Assurance By: David Porter	I = 4 L = 3 12	New Procurement Strategy in place from 1 December 2018 to 30 November 2020. A revised strategy will be put in place in the event of changes to current legislation. <b>Person Responsible:</b> David Porter <b>To be implemented by:</b> 30 Nov 2020	<b>14 Jan 2020</b> This is an ongoing requirement and will be reviewed on a monthly basis.	I = 4 L = 1 4
					Evaluation Process to determine the most economically advantageous tender offer.	Allows the Authority to equitably and fairly select the most economically advantageous offer in accordance with UK and EU procurement (Public Contracts) legislation and GCCG procurement strategy.	Positive Assurance Date: 02 Oct 2019 Assurance By: David Porter				
					Management of Conflicts of Interest associated with Procurement Processes	- Following GCCG Standards of Business Conduct Policy - Completion of Declaration of Interest forms (authority and potential bidding organisations) - Mandatory Conflicts of Interest training - Conflicts of Interest Register published on GCCG external website (Completed Procurements page)	Positive Assurance Date: 02 Oct 2019 Assurance By: David Porter				
Finance & Information Directorate	F&ID 2	The CCG does not meet its breakeven control total in 2019/20 <b>Risk Owner:</b> Cath Leech <b>Risk Lead:</b> Andrew Beard <b>Last Updated:</b> 14 Jan 2020 <b>Latest Review Date:</b> 15 Jan 2020 <b>Latest Review By:</b> Alex Webb <b>Last Review Comments:</b> Other than changes around risk owner (changing from A Webb to A Beard), no further updates on the Risk	<b>Cause</b> 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. <b>Effect</b> This will have an adverse impact on cash balances held by the CCG resulting in the CCG not being able to meet its breakeven control total in 2019/20. - Increased prescribing costs; - Increased expenditure on CHC and LD cases; - Increased expenditure in commissioning.	I = 4 L = 4 16	Assessment of all transfers validated and quantified	Assessment of all transfers validated and quantified		I = 4 L = 4 16	Close monitoring of assumptions against initial plan <b>Person Responsible:</b> Andrew Beard <b>To be implemented by:</b> 31 Mar 2020	<b>25 Sep 2019</b> Progress in monitoring across providers by specialty	I = 4 L = 1 4
					Contract monitoring in place	Monthly contract monitoring in place					
					Financial controls & processes in place	CCG constitution including Standing Orders, Prime Financial Policies and Scheme of Delegation approved					
					Financial plan aligned to commissioning strategy	Robust financial plan aligned to commissioning strategy.	Positive Assurance Date: 25 Sep 2019 Assurance By: Lauren Peachey				
					ICS Solutions/Savings	Savings plans developed with appropriate governance processes including monitoring					
					Robust cash monitoring with early warnings	Robust cash monitoring with early warnings					

## Governing Body Assurance Framework

6.Deliver strong leadership as commissioners ensuring good governance and financial sustainability											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Finance & Information Directorate	F&ID 3	New EPR system causing reporting issues <b>Risk Owner:</b> Cath Leech <b>Risk Lead:</b> Haydn Jones <b>Last Updated:</b> 15 Jan 2020 <b>Latest Review Date:</b> 15 Jan 2020 <b>Latest Review By:</b> Alex Webb <b>Last Review Comments:</b> Risk reviewed. Updated people responsible, but no further updates. AWebb 15.01.2020	<b>Cause</b> - Implementation of Electronic Patient Record (EPR) system within our main acute provider has led to reporting issues for clinical correspondence, national performance reporting and contractual management. <b>Effect</b> - Inaccurate reports and returns being generated, distorting actual performance - Lack of reportable data for maternity services	I = 4 L = 4 16	Regular communication with NHSE			I = 4 L = 3 12	Development of a remedial action plan for performance monitoring and data completeness within the Electronic Patient Records System <b>Person Responsible:</b> Haydn Jones <b>To be implemented by:</b> 31 Mar 2020	25 Sep 2019 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 25 Sep 2019 The quality and comprehensiveness of activity and financial reporting continues to improve	I = 4 L = 1 4
					Remedial Action Plan	Development of a remedial action plan supported by CCG/CSU staff to mitigate risks of adverse clinical communication and incomplete reporting	Positive Assurance Date: 25 Sep 2019 Assurance By: Alex Webb				
Finance & Information Directorate	F&ID 7	Data Landing Portal (DLP): All local data flows from providers in to CCG's must come via the DLP from April 20 <b>Risk Owner:</b> Cath Leech <b>Risk Lead:</b> Lee Tarbuck <b>Last Updated:</b> 22 Jan 2020 <b>Latest Review Date:</b> 15 Jan 2020 <b>Latest Review By:</b> Alex Webb <b>Last Review Comments:</b> No change to risk as of 15.01.2020 - AWebb	<b>Cause</b> - National guidance has mandated that all local data flows from providers in to CCG's must come via the DLP from April 2020. <b>Effect</b> - The current mechanism in place will not be IG compliant come the above date and therefore the CCG will be unable to receive local data flows unless providers move to using the DLP.	I = 4 L = 3 12	Development of an action plan supported by CCG/CSU staff to mitigate risks of loss of local data flows due to Providers inability to utilise the DLP	CSU/CCG Monthly DMS meeting		I = 4 L = 3 12	CCG to identify all other data flows that will need to be sent via DLP by Providers and develop action plan <b>Person Responsible:</b> Alex Webb <b>To be implemented by:</b> 31 Mar 2020	23 Oct 2019 Action plan in place for GHFT to work with CCG/CSU to migrate data flows to DLP	I = 4 L = 1 4
							All 19/20 contracts and any new contracts stipulate data to be sent via the DLP <b>Person Responsible:</b> Alex Webb <b>To be implemented by:</b> 31 Mar 2020		23 Oct 2019 All 2018/19 contracts has DLP stipulated at the transfer mechanism where there is a data requirement		
							CCG/CSU to work with 2G and GCS to migrate local flows across to the DLP <b>Person Responsible:</b> Alex Webb <b>To be implemented by:</b> 31 Mar 2020		23 Oct 2019 GCS and 2G are currently building processes to send data through the DLP before the end of October		
Quality Directorate	QD 12	EU-Exit arrangements affecting some areas of healthcare delivery <b>Risk Owner:</b> Marion Andrews-Evans <b>Risk Lead:</b> Teresa Middleton <b>Last Updated:</b> 10 Dec 2019 <b>Latest Review Date:</b> <b>Latest Review By:</b> <b>Last Review Comments:</b>	<b>Cause</b> - Due to the uncertainty surrounding EU/EXIT arrangements These include: • supply of medicines and vaccines; • supply of medical devices and clinical consumables; • supply of non-clinical consumables, goods and services; • workforce; • reciprocal healthcare; • research and clinical trials; and • data sharing, processing and access. <b>Effect</b>	I = 4 L = 3 12	LHRF Business group are co-ordinating the planning arrangements and liaising with the LRF SCG. If no-deal by last week of March then the Exec LHRP will meet to co-ordinate actions at a tactical level. NHSE and CCG are members of the LRF SCG.	GCCG are fully engaged with the NHSE EU Exit Planning Group. The Local Health Resilience Forum (LHRF) Business Group are coordinating local planning arrangements. Preparation work to date has not identified any anticipated local impacts.		I = 4 L = 3 12	<b>Person Responsible:</b> <b>To be implemented by:</b>		I = 4 L = 1 4

7. Develop plans for proactive care focused on early intervention, prevention and detection of mental health and physical health conditions.											
Risk Registers	Risk Ref	Risk Description	Cause & Effect	Original Risk Rating	Risk Control	Control Assurance (Overall Assurance)	Overall Assurance Level	Current Risk Rating	Action Required	Progress Notes	Target Risk Priority
Quality Directorate	QD 5	<p>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.</p> <p><b>Risk Owner:</b> Marion Andrews-Evans</p> <p><b>Risk Lead:</b> Cate White</p> <p><b>Last Updated:</b> 11 Dec 2019</p> <p><b>Latest Review Date:</b></p> <p><b>Latest Review By:</b></p> <p><b>Last Review Comments:</b></p>	<p><b>Cause</b> 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.</p> <p><b>Effect</b> This is known to have a negative impact on subsequent longer term health and wellbeing outcomes later in life</p>	I = 4 L = 3 12	<p>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.</p>			I = 4 L = 3 12	<p>Joint Commissioner leading the finalising of potential new service model, including the need for investment in additional staff and the split of funding between CCG and council. Decision by JCPE followed by implementation of the new arrangements (including recruitment) to follow.</p> <p><b>Person Responsible:</b> Cate White</p> <p><b>To be implemented by:</b> 31 Mar 2020</p>		I = 4 L = 1 4

## Agenda Item 11

### Governing Body

<b>Meeting Date</b>	<b>Thursday 30<sup>th</sup> January 2020</b>
<b>Report Title</b>	<b>Integrated Care System (ICS) Lead's Update</b>
<b>Executive Summary</b>	<p>This report provides an update on Gloucestershire Integrated Care System.</p> <p>The report provides an insight into the progress being made in the ICS transformation programmes against the system vision and priorities.</p>
<b>Key Issues</b>	<p>This report provides focus in the main programme areas;</p> <ul style="list-style-type: none"> <li>• Enabling Active Communities;</li> <li>• Reducing Clinical Variation;</li> <li>• One Place, One Budget, One System</li> <li>• Clinical Programme Groups.</li> </ul>
<b>Risk Issues:</b>  <b>Original Risk (CxL)</b> <b>Residual Risk (CxL)</b>	<p>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.</p>
<b>Management of Conflicts of Interest</b>	N/A
<b>Financial Impact</b>	N/A
<b>Legal Issues (including NHS Constitution)</b>	N/A
<b>Impact on Health Inequalities</b>	The report supports the effort to reduce health inequalities
<b>Impact on Equality and Diversity</b>	The report positively impacts on improving equality and diversity
<b>Impact on Sustainable Development</b>	N/A

<b>Patient and Public Involvement</b>	The report considers the matters of public engagement and is also submitted to the Health and Care Overview and Scrutiny Committee.
<b>Recommendation</b>	Governing Body/Board members are asked to note the content of the report.
<b>Author</b>	Emily Beardshall: Deputy ICS Programme Director
<b>Sponsoring Director (if not author)</b>	Ellen Rule: Director of Transformation & Service Redesign

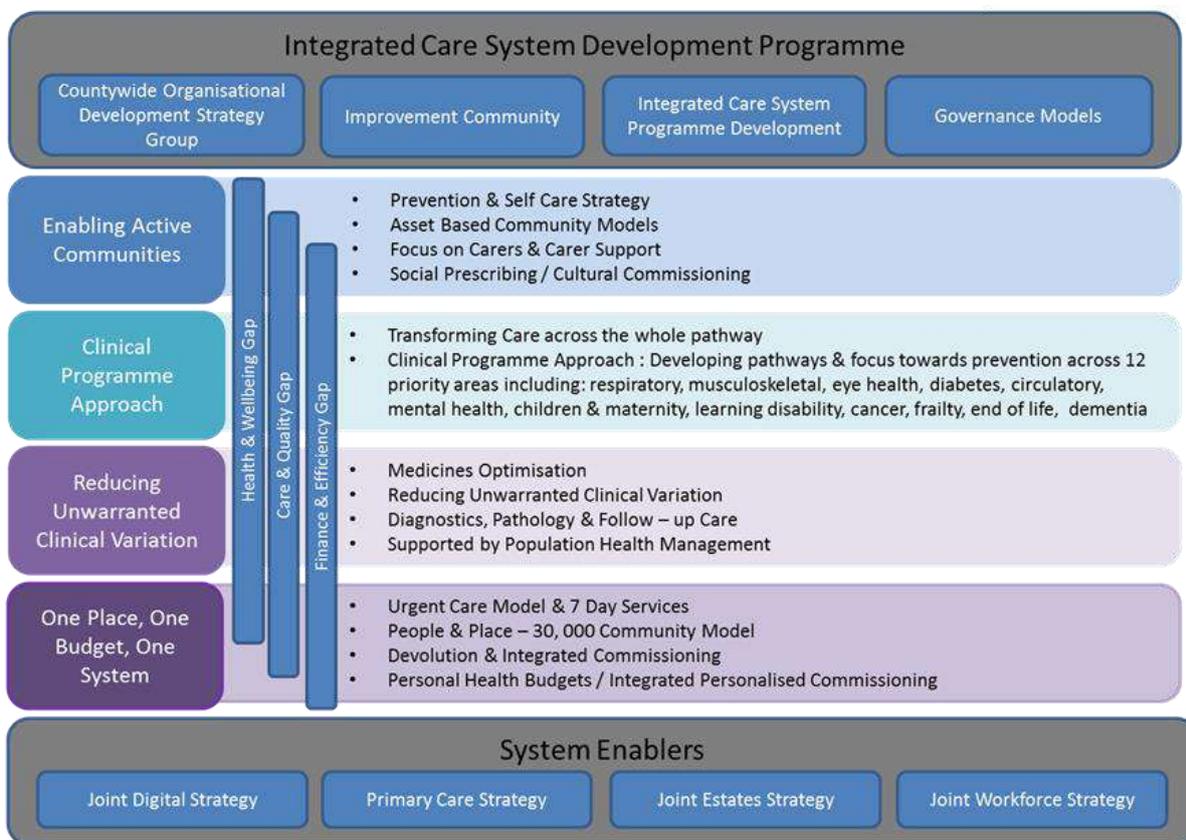
January 2020

**One Gloucestershire ICS Lead Report**

**1. Introduction**

The following report provides an update to the CCG Governing Body 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 reviewed the plans as part of our planning work on the One 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.



11.1

*Gloucestershire’s ICS Plan on a page*

## 2. Enabling Active Communities

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

The development of the Gloucestershire Prevention and Shared Care Plan, led by Public Health, aims to 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 make an important contribution to the maintenance of 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. Tier 2 services focus on lifestyle changes to support healthy weight.
- **Tier 3 (specialist) Child weight management service** clinics are due to start in January 2020.
- As at the end of November there are now 12 people on the Gloucester Cohort and 8 people on the Cheltenham cohort as part of the **Blue Light Change Resistant** Drinkers project. There was more attendance at the Cheltenham meeting, with colleagues from YMCA, Police, Safe Spaces and Cheltenham Borough Homes.
- **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

- The **Self-Management - Live Better, Feel Better** has shown positive results for how people manage their conditions and report their progress and concerns to health care staff. The service has managed to reach the right people as planned.
- 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 4,314 referrals made since the service began nearly 3 years ago. Of these referrals, 73% of individuals have shown an improvement in their mental health. Staff within Primary Care and the CCG are working closely together to make sure we have staff in the right places.

### We Can Move programme:

- Stroud district council have purchased 800 falls sets to train their housing staff. A total of 717 People have now received falls packs via community groups. These will help prevent people

from falling.

- There are currently 155 schools taking part in The Daily Mile. The 'Big Day' campaign registered 133 Gloucestershire primary schools, with a total of 26,380 children taking part. 27 of these schools had never run The Daily Mile before which was a fantastic outcome for this campaign.
- Barton & Tredworth women's steering group have linked to the Friendship Cafe Inspire women's project. Monthly female-only activity sessions and Wednesday Wellbeing Evenings are being planned. They are working with local activity providers to help train individuals.
- The first Active Travel session for staff was held and 2 new Action Learning Groups (young people and disability groups) took place in November. We are looking at how knowledge can be shared on line as well exploring the development of the 'We can move' website.

### Strengthening Local Communities

- In the Cotswolds 13 local people have been trained to become Community Dementia Link Workers and in Gloucester City, Monday evening community engagement drop-ins are being run by an active resident. In the area. .

### Supporting Workforce

- **Workplace Health and Wellbeing:** The Healthy Lifestyle Service has successfully recruited to the accreditator post. Work is underway to plan an official launch event for the new Gloucestershire accreditation.

### 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 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.

Health Education England funding has been approved to support the education and training approach in 2019/20 across primary care, community and acute care. There are significant opportunities for education across community and hospital teams including Pulmonary Rehabilitation, Leadership and Asthma.

Educational video and podcast resources are being planned and developed for the Forest of Dean.

There has been an agreement to change the description for Home Oxygen Assessment and detailed planning is under way. This change will enable a joined up approach to supported discharge to be embedded across the respiratory specialist team.

#### Diabetes:

The new National Diabetes Prevention Programme (NDPP) provider ICS Health and Wellbeing is working well and there have been 650 referrals made since August 2019. The CCG is working closely with Primary Care Networks to look at ways to increase referrals onto NDPP and share good practice examples.

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

The 10 Year Diabetes Strategy has been finalised and has been approved by the Diabetes Clinical Programme Group in November 2019.

The virtual clinics held by the GP Clinical Champion are progressing and working well.

A diabetes integration workshop is taking place with Gloucester City in December 2019 to test the proposed way of working.

The CCG was successful in being awarded £40,500 for using volunteering approaches to appoint a person/s with a lived experience of diabetes to interact with others in community setting to improve health & wellbeing outcomes.

#### Circulatory:

An evaluation workshop for the Community Stroke Rehab Unit has taken place with a report and action plan to follow

Atrial fibrillation (AF) podcast has been recorded as part of action in Primary Care. All practices are in the process of completing a review of patients prescribed treatment for AF to provide assurance that patients are receiving the correct dose.

We are looking at the journey for patients with chest pain who go to hospital. This involves working with the Urgent Care team to identify ways to reduce emergency admissions for this condition.

Gloucestershire Hospital has commenced a quality improvement project to increase referrals to Cardiac Rehab.

REACH-HF project for home-based rehabilitation for patients with heart failure is on track, with positive feedback from patients so far.

The Nature on Prescription project for people who have had a cardiac event is now on the 2nd intake and referrals are starting to be received for the Forest of Dean as well as Gloucester,

#### **Frailty & Dementia:**

At the most recent Frailty Clinical Programme Group, the group agreed the approach to divide people into 4 groups (pre-frail, patients living with mild frailty, patients living with moderate frailty and patients living with severe frailty). The definition of these groups was agreed and the approach to looking at data and defining appropriate interventions was also agreed.

Health Education England funded Young Onset Dementia training which was delivered to Community Dementia Nurses and Dementia Advisors which was well received and outcomes included best practice examples and research.

The Community Dementia Dog project has been extended to 12 months based on positive outcomes from mid-point review. The most effective and beneficial referral source is Social Prescribing and it is hoped that this can be continued. The national Dementia Dog project in Forest of Dean has seen a mix of regular community Dog Days and home based interventions.



## Focus on Stroke Early Supported Discharge (ESD)

The following case studies give some insight into the support the early supported discharge team and approach can give to stroke patients.

### Mr T

Mr T was seen over a period of 3 years and is now walking independently, managing the stairs and his speech continues to improve. He has the flexibility to self-refer back to Assessment and Rehabilitation Unit as required. Mr T's discharge from the Dean Hospital was expedited by ESD therefore making cost savings and enabling him to get home which benefitted his wellbeing and rehabilitation. The severity/complexity of his stroke required longer term stroke specialist intervention and there was an overall improvement achieved with further rehabilitation. The fact that Mr T could access the Tewkesbury Assessment and Rehabilitation Unit after ESD and the community neuro physio specialist enabled him to achieve his goals of walking independently indoors, making a meal for himself, attending to his own personal care (therefore not being reliant on a package of care) and improve his cognition.

### Mr C

Mr C benefitted from 12 weeks with ESD, preventing admission to another rehabilitation facility or needing to go out of county for treatment. Mr C had significant loss of independence with regards to his communication, personal care, mobility and had already had a long stay in hospital, he needed a significant level of input from the Occupational Therapists, Physiotherapist and Speech and Language Team over the 12 week period:

- At 6 weeks he was walking supported with one carer, but it was evident that he was unlikely to be independently mobile in the future. The additional 6 weeks enabled ESD to concentrate on getting him out of the house, exploration of potential interests/hobbies and onward referral for Electrically Powered chair.
- Mr C and his wife needed time to adjust to life after stroke. It was essential that ESD had adequate time to support this beyond the standard 6 weeks of service. At discharge Mr C and his wife felt well supported and that great progress had been made in the 12 weeks, with onward plans established.
- He significantly improved in confidence in his ability to transfer, balance and mobilise with supervision from his wife independently in his home environment.
- 

Mr C did not fit into the mild to moderate category of stroke and as such did not meet ESD criteria. However, the team accepted him because it was his best interests to receive stroke specialist input and because there was no other appropriate community service available. Mr C would not have been able to attend outpatient services at 6 weeks as he was still unable to get out of the house, get in a car, and was too fatigued to have managed a session if he had been taken on hospital transport. Providing longer term intervention at home was definitely the most appropriate service for him.

## 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 is 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.
- Funding from the Primary Care Training Hub has enabled Gloucestershire CCG to run training days for GPs covering how to identify skin lesions and how to take high quality images. Training days were well received with a total of 96 GPs being trained. Further resources to continue to support learning have been provided on the G-care website.
- In Rheumatology the GP practices with high numbers of inappropriate referrals have been identified and agreed a programme of training with GPs in Forest of Dean to improve their knowledge of Rheumatic Disorders.
- Primary care pathology differences was investigated and presented at Reducing Clinical

Variation Board (RCV). The RCV Board agreed that a series of bitesize guides for primary and secondary care would be beneficial.

- The £200 million capital announcement for replacement of old (over 10 year at March 2019) diagnostic equipment resulted in the hospital receiving an allocation of new machines.

## 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:

- The Population Health Management Programme across Cheltenham ILP has been well received and has gathered momentum. Each PCN has defined their patient cohort in conjunction with wider community partners.
- A planning event was held for Tewkesbury ILP in December and wider partners have been asked to suggest collective priorities in January and agree them during February. All Remaining ILPs have agreed collective priorities.

### South Cotswolds Frailty Service

- Flu' clinic packs have been assembled and Wellbeing Coordinators have dates in their diary to attend the clinics.

- Work continues to look at identifying and supporting people who are at the End of Life. This includes supporting GP practices. Looking at how patients can be supported to call the Frailty Team directly. This will help make sure that resources are used correctly and free up Frailty team time
- Aiming to improve partnership working with Cirencester Community Hospital
- Development of a communications and training plan for the Ambulance Trust, to include Me @ My Best and training on managing frailty in urgent situations is being developed.

## 5b. One Place, One Budget, One System

### 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 of 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 Fit for the Future 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

The Fit for the Future engagement was on ‘pause’ during the pre-general election purdah period but is now however, ready to resume conversations.

An independent Citizens’ Jury will meet on 20<sup>th</sup> January to begin its work and look at how specialist hospital services in Gloucestershire could develop in the future. The Jury will sit for five days in public with participants reflecting the county’s diverse population.

Jury members will consider feedback from the Fit for the Future public and staff engagement, together with evidence on the need for change across Gloucestershire’s two main hospital sites – Cheltenham General and Gloucestershire Royal. They will hear from NHS staff working in the services, from public and patient representatives and from a variety of other speakers on relevant topics.

They will consider, and be asked for their views on, a vision for centres of excellence approach to providing hospital services. This approach reflects the way a number of services are already delivered across the Trust such as stroke, children’s services and trauma and orthopaedics, which is serving patients well.

Following a period of advertising, 181 people applied to be a member of the Jury. 18 people were selected and are broadly representative of the people of Gloucestershire in relation to age, gender, education, ethnicity and postcode.

## 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

- Cinapsis (an Advice and Guidance system), has now been rolled out to 58 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 (JUJI) is being viewed 240 times a day on average supporting the sharing of information across our health and care providers.
- 26.08% of patients are now registered for online primary care digital services.
- A Children's & Young People Mental Health digital bid has been submitted for central support to develop an online portal for young people to manage their appointments, advice, message their therapist and access a moderated group chat

### 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.

The Leadership Programme is progressing well and positive feedback has been received. In terms of cohorts;

- Cohort 3 (Urgent Care) has finished the programme;
- Cohort 4 (Dementia & Frailty) remains ongoing;
- Cohort 5 (CVD & Diabetes) remains ongoing; and
- Cohort 6 (Respiratory & End of Life Care) remains ongoing.

We held our first workshop to look at the whole system impact of the promoted new roles in primary care. This focused around pharmacists and working together as a system to support the best way to deliver these new roles.

### 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. The proposal for a new Minchinhampton surgery has been approved.

### 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:

- enable services to remain flexible and 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.

**Developing the Primary Care Workforce:** A number of schemes are ongoing to help develop and improve the Primary Care Workforce. We have continued the Care Navigation trial with a training provider. Roles Reimbursement scheme is continuing with a Gloucestershire ICS stakeholder workshop for Pharmacy and Medicines Optimisation and this took place on 10 December 2019. There are Three GPs currently on the Health Equalities Fellowships scheme. The Primary Care Workforce website has been developed.



### Focus on Digital Technology

Our vision is to work together to deliver digital convergence and collaboration across the ICS and to ensure that digital technology is one of the key drivers facilitating service transformation and sustainability. We will invest in a sustainable and underpinning technical infrastructure to support the delivery of transformational service changes, driven by care professionals and focused on empowering people to take control of their own health and care.



1. **Converge our digital, data and technology platforms, services and teams** to overcome funding, expertise and care co-ordination barriers.
2. **Closer formal linkages with clinical and transformation programmes**, to ensure the right solutions that are most likely to realise the greatest benefits are prioritised.
3. **The ICS governance to make system wide decisions will be refreshed** to increase visibility, co-ordinate investments and speed-up decision making.
4. **Starting to develop our skills in Agile digital delivery and user centred design processes** will increase the value of investments, visibility of progress and velocity.
5. **Developing career pathways and skills development programmes** will increase our expertise, retain more staff and attract new high quality people of high quality.
6. **Care CIOs will be developed and embedded into our delivery processes** to improve the design and adoption of digital services.
7. We can't do this alone, so **need to develop our partnerships with academia, industry, suppliers and other ICS'. Partnerships**, This will focus on raising our expertise levels, sharing effort, cost efficiencies and planning for the future.

11.1

**So Far....**

- The first phase of the new Hospital Electronic Patient Record went live in Gloucester Royal Hospital in December. This started with electronic documentation, tracking boards and a clinical record portal, which also allows access to a Shared Care Records. Time savings for staff as well as improved quality of care are already being evidenced, helped by a high level of engagement from nursing staff in In-patient wards.
- The clinician to clinician messaging pilot, called Cinapsis, has been rolled out to 68 GP practices and the frailty service. This allows GPs to seek specialist advice on patients that may need to be sent to urgent care services and dermatology services. Early feedback on the impacts are positive
- Funding has been awarded to the hospital and mental health services in Gloucestershire to implement Electronic Prescribing and Medicines Administration. This will improve safety and efficiency significantly compared to the paper based mechanisms in place currently.
- 40 new GP websites have gone live, including new capabilities to do online messaging from patients to the practices. A programme of support is being developed for best usage and benefits from increasing usage of digital primary care services.
- A new Gloucestershire Digital Technology professional network has been established called Glos Care Informatics. The Academic Health Science Network has sponsored the first two events and speakers have been lined up for the next two from national and local teams. The group aims to increase the network, skills and knowledge of technology and health care staff in the county. This includes introducing aspiring informaticians to the career pathways and opportunities to learn more.

## 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;

- Dame Gill Morgan has been appointed as Independent Chair of the One Gloucestershire Integrated Care System (ICS) and has taken up her role in January 2020. Gill has enjoyed a long and distinguished career in the NHS and third sector at national and local level. She has extensive

leadership experience having held a number of senior roles including Chair of the Alzheimer's Society, Chief Executive of the NHS Confederation and Chief Executive of North and East Devon Health Authority. She has also been a Permanent Secretary in the Welsh Government. More recently Gill has been Chair of NHS Providers since 2014, Vice Chair of the Lloyds' Bank Foundation for England and Wales, Commissioner (Vice Chair) for the review of physical and sexual abuse in women suffering multiple disadvantages and is Patron of the Infection Prevention Society. We are excited to welcome her to the One Gloucestershire system.

- One Gloucestershire ICS Web 'Bitesize' Priority Summaries: A useful resource for community partners and health and care professionals these summaries cover everything from active communities to transforming services. The summaries cover what we are doing as a partnership, a case study and highlight our plans going forward. The first 16 summaries have recently been added to the onegloucestershire.net website and provide a 'bitesize' overview of ICS priorities. A further 13 are in production. The summaries can be found at <https://www.onegloucestershire.net/>
- The third draft of the One Gloucestershire Long Term Plan response has been submitted and the overall shift in compliance was positive. The plan is moving towards finalisation with a plan to publish a public facing guide and the full narrative plan.
- A number of system wide strategies are progressing rapidly including outpatients, digital, primary care, Health & Wellbeing Strategy and the Prevention & Inequalities Framework.

## 8. Recommendations

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

**Mary Hutton**

ICS Lead, One Gloucestershire ICS

## Agenda Item 12

### Governing Body

<b>Meeting Date</b>	<b>Thursday 30 January 2020</b>
<b>Report Title</b>	<b>Quality Report</b>
<b>Executive Summary</b>	This report provides assurance to the Governing Body that quality and patient safety issues are given the appropriate priority.
<b>Key Issues</b>	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.
<b>Risk Issues: Original Risk (CxL) Residual Risk (CxL)</b>	Failure to secure quality, safe services for the population of Gloucestershire
<b>Management of Conflicts of Interest</b>	Not applicable
<b>Financial Impact</b>	There is no financial impact
<b>Legal Issues (including NHS Constitution)</b>	Compliance with the NHS Constitution, NHS Outcomes Framework and recommendations from NICE and CQC.
<b>Impact on Health Inequalities</b>	A focus on the delivery of equitable services for the residents of Gloucestershire and which will reflect the diversity of the population served.
<b>Impact on Equality and Diversity</b>	There are no direct health and equality implications contained within this report.
<b>Impact on Sustainable Development</b>	There are no direct sustainability implications contained within this report.
<b>Patient and Public Involvement</b>	There is no impact
<b>Recommendation</b>	The Governing Body is asked to note the contents of this report.
<b>Author</b>	Marion Andrews-Evans
<b>Designation</b>	Executive Nurse and Quality Lead
<b>Sponsoring Director (if not author)</b>	Not applicable

<b>1</b>	<b>Introduction</b>																																		
	<p>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.</p> <p>Formal assurance of the quality of NHS contracted 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</p>																																		
<b>2</b>	<b>Summary Serious Incidents &amp; Never Events</b>																																		
<b>2.1</b>	<p>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.</p>																																		
<b>2.2</b>	<p>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.</p>																																		
<b>2.3</b>	<table border="1"> <thead> <tr> <th style="background-color: #4F81BD; color: white;">Gloucestershire Hospitals NHF FT</th> <th>Q2 2018/19</th> <th>Q3 2018/19</th> <th>Q4 2018/19</th> <th>Q1 2019/20</th> <th>Q2 19/20</th> <th>Q3 19/20</th> </tr> </thead> <tbody> <tr> <td>Never Event</td> <td style="text-align: center;">1</td> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> <td style="text-align: center;">1</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Serious Incidents</td> <td style="text-align: center;">6</td> <td style="text-align: center;">5</td> <td style="text-align: center;">5</td> <td style="text-align: center;">7</td> <td style="text-align: center;">9</td> <td style="text-align: center;">6</td> </tr> <tr> <td></td> <td style="text-align: center;"><b>7</b></td> <td style="text-align: center;"><b>5</b></td> <td style="text-align: center;"><b>6</b></td> <td style="text-align: center;"><b>8</b></td> <td style="text-align: center;"><b>10</b></td> <td style="text-align: center;"><b>8</b></td> </tr> </tbody> </table>							Gloucestershire Hospitals NHF FT	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 19/20	Q3 19/20	Never Event	1	0	1	1	1	2	Serious Incidents	6	5	5	7	9	6		<b>7</b>	<b>5</b>	<b>6</b>	<b>8</b>	<b>10</b>	<b>8</b>
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<b>2.4</b>	<b>Gloucestershire Health and Care NHSFT</b>	Q3 2019/20					
	<b>Never Event</b>	<b>0</b>					
	<b>Serious Incidents</b>	<b>9</b>					
		<b>9</b>					
<b>2.5</b>	Legacy reporting for 2g and GCS						
	<b>Gloucestershire Care Service NHS Trust</b>	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 19/20
	Never Event	0	0	0	0	0	1
	Serious Incidents	3	1	5	2	5	0
		<b>3</b>	<b>1</b>	<b>5</b>	<b>2</b>	<b>5</b>	<b>1</b>
	<b>2gether NHS FT</b>	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 19/20
	Never Event	0	0	0	0	0	0
	Serious Incidents	7	3	10	5	4	12
		<b>7</b>	<b>3</b>	<b>10</b>	<b>5</b>	<b>5</b>	<b>12</b>
<b>2.6</b>	<b>Never Events</b>						
	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 3 two Never Events have occurred with GHNHSFT. One Never Event relates to wrong site surgery on varicose veins and the other also wrong site surgery on a little finger.						

<b>3</b>	<b>Patient Advice and Liaison Service (PALS) Activity</b>																																																																													
<b>3.1</b>	<p><b>GCCG Patient Advice and Liaison Service (PALS)</b>                  The table below gives a breakdown of the types of enquiries the CCG PALS team has responded to during Q3 2019.</p> <table border="1"> <thead> <tr> <th>Type</th> <th>Q2 18/19</th> <th>Q3 18/19</th> <th>Q4 18/19</th> <th>Q1 19/20</th> <th>Q2 19/20</th> <th>Q3 19/20*</th> </tr> </thead> <tbody> <tr> <td>Advice Information</td> <td>1 (PC 12)</td> <td>110 (PC 22)</td> <td>38 (PC 8)</td> <td>38 (PC 11)</td> <td>21 (PC 8)</td> <td>51 (9 PC)</td> </tr> <tr> <td>Comment</td> <td></td> <td>11 (PC 4)</td> <td>0</td> <td>1</td> <td>0</td> <td>1</td> </tr> <tr> <td>Compliment</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> <td>4</td> <td>1</td> </tr> <tr> <td>Concern</td> <td>110 (PC 14)</td> <td>75 (PC 22)</td> <td>72 (PC)</td> <td>50 (PC 10)</td> <td>35 (PC6)</td> <td>46 (PC 12)</td> </tr> <tr> <td>Complaint about GCCG</td> <td>5</td> <td>7</td> <td>5</td> <td>7</td> <td>12</td> <td>12</td> </tr> <tr> <td>Complaint about provider</td> <td>18</td> <td>18 (PC 5)</td> <td>35</td> <td>33 (PC 7)</td> <td>33 (PC2)</td> <td>36 (8PC)</td> </tr> <tr> <td>NHSE complaint responses copied to GCCG PALS</td> <td>0</td> <td>0</td> <td>1</td> <td>10*</td> <td>15*</td> <td>16**</td> </tr> <tr> <td>Other</td> <td>52 (PC 5)</td> <td>34 (PC 4)</td> <td>67 (PC 9)</td> <td>74 (PC 6)</td> <td>87 (PC15)</td> <td>57 (16 PC)</td> </tr> <tr> <td>Clinical Variation (Gluten Free)</td> <td>2</td> <td>0</td> <td>1</td> <td>1</td> <td>1</td> <td>0</td> </tr> <tr> <td><b>Total contacts</b></td> <td><b>288</b></td> <td><b>257 (PC 57)</b></td> <td><b>221</b></td> <td><b>216 (PC 34)</b></td> <td><b>208 (PC46)</b></td> <td><b>220 (PC 53)</b></td> </tr> </tbody> </table> <p>*(Please note not a compete Q)                  ** <b>NHSE complaint investigations &amp; responses copied to GCCG PALS:</b> NHSE are now consistently sharing complaints for logging only.</p>	Type	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20*	Advice Information	1 (PC 12)	110 (PC 22)	38 (PC 8)	38 (PC 11)	21 (PC 8)	51 (9 PC)	Comment		11 (PC 4)	0	1	0	1	Compliment	2	2	2	2	4	1	Concern	110 (PC 14)	75 (PC 22)	72 (PC)	50 (PC 10)	35 (PC6)	46 (PC 12)	Complaint about GCCG	5	7	5	7	12	12	Complaint about provider	18	18 (PC 5)	35	33 (PC 7)	33 (PC2)	36 (8PC)	NHSE complaint responses copied to GCCG PALS	0	0	1	10*	15*	16**	Other	52 (PC 5)	34 (PC 4)	67 (PC 9)	74 (PC 6)	87 (PC15)	57 (16 PC)	Clinical Variation (Gluten Free)	2	0	1	1	1	0	<b>Total contacts</b>	<b>288</b>	<b>257 (PC 57)</b>	<b>221</b>	<b>216 (PC 34)</b>	<b>208 (PC46)</b>	<b>220 (PC 53)</b>
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<b>3.2</b>	<p><b>GCCG 12 Complaints</b></p> <p>This breaks down as follows:</p> <ul style="list-style-type: none"> <li>• 3 x commissioning (communications in CYPS, Pain services</li> </ul>																																																																													

<p><b>3.3</b></p>	<p>and Health &amp; Social Care).</p> <ul style="list-style-type: none"> <li>• 2 x MP complaints from constituents (Autism Pathway &amp; Neurological Services for a young person).</li> <li>• 6 x CHC complaints (retrospective funding, fast track and outcome, Personal Health Budget).</li> <li>• 1 x over the counter prescribing of QV wash.</li> </ul> <p><b>Engagement activities</b></p> <p>Currently the CCG Engagement Team is involved in activities across all localities and the majority of programme areas across the ICS. The following are examples of recent and current engagement activities:</p> <p><b><i>Fit for the future (FFTF) Engagement</i></b></p> <p><b>Output of Engagement</b></p> <p><a href="https://www.onegloucestershire.net/yoursay/fit-for-the-future-output-of-engagement/">https://www.onegloucestershire.net/yoursay/fit-for-the-future-output-of-engagement/</a></p> <p>The FFTF Output of Engagement Report and Appendices was published on 6 January 2020. A presentation of the highlights from the Engagement was presented to the Health Overview and Scrutiny Committee on 14 January 2020. The contents of the Output of Engagement Report will be reviewed in detail by NHS partners and will help inform the development of potential solutions and options for change.</p>
<p><b>3.4</b></p>	<p><b>Engagement Activity Summary:</b></p> <ul style="list-style-type: none"> <li>• Over 3300 local people took part in planned activities</li> <li>• Over 50 events</li> <li>• 1230 FFTF online surveys completed</li> <li>• 1252 FFTF surveys (template) received from Cheltenham MP</li> <li>• 153 FoD Hospitals surveys completed</li> </ul>
<p><b>3.5</b></p>	<p><b>Feedback focussed on the following themes:</b></p> <ul style="list-style-type: none"> <li>• Centres of excellence: Both positive and negative feedback about this approach to future hospital service configuration</li> </ul>

	<ul style="list-style-type: none"> <li>• Quality/Equity/Sustainability</li> <li>• Access</li> <li>• Population growth/demographic</li> <li>• £Funding</li> <li>• Workforce / Technology</li> <li>• Communications/pathways</li> <li>• Access to GP services</li> <li>• Integration</li> <li>• Workforce</li> </ul> <p><b>3.6 Next steps</b></p> <p>First stage</p> <ul style="list-style-type: none"> <li>• Consideration of Output of Engagement Report</li> <li>• Citizens’ Jury</li> <li>• Solutions Appraisal</li> </ul> <p>Second stage</p> <ul style="list-style-type: none"> <li>• Development of business cases</li> <li>• NHS England Assurance</li> </ul> <p>Third stage</p> <ul style="list-style-type: none"> <li>• Consultation (as required)</li> <li>• Consideration of Output of Consultation</li> <li>• Decisions</li> </ul> <p><b>3.7 Centres of excellence Citizens’ Jury – w/c 20 January 2020</b></p> <p>An independent Citizens’ Jury will meet in January 2020 to begin its work to look at how specialist hospital services in Gloucestershire could develop in the future. 18 local residents have been recruited as Jurors by Citizens’ Jury Community Interest Company (CIC), to reflect the county’s diverse population.</p> <p>Jury members will consider feedback from the <i>Fit for the Future</i> public and staff engagement, together with evidence on the potential for change across Gloucestershire’s two main hospital sites – Cheltenham General and Gloucestershire Royal.</p> <p>Jurors will hear from NHS doctors about current services, from public and patient representatives and from a variety of other speakers on</p>
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	<p>relevant topics. They will consider, and be asked for their views on, the idea of developing the <i>centres of excellence</i> approach to providing hospital services. This approach reflects the way a number of services are already delivered across the Trust.</p> <p>They will also make recommendations on their priorities for development of three specialist hospital services - general surgery, image guided surgery and emergency and acute medicine.</p> <p>This Jury forms part of the FFTF Engagement. A second Citizens' Jury is planned for later in the year to make recommendations to us about how the three specialist hospital services should be provided. Ultimately, it is the responsibility of One Gloucestershire NHS partners to pay attention to the feedback received during the Engagement and during any subsequent public Consultation.</p> <p><b>3.8 Phlebotomy</b></p> <p>A Patient and Public engagement workshop was held on 29 November 2019 which enabled testing of some ideas and identification of the top priorities patients would like from a Phlebotomy Service. A survey has been developed and tested with patients to enable a baseline for patient experience of the current Phlebotomy service to ensure any changes are an improvement. Any feedback will be used to develop solutions for local potential service developments.</p> <p><b>3.9 Engagement support in Primary Care</b></p> <p><b>Practice support</b></p> <p>The GCCG Engagement Team continues to support practices undergoing change, such as branch closures, staff changes and premises developments. Currently the CCG is providing specific support to practices in Stroud and Berkley Vale, Gloucester City, Cheltenham, Forest of Dean and South Cotswolds Localities.</p> <p><b>Examples of CCG Engagement Team support in primary care: HOSC visit to Aspen Medical Centre and Hucclecote and Brockworth redevelopment</b></p> <p>The CCG Engagement team supported a visit of members from</p>
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	<p>Gloucestershire Health Overview and Scrutiny Committee to Aspen Medical Centre. This visit included an opportunity for HOSC members to meet and ask questions of senior partners, Aspen staff and PPG members. This was followed by a tour of the centre. The visit was very successful and allowed good practice and learning to be shared.</p> <p>Members of the CCG Engagement Team have been liaising closely with Hucclecote Surgery and Brockworth Surgery (and their respective PPGs) to support engagement with their combined practice patient populations on the proposal to relocate the two practices into a purpose built facility. The practices have run a survey which has been completed by 253 patients across both practices. The general feedback has been positive regarding the new practice estate development. The practices have also held a joint drop in engagement event attended by over 80 people.</p>
<p><b>3.10</b></p>	<p><b>Countywide Patient Participation Group (PPG) Network</b></p> <p>The PPG Network last met on 22 November 2019. There was a varied agenda for this last PPG Network meeting of 2019:</p> <ul style="list-style-type: none"> <li>• 15 Steps Challenge with PPG's, Sophie Ayre – Social Inclusion Development Worker Gloucestershire Health and Care NHS Foundation Trust</li> <li>• Knead 2 Know project – positive later life planning in the community, Rob Fountain – CEO, Gloucestershire Age UK and Abby Guilding, Wiggly Worm</li> <li>• Spotlight on... Use of technology in your PPG, Kevin Gannaway-Pitts –member Aspen Medical Practice PPG</li> <li>• Personalised Care in Gloucestershire, Joanne Appleton – Programme Manager, Personalised Care NHS Gloucestershire Clinical Commissioning Group</li> </ul> <p>The next PPG Network Meeting is scheduled for 14 February 2020.</p>
<p><b>3.11</b></p>	<p><b>PPGs, PCNS and ILPs</b></p> <p>Involvement of PPG in PCNs and ILPs continues to grow across the county with different areas trying different approaches. The CCG Engagement Team provides support where required and is researching</p>

	current PPG involvement in order to identify any gaps and opportunities for joint working and shared learning. It is intended to design and present a countywide PCN engagement offer in the New Year for consideration by ILPs, PCNs and the CCG Locality Development Team.
<b>4</b>	<b>Infection Control</b>
<b>4.1</b>	<p><b>Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia</b></p> <p>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.</p> <p>1 April 2019 – 30 December 2019 there has been seven MRSA Bacteremia cases assigned to the Gloucestershire CCG. The hospital onset cases include 2 cases from GHNFT and 2 cases from Southmead Hospital. Three cases had a community onset.</p>
<b>4.2</b>	<p><b>Clostridium difficile Infections (CDI)</b></p> <p>The threshold set by NHS Improvement (NHSI) for Gloucestershire for 2019/20 is 194 cases which equates to 16 or less cases per month.</p> <p>Initially this year the number of CDI cases reported in Gloucestershire showed a downward trend compared to 2018/19. However due to an increase in cases since October 2019 we anticipate exceeding the threshold target. As of 31 December 2019 158 cases have been reported. These can be broken down into 75 cases with a hospital onset, 79 cases with a community onset and 4 cases with an unknown onset.</p> <p>Factors identified as contributing to the increase in cases includes changes in cleaning practices in the Acute Hospital Trust and a CDI outbreak in a hospital. Higher levels of norovirus in the community than usual over November and December may have increased testing of stool specimens and the identification of CDI.</p>
<b>4.3</b>	The CDI outbreak was robustly investigated, learning identified and actions for improvement implemented. Work is in progress to address

<p><b>4.4</b></p> <p><b>4.5</b></p> <p><b>4.6</b></p>	<p>the problems impacting cleaning on in the hospital.</p> <p>An Assurance Panel chaired by the CCG meets monthly to review CDI cases reported as hospital onset. The panel further oversees the CDI reduction strategy. Under this strategy is an action plan for each Trust, also there are collaborative actions undertaken to reduce CDI. An example of an action is the development of an educational initiative to improve diarrhoea management across all health care settings.</p> <p><b>Gram Negative Bloodstream Infections (GNBIs) Escherichia coli (E.coli) Infections</b></p> <p>The national ambition, announced by the Government in 2016, is to halve the number of healthcare-associated Gram-negative bacteraemia by March 2021.</p> <p>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.</p> <p>The Quality Premium for 17/19 (two years) includes an annual threshold target of 257 incidences of E.coli Bloodstream infections in Gloucestershire.</p> <p>April 2019 – December 2019, 207 <i>E.coli</i> bacteraemia cases were reported of which 42 cases (20%) had a hospital onset and 165 cases (80%) a community onset.</p> <p>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.</p> <p>Due to our lower rate of Urinary Tract Infections (UTI) a team from NHSE are visiting the county in February to learn about the actions being taken to reduce UTI infections.</p> <p><b>Influenza Season 19/20 Update</b></p> <p>The level of influenza reported across the county remains lower than the National picture with the peak of reported cases being in week 52.</p>
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During November 2019 two wards at Cirencester Community Hospital reported cases (both staff and patients). Since week 2 of 2020 confirmed cases of influenza A have been reported in the Acute Mental Health Trust (2 wards) and Acute Trust (4 wards) involving staff and patients.

Starting in week 2 of 2020 cases of Influenza A are being reported in care homes. A Point of Care Testing programme is in place facilitating quick diagnosis, appropriate implementation of infection control processes and the use of antivirals to diminish the spread of Influenza.

Feedback from Primary Care indicates that consultations mainly consist of coughs, colds, chest infections etc. Consultations for flu have been lower in Gloucestershire compared to the rest of the South West.

**Flu vaccination uptake for frontline workers**

Flu vaccination uptake for frontline workers exceeds 80% (CQINN target) for both Gloucestershire Trusts. It is currently 81% for GHNFT and 86% for GHC. These are some of the best staff vaccination rates in the South West.

**Flu vaccinations for care home staff**

Gloucestershire County Council has commissioned a provider to deliver flu vaccinations to care home staff at their place of work. The pilot included approximately 60 care homes. The initial data indicates approximately 500 flu vaccinations have been given. The report, with confirmed data, is anticipated in March 2020.

**4.7 Flu vaccination uptake for high risk patients**

**Current Uptake % - Flu vaccination for At risk groups  
Week 1 (w/e 05/01/2020)**

At risk group	65+	<65yrs Risk Groups	Pregnant All	Pregnant At risk	2-under 5yrs Risk Groups	5-under 16yrs Risk Groups
2019/20	74	42.2	43	54.4	40.6	25.3
Target	74	44	43	54.4	40.6	25.3

5	<b>Provider Updates</b>
5.1	<p><b>Gloucestershire Hospitals NHS Foundation Trust</b></p> <p><b>Risk and Assurance-</b> Oversight of Quality and Safety risks is an essential part of the Trust’s Quality and Performance Committee to ensure alignment and appropriate challenge of key quality and safety concerns.</p> <p>The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures and reduce patient flow as a result of high registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital has been added as a new quality and performance risk to the register.</p> <p>Along with a risk for Emergency General Surgery described as the risk of sub-optimal surgical staffing caused by a combination of insufficient trainees, senior staff and increased demand. This has resulted in compromised trainee supervision, excessive work patterns and use of agency staff impacting on the ability to run a safe and high quality surgical rota. Also a risk to patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients.</p> <p>A Single Item Quality Surveillance Group was called by Region, attended by the CCG. To share intelligence about the risks to quality.</p> <p>There remains a risk that inadequate cleaning could contribute to further acquisition of Hospital Acquired Infections (HAIs) and possibly result in outbreaks. This could be further confounded by a seasonal increase in transmissible infections such as Influenza and Norovirus over the coming months. The CCG continues to work with the Trust to ensure improvements to the standard of cleaning and mitigate risk to patients including establishing an escalation and prioritisation process for clinical area estates issues, regular monitoring of compliance and audits.</p>
5.2	

### **GHC NHS Foundation Trust**

On the 1<sup>st</sup> 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 4, 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.

**Workforce-** The CCG have raised concerns with GHC in relation to workforce risks and the impact on quality. There is also an overlap with other areas such as finance within agency spend. The GHC Quality and Operational directorates are undertaking a piece of work around further developing safe staffing reporting and how it is reported to Trust Board and the CCG.

The key issues highlighted are:

- Community nursing vacancies in some localities are high.
- Inpatient Nursing vacancy rate circa RMN 30% and RN 20%
- Medical vacancy level covered by locums at Wotton Lawn Hospital is 70%
- RMN staff moving from inpatient units to community posts for promotion or specialisation.
- There were more RMN students recruited in 2019 than in 2018.
- There is a variation in acuity/length of stay requiring additional staff.
- Nursing Safe Staffing has been “maintained” against national standards
- Dilke and Tewkesbury community hospitals have high nursing vacancy rate circa 21%.

5.3	<p>The GHC Director of Nursing and Quality has agreed to lead a focussed piece of work in order to understand the safe staffing information in greater detail and triangulate it with patient quality measures.</p> <p>The GHC Patient Safety Team have held a series of workshops throughout December 2019 to map and explore in detail the legacy processes for Incident Management (including SIRIs), Duty of Candour and Complaints Management for both GCS and 2G. These processes are now being reviewed and harmonised to develop fully integrated approaches for GHC for implementation from April 2020. An additional workshop is planned for January 2020 to further progress this and to consider the approach to embedding learning/provision of learning assurance. The CCG have been in attendance at all workshops.</p>
<b>6</b>	<b>Quality Team Activity</b>
6.1	<p><b>Practice Nurse Development</b></p> <p>GCCG is running a series of Practice Nurse/Health Care Assistant training sessions in March and May covering immunisations and travel health. These sessions cover both introductory training and annual update. Registration for these sessions has been high and further dates will be planned for the autumn prior to ensure all nurses/HCA's have the opportunity to attend.</p>
6.2	<p>GCCG received funds from NHSE to specifically support awareness raising and implementation of the General Practice Nursing 10 Point Plan. Events are being held in localities during January 2020 with a training event planned in support of this aim in June 2020.</p>
6.3	<p><b>Gloucestershire Non-Medical Prescribing Update</b></p> <p>GCCG is holding a Non-Medical Prescribing (NMP) update day on 18<sup>th</sup> March. This event is open to all NMP's in county, ensuring a multi-disciplinary attendance, and will be titled Personalising Patient Care in Gloucestershire. Registration has been good and all 80 places are currently full.</p>

<b>6.4</b>	<b>2020 The Year of the Nurse and Midwife</b>  The CCG are leading a working group containing nurses from all providers in county to develop a programme of activities throughout the year to celebrate the work of nurses and midwives.
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**Agenda Item 13****Governing Body**

<b>Meeting Date</b>	30/01/2020
<b>Title</b>	Fit For the Future Outcome of Engagement report
<b>Executive Summary</b>	The Fit for the Future (FFTF) public and staff engagement programme started in August 2019 to seek views on the future provision of urgent and specialist hospital care in Gloucestershire. All feedback received is collated into this comprehensive Engagement Report and online appendices and will be used to inform the development of potential solutions for future local NHS services.
<b>Link to the Report/Appendices</b>	<a href="https://www.onegloucestershire.net/yoursay/fit-for-the-future-output-of-engagement/">https://www.onegloucestershire.net/yoursay/fit-for-the-future-output-of-engagement/</a>
<b>Key Issues</b>	See below -
<b>Risk Issues: Original Risk Residual Risk</b>	<p>If we fail to take into account the outputs from the engagement report then views expressed may not be accounted for.</p> <p>Then this may be challenged at some stage in the process resulting in the process timeline being affected and costs may increase.</p> <p>Original risk score 5 x 3 = 15 (Red) Residual risk score 5 x 2 = 10 (Amber)</p>
<b>Financial Impact</b>	Legal challenge may result in costs being incurred. Financial impact is currently not quantifiable.
<b>Legal Issues (including NHS Constitution)</b>	See above.
<b>Impact on Health Inequalities</b>	Health inequalities will be managed through a baseline integrated impact assessment. A further impact assessment will be completed



	for each of the clinical model design options.
<b>Impact on Equality and Diversity</b>	Equality & Diversity will be managed through a baseline integrated impact assessment. A further impact assessment will be completed for each of the clinical model design options.
<b>Impact on Sustainable Development</b>	It is currently assumed that any service design reconfiguration will be within the current financial envelope.
<b>Patient and Public Involvement</b>	This report summarises the engagement phase of the programme which has involved a detailed patient and public involvement exercise. A future phase of the programme will focus on a consultation of potential design options involving both patient and public representation.
<b>Recommendation</b>	To note the comments raised within the report.
<b>Author</b>	Becky Parish / Micky Griffith
<b>Designation</b>	
<b>Sponsoring Director (if not author)</b>	

# Output of Engagement

The FFTF Engagement sought views on the future provision of urgent and specialist hospital care in Gloucestershire.

# Key Findings

A comprehensive Output of Engagement Report can be found at:  
[www.onegloucestershire.net](http://www.onegloucestershire.net)

Date:  
January 2020

## ***What was the engagement about and what did we ask the public and staff to help us with?***

### **The engagement was an opportunity to talk about :**

- the ways services could be organised to get the best urgent advice, support and care across Gloucestershire
- The benefits of having two thriving specialist hospitals in future in Cheltenham and Gloucester

### **We said we think it's important to:**

- make it easier, faster and more convenient to get advice, support and services 7 days a week
- ensure care is co-ordinated
- provide most care in or near home
- ensure high quality services in the right place: right staff, skills and equipment
- Have outstanding hospital care when you are unwell

## ***What was the engagement about and what did we ask the public and staff to help us with?***

### **We asked the public and staff:**

- **to help us to develop ideas** to support easier, faster and more convenient ways to get urgent same day advice and care wherever people live in Gloucestershire
- **what's important to them** in getting urgent (not life threatening) same day advice and care
- **to tell us what they think about** our ideas for a '*centres of excellence*' approach to providing specialist services at the two large hospital sites in the county
- **to help us with developing potential solutions** for some specialist services: Emergency and Acute Medicine, General Surgery and Image Guided Interventional Surgery
- **to consider** the new hospital for the Forest of Dean

## What did we do during the public engagement and how many people got involved?

- **1230** FFTF online surveys completed
- **1252** FFTF surveys (template) received from Cheltenham MP
- **153** FoD Hospitals surveys completed
- **28** Public Drop in Events
- **12** Independently facilitated workshops
- **1** Engagement Hearing
- **13** Other events
- Staff communication and engagement
- Media advertising
- **Website** - **18,872** views of the One Gloucestershire website, incl. 4,755 views of the Fit for the Future engagement page.
- **1,800** visits to the Forest of Dean website
- **21 Facebook** posts (non- paid for activity), with a total reach of 34,406.
- 4-week paid for **Facebook** advert that linked to the engagement section on the One Gloucestershire website. This achieved a reach of **57,440** with **82** shares.
- **49 tweets**, with a total of 42,625 impressions.
- **7,000** Hardcopy engagement booklets



**OVER 3300 local people participated in planned activities – but the focus of engagement is not about numbers it is about receiving qualitative feedback from a broad range of people**

## Does the feedback reflect the views of a cross-section of people in Gloucestershire?

We worked with **Inclusion Gloucestershire** to ensure the voices of people with protected characteristics were heard



We collected a range of demographic data from the FFTF survey respondents\* **Age, Role, Postcode, Disability status, Carer status, Ethnicity, Religion/belief, Gender identity, Sexual orientation, whether Pregnant or recently given birth.**

Respondents to the demographic survey questions broadly represent the local population profile. Exception are a high response rate from people with a Cheltenham postcode and people who identify as an unpaid carer.

All feedback received during engagement is collated, read and considered; no 'weighting' is applied to feedback.

*\*note individuals self-select to complete surveys*

## **What were the main feedback themes? These are some of the things people said about: Urgent Care Services in Local Areas**

**Cheltenham** Keep A&E at CGH/ Restore 24/7 A&E at CGH

**£/Funding** Additional investment needed in the NHS / ensure value for money/best use of resources

**111:** Need improved 111 people have confidence in / directs to the most appropriate service

**Accessible and timely** opening hours, travel times/location essential / Services provided in a timely manner / consider the needs of population/demographic, now and into the future

**Pathways and communication** Ensure people know where and when to seek support / Establish simple, accessible pathways

**Access to GP services** Improved access to GP appointments, both urgent and routine and “out of hours” / Better use of range of healthcare professionals at GP practices

**Integration & workforce** More joined up way of providing care / Make the most of diversity of workforce / Ensure sufficient staff, with mix of skills deliver range of services / Staff recruitment and retention

**Minor Illness and Injury Units (MIU)** Ensure MIUs provide local, equitable access, are well-resourced (staff and equipment) with access to a range of diagnostics / Introduce MIUs for Gloucester and Cheltenham

**Quality and Equity** Ensure provision is resilient; of a high quality; is fair and equitable across the county

## What were the main feedback themes ? These are some of the things people said about: **Emergency and acute medicine**

**Cheltenham** Retain CGH A&E / Re-instate A&E 24.7 at CGH / CGH is a General Hospital

**Centres of excellence** Emergency Medicine is not a specialist service / GRH A&E won't have capacity to cope with increased demand / Some support for ED at GRH only

**Quality/Equity/Sustainability** Safety risk – people will have poorer outcomes / Important: Quality of care/ Outcomes/Safety/Patient experience / Not sustainable as it is, the system is going to have to change

Ensure **mental health** is considered and built into the system

**Communications/pathways** NHS 111 sends too many people to A&E / Better communications – public don't know where to go

**Access/Population** Access from the east of the County = Inequality / A&E attendance increased by poor GP access / Travel delays / Poor public transport / Car parking charges / consider population growth

**Workforce / Technology** Attract next generation of A&E clinicians / More joined up way of providing care / Make the most of diversity of workforce / Ensure sufficient numbers of staff, with appropriate mix of skills to deliver range of services required / Focus on staff recruitment and retention

## What were the main feedback themes?

These are some of the things people said about:

### General (incl. Emergency) Surgery

**Cheltenham or Gloucester** Retain General Surgery at CGH and GRH / Centralise General Surgery at GRH

**Centres of excellence** Centralising emergency general surgery enables running of a daily emergency surgical clinic / Would one hospital site have capacity for all emergency general surgery beds?

**Access/Population** Concern about having a site without critical care or general surgery

**Workforce** Attract next generation of sub-specialist surgeons to Gloucestershire

### Image Guided Interventional Surgery (IGIS)

**Cheltenham or Gloucester** Establish IGIS at both CGH and GRH / at GRH only/ or at CGH only

**Centres of excellence**  
**Sustainability** Why aren't we doing this already?

**£Funding** Cost effective to establish IGIS on one site

**Access** Surprise and shock at current situation (patients having to go out of county for treatment)

## What were the main feedback themes?

These are some of the **Other** things people said:

- Build one hospital half way between CGH and GRH
- Charge 'timewasters': sports injuries, drunks and health tourists
- Car parking too expensive
- Extend hours of shuttle bus between CGH and GRH
- Join up services with social care better
- Prevention and self care a priority to manage demand
- More investment in NHS
- Staff recruitment into Gloucestershire vital
- Maximise use of digital/technology
- Concentrate on staff morale
- Sustainability: Increasing population/housebuilding
- *Centres of excellence* = Parcels for privatisation
- Reduce administration and management costs

## ***A new hospital for the Forest of Dean - what did we ask the public and staff to help us with?***

### **The focus of the engagement was to:**

- **test and develop ideas** to support our planning for inpatient services in the new hospital;
- **find out what's important** to local people in accessing consistent urgent (not life threatening) advice, assessment and treatment;
- **gather feedback** on the range of outpatient and diagnostic services that should be provided in the new hospital;
- **understand what's important** to local people when accessing services in the new hospital.

# ***A new hospital for the Forest of Dean: Feedback themes - These are some of the things people told us:***

## **Numbers of beds**

- Significant concerns about any reduction in beds, given the rising population and increase in elderly demographic.
- Insufficient detail regarding alternative provision for Gloucester and Cheltenham residents was provided
- The bed planning does not seem to account for people who chose to die in a community hospital.

## **Urgent care**

- Transport/accessibility in the Forest of Dean is really difficult. Cinderford is particularly difficult to reach from the southern part of the Forest.
- GP appointments – improvements to accessibility of local GP appointments are required to support urgent/out-of-hours care.

## **Outpatient and Diagnostic Services**

- Current range of services provided at the Dilke and Lydney hospitals should be provided in the new hospital - including therapies, follow-up appointments, children's services, screening, ophthalmology and audiology/hearing aid service.
- Some of the diagnostic services commonly mentioned include: blood tests, endoscopy and colonoscopy, screening, x-ray, and ultrasound.

# Summary of key feedback and next steps

## Key feedback

- *Centres of excellence:* Both positive and negative feedback about this approach to future hospital service configuration
- Quality/Equity/Sustainability
- Access
- Population growth/demographic
- £Funding
- Workforce / Technology
- Communications/pathways
- Access to GP services
- Integration
- Workforce

Over 3300  
local  
people  
took  
part in  
planned  
activities

Over 50  
events

Feedback  
Report  
published  
and  
considered

## Next steps

### First stage

- Consideration of Output of Engagement Report
- Citizens' Jury
- Solutions Appraisal

### Second stage

- Development of business cases
- NHS England Assurance

### Third stage

- Consultation (as required)
- Consideration of Output of Consultation
- Decisions

**Agenda Item 14**

**Governing Body**

<b>Meeting Date</b>	30 <sup>th</sup> January 2020		
<b>Title</b>	NHS England Emergency Preparedness, Response and Resilience Annual Assurance 2019/2020		
<b>Executive Summary</b>	<p>The CCG has recently completed its assurance of the main NHS funded healthcare providers in the county (GHT, GCS, 2g) using the NHS England and NHS Improvement (NHS E&amp;I) Core Standard process.</p> <p>The merger of GCS and 2g in October 2019, was disregarded for the purposes of this assessment with both being individually assessed for the 2019 / 20 period. The new organisation (GHC) will be subject of a combined return for the period 2020 / 21</p> <p>As an addition this year, NHS E&amp;I asked for a projected assurance for the merged trust going forward from October 2019 into 2020. The resultant report has provided assurance that the new organisation are on a sound footing going forward.</p> <p>The assurance process this year was extremely robust. Allowing for the merger between two of the provider agencies, EU Exit planning (which fell to the EPRR teams to organise) and a long term secondment of the CCG's EPRR officer, the overall assurance compliance from NHS E&amp;I was as follows: -</p> <table border="1" data-bbox="667 1877 1185 2002"> <tr> <td>Organisation</td> <td>Compliance post NHSE/I confirm &amp;</td> </tr> </table>	Organisation	Compliance post NHSE/I confirm &
Organisation	Compliance post NHSE/I confirm &		



	<i>challenge</i>
Gloucestershire CCG	Substantial (39/43)
2gether NHS Foundation Trust	Partial (46/54)
Gloucestershire Care Services NHS Trust	Partial (45/54)
Gloucestershire Hospitals NHS Foundation Trust	Partial (53/64)
	<p>The submissions, supported by confirm and challenge meetings held in October, identified some gaps in compliance against the Core standards which are acknowledged. These gaps have already been incorporated into the ongoing action plans of the provider agencies, to ensure improvement for 2020/21</p> <p>Whilst there are some gaps to fill for our providers, NHS England &amp; NHS Improvement South West have declared themselves as being partially assured for the Gloucestershire Healthcare system, believing that the Commissioner and Providers are resilient and would be able to respond adequately to an incident.</p>
<b>Key Issues</b>	<p>The following areas have had a particular focus this year:</p> <p>Influenza Pandemic Severe Weather Training</p>
<b>Risk Issues: Original Risk Residual Risk</b>	<p>An Influenza Pandemic is still considered to be the most significant risk across the UK and sits alongside severe weather and Terrorism as out most significant risks. The healthcare</p>

	<p>community have worked very hard this year to develop a robust regional plan that is designed to produce a “best fit” response to a Pandemic, recognising the fact that an outbreak cannot by definition be restricted to one district.</p> <p>Severe weather continues to affect the country, particularly flooding, snow and heat. The effects on the community, particularly residents that have mobility or respiratory difficulties is acknowledged. The CCG have produced an information sharing process that will enable the identification of vulnerable persons within the community to receive the best response possible within the “multi agency” environment.</p> <p>Training of staff and the availability of staff to attend training is problematic for individual agencies. Work has been started to identify a better model of sharing resources across the Local Health Resilience Partnership (LHRP) to ensure that our staff get the training and support they need to perform their role during an EPRR incident.</p>
<b>Financial Impact</b>	N/A
<b>Legal Issues (including NHS Constitution)</b>	N/A
<b>Impact on Health Inequalities</b>	N/A
<b>Impact on Equality and Diversity</b>	N/A
<b>Impact on Sustainable Development</b>	No
<b>Patient and Public Involvement</b>	N/A
<b>Recommendation</b>	The Governing Body is asked to note the contents of the report.

<b>Author</b>	Andy Ewens / Julia Doyle
<b>Designation</b>	CCG EPRR & BC officer
<b>Sponsoring Director (if not author)</b>	Dr Marion Andrews-Evans (Executive Nurse and Accountable EPRR officer)

## Agenda Item 15

### Governing Body

<b>Meeting Date</b>	<b>Thursday 30 January 2020</b>
<b>Report Title</b>	<b>Primary Care Strategy Refresh: 2019 – 2024</b>
<b>Executive Summary</b>	<p>The Gloucestershire Primary Care Strategy 2016-2021 was explicitly an enabler of the Gloucestershire STP, and later the ICS, and was approved by the Governing Body in September 2016. We have been asked by NHS England to refresh our Primary Care Strategy to ensure it reflects the NHS Long Term Plan (LTP). Regardless of this requirement, it is also a good opportunity to reflect on the significant progress made to date on the original strategy, before setting our course for the next five years as an ICS for primary care.</p> <p>As the original strategy was developed based on feedback from a very wide ranging stakeholder group, and was very well received, we have taken the approach of utilising that original strategy as the foundation for this one.</p> <p>The period in which this strategy is set will see the biggest change to primary care in at least fifteen years and is arguably one of the largest and most rapid changes in the history of the NHS. This is therefore an important document that sets out how we are responding in Gloucestershire to these changes. We are ahead of the game in many respects; our original Primary Care</p>

	<p>Strategy set a blueprint that many other areas across the country are now replicating in implementation of the LTP. However, there is still much to do.</p> <p>Refreshing our strategy has given us the opportunity to celebrate our achievements (Chapter 1), reflect on our patient feedback (Chapter 2), revisit our strategic intent including an update to our vision to reflect the LTP and our maturing ICS (Chapter 3), while our development themes for the next five years are evolved from our original strategy as the following six goals:</p> <ol style="list-style-type: none"> <li>1. Primary Care at Scale: Partnerships and Integration</li> <li>2. Improving Access and our Urgent Care Offer</li> <li>3. Population Health, Improving Quality, Tackling Inequalities</li> <li>4. Developing the Workforce</li> <li>5. Digitally Enabled</li> <li>6. Estates</li> </ol> <p>These are then expanded with details of our plans and commitments in Chapter 4. This strategy therefore explicitly replaces the existing Primary Care Strategy 2016 - 2021, Primary Care Workforce Strategy 2017 – 2021 and includes an update to the Primary Care Infrastructure Plan 2016 - 2021, which takes into account progress made on priorities, NHS policy development at a national and local, and a review of housing and associated population growth.</p>
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	<p>The version presented to Governing Body under the cover of this paper has been recommended for approval by the Primary Care Commissioning Committee at the October 2019 meeting and reflects the updates requested by them. This version was also formally submitted to NHS England with our ICS LTP response on 15 November.</p> <p>In reaching this version, engagement has been undertaken with:</p> <ul style="list-style-type: none"> <li>• PCN Clinical Directors;</li> <li>• ILP Chairs;</li> <li>• Gloucestershire Patient Participation Group Network;</li> <li>• County, District and Parish Councils;</li> <li>• GHNHSFT, GCS, 2gether and SWAST;</li> <li>• West of England Academic Health Science Network (WEAHSN);</li> <li>• VCS Alliance;</li> <li>• Healthwatch Gloucestershire;</li> <li>• Gloucestershire Police and Crime Commissioner;</li> <li>• Gloucestershire Local Medical Committee (LMC).</li> <li>• NHS England.</li> </ul> <p>A Primary Care Strategy Implementation Plan is now being developed to sit underneath the Strategy, assigning ownership of delivery, timescales and reporting.</p>
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<p><b>Key Issues</b></p>	<p>The key issue with the intentions set out in the Strategy is the growth in workforce anticipated within primary care as a result of the advent of Primary Care Networks. The assumptions made in the forecasts are based on local intelligence for Year 1, then application of national allocations thereafter and so are likely to be less accurate over time. However, the growth in non-traditional primary care roles is exceptional and so a joined-up approach is required across the ICS to ensure recruitment to the roles does not destabilise any individual provider..</p>
<p><b>Risk Issues:</b></p>	<p>It is recognised there are risks associated with each of the six strategic goals, some of which are already developed and included. The same exercise will be undertaken for each strategic goal as part of the programme planning process.</p> <p>An initial risk identified across the whole strategy is the pace of change for primary care. The document is necessarily lengthy owing to the extent of change our practices are facing as the LTP expands the role of primary care through Primary Care Networks, which become the organising principle for all other community and voluntary services. The national Primary Care Network Maturity Matrix and associated PCN Development Programme attest to this. PCNs - wider than general practice alone – need to be ready to commence delivery of the national service specifications from April 2020. This will see primary and community care working together for the first time on delivery of national specifications. We are well placed with our Director of Locality Development and Primary</p>

	Care now a joint appointment with our community trust, but the risk for our practices and our networks of remaining stable through this period of change, and our capacity to support that, will need to be well mitigated through joined-up working in our CCG and across our ICS.
<b>Management of Conflicts of Interest</b>	Not Applicable
<b>Financial Impact</b>	GCCG receive a range of funding streams from NHS England in relation to the Primary Care Strategy, which relates mainly to our delegated authority for primary care commissioning, along with individual, specific, funding streams for delivering projects under the General Practice Forward View or the NHS Long Term Plan. Any plans for additional investment required as a result of this strategy will be subject to the usual CCG approvals process.
<b>Legal Issues (including NHS Constitution)</b>	<p>Gloucestershire CCG needs to act within the terms of the Delegation Agreement with NHS England dated 26 March 2015 for undertaking the functions relating to Primary Care Medical Services and is therefore working within this remit in the development and delivery of this strategy.</p> <p>The CCG’s responsibilities with regards to premises are set out in The National Health Service (general medical services premises costs) Directions 2013, while currently any capital funding requirements are not delegated to the CCG and NHS England approval is required.</p>
<b>Impact on Health Inequalities</b>	The Primary Care Strategy seeks to reduce identified health inequalities through, for example, our Primary Care Networks and Integrated

	Locality Partnerships working collaboratively on a place-based approach to ensure that local needs are best met.
<b>Impact on Equality and Diversity</b>	The Equalities Impact Assessment completed for the original Primary Care Strategy has been refreshed and updated for this new iteration. No adverse impacts have been identified. The Strategy, as part of our ICS Long Term Plan response, will also be compliant with our ICS approach to equality and engagement impact assessment described in the overarching document, as we implement the projects in execution of this Strategy.
<b>Impact on Sustainable Development</b>	This strategy seeks to maximise the delivery of appropriate services in the community.
<b>Patient and Public Involvement</b>	As for the original strategy, engagement with the public and patients has been focused through representative bodies, in particular the Patient Participation Group Network and Healthwatch Gloucestershire.  We are currently developing a short public-facing version of this strategy to create a format that is best suited to patients and the public.
<b>Recommendation</b>	The Governing Body is asked to: <ul style="list-style-type: none"> <li>• Approve the Primary Care Strategy</li> </ul>
<b>Author</b>	Stephen Rudd
<b>Designation</b>	Head of Locality and Primary Care Development
<b>Sponsoring Director (if not author)</b>	Helen Goodey, Director of Locality Development and Primary Care



**One**  
Gloucestershire

Transforming Care, Transforming Communities

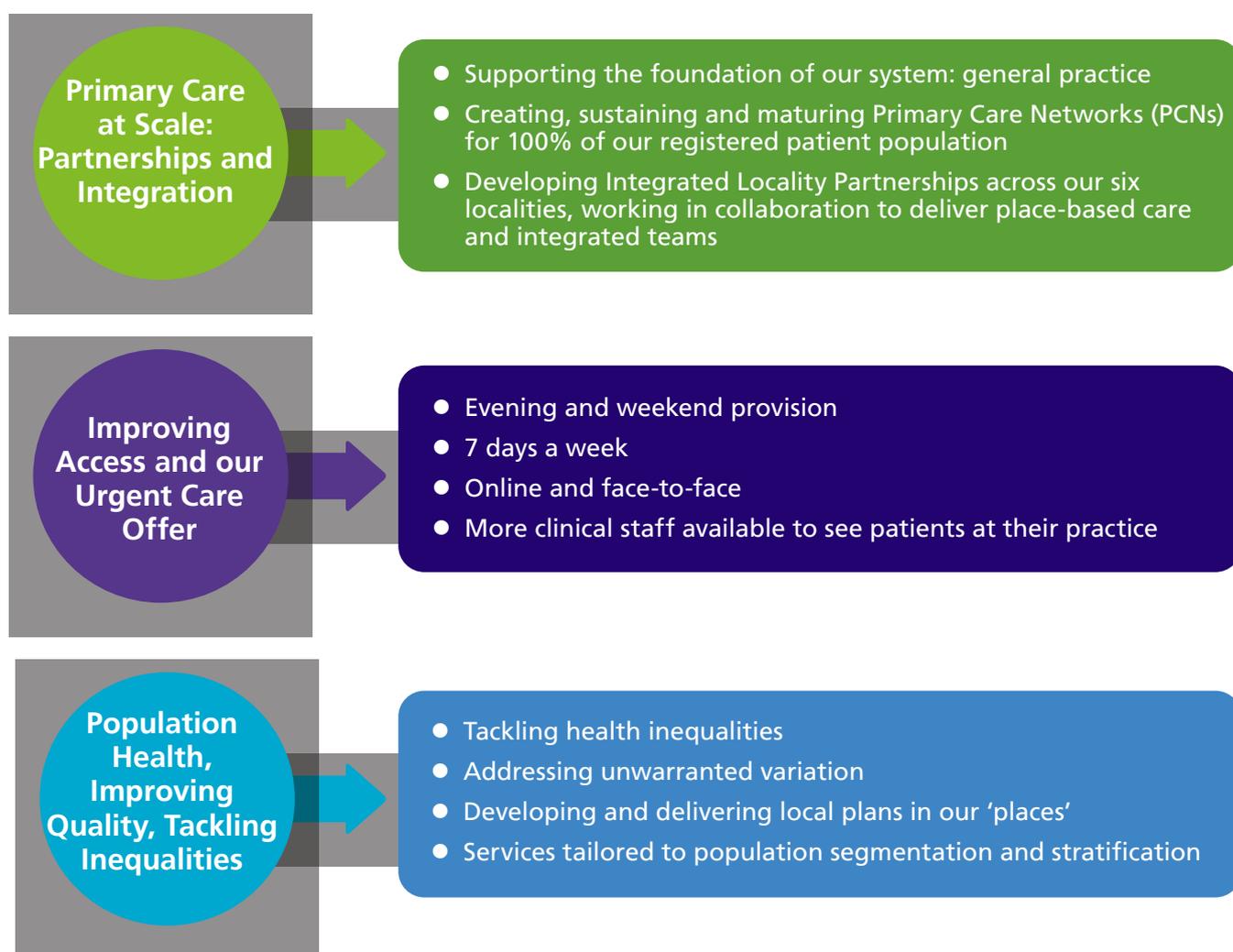
# Gloucestershire ICS Primary Care Strategy 2019 - 2024

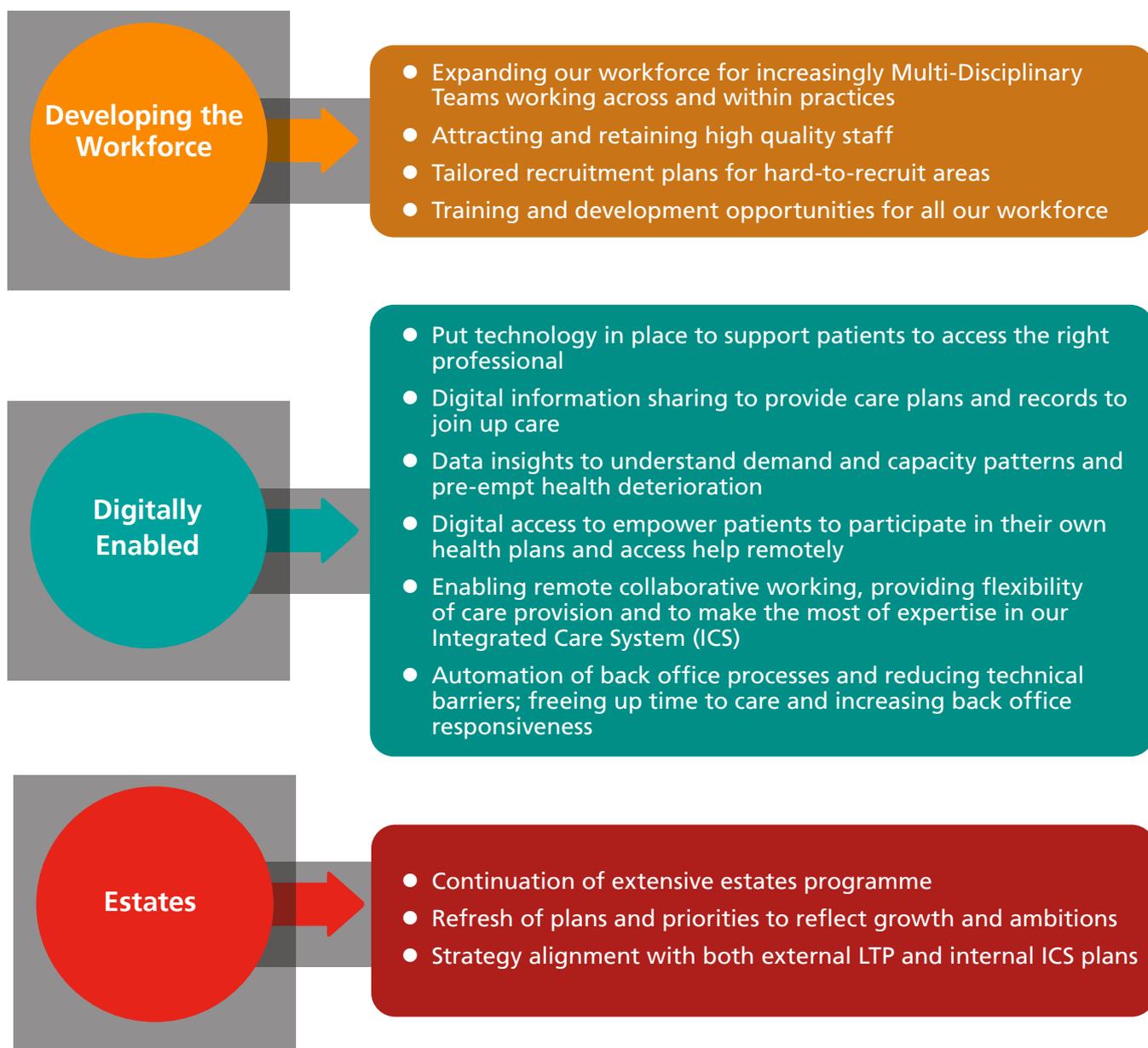


## Executive Summary

This Gloucestershire Integrated Care System (ICS) Primary Care Strategy 2019 – 2024 builds on the progress to date, with this document an explicit refresh of our original Primary Care Strategy published in 2016. We have laid the foundations for the implementation of the NHS Long Term Plan (LTP) with the continued ambition to provide safe, high-quality care from across our GP practices to support people to age well. This document, therefore, is explicitly not a rewrite or an abandonment of our original Strategy. Rather, it is a celebration of where we are and how we will take this momentum forward to deliver the NHS LTP for primary care over the next five years, improving integration and joined-up working as an ICS.

Gloucestershire ICS is proud of the continued hard work from its providers, CCG and voluntary organisations; whilst there are challenges facing not just Gloucestershire, but the NHS at a national level, we are ambitious in what we can do to deliver further benefits to our patients. Our strategic vision is for patients to stay well for longer, access out of hospital care – where appropriate – and to further integrate general practice with other local primary and community care providers. This strategic vision will be delivered through six goals, detailed below.





For general practice to deliver these six goals, with further details of how they will be delivered throughout the course of this Strategy, it is imperative that Gloucestershire works as an integrated health and care community. Therefore this Strategy is designed to enable, and be enabled by, the work of our provider colleagues, as well as being an integral part of the Gloucestershire LTP. There are a number of innovative new models of care detailed throughout this Strategy, but we recognise the importance of supporting a sustainable and resilient general practice too – the combination of these ambitions will enable Gloucestershire’s primary care, and wider ICS, to thrive.

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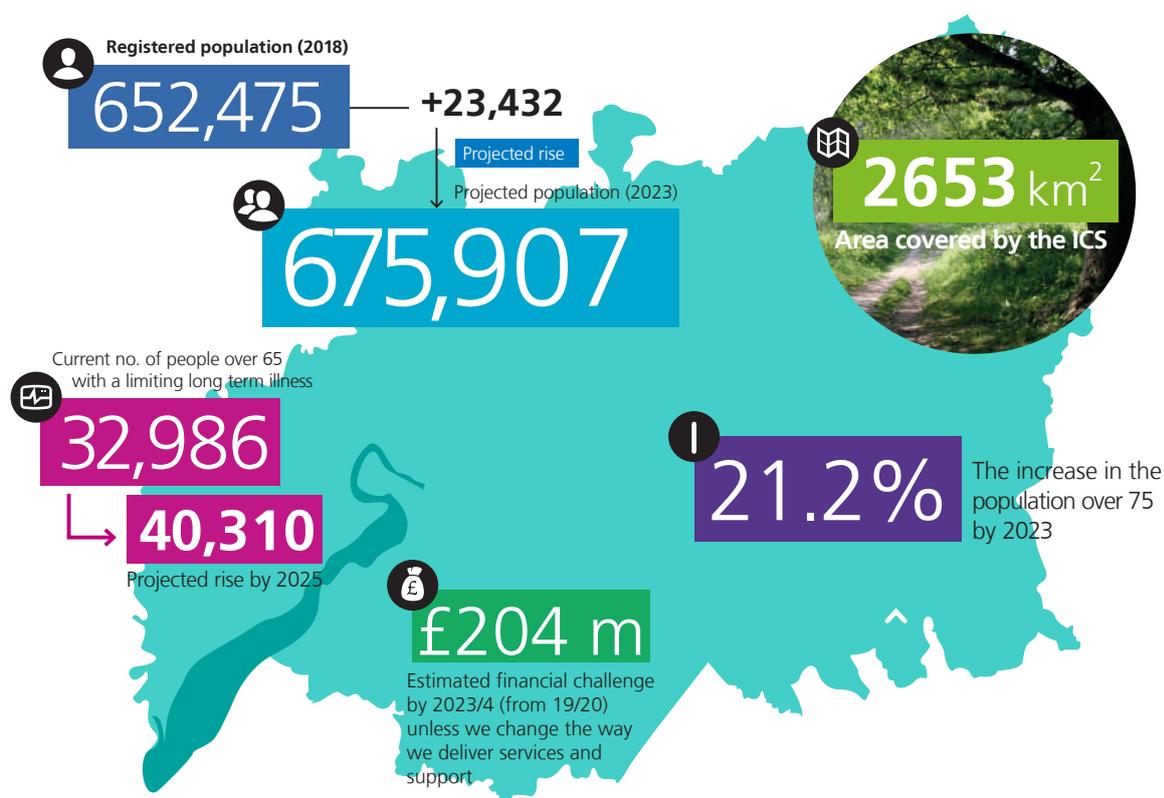
## Glossary

Listed below are some of the commonly used abbreviations used within this document, which are stated here in full for ease.

Term	Description
APMS	Alternative Provider Medical Services
BMA	British Medical Association
HEE	Health Education England
GCCG	Gloucestershire Clinical Commissioning Group
GCC	Gloucestershire County Council
GDoc	Gloucestershire Doctors – an organisation in which Gloucestershire GP practices are shareholders
GHCNHSFT	Gloucestershire Health and Care NHS Foundation Trust
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
GMS	General Medical Services – the contract most commonly held between the commissioners and the GPs practices for delivering primary care services
HCA	Health Care Assistant
ICS	Integrated Care System
ILP	Integrated Locality Partnerships – an aggregation of PCNs within a locality
ILR	Integrated Locality Reporting – an in-house developed business intelligence tool
LMC	Local Medical Committee
LTP	NHS Long Term Plan
LSOA	Lower Super Output Area
MDT	Multi-Disciplinary Team
NHS	National Health Service
ONS	Office for National Statistics
PALS	Patient Advice and Liaison Service
PCIP	Primary Care Infrastructure Plan
PCN	Primary Care Network
PCTH	Primary Care Training Hub
PHM	Population Health Management
PPG	Patient Participation Group
QOF	Quality and Outcomes Framework
SAR	Standardised Admissions Ratio
VCS	Voluntary and Community Sector

## 1. Foreword, Introduction and Context

Gloucestershire has 74 GP practices across 100 sites, with 650,000 registered patients. Our number of patients is predicted to grow to over 675,000 by 2023, with almost 25% growth in 75-84 year olds during that period, as seen at Figure 1. A summary position of our 74 practices can be found at Appendix 1.

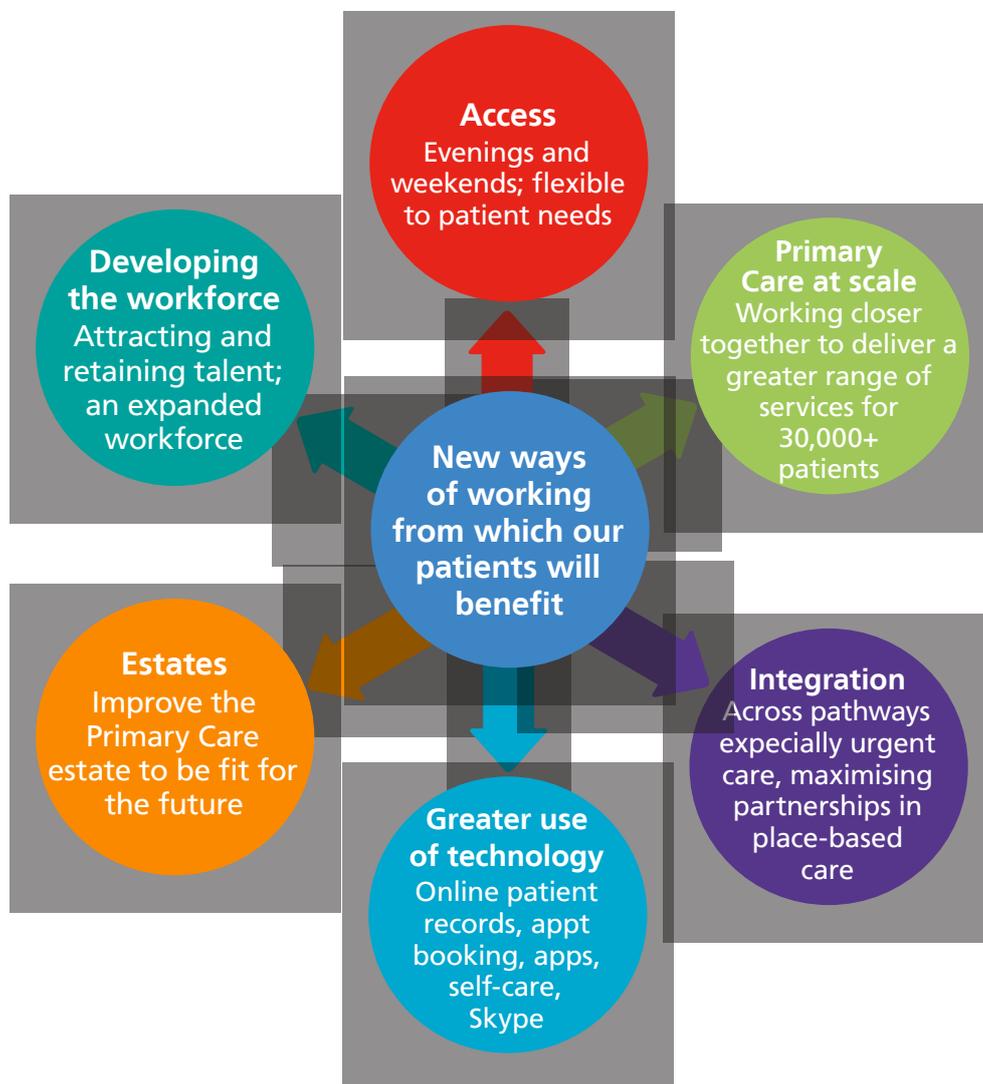


**Figure 1: Gloucestershire's Population and Geographical area**

We are one Integrated Care System (ICS), with one Clinical Commissioning Group, one local authority, one acute trust, one community and mental health trust and all partners are committed to meeting the need of our patients through working together to deliver one coherent plan. This Primary Care Strategy therefore forms part of that overall ICS Strategy, and is supportive of Gloucestershire's Joint Health and Wellbeing Strategy.

## 1.1 Progress so far

In Gloucestershire we are proud of the progress we have made in developing general practice since we took delegated commissioning arrangements in April 2015. One of our initial aims was to stabilise the current practices to provide a footing on which to develop primary care. We then listened to the feedback of our patients, our member practice staff and our partners and published a five year Primary Care Strategy in September 2016. This committed us to deliver against six components over the five years of the Strategy – see Figure 2.



**Figure 2: Our original six key strategic components (Gloucestershire CCG, 2016)**

As we approach three years since its publication, we can reflect on some significant achievements:

### Access:

- Evening and weekend appointments made available to every patient in our county, 7 days a week including bank holidays, along with additional appointments in the day to increase access to our primary care services. Totalling over 100,000 additional appointments offered per year (105,000 appointments in 18/19); patients can now see a clinical pharmacist, paramedic, mental health practitioner, physiotherapist, nurse or GP in these additional clinics we have commissioned to improve access.



- At least two High Impact Actions, as defined by NHS England (NHSE) within the General Practice Forward View (NHS England, 2016), have been undertaken by all of our practices. We also secured: the Productive General Practice programme for more than half of all our practices, which alone resulted in releasing thousands of hours of clinical and administration time; two cohorts of local improvement leaders courses specifically tailored for general practice that aligned with the ICS's Quality, Service Improvement and Redesign programme; and workshops for each locality on service improvement activity linked to the High Impact Actions. Furthermore we have supported, through NHSE funding and approval, care navigation and clinical correspondence training for staff in practices in order to support patients to see the right professional, alongside freeing up clinician time to spend with patients.

### Primary Care at Scale:

- We initially developed 16 primary care clusters of c.18,000 to c.65,000 registered patients, all live by January 2017, with CCG investment of a recurrent £1.89/head transformation (against the national requirement of £1.50/head non-recurrent) to each cluster. All clusters invested in workforce, with clinical pharmacists, community matrons and paramedics working across practices in their clusters for the first time, often working with our ICS partners. This created a strong foundation for Primary Care Networks (PCNs), of which we now have migrated to 14 (see Appendix 2) to ensure the minimum requirement of 30,000 registered patients. Our PCNs are therefore already relatively mature, compared to many other parts of the country, and the CCG, and ICS, is committed to ensure they continue to thrive and are at the centre of our system.
- Established a GP leader in every cluster, with leadership development opportunities locally and nationally, with one GP leader from every locality a member of the ICS's New Models of Care Board, ensuring a strong Primary Care representation within the ICS. Again this has been an organic process for us to migrate to Clinical Directors of our 14 PCNs, most of which are our previous GP leaders.



### Integration:

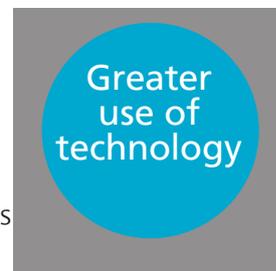
- Through trialling and refining the approach in Cheltenham, Forest of Dean and Stroud & Berkeley Vale, working with our ICS partners we are now rolling out Integrated Locality Partnerships (ILPs) across our county. Our 14 PCNs are organised into 6 ILPs: Cheltenham, Cotswolds, Forest of Dean, Gloucester, Stroud & Berkeley Vale and Tewkesbury. Appendix 2 provides details of the constituent practices within each PCN and how the PCNs aggregate to the ILPs. Appendix 3 provides details about each ILP.
- ILPs are the organising principle of our ICS' place-based ambitions and are where all of our partners are able to play a full and active part in shaping the Strategy and delivery of services for their local populations within their defined 'place'. Launched collectively by our ICS Lead (CCG Accountable Officer), ICS Chair (independent lay chair) and ICS Place CEO Sponsor (Chief Executive of Gloucestershire Health and Care NHS Foundation Trust), they are often led by senior GPs with representation from senior leadership teams from our ICS partners, including Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), Gloucestershire Health and Care NHS Foundation Trust (GHCNSHFT) and the local authority.



- Within the three pilot areas, the collaboration between professionals and organisations has brought new insights and collective responsibility to design and deliver new services, bringing together their expertise and workforce to focus care around their patient needs. This introduced mental health practitioners and community dementia nurses into general practice, launched a Complex Care at Home scheme and commenced Multi-Disciplinary Team (MDT) meetings where clinicians discuss patients who require joined-up care and design tailored packages of support.

### Greater use of technology:

- We have significantly improved our digital patient offer and will continue to do so. The NHS App is live across almost all of our practices, we are trialling online symptom-checking and triage in ten practices across the county, and have procured – through a national procurement framework – a total website replacement product for more than half of our practices that provides our patients with much greater online connectivity with their practice. We have also been supporting patients and their practices to increase the number of people registered for online services (increasing 5 percentage points over the last 2 years), reducing time spent for patients waiting to get through on the telephone to busy practice receptions.
- Prescriptions are being managed far more effectively electronically in Gloucestershire. Utilisation is higher than national average for Electronic Prescribing and markedly so for Electronic Repeat Dispensing, which offers convenience for patients and efficiencies for practices.
- We have supported all our PCNs to be able to deliver services for the patients across their practices for improving access to appointments. This was enabled through shared records across their IT clinical systems and direct booking between practices. Trials are ongoing to undertake virtual consultations, getting contemporaneous consultant input to support patient consultations and preventing hospital attendance, and video technology for supporting MDT meetings across professionals.
- We have rolled out Wi-Fi across all our practices, both for our patients while waiting and also for our practice and PCN staff working across surgeries to provide easy mobility between sites, underpinned by an improved network infrastructure.
- We are in the process of rolling out the Joining Up Your Information (JUYI) project, which is bringing together information across a range of clinical systems, across primary and secondary care, to provide clinicians with the information they need – such as medical conditions and medication taken – to provide safe and high-quality care for patients.
- All practices are live with Summary Care Records (SCRs) with some of the highest levels of SCR Additional Information in the country being uploaded to support the most complex patients.
- As an ICS we also achieved Paper Switch Off for patient referrals from practices in June 2018, streamlining the referral process and offering greater patient choice and flexibility.



### Estates:

- Our Primary Care Infrastructure Plan (PCIP) 2016 – 2021 described a set of priorities informed by intelligence gathered from a six facet survey, along with a number of legacy schemes that had not yet come to fruition prior to GCCG taking delegated commissioning arrangements.



- Since then we have delivered new primary care premises for five practices across our county:

- **Cheltenham:** Cleavelands Medical Centre
- **Gloucester:** Kingsway Health Centre and Churchdown Surgery
- **Tewkesbury:** Mythe Medical Practice and Church Street Medical Practice



- We have also delivered significant extensions and refurbishments for four other practices:

- **Cheltenham:** Stoke Road Surgery
- **Gloucester:** Hadwen Medical Practice and Longlevens Surgery
- **Stroud & Berkeley Vale:** Culverhay Surgery



- New surgery buildings have also been approved for existing practices in Cheltenham, Cotswolds, Forest of Dean and Gloucester City. A further seven schemes are also already in progress across the county. Full details of all schemes delivered and in progress can be found at Appendix 4.

- To achieve this significant improvement in our estate has required investment, and has seen our revenue contribution increase from £7.7m per year in 2015/16 to £8.6m per year in 2019/20, with further growth planned as the buildings open which are detailed in Appendix 4.

### Developing the workforce

- We published our Primary Care Workforce Strategy 2018-2021 in March 2018, replacing the workforce plan annexed to the original Primary Care Strategy. This Strategy set out five strategic commitments (Figure 3). While the Strategy was only published a little over a year ago, we have already made substantial progress and are on track, or ahead, for the workforce targets we set out:



**Figure 3: Our original five workforce strategic components (Gloucestershire CCG, 2018)**

	September 2017 (original baseline)	March 2019 (latest data)	Original March 2021 Target
GPs WTE (excluding locum, registrars, retainers)	339*	351	368
GP headcount (excluding locum, registrars, retainers)	434	458	471
Nurses WTE	179**	213	179***
Nurses headcount	280	317	280

**Table 1: Primary Care Workforce Data** (\* revised by NHSD to 341 in later data cleansing; \*\* revised by NHSD to 204 in later data cleansing; \*\*\* trajectory held at September 2017 figures due to the large number of impending retirements)

- As at March 2019, according to the NHS England national data set, we have 1,413 patients per qualified permanent GP, which compares to the national average of 1,788, which ranges from 1,222 patients per GP to 2,558 patients, meaning we have one of the best ratios in the country. We also see a similar position for our practice nurses (2,063 against a national average of 2,513).
- In addition to GPs and nurses, we have seen considerable growth in our wider clinical workforce due to the schemes previously outlined, including clinical pharmacists, paramedics, physiotherapists, physician associates, mental health workers, community dementia nurses and community matrons. These new roles total more than 35 WTE staff working in general practice in Gloucestershire, mostly working across practices within their PCNs. As for GPs and nurses, we also are better than the national average in terms of the numbers of these staff per patient against the national average (2,459 against a national average of 3,100).
- As set out as a part of our planned developments within our Strategy, we have now developed a local primary care data extraction that is stored within our local warehouse, enabling analysis of demand over time, by practice, PCN and ILP. Coupling this with the data from the national workforce reporting is enabling us to start developing reports for PCNs that include this capacity and demand over time.
- In terms of reducing workload, we have evaluated the impact of care navigation to date and procured a solution for trialling in two PCNs that addressed the learning to ensure a greater impact on workload reduction. This learning will then be used to create a tailored countywide offer for rollout, utilising the local Directory of Services.
- Our Community Education Provider Network (CEPN) has migrated to a Primary Care Training Hub (PCTH) which is embedded in our CCG Primary Care team. The PCTH has undertaken significant work in engaging with higher education institutes to develop our staffing pipeline, create a Primary Care Workforce Centre website, host multi-disciplinary primary care events, and run network based training and education schemes.
- We have successfully developed and launched a Health Inequalities Fellowship to tackle the long-standing recruitment issues in Gloucester City. GP Fellows gain specialist knowledge and expertise to support populations with increased health and social challenges. They work as GPs for five clinical sessions per week, complete a project and a Post-Graduate Certificate in Public Health. This innovative scheme has attracted attention from other areas of the country and was shortlisted in the NHS Parliamentary Awards 2019.

- Further initiatives include our Newly Qualified GP scheme, our Next Generation GP scheme, our GP Retainer scheme and participation in the NHSE International GP Recruitment scheme.
- Our workforce programme is embedded within the ICS workforce programme, with initiative sharing on organisational development, recruitment planning and bringing our recruitment schemes together under the 'Proud to Care' and 'One Gloucestershire' brand.

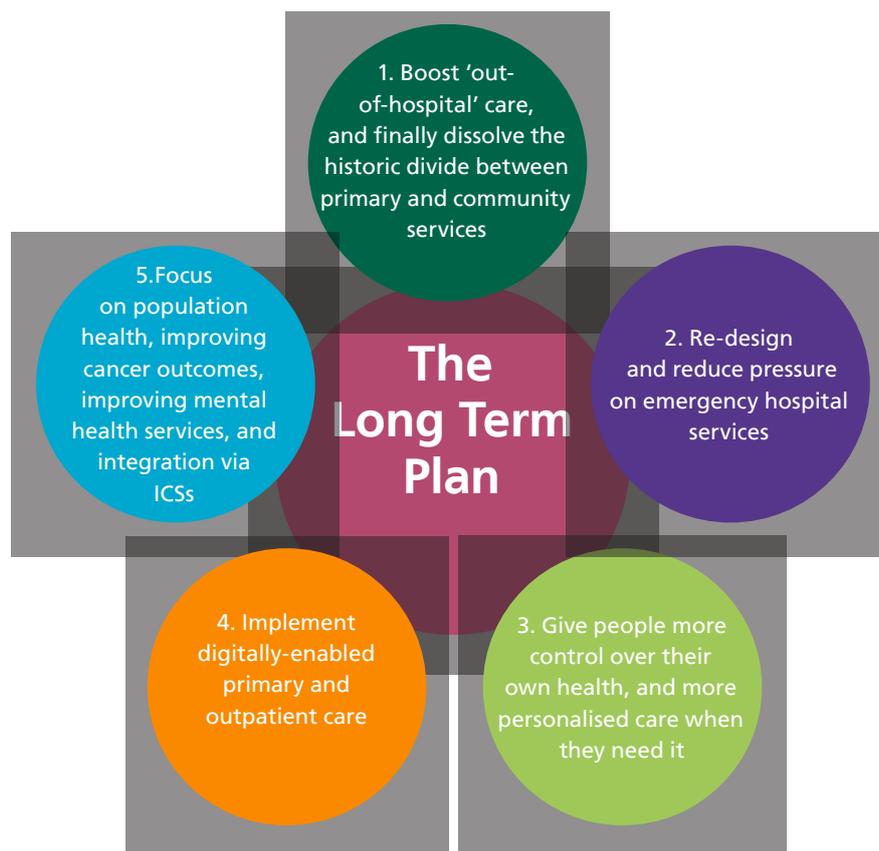
## 1.2 Why we need a new Strategy

Clearly fantastic progress has been made against our original Strategy, but in light of the NHS Long Term Plan (LTP) (NHS England, 2019) and new GP contract framework (BMA & NHS England, 2019), we must now refresh the Strategy to ensure our ambitions are reframed and refocused. Full details of the contract can be found by following the link within the References Chapter, however in brief this new contract announced:



- A permanent solution to rising indemnity costs through a new NHS Resolution Clinical Negligence for General Practice, which started on 1 April 2019;
- A reformed Quality and Outcomes Framework (QOF), including new Quality Improvement modules developed by the Royal College of General Practitioners (RCGP), the National Institute of Clinical Excellence (NICE) and the Health Foundation;
- Major investment in a diversified workforce for primary care, through PCNs;
- An automatic entitlement for practices to a new PCN contract;
- Plans to simplify and improve access;
- Plans for 'digital-first';
- A phased introduction of seven new national service specifications for primary care to align primary care with the LTP deliverables;
- A five-year funding guarantee;
- A PCN dashboard and an investment fund based on PCN impact to maximise the benefits for patients and the wider NHS for this additional investment.

The LTP, meanwhile, set out five major, practical changes to the NHS service model to meet the challenges facing health systems (Figure 4).



**Figure 4: The Long Term Plan's five major practical changes**

Furthermore, Gloucestershire has become an Integrated Care System (ICS) since our original Strategy, a strong part of which is due to the work we've done in primary care and joining up with the rest of the system. This document, therefore, is explicitly not a rewrite or an abandonment of our original Strategy. Rather, it is a celebration of where we're at and building on this strong foundation to deliver against the LTP for our patients over the next five years.

The next chapter of this Strategy considers patient feedback regarding primary care and demonstrates how that feedback shapes our strategic planning and supports informed decision making. The following chapter sets out our strategic intent for 2019-2024, defined through our mission, vision, values and goals. These goals are then specified in more detail in Chapter 4, 'Our Strategic Plan'. Our governance structure is then detailed at Chapter 5, followed by our approach to engagement and equality.

The period in which this Strategy is set will see the biggest change to primary care in at least fifteen years and is, arguably, one of the largest and most rapid changes in the history of the NHS. Therefore this is an important document that sets out how we are responding to these changes in Gloucestershire. We are ahead of the game in many respects; our original Primary Care Strategy set a blueprint that many other

areas across the country are now replicating as a result of the LTP. However, there is still much to do. I am proud to be a GP in this county; prouder still to be the Clinical Chair. We have a fantastic set of primary care professionals in this county, who care passionately about our patients. I know we will make a success of everything detailed in this Strategy, it is what we're good at – delivering safe, high-quality primary care by working together with patients and our partners.



*Dr Andy Seymour*

*Clinical Chair – Gloucestershire CCG*



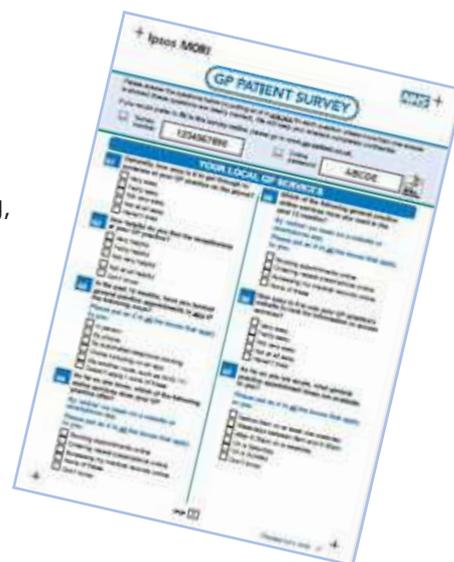
## 2. Listening to and learning from our patients’ experiences

### 2.1 Introduction

Our patients are at the heart of ‘the how’, ‘the why’, ‘the when’, ‘the where’ and ‘the what’, of everything we do. We have a range of feedback mechanisms for our primary medical care services, from national surveys to local feedback through our Patient Advice and Liaison Service (PALS) and Patient Participation Network. Furthermore, all our practices have Patient Participation Groups (PPGs) who act as critical friends to their practice, providing insight on the patient experience. In this chapter, some key information from national datasets are shared and considered, followed by local insight from our patients. In Chapter 6, we share how we’ve engaged, and will continue to engage, with patients and all our stakeholders in the development and implementation of this Strategy.

### 2.2 National GP Patient Survey

The latest national GP Patient Survey (Ipsos MORI, 2019), relates to the publication in July 2019. The data captured by this survey is wide-ranging, measuring patients’ experiences across a range of topics and themes, such as appointment making, perceptions of care, management of health conditions, practice opening hours and much more. Therefore for completeness, all data from the survey can be found at <https://gp-patient.co.uk/>, while the link to the slide pack for Gloucestershire’s specific report can be found in the References chapter.



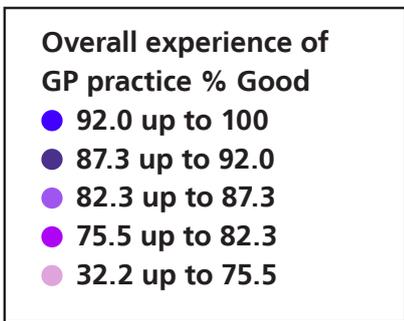
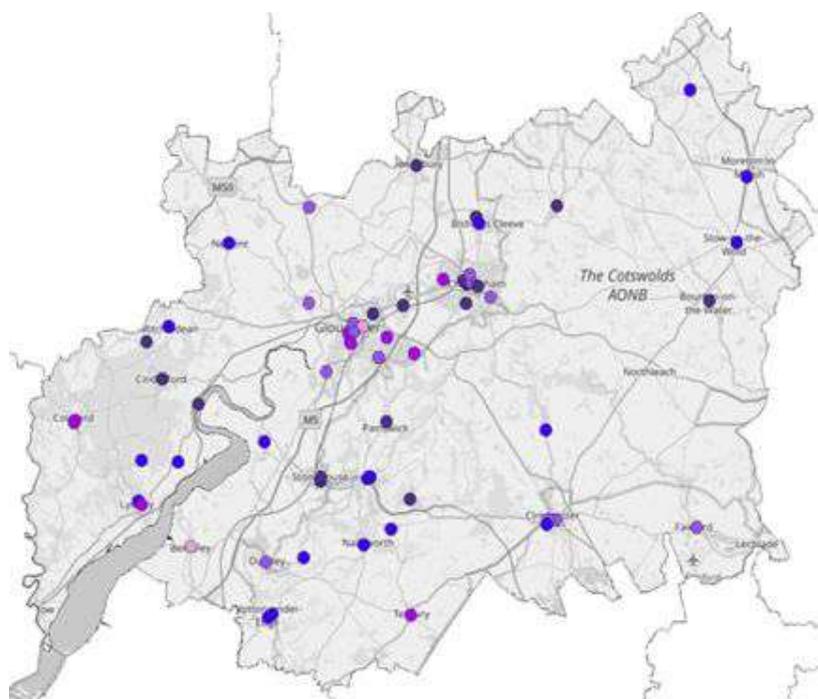
The overall results are well summarised by the following question:

**Overall, how would you describe your experience of your GP practice?**

Result	Gloucestershire CCG		National Average	
	2016	2019	2016	2019
Good	89%	87%	85%	83%
Poor	4%	4%	5%	6%

**Table 2: GP patient reported experience 2019 against 2016 (Ipsos MORI, 2019)**

While it is disappointing that our position is not quite as strong as it has been previously, Gloucestershire practices overall have maintained a position above the national average figures, as we achieved in 2016, the date of our inaugural Primary Care Strategy. The Gloucestershire position has predominantly deteriorated due to some acute practice issues brought about by changes leading up to the reporting period. We are aware of these issues and are supporting those practices affected. Consequently, we see a range of patients scoring their practice as 'good' from 63%, up to 99% of all patients rating their practices at this level. The spread across our county is represented by this map, demonstrating that Gloucester City is an area that particularly needs further support to improve their patient experience.



**Figure 5: GP patient reported experience 2019 (Ipsos MORI, 2019)**

Similarly, the GP Patient Survey in 2018 (Ipsos Mori, 2018) found nationally that young people (16-24 year olds) were less satisfied than other adult patients at 77.3%. Again, Gloucestershire outperformed this national statistic, with 84% of young patients rating their overall experience as 'good', however it demonstrates that we can still do more to improve their experience when compared to our overall figures at Table 2. Some other notable results from the survey are:

Question	Gloucestershire	National
Generally, how easy is it to get through to someone at your GP practice on the phone?	<b>80%</b> (Easy)	<b>68%</b> (Easy)
Which ... practice online services have you used in the past 12 months?	<b>75%</b> (None)	<b>76%</b> (None)
In the last 12 months, have you had enough support from local services or organisations to help you to manage your condition(s)?	<b>84%</b> (Yes)	<b>78%</b> (Yes)
How satisfied are you with the general practice appointment times that are available to you?	<b>69%</b> (Satisfied)	<b>65%</b> (Satisfied)

**Table 3: National Patient Survey extract (Ipsos MORI, 2019)**

These figures suggest that, while we continue to outperform the national average, we need to continue to maintain such performance and seek to stretch ourselves to perform even better. We will be predominantly focusing on: developing and promoting our online patient services, creating an even more comprehensive service for our patients in their local communities and continuing to improve access to general practice to ensure appointments are available at times when our patients need them. Our Strategy has been informed by these findings and seeks to directly address them.

The CCG will continue to monitor and promote the national GP Patient Survey and encourage practices to discuss their individual results with their PPGs to identify areas for local improvement and action. Furthermore, our Associate Director for Engagement and Experience is on the national steering group to help inform further development of the GP Patient Survey, while our local PPG Network – which represents the PPGs across our county – have also been involved in the development.

We are aware that there is a national review underway of the Friends and Family Test and we are awaiting the outcome of this from NHSE to understand how we will be required to implement the changes.

### **2.3 GCCG Patient Advice and Liaison Service (PALS)**

Our PALS team receive between 200 – 300 patient contacts per quarter, of which c.30-55 contacts relate to primary care. The most common theme relates to telephony systems, which resonates with the GP Patient Survey, which despite the fact that we outperform the national average, we strive to do even better and recognise there is local variance and some practices need further support to improve. Bolstering our digital offer will also alleviate some of these pressures on telephony.

### **2.4 Summary**

This chapter considered the range of patient feedback we receive and highlighted some of the areas patients would like us to focus and we continue to test these with our patients through the PPG Network (see Chapter 6). The next chapter sets out our strategic intent, taking into consideration this feedback from our patients, alongside national and local data and intelligence on our performance, feedback from our practices, the ambitions of our ICS and the commitments made to patients in the NHS LTP.

## 3. Our Strategic Intent

### 3.1 Our Mission

To provide safe, high-quality care from across our GP practices to support people to age well.

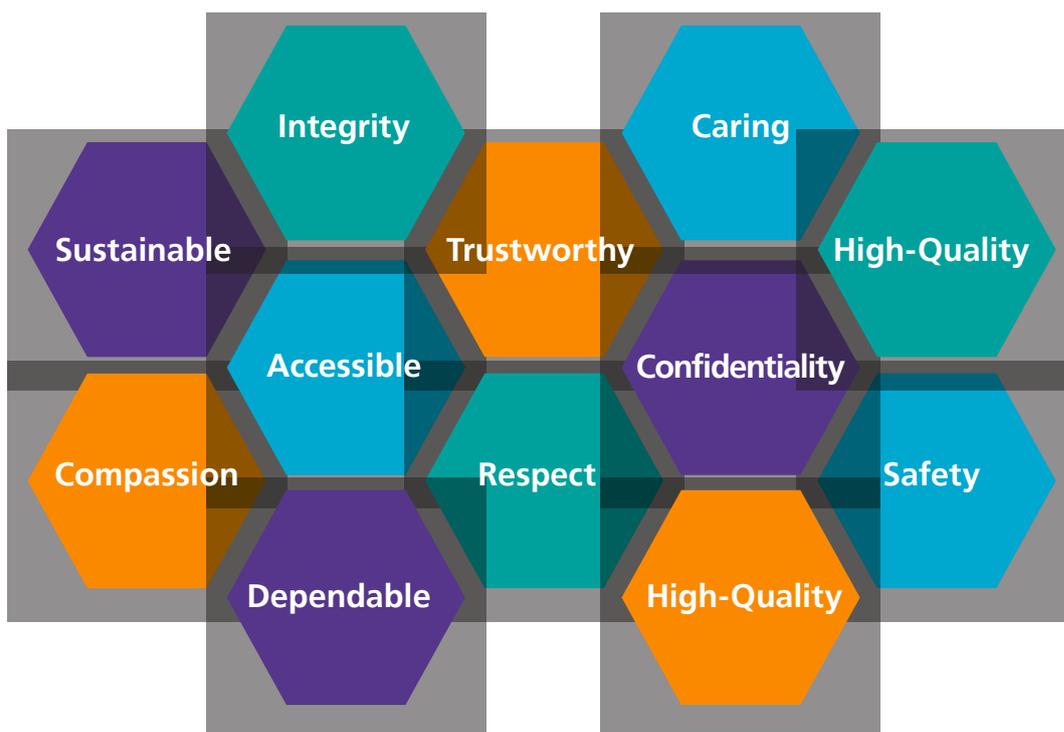
### 3.2 Our Vision

In order for patients in Gloucestershire to stay well for longer and receive joined-up out of hospital care where possible, we will provide a sustainable, safe and high quality primary care service, provided in modern premises that are fit for the future.

To achieve this, we will:

- **Dissolve the historic divide** between organisations through the closer alignment and greater integration between our ICS organisations through our **Primary Care Networks** and **Integrated Locality Partnerships**;
- Provide patients with more **control over their own health, anticipatory care** and personalised care when they need it and support **early cancer diagnosis**;
- **Utilise population health to tackle inequalities**, assessing our local population by risk of unwarranted health outcomes to **make services available where they are most needed**;
- **Grow our multi-disciplinary primary care teams, attracting and retaining high quality staff** through promoting Gloucestershire as a great place to live and work, creating a better work-life balance for staff, and offering excellent training opportunities;
- Ensure **good access** to primary care **7 days a week**, meaning better support for patients while also **reducing urgent demand** at our hospitals to enable them to care for the most acutely unwell patients;
- **Digitally-enable primary care to maximise the use of technology**;
- Support Primary Care Networks and Integrated Locality Partnerships to explore how they can provide a **greater range of services** for larger numbers of patients.

### 3.3 Our Values



### 3.4 Our Goals

To deliver our Vision and achieve our Mission, we will pursue a set of strategic goals that align not only with the ambitions of NHS England’s LTP (NHS England, 2019), but also our local ambitions as an ICS. These goals build on the original six components of our Primary Care Strategy 2016 – 2021 (Gloucestershire CCG, 2016) (please see figure 2 in the foreword), which have been revisited following the publication of the LTP and the new GP contract (BMA and NHS England, 2019). They are underpinned by an enabling goal of sustaining and improving the quality of general practice.

#### Primary Care at Scale: Partnerships and Integration

- Supporting the foundation of our system: general practice
- Creating, sustaining and maturing Primary Care Networks (PCNs) for 100% of our registered patient population
- Developing Integrated Locality Partnerships across our six localities, working in collaboration to deliver place-based care and integrated teams

#### Improving Access and our Urgent Care Offer

- Evening and weekend provision
- 7 days a week
- Online and face-to-face
- More clinical staff available to see patients at their practice

### Population Health, Improving Quality, Tackling Inequalities

- Tackling health inequalities
- Addressing unwarranted variation
- Developing and delivering local plans in our 'places'
- Services tailored to population segmentation and stratification

### Developing the Workforce

- Expanding our workforce for increasingly Multi-Disciplinary Teams working across and within practices
- Attracting and retaining high quality staff
- Tailored recruitment plans for hard-to-recruit areas
- Training and development opportunities for all our workforce

### Digitally Enabled

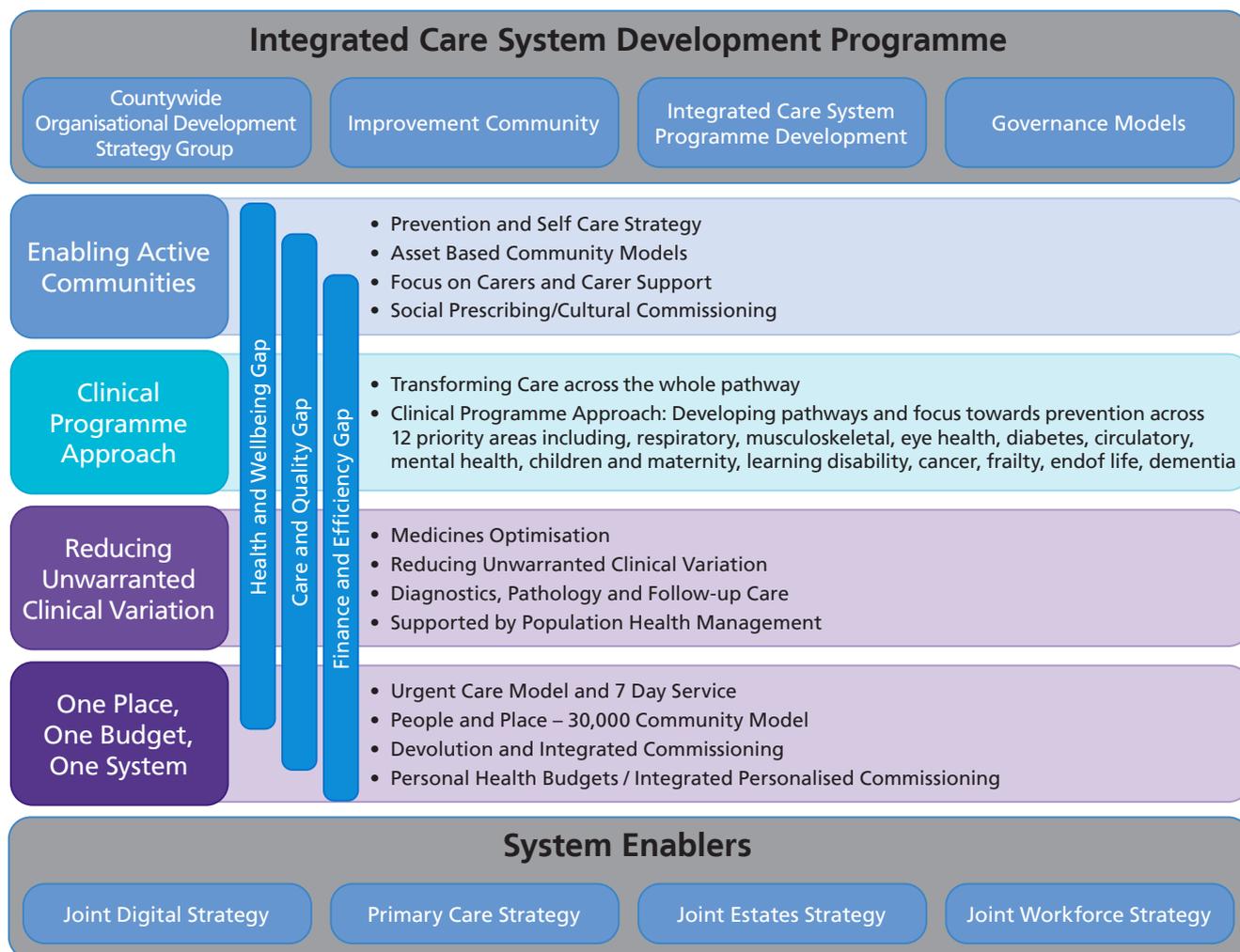
- Put technology in place to support patients to access the right professional
- Digital information sharing to provide care plans and records to join up care
- Data insights to understand demand and capacity patterns and pre-empt health deterioration
- Digital access to empower patients to participate in their own health plans and access help remotely
- Enabling remote collaborative working, providing flexibility of care provision and to make the most of expertise in our Integrated Care System (ICS)
- Automation of back office processes and reducing technical barriers; freeing up time to care and increasing back office responsiveness

### Estates

- Continuation of extensive estates programme
- Refresh of plans and priorities to reflect growth and ambitions
- Strategy alignment with both external Long Term Plan (LTP) and internal ICS plans

## 4. Our Strategic Plan

Our Strategic Plan for Primary Care, under the delegating commissioning arrangements from NHSE, resides within our overall ICS LTP as a key system enabler (see Figure 6). This Strategy and the goals that follow within this chapter are only achievable through a partnership approach that is led by the ICS, where PCNs and ILPs are front and centre of our ICS’s plans.



**Figure 6: Our ICS Development Programme**

Our ICS is underpinned by the shared mission to have a Gloucestershire population that is healthy and well, where they are empowered to take personal responsibility for their own health and care and are reaping the personal benefits that this can bring: less dependent on health and social care services for support; living in healthy, active communities; benefitting from strong networks of community services and support; are able, when needed, to access consistently high-quality, safe care in the right place, at the right time.

The ICS’s vision is:

**To improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people**

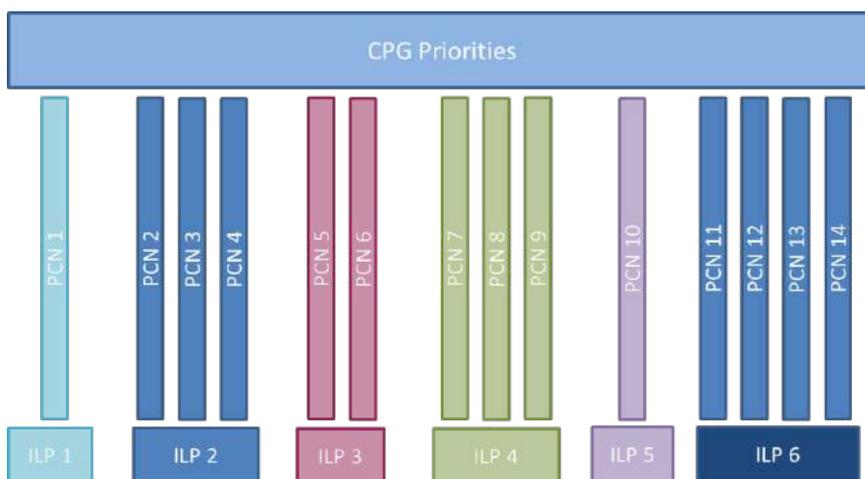
The ICS’s key strategic objectives are as follows:

- Place a far greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves.
- Place a greater emphasis on joined up community based care and support, provided in patients’ own homes and in the right number of community centres, supported by specialist staff and teams when needed.
- Continue to bring together specialist services and resources where possible reducing the reliance on inpatient care across our system by repurposing the facilities we have in order to use them more efficiently and effectively in future.
- Develop new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care.

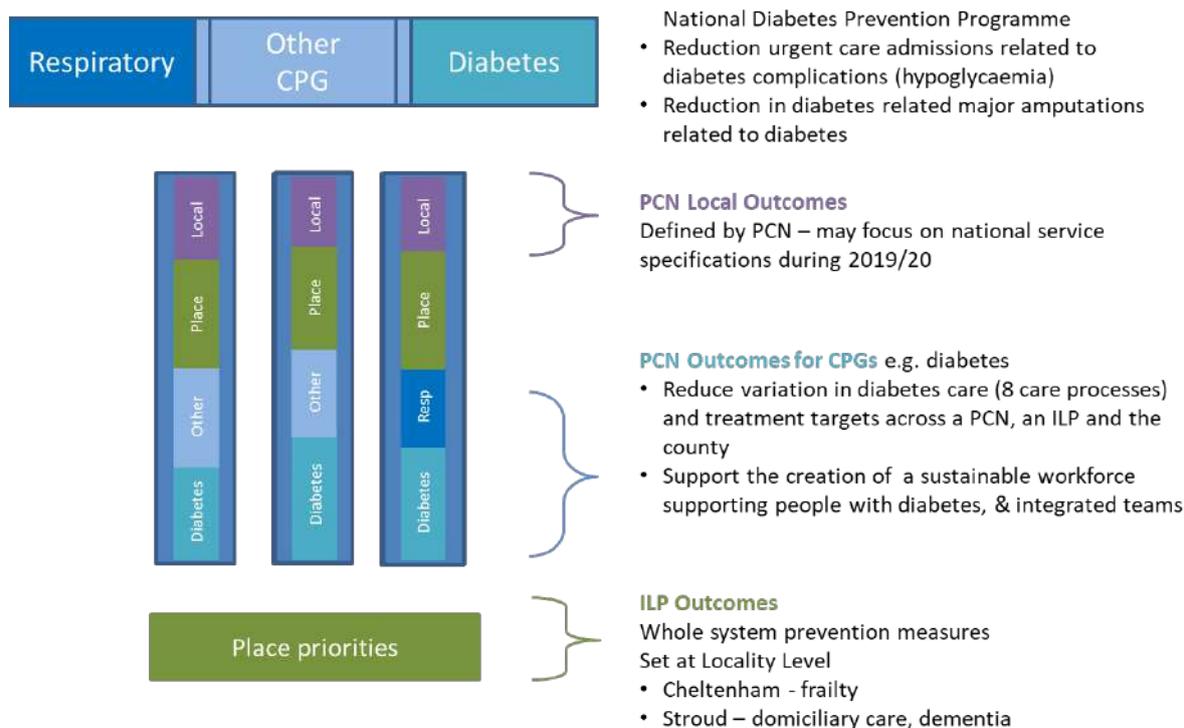
This Primary Care Strategy enables these key strategic objectives along with all of the four ICS programme areas (Enabling Active Communities, Clinical Programme Approach, Reducing Unwarranted Clinical Variation and One Place, One Budget, One System) to deliver through setting out a clear development trajectory for primary care. With c.90% of all NHS patient contacts being with general practice (NHS England, 2015) and our ambitions for access, integration, Population Health Management, workforce expansion and digital-enablement described over the following pages, the ICS will focus on delivering this Strategy for the benefit of our patients, with the PCN Clinical Directors key to our decision making.

This means that, for example, our Clinical Programme Approach will mature to allocate programme budgets and clinical priorities across our new primary care system architecture of PCNs and ILPs as described in this Strategy. This matrix

of priorities will need to consider our ICS priorities, as defined within our local LTP response, Health & Wellbeing Strategy priorities, along with priorities by Place – i.e. at ILP level – and those priorities determined both nationally and locally for PCNs. We are already beginning to consider how this might look (see Figure 7), however as all PCNs are at their initiation stage, and at different



stages of their maturity, we need to support their development (see ‘Goal 1’) in 2019/20 in readiness for the national ‘asks’ from 2020/21 onwards, whilst also progressing our priorities as an ICS. We are testing these approaches with our newly appointed Clinical Directors across the PCNs, and ILP Chairs, to develop the most appropriate mechanism to align the ICS, the ILPs and PCNs, to ensure our system is delivering the right outcomes for patients across Gloucestershire, while also providing the freedom to innovate locally to ensure services are moulded to patient need



**Figure 7: A “matrix of priorities” for PCNs and ILPs**

Triangulating our ICS ambitions and priorities, the NHS LTP and the feedback from our patients, has led to the development of the six goals of this Strategy introduced in Chapter 3. Delivering these six goals will mean, as an ICS, we focus on:

- Supporting primary care to undertake pro-active case management and co-ordination of care of patients to increase out-of-hospital care where appropriate, successful implementation of which will reduce the pressures experienced on hospital based urgent care;
- Supporting patients to self-care and make more use of voluntary services in our communities, often accessed through social prescribers in our PCNs;
- An eradication of the boundaries experienced by our patients between our in-hours and out-of-hours primary care services;
- Ensuring primary care and PCNs, through our PCN-appointed Clinical Directors, are empowered to deliver care as needed for their patient population, co-ordinating an integrated care offer for all patients while developing specific pathways of care for those patients with long term conditions through the Clinical Programme Approach;
- Extending the range of services offered in our PCNs, recognising the diverse demography and health needs of our population, including diagnostics, rehabilitation, mental health, therapies and outpatients;
- Ensure greater utilisation of digital technologies to join-up care, focus on prevention and improve access to primary care services.

The rest of this Chapter now explores the six goals of this Strategy in more detail.

## 4.1 Goal 1: Primary Care at Scale: Partnerships and Integration

### General Practice as the foundation of our system

Our practices are the bedrock of our whole system and we care passionately about the general practice partnership model and the hardworking clinical, administration and management staff who work within them. The partners are equally passionate about their patients and their staff and together we form an unequalled team in delivering improved quality and safety, driving leadership and innovation and treasuring the partnership model that delivers the fantastic care our patients deserve. We have a strong relationship with our Local Medical Committee (LMC), our local GP Provider Company (GDoc) and engage frequently across our member practices. This includes practice visits by senior executives, senior GP leadership meetings, whole county forums and weekly electronic newsletters, along with a dedicated Primary Care and Localities Directorate who have close working relationships across all practices and other teams and key personnel who frequently interface with general practice. Recent feedback demonstrates that our member practices feel well supported by and have a close relationship with the CCG.

The platform on which our ICS is built must have strong foundations. Through developing the close relationship over the course of the previous Strategy, we know there continues to be some practices struggling with their sustainability and resilience. We have put measures in place to support these practices, as we set out to do under the previous Strategy, and we recognise we must continue to invest. Over the course of this Strategy we will continue to ensure the sustainability and resilience of our practices. Our measures will include:

- Investing in workforce, separate from practice and PCN staff, who can be placed in practices for short periods of time to support acute workforce pressures caused by unexpected but extended illness (see Goal 4);
- Close working with the LMC to work together to support those practices most in need, supporting mergers or other solutions where appropriate;
- Prioritise GPFV resilience funding to our practices most at risk;
- Continue investing in general practice and PCNs, inclusive of recurrent 'transformation' funding, our Primary Care Offer (see Goal 3) and other enhanced services that bring investment into general practice.

By securing these foundations, we have the necessary infrastructure in place to provide patients with integrated care built up from our patients, through to general practice, through PCNs to ILPs to the ICS (see Figure 8) who hold overall responsibility for ensuring the success of our ILPs, PCNs and GP practices for the benefit of our patients; the reason this Strategy exists. For details of which practices are in which PCN, please see Appendix 2. This is the structure we are rolling out in 2019/20 and will be the basis of reorganising our ICS partners around over the course of this Strategy, starting with our community teams.



Figure 8: Structure of our ICS

## Primary Care Networks

### What is a Primary Care Network (PCN)?

Introduced nationally by NHS England through the NHS LTP and the GP Contract Reform 2019-2024, PCNs have been created across England, with over 1,250 PCNs in existence from 1 July 2019. These are based on minimum registered list sizes of 30,000 patients – not usually more than 50,000 – commissioned through general practice in the form of a Directed Enhanced Service (DES) that forms the network contract. A mandated network agreement, with associated schedules, sets out the relationship and operating protocols of the PCN. Guaranteed real-terms investment of £4.5bn has been pledged for primary and community care from 2019/20 to 2023/24.



The core characteristics of a Primary Care Network are:

- **Practices working together and with other local health and care providers**, around natural local communities that make sense geographically, to provide coordinated care through integrated teams
- **Providing care in different ways to match different people’s needs**, including flexible access to advice and support for ‘healthier’ sections of the population, and joined up multidisciplinary care for those with more complex conditions
- **Focus on prevention and personalised care**, supporting patients to make informed decisions about their care and look after their own health, by connecting them with the full range of statutory and voluntary services
- **Use of data and technology to assess population health needs and health inequalities**, to inform, design and deliver practice and population scale care models; support clinical decision making, and monitor performance and variation to inform continuous service improvement
- **Making best use of collective resources** across practices and other local health and care providers to allow greater resilience, more sustainable workload and access to a larger range of professional groups

Source: NHSE, 2019

NHSE has set out five aspirations for PCNs across the country, which we have adopted in Gloucestershire and informs our specific commitments to our PCNs over the course of this Strategy:

1. Stabilise the GP partnership model;
2. Create 20,000 new staff working in general practice through an 'Additional Roles Reimbursement' scheme (see Goal 4 for our local commitments in this regard);
3. Create a wider platform for investment;
4. Dissolve the historic divide between primary and community care – which we will achieve through our PCNs and ILPs and have expanded the remit of our Director of Locality Development and Primary Care to be a joint appointment across CCG and GHC;
5. Have a clear, quantified, positive impact for the NHS system and our patients, with fewer patients being seen in hospital and more being seen and treated in our communities.

PCNs are wider than just general practice, they must include all of primary and community care staff, working together to deliver preventative, out of hospital, care for their patient population. So while GP practices are at their heart, and the initial partners from July 2019, they must grow from April 2020 to begin to include these other partners. This will enable them to commence the new service specifications that will go live from April 2020, with some mirrored service specifications for community teams to support the staff integration and joint working:

- **Structure Medications Review and Optimisation;**
- **Enhanced Health in Care Homes;**
- **Anticipatory Care** for high need patients with several long term-conditions;
- **Personalised Care;**
- **Supporting Early Cancer Diagnosis.**

From April 2021, there will be a further two specifications:

- **CVD Prevention and Diagnosis;**
- **Tacking Neighbourhood Inequalities.**

From April 2020, every PCN will receive a new national Network Dashboard to measure impact, including A&E attendances, admissions, prescribing and performance against these new service specifications. Also commencing in 2020 is a new national Network Investment and Impact Fund, linked to performance against metrics in the Network Dashboard. This will mean that PCNs that can evidence a positive, demonstrable, impact in these measures will receive further investment to support their growth.

## What this means for Gloucestershire

Having set out a commitment in our previous Primary Care Strategy to create clusters of c.30,000-50,000 patients and achieving this with 16 clusters, we were particularly well placed for the development of PCNs. As shown at Figure 8 above and at Appendix 2, our member practices have coalesced to create 14 PCNs, largely similar to those original cluster configurations, which all went live from 1 July 2019. Gloucestershire ICS has been allocated funding from NHSE to support the development of our 14 PCNs and their Clinical Directors (see Goal 4). The PCN Development Programme has been co-produced by NHSE and Primary Care colleagues across the country, including representatives from Gloucestershire and is expected to run for five years. It comprises six support domains which represent the essential elements systems will use to meet local needs (see Figure 9).



**Figure 9: The six PCN Development Programme Domains**

We are working in close collaboration with our PCNs and their respective Clinical Directors to ensure there are appropriate development options for our PCNs’ requirements. This work is informed by completion of NHSE’s PCN maturity matrix, which gives each PCN the opportunity to identify their development needs in relation to their own vision and goals, along with their requirements to meet these aspirations. Utilising this feedback, and iteratively capturing progress and new goals over the course of this Strategy, we will support the mobilisation, implementation and ongoing delivery of the programme to fulfil the various development needs across our county. Our explicit aim under this Goal is for our PCNs to be supported to achieve ‘Step 3’ maturity by 2023/24. This will mean a joined-up ICS programme of work and investment in urgent care (see Goal 2), population health management (Goal 3), our workforce (Goal 4), our IT (Goal 5) and our estates (Goal 6).

We will also support all our PCNs to reach their maximum potential through providing dedicated management support from the ICS to support their planning and development, along with local metrics ahead of the national dashboard (see Goal 3).

## Integration with wider Primary Care

During 2019/20, it is expected that PCNs will begin to develop wider relationships with their partners to deliver integrated care and by April 2020, it is expected that Community Pharmacy will be a key partner in local PCNs. Community pharmacists are highly trained healthcare professionals, passionate about providing high quality services to their patients. Community pharmacists have the potential to play a greater role in clinical service delivery, helping people to stay well. Whilst the supply of medicines remains an ongoing and critical part of what community pharmacy provides, there is an opportunity to focus on minor illness and the prevention and detection of ill health. The agreement reached between the Government, the NHS and the Pharmaceutical Services Negotiating Committee (PSNC) describes the joint vision for how community pharmacy will support delivery of the NHS LTP. The community Contractual Framework 2019/20 – 2023/24, published on the 22 July, outlines the deal which has been agreed:

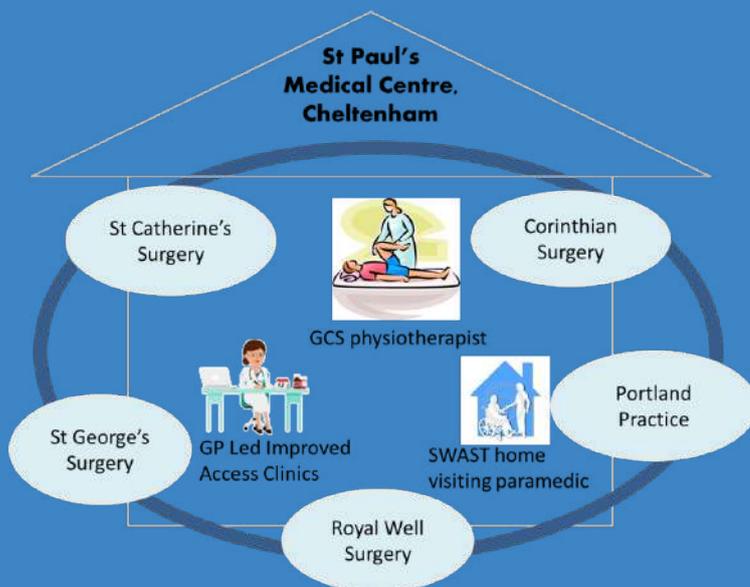
- Commits almost £13 billion to community pharmacy through its contractual framework, with a commitment to spend £2.592 billion in each of the next five financial years;
- Is in line with the GP contract, providing 5-year stability and reassurance to community pharmacy;
- Builds upon the reforms started in 2015 with the introduction of the Quality Payments Scheme to move pharmacies towards a much more clinically focused service;
- Confirms community pharmacy’s future as an integral part of the NHS, delivering clinical services as a full partner in local PCNs;
- Describes new services which will immediately be offered through community pharmacy as well as a programme to develop evidence-based additions to those services. Foremost amongst the new services is the new national NHS Community Pharmacist Consultation Service, connecting patients who have a minor illness with a community pharmacy which should rightly be their first port of call (see Goal 4);
- Underlines the critical role of community pharmacy as an agent of improved public health and prevention, embedded in the local community;
- Recognises that an expanded service role is dependent on action to release pharmacist capacity from existing work, including developments in information technology and skill mix, to deliver efficiencies in dispensing and services that release pharmacist time;
- Continues to prioritise quality in community pharmacy and to promote medicines safety and optimisation; and
- Underlines the necessity of protecting access to local community pharmacies through a Pharmacy Access Scheme.

We recognise that attempting to align all our ICS partners to 14 PCNs would be resource-intensive and inefficient and prevent planning at a district – or ‘place’ level. For this reason, we have created Integrated Locality Partnerships (ILPs), where PCNs come together with their ICS partners to develop and plan services at this larger footprint.

### Case Study: Cheltenham St Paul's PCN

This PCN is made up of 5 co-located practices serving around 50,000 patients. The practices work together in their network along with other providers such as to GHCNHSFT and SWAST to provide a wider skill mix.

Shared physiotherapist appointments are provided through a GHCNHSFT employed physiotherapist, while home visiting and other urgent appointments are provided by a paramedic employed by SWAST. This has enabled the GPs to spend longer with patients with more complex needs, reducing hospital admissions and improving GP morale and patient satisfaction.



### Integrated Locality Partnerships (ILPs)

We know that to have sustainable health and care services in Gloucestershire we need to work collaboratively as one integrated system to deliver the vision and ambitions of our ICS. This neatly dovetails with the LTP, reflecting the journey we've already commenced of taking collective responsibility for managing resources, delivering NHS standards, and improving the health and wellbeing of the population we serve through breaking down the barriers between our individual organisations to deliver better health and care. We have embraced the opportunity to do more at pace and at scale, encouraging a population based approach to improving health and care through the delivery of place based care. Over the course of this Strategy, we will continue to align with the other public services working across Gloucestershire in order to address the wider social determinants of physical and mental health. This will be achieved through our six ILPs (see Appendix 2 for breakdown on ILPs and PCNs; Appendix 3 provides a profile for each ILP). We will build on the Health and Wellbeing Strategy using Population Health Data (see 'Goal 3') to drive the identification and prioritisation of the most appropriate response to the management of care. By removing silos of provision, we will encourage providers over health outcomes not levels of activity, working together in an integrated delivery model.

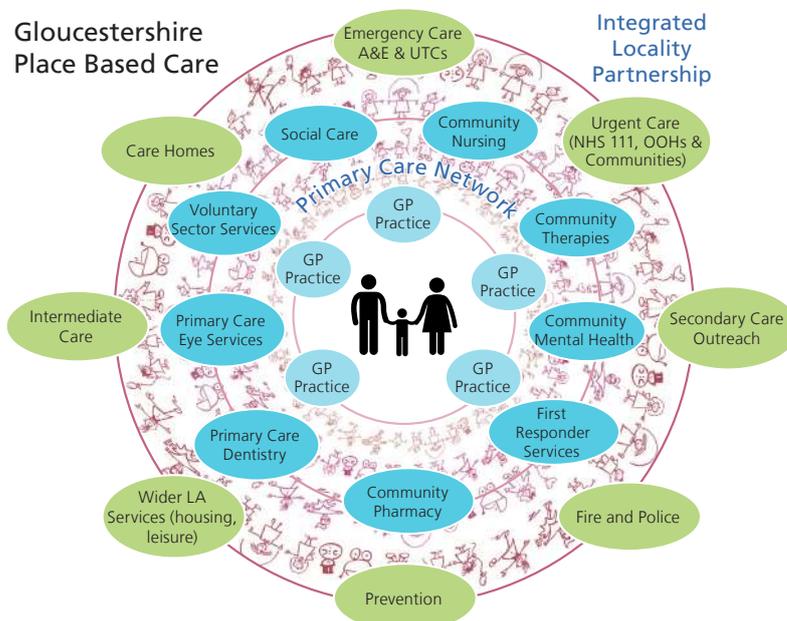


Figure 10: Gloucestershire's Place Based Care Model

We will deliver this place-based care through our PCNs described above, which will see multi-disciplinary teams working together to serve their populations and making the most of the many supportive 'community assets' such as voluntary and community groups that also work within our neighbourhoods, i.e. PCNs, while strategic planning and delivery on larger footprints will be organised at ILP level. As seen in Figure 10, we are proposing a person-centred, place-based model of proactive community based care, closer to home, with primary care at its core. This entails not just integrating health and social care but a joined-up approach with education and skills, welfare and benefits, leisure, housing and community safety programmes to deliver a more appropriate mix of medical and social interventions to tackle the root cause of health inequalities.

This means:

- There will be more support for people to stay healthy and independent and develop active communities that promote prevention and self-care;
- Local people with long-term conditions will benefit from more joined-up care and support in their own home, GP surgery, community or hospital;
- Staff should find it easier to work with colleagues from other organisations to support shared health priorities and deliver better outcomes for patients;
- Seamless care between primary care and NHS community services – that fundamentally removes the historic separation of these parts of the NHS and brings community services together (across physical and mental health);
- Joined-up care planning, co-ordination and delivery between primary care and social care – with NHS and social care staff working together in MDTs and hubs;
- We will leverage our strength as one system to integrate with wider partners in fire, housing, leisure, police, Voluntary and Community Sector (VCS) organisations and education – with shared responsibility and mature relationships;
- We will fully harness the opportunities from technology – for digital provision of care for patients, real-time single care records and Business Intelligence systems, including predictive modelling for risk stratification and care segmentation (see Goal 5);
- Sustainable workloads for staff and more attractive and structured career pathways – that enable MDT working and new integrated care roles, portfolio-based careers and support for staff to move between care sectors.

In working together, our ICS partner organisations will have greater freedom and control to make decisions about service configuration, meaning services and support can be best targeted towards local need.

We are committed to moving forward with system-wide models of care, making sense of the problems we face together and encouraging innovative solutions at all levels.



## Integrated Locality Partnerships – how will they work?

Our ICS system partners have collectively agreed that ILPs will have the following characteristics and responsibilities:

- Be an Operational and Strategic partnership of senior leaders of health and social care providers and local government, supporting the integration of services and teams at PCN level;
- Unblocking issues for PCNs and sharing responsibility, finding local solutions to delivering ICS priorities and tackling issues which arise locally which can only be resolved collectively;
- Focus on cultural change and the way we work together, rather than on structural change;
- Provide clinically-led integration of decision making, involving staff and local people in decisions, to support more people in the community and out of hospital;
- Develop multidisciplinary workforce models which will operate at PCN level with staff empowered to work in innovative ways to meet the needs of patients regardless of organisational boundaries;
- Collectively produce an ILP Plan to deliver improved population health including prevention and public health and reduced inequalities with aligned priorities agreed to improve outcomes.

In time, our ambition is to see the membership of ILPs broaden to include partners whose work impacts on health and wellbeing and the wider determinants of health, for example social prescribing, education and employment and working alongside a range of other partners and local communities.

We recognise that this development will take time as there will inevitably be cultural, technological and resourcing hurdles as we integrate our teams. To tackle this, we will create the right environment and senior leadership to create shared incentives, a shared sense of place and a shared set of priorities (see Table 3 below); with one set of patients, we know that by doing this our teams will coalesce around delivering the best possible outcomes for their shared, common, goal: the health and wellbeing of their patients.

<b>ICS Clinical Priorities</b>	Respiratory, Cardiovascular Disease (CVD), Diabetes and Frailty including Dementia.
<b>Health &amp; Wellbeing Strategy Priorities</b>	Social Isolation, Adverse Childhood Experiences (ACEs), Physical Activity, Health Lifestyles (with initial focus on healthy weight), Housing and Health, Mental Wellbeing, Early Years/Best Start in Life.
<b>Prevention and reducing inequalities framework (NHS Long Term Plan response)</b>	Smoking, Obesity, Alcohol, Air pollution, Antimicrobial resistance, Health inequalities
<b>Local Priorities</b>	PCN defined inclusive of national service specifications and priorities determined through local and national datasets

**Table 4: The six PCN Development Programme Domains**

## Summary of our priorities for Goal 1

### Goal 1: Primary Care at Scale: Partnerships and Integration

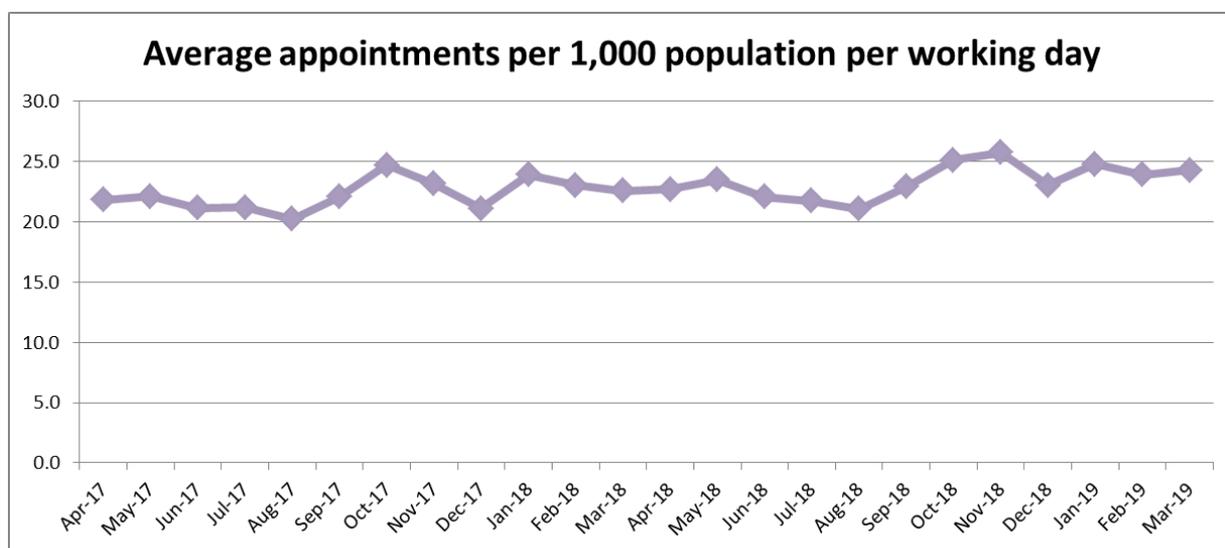
Our strategic commitments to this goal during the timeframe of this Strategy are as follows. We will:

- Continue to ensure the sustainability and resilience of our individual GP practices as the foundation of our whole system.
- Support the development of each PCN across the Maturity Matrix to achieve 'Step 3' maturity by 2023/24, with dedicated resource made available.
- Align and integrate all of our primary and community care provision through our PCNs to address the wider social determinants of physical and mental health.
- Support the maturity of our ILPs – the aggregation of our PCNs at 'Place' level – to remove silos of provision, incentivising providers over health outcomes not levels of activity, working together in an integrated delivery model. This will include wider partners in fire, housing, leisure, police and education.

## 4.2 Goal 2: Improving Access and our Urgent Care Offer

We want patients in Gloucestershire to continue to have good access to high quality primary medical services through their local GP practice when they need to, getting the right care, in the right place at the right time. To do this we will increase the ways in which patients can access both digital services and face-to-face services. In turn, this will ensure valuable resources are used carefully and appropriately so that patients get the best care when they need it, whilst keeping GP services sustainable and fit for the future.

While many of our GP practices are thriving, like many other services, they are very busy and in some cases overstretched. As can be seen at Figure 11 below, the average number of appointments attended per 1,000 population per working day for our county has been steadily rising. In 2017/18, our GP practices saw an average of 22.2 appointments per 1,000 patients (based on average list size over 2017/18), or c.14,250 appointments per day. By 2018/19, this had risen to an average of 23.4 appointments, or 15,200 appointments per day (based on average list size over 2018/19). Early data from 2019/20 suggests a continuation of this increasing trend. Capturing this primary care activity data is a recent capability and one that we committed to in our original Primary Care Workforce Strategy. Through this new data source we have also identified variation by practice, PCN and locality, which we commit to analysing and triangulating with other data sources so we can understand the drivers for this variation and develop our plans and support accordingly.



**Figure 11: Average attended appointments per 1,000 population per working day, April 2017 – March 2019 (based on extracted, anonymised, data from Gloucestershire GP clinical systems)**

In line with the aims of the NHS LTP, Gloucestershire practices – through their PCNs – will be employing more new roles in primary care to improve access for patients and to support prevention and early intervention. A variety of these roles already exist in county and further expansion of these roles is detailed in Goal 5.

## Improved Access

To improve access to GP services our practices have been working together to provide general medical services 8am to 8pm, 7 days a week including bank holidays. In Gloucestershire we have provided over 100,000 additional appointments in the past year through the delivery of Improved Access; Improved Access provides both routine and same day pre-bookable appointments between 6.30pm to 8pm on weekdays and at weekends and bank holidays. We have various delivery models designed to meet the needs of patients and to support the sustainability and resilience of general practice, with many models rotating evening appointment sessions around practices in their respective PCNs to improve access, even in the most rural areas.

Saturday afternoon, Sunday and Bank Holiday Improved Access appointments are delivered through a countywide service which operates from three urban locations and provides support to urgent care services for minor illness presentations requiring a GP. Pre-bookable, on-the-day appointments are available through NHS 111 into our countywide service and this is being expanded into general practice as part of the commitment made in the LTP and the GP Contract Reform, with a minimum of 1 appointment per 3,000 registered patients a day being made available for 111 booking, rising in 3,000 bandings. “Click or Call” will be the key messages for our patients, to ensure effective signposting and management of timely access, with a plan for robust engagement and communication to ensure excellent utilisation, including advertising on digital and other media platforms. Further detail on how digital technologies will support our urgent care offer is detailed at Goal 5.

By 2021, Improved Access will be integrated with Extended Hours commissioned from PCNs. The detail of this will be informed by a national Access Review through 2019, which has one main objective: to improve patient access both in hours and at evenings and weekends and to reduce unwarranted variation in experience. The Access Review will include:

- Review of current and previous models of service delivery and evidence of the benefits and costs of service provision and impact on the wider system;
- Identifying ways to reduce fragmentation of care and offer a more joined up service for patients;
- Looking at the workforce and workload and how to support patients and staff to make best use of services, including using digital technologies;
- Engaging with patients and the public through bespoke patient and voluntary sector focused events;
- Finding ways to make best use of available general practice appointments that offer continuity and choice for patients;
- Reviewing care navigation and demand management to ensure the most appropriate use of general practice services;
- Understanding reasons for unwarranted variations in waiting times with a view to improving satisfaction;
- Understanding the relationship between workload pressure, workforce wellbeing and the delivery of good quality care;
- Developing a comprehensive offer for out of hospital care including when practices are closed or unavailable;

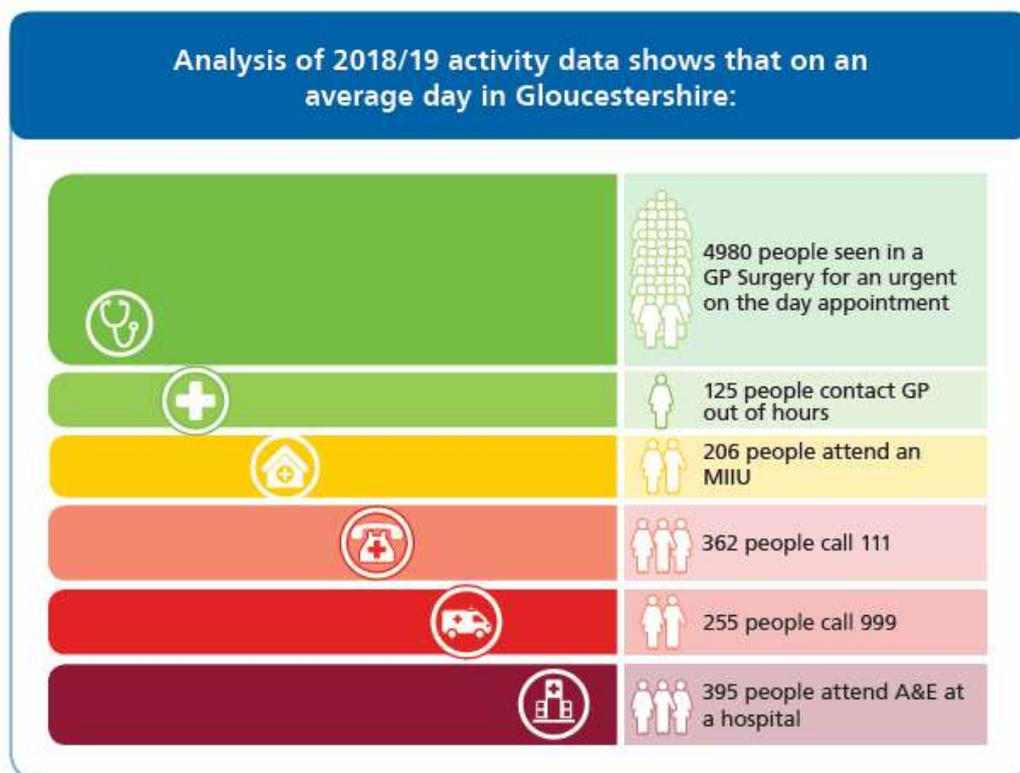
- Making the most effective use of resources in the NHS’ investment in this area;
- Understanding any likely issues with inequalities in access to routine and urgent appointments in general practice and the community.

While increasing additional appointments is important, it should be noted that there is finite capacity within the system and a need to support patients better and earlier in their pathway. To address these challenges, we will support the reduction of avoidable demand by empowering patients to self-care and engage with the prevention agenda.

We believe the developments will help to reduce unnecessary attendances in urgent and emergency care settings and will form part of a greater network of services to include prevention and self-care, clinical advice and assessment over the telephone and online, pre-bookable appointments where required for both minor illness and injury presentations, and access to outstanding specialist hospital care for when patients are very unwell – a service offer that reflects the diversity of the Gloucestershire county and patient acuity. Further details on workload reduction can be found at Goal 4.

### Joining up the urgent care offer

Our commitment to further developing our out of hospital ambulatory offer will also aim to appropriately reduce acute hospital admissions or assessments and therefore, our plans are integrated with the ICS urgent care offer, described in our overall Gloucestershire long term plan . These plans will be supported by Point of Care testing in the community and professional access to specialist clinical advice so that more people can be treated closer to home where appropriate.



**Figure 12: Daily Gloucestershire ICS urgent care activity by point of care delivery**

As can be seen at Figure 12, general practice makes a significant contribution to urgent on the day demand in our county, with nearly 5,000 people being seen on an average weekday.

Increasingly patients will have seamless access to appropriate services in primary care with GP practices working closely with local pharmacies and community services through their PCNs, alongside local dentists and optometrists.

Pharmacies will provide consultations to give advice on minor health issues and provide urgent prescriptions to reduce demand on general practice and other urgent care services. Patients will be able to access these services at their local community pharmacy or through calling 111. Community pharmacy will become the “first port of call” for low acuity conditions needing a consultation or face to face advice and for medicines access and advice. Gloucestershire are piloting with NHS England a scheme to provide further capacity through community pharmacy, called the Community Pharmacist Consultation Service – further details can be found at Goal 4, commitment 2.

PCNs integrating and joining-up the delivery of urgent care will be a vital element of the primary and community service offer, along with the additional workforce, digital enablement and estates plans described in this document, as we strive to improve patient experience while providing excellent quality care and sustainable services.

## Summary of our priorities for Goal 2

### Goal 2: Improving Access and our Urgent Care Offer

Our strategic commitments to this goal during the timeframe of this Strategy are as follows. We will:

- Commit to **analysing and triangulating our primary care activity data** to understand the drivers for variation and develop our plans accordingly;
- Fully **engage with the national Access review** and support PCNs who wish to integrate extended hours and improved access early, in order to sustainably provide better access to appointments for our patients;
- Further **develop our out of hospital ambulatory offer** to bring care closer to home for our patients, supported by Point of Care testing in the community;
- Continue to build **collaborative working** between urgent, primary and community care,
- Support the **rollout other modes** of improving access, such as digital enablement.

### 4.3 Goal 3: Population Health, Improving Quality and Tackling Inequalities

The King's Fund (2019) describe four pillars of population health – see figure 13 below – improving health requires action across all four. As an ICS, and with the infrastructure of PCNs and ILPs described in Goal 1, we have already begun this journey, but we have much more to do. This is described within this Goal, but should also be read in conjunction with our ICS's long term plan.



**Figure 13: The four pillars of population health (The King's Fund, 2019)**

Population Health Management (PHM) therefore aims to improve population health, mental and physical, whilst reducing health inequalities within and across a defined population, through data driven planning and delivery of proactive care to achieve maximum impact. PHM includes segmentation, stratification and 'impactability' modelling to identify local 'at risk' cohorts and involves:

- Designing and targeting interventions to prevent ill-health;
- Reducing unwarranted variations in outcomes;
- Improving care and support for people with ongoing health conditions;
- Identifying those patients who are most at risk of suffering ill-health.

It is a national LTP expectation that ICSs deploy PHM solutions to understand the areas of greatest health need and match and design NHS services to meet them. Therefore we need to ensure we have the tools and systems in place to support these requirements and, while national datasets are being developed to support PCNs with this planning, we have pursued our own local dataset development to commence early work with our PCNs and ILPs. This has been co-produced by ICS partners, including GCC's Public Health team, to bring together an initial overview for each ILP; these can be found at Appendix 3. This is developing insights such as the relationship between deprivation and the average number of long term conditions (LTCs) our patients have by age (see Figure 13), which shows that the average patient in the most deprived quintile will have one LTC by the age of 45-49, whereas the average patient in the least deprived quintile will be in a similar position but 10 years later. This demonstrates how we need to respond as an ICS to tackle these health inequalities within our county.

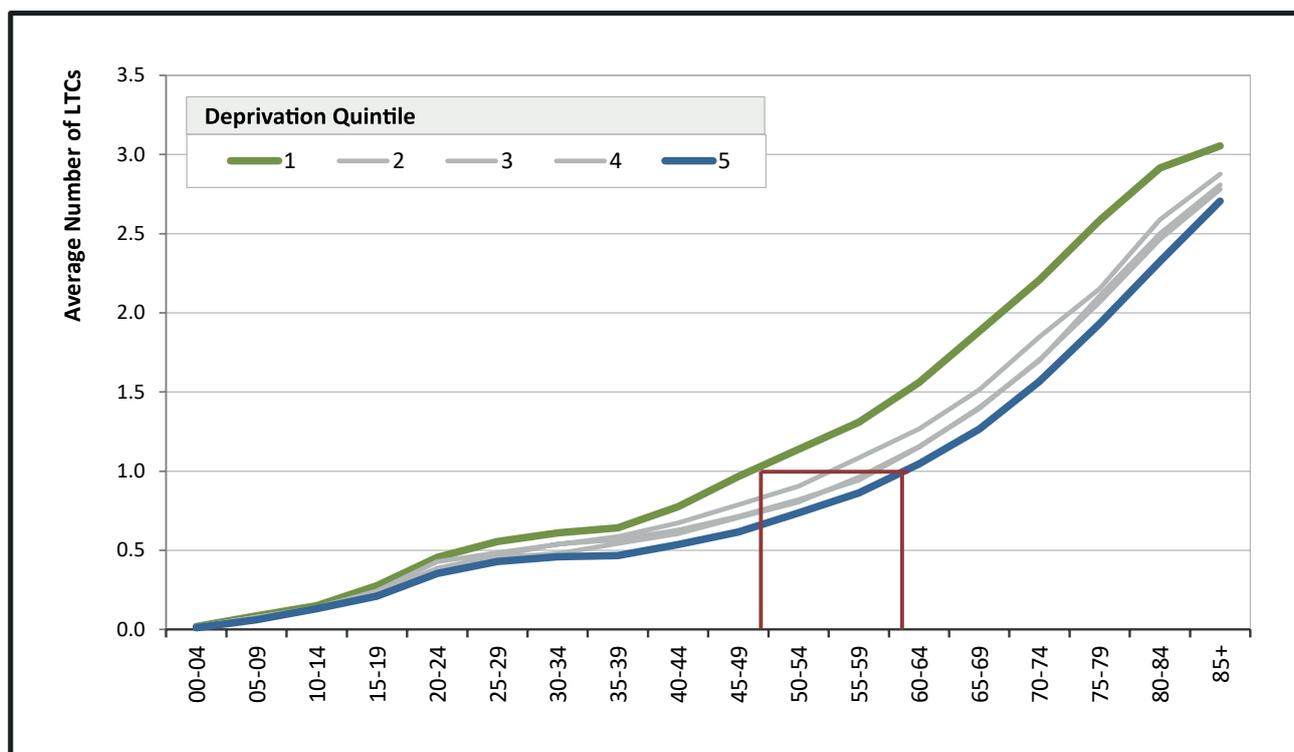
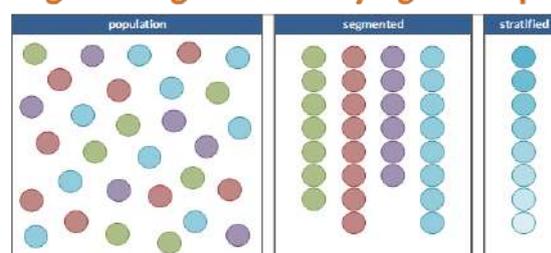


Figure 14: relationship between deprivation and long-term conditions by age

We have also undertaken some initial population segmentation, which we will continue to develop and refine, along with population risk stratification, proactive case finding and identification of high intensity users for MDTs. These will continue to be developed to provide population health intelligence for our PCNs, ILPs and the ICS with the aim of addressing the health inequalities within our system. We are also finalising a dynamic tool for Integrated Locality Reporting (ILR) (see below).

### Segmenting and Stratifying our Population



**Better able to describe our Population and group cohorts with similar characteristics**

These groups can then be stratified according to a number of risk measures to determine **impactability**

### Developing our PHM capabilities

In order to provide PHM, we will be working as an ICS to iteratively develop the following three capabilities over the course of this Strategy, utilising feedback from our PCNs and ILPs and as we continue to develop our technology to implement appropriate IT infrastructure to optimise performance, storage and accessibility (see Goal 5).



**Infrastructure:**

*What are the basic building blocks that must be in place ?*

Information Governance and IT. Getting the data.



**Intelligence:**

*Opportunities to improve care quality, efficiency and equity*

Analysis and presentation of data



**Interventions:** *proactive clinical and non-clinical interventions to prevent illness, reduce the risk of hospitalisation and address inequalities.*

1. **Workforce development** – upskilling teams, realigning and creating new roles
2. **Community well-being approaches**, social prescribing and social value projects
3. **Assistive technologies** and digital tools to empower patients and smooth care transitions
4. **Incentives alignment**, financial modelling and risk sharing mechanisms

This PHM development will be led by a system-wide PHM Steering Group Co-Chaired by the CCG Chief Finance Officer and the Director of Public Health at GCC. This will also require development of our ICS Data Asset, which will be achieved through data acquisition projects such as the Social Care Data Sharing Project. This will then create a person-centred linked data set, including the primary care record:



Furthermore, our ICS has been successful in its bid to NHSE to become a Wave Two site under the NHSE and NHS Improvement Integrated Care Systems PHM Development Programme. This gives us the opportunity to use the data and analysis carried out by the national PHM team alongside Gloucestershire clinicians, analysts and managers to demonstrably improve health outcomes and tackle inequalities for selected local population cohorts. The programme will involve completing a 20 week supported cycle with three PCNs and we plan to then share this learning across the system. Utilising the experience will enable us to more fully develop our plans and support our capability development over the course of this Strategy. PHM is a module within the PCN Development Programme, designed to directly support preparation for the Anticipatory Care national service specification in 2020, so we will link the development needs and opportunities borne from each programme.

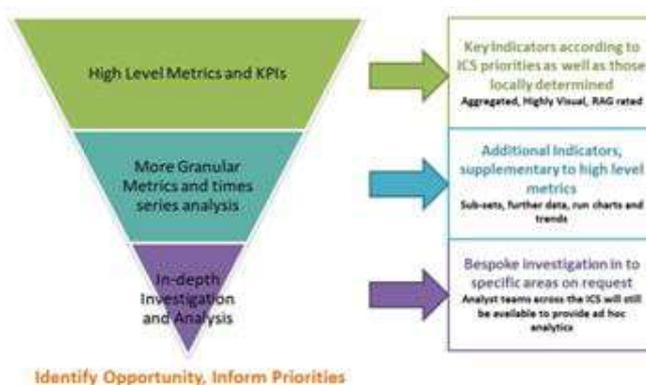
A PHM strategy has been developed to support the ICS, which aims to have PHM embedded across our system and key priority Clinical Programme Groups by 2022. PHM will support our decision making and to tailor our services to the needs of our population. The PHM outcomes for the ICS are:

- The ICS understands the health and care needs of its population;
- Data is developed into intelligence and used to predict health outcomes and the impact that these have on the Gloucestershire health and care system;
- Data is developed into intelligence to reduce health inequalities;
- Care interventions are designed and implemented in a personalised way based on advanced population analytics and evidence;
- Care interventions are focused on proactive prevention and early intervention.

Over the coming years, our PHM solutions will become increasingly sophisticated in identifying those groups of people who are at risk of adverse health outcomes, predict which individuals are most likely to benefit from different health and care interventions, as well as identifying health inequalities. This will also support greater transparency of health and social care data on population health outcomes and organisational performance. Through our work with the national PHM development programme, we are taking a lead in progressing complex solutions to linking and using data for local PHM solutions, ensuring that they enable achievement of the LTP goals (e.g. develop and build on locality data to better identify inequalities and unwarranted variation in processes and outcomes).

### Integrated Locality Reporting

To support our practices, PCNs and ILPs to begin to understand their practices, populations and priorities we are developing an ILR tool. The ILR tool, initially Excel based (see screenshots below), will be made available to all PCNs during 2019/20 – ahead of the national Network Dashboard – to allow early planning and implementation at neighbourhood and place level and is being developed in partnership with our Clinical Directors and ILP Chairs as well as our wider system partners. Our ambition is that this will continue to mature and will complement the nationally available datasets to give the most practical and informative intelligence to enable action that benefits our populations. The ILR tool allows users to interact with analytics developed from our current ICS dataset, providing a high-level view of populations and resource usage, it will provide timely and appropriate information to help shape priorities, deliver a consistent ICS message, support PHM and integrated system working (Figure 14).



**Figure 15: The concept of our ILR tool**

Furthermore, the ILR tool will measure performance, outcomes and evaluate impact. It includes the following range of metrics:

- Demography and PHM;
- Primary Care Metrics, inclusive of CQC ratings, appointment data, workforce data, patient feedback;
- Secondary Care urgent care utilisation, such as Emergency Department and Emergency Admissions data;
- Secondary Care planned care utilisation, such as day care utilisation, elective inpatients and outpatient data;

- Prescribing data;
- Community data, such as rapid response and physiotherapy utilisation.

We will continue to develop this tool over the course of this Strategy to move to a business intelligence platform – improving functionality and accessibility – and integrate further data from across our ICS including NHS111, out of hours, ambulance data from SWASFT, social care and public health measures. We will also include in-depth analysis in conjunction with our Clinical Programme Groups.

Our ILR tool will also support our wider data driven approach to case finding, for example in our use of link data to develop clinically informed searches to pro-actively identify patients suitable for a particular service or intervention.

### Improving Quality and Tackling Variation and Inequalities

Our approach to improving primary care quality will be through an ICS-wide quality framework and objectives, with quality surveillance and assurance and committees in common. Our framework will consider the safety and treatment of our patients, the effectiveness of care and treatment, our patients’ experience of care and the fundamentals standards of care. This will be detailed within an ICS Quality Strategy underpinned by provider plans, including for Primary Care, led by the CCG Quality Team.

Through the work described above, we will be improving the quality of care for our patients and tackling variation, but these are not our only measures.

### Primary Care Offer

Our ‘Primary Care Offer’ is a local enhanced service offered to all of our practices. In place and being iteratively developed since 2014/15, we have 100% of our practices signed up to this service that invests £3m in new services for our patients in general practice, improving quality and reducing variation. The scheme is reviewed annually to ensure the priorities are aligned across the CCG and – now – our ICS, allowing us to also align incentives across our system for the benefit of our patients. Our 2019/20 scheme focuses on:

Pain	<ul style="list-style-type: none"> <li>● Appropriate prescribing for pain</li> <li>● Lower back pain - support for patients</li> </ul>
Frailty	<ul style="list-style-type: none"> <li>● Management of severely &amp; moderately frail patients</li> <li>● Education on falls and frailty</li> <li>● Hospital discharges for frail patients</li> </ul>
Atrial Fibrillation	<ul style="list-style-type: none"> <li>● Raising awareness on best practice management</li> </ul>
Expanding tele-dermatology	<ul style="list-style-type: none"> <li>● Supporting patients to get quicker diagnosis and treatment through GP access to consultant advice through tele-dermatology</li> </ul>
End of Life	<ul style="list-style-type: none"> <li>● Rolling out Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) for our patients</li> <li>● Anticipatory Prescribing for palliative patients</li> </ul>

Cinapsis	<ul style="list-style-type: none"> <li>● Making urgent advice securely available for GPs from hospital consultants for advice, guidance and referral management</li> </ul>
Prescribing	<ul style="list-style-type: none"> <li>● Prescribing Improvement Plan, including repeat prescribing efficiency, formulary adherence, medicines safety and polypharmacy</li> </ul>
Practice based clinical audit	<ul style="list-style-type: none"> <li>● Practices participating in CCG-wide clinical audit and implementing findings from the results</li> </ul>
Practice engagement	<ul style="list-style-type: none"> <li>● Practice participation in annual CCG practice visits</li> <li>● Attending place and countywide commissioning events</li> </ul>
Diabetes prevention	<ul style="list-style-type: none"> <li>● Referring our suitable diabetic patients to the National Diabetes Prevention Programme</li> </ul>

We will continue to support and enhance the delivery of the Primary Care Offer with additional resources for our practices that also seek to tackle inequalities and improve quality:

- Practice prescribing support, provided by both pharmacists and a smaller team of qualified pharmacy technicians, assisting with the progress of the local prescribing improvement plan, supporting cost efficiency and safety aspects. Each practice will continue to receive at least half a day of Prescribing Support Pharmacist or Prescribing Support Technician support per week, depending upon individual practice need.
- The provision of specific prescribing support software to assist clinicians in making cost effective choices, as well as providing prescribing safety and quality messages based on local and national guidance at the point of prescribing.
- A prescribing dashboard to provide practices with direct access to their prescribing performance figures of relevance to the local prescribing savings plan initiatives, helping them to track their progress against specific key performance indicators of prescribing quality. This includes the reduction in prescribing of low clinical value, maximising beneficial clinical outcomes with an emphasis on safety, governance, professional collaboration and patient engagement.
- Reducing medication errors, including prescribing, dispensing, administration and monitoring errors, via our Prescription Ordering Line.
- Reducing medication waste through campaigns and communications online and in GP practices.
- Maintaining the focus on medication safety through audit, medicines review with a focus on frailty, polypharmacy and high risk medicines combinations.
- Continue to support practices undergoing change, such as branch closures, staff changes and premises developments, along with CQC required improvements, with dedicated support to ensure high quality patient care is maintained.
- Working with our ICS colleagues in GCC, in accordance with Public Health Section 7a, to improve uptake in vaccinations, immunisations and screening to tackle health inequalities as we await the national review;

- In addition to the national PCN service specifications which will be in place from 2020/21 (see Goal 1), further key focus areas for us during the course of this Strategy will be:
  - Supporting integration of pharmacists into new roles including GP practices, localities and care homes, where residents will get regular clinical pharmacist led medicines reviews;
  - Promoting self-care, including use of community pharmacies and increasing uptake of electronic repeat dispensing.

We also commit to improving coverage of health checks for people with a learning disability, along with:

- Improving the quality of registers for people with a learning disability;
- A concerted effort to increase the number of people with a learning disability receiving the flu vaccine, given the level of avoidable mortality associated with respiratory problems;
- Introducing the QOF Quality Improvement module for learning disability in 2020/21;
- Aiming to achieve early delivery of the 75% target for comprehensive health checks, aiming to achieve the 75% goal collectively and in every PCN.

### Summary of our priorities for Goal 3

#### Goal 3: Population Health, Improving Quality and Tackling Inequalities

Our strategic commitments to this goal during the timeframe of this Strategy are as follows. We will:

- **Develop our PHM capabilities** to support our practices, PCNs, ILPs and our ICS with the intelligence to improve care quality, efficiency and equity;
- Take the learning from our **Wave 2 PHM work** in three PCNs in 2019/20 to develop an offer for all 14 PCNs from 2020/21 onwards;
- **Further develop our Integrated Locality Reporting tool** and move to a business intelligence platform – improving functionality and accessibility – and integrate further data from across our ICS;
- Continue to **invest in improving quality and tackling inequalities** through a range of measures, including looking for more opportunities at practice, PCN and ILP level, to target resources effectively through our Primary Care Offer and other enhanced services.

## 4.4 Goal 4: Developing the Workforce

Over the last two years we have made significant progress on the aims of our Primary Care Workforce Strategy 2017 – 2021, which are summarised in Chapter 1.1. The lessons learnt have helped us to understand the opportunities and challenges to consider for future design, delivery and implementation of our successful schemes. Successful workforce recruitment, development and transformation underlie many of the key changes introduced as part of the LTP and indeed this Strategy. While we remain committed to our original principles described in our Primary Care Workforce Strategy, this section explicitly replaces this Strategy, building upon that existing approach and the commitments made. We have integrated this approach with the NHS Interim People Plan, in order to have a workforce which provides safe, high quality care and supports the sustainability of our practices and our local NHS. We continue to work with co-produced local initiatives with our stakeholders and work closely with NHSE/I and HEE, as well as relevant professional bodies to support the outlined commitments.



The GP-led Gloucestershire Primary Care Training Hub (PCTH) is a key enabler for supporting future workforce transformation developments, working closely with key stakeholders such as HEE, Public Health and ICS organisations, including established providers and voluntary and community based organisations. As well as the function of the PCTH we have appointed to the role of Clinical Learning and Development Matron to be based within the Quality Directorate. This role will be responsible for leading primary care education, working with individual clinicians, practices and education providers to ensure training needs are captured and addressed and that Gloucestershire is represented at a wider regional level.

### Commitment 1: Understanding demand and capacity

Together with colleagues in the CCG Information team, NHSE and HEE, we continue to collate information through primary care workforce data extraction for review and for projecting future workforce demand and capacity. This includes national tools such as the National Workforce Reporting System, GP Workforce Trajectory Analysis Report, STP/ICS GP Workforce supply and demand tool and the Primary Care Nursing Workforce General Practice Nursing data tool. For the future we will include the NHS Digital Practice Data portal into this collation to support the workforce planning process. As shown in Chapter 1, we also benchmark ourselves nationally and locally to determine progress, which demonstrates we are doing well against our peers for recruitment and retention of staff in general practice.

Furthermore, as we continue to improve our local primary care data, as described in Goals 2 and 3, we will utilise this demand trend data to ensure our workforce plans address those areas of greatest need. We will also continue to undertake a localised annual workforce baseline survey which enables us to understand the recruitment status of practices and PCNs to develop and implement appropriate support for our GP practices. We will supply all this data to our PCNs so they can be better equipped and empowered to locally plan for their workforce growth needs and pipeline development.

## Our current primary care workforce baseline and planned trajectory

As set out in Chapter 1, we have grown our GP and nurse workforce in accordance with – or above – our planned trajectory since 2017. However, we recognise this has required considerable effort from the PCTH, the wider CCG, NHSE and HEE colleagues and the practices themselves. We will not only maintain this momentum, but build on it, to continue to grow our workforce to meet rising patient demand and retain and develop the skilled workforce we already have in place. The commitments that follow describe how we will do this.

In order to have an accurate baseline for this Strategy, we have utilised all of the tools already described, along with a further one-off workforce survey of all practices to ascertain the baseline of those roles impacted by the new PCN contract that allows reimbursement for additional roles above those in post as at 31 March 2019. This is described in more detail in Commitment 3 below. We have then utilised information from NHSE, HEE and local intelligence on likely workforce changes due to growth, leavers and retirements, along with the roles PCNs can employ over the term of this Strategy, to make assumptions on our trajectory. This is built by quarter over the five years to March 2024 and is shown in more detail at Appendix 5. The trajectories are explicitly draft, as the assumptions are predicated on each PCN utilising their full additional roles allocations to recruit to these levels along with holding a steady state (with leavers and retirements fully recruited to) for those roles where no intelligence is available to support a different assumption. Therefore these trajectories will be updated on an annual basis to reflect the latest positions and to update the underlying assumptions as more data, nationally and locally, becomes available. It should be noted that our Practice Nurses have been held at a steady state, owing to the number of nurses due to retire by 2024. Therefore, maintaining current numbers whilst growing other clinical workforce, will represent a significant achievement.

With all this in mind, Table 5 below provides the baseline position as at 31 March 2019 and the potential trajectory by March 2024:

Role	March 2019 Actual Full Time Equivalent (FTE)	March 2024 Forecast Full Time Equivalent (FTE)
GPs (all including Registrars)	415.8	447.8
Nurses	212.8	212.8
Health Care Assistants	73.5	73.5
Dispensers	70.6	70.6
Phlebotomists	8.0	8.0
Pharmacists	26.3	74.3
Pharmacy Technicians	1.7	1.7
Physiotherapists	2.0	44.0
Therapists	3.2	3.2
Physician Associates	0	28.0
Paramedics	3.6	17.6
Nursing Associates	0	1.2
Apprenticeships	0.7	5.7
Social Prescribers	16.7	58.7
Other Direct Patient Care Staff	3.3	3.3
<b>TOTAL Clinical FTE</b>	<b>838.2</b>	<b>1,050.4</b>

**Table 5: Baseline and forecast primary care workforce 2019-2024**

### Joined-up ICS workforce planning

To ensure demand and capacity planning in primary care is integrated with our wider Gloucestershire ICS workforce plans, we regularly engage with colleagues and workforce leaders across our providers and will continue to strengthen this relationship over the next couple of years. Primary care GP and managerial workforce leads engage regularly with the Gloucestershire Local Workforce Action Board and are active members of the two ICS steering groups – Organisational Development and Workforce – and their associated sub-groups (see structure at Figure 16 below). Our workforce planning is undertaken in a shared and integrated way to ensure that growth in no one part of our system destabilises any other part, and we commit to ensuring this continues as the range of new roles are introduced to PCNs over the coming five years.



**Figure 16: Gloucestershire ICS Workforce Governance Structure**

We understand that GP practices are different in their infrastructure systems and cultures in comparison to the larger providers in the ICS. Engaging with ICS colleagues within these groups allows us to highlight both the challenges and opportunities faced by primary care, creating awareness of approaches and best practice by sharing learning – as well as working with larger providers to support innovative new ways of working across the ICS within primary care. This is demonstrated in our work to introduce new specialist roles in primary care, such as mental health workers, physiotherapists and paramedics by working with ICS colleagues to introduce these roles through a measured, safe and sustainable methodology. This experience will prove vital as we look to the same approach to introduce the new roles in our PCNs described in the NHS LTP (described in more detail in Commitment 3).

### Commitment 2: Reducing Workload

In Gloucestershire, the success and learning of projects undertaken over the last 18 months have delivered a variety of enablers on this commitment which will continue into the future. Two good examples of this are training to up-skill practices’ front and back office staff in handling clinical correspondence and navigating patients to the most appropriate service for them.

#### Clinical Correspondence and Care Navigation

Training for admin and reception staff on Clinical Correspondence has been completed by more than 20 practices in Gloucestershire so far. This training aims to have 80% of letters in primary care being processed without GP intervention. We are aiming to create a countywide offer by procuring a bespoke training solution for our PCNs to ensure every practice can benefit from this by the end of 2020/21.

Care Navigation training allows for staff to become more aware of the variety of services which exist to support a patient's healthcare across the system. The aim of care navigation is to release 5% of demand for GP appointments. While we initially supported our practices and localities to source their own training, our evaluation of this determined that we needed to create a core offer for our practices that was centrally procured on their behalf. We are currently trialling this approach in three of our PCNs, integrating care navigation training with our local Directory of Services, consisting of input from providers, workshops, online training and in-practice soft skills training. We commit to evaluating this approach before procuring a countywide rollout model by the end of 2019/20. These skills are likely to become even more important for our practices as they work together in their PCNs to bring more skills into the network and increasingly work as a larger team incorporating primary and community care.

Clearly technology will also support the approaches described here and workload reduction through enhanced digital solutions features as outlined in Goal 5: Digitally Enabled.

### **Reducing the workload – Supporting GP practices with additional resources**

The CCG is working with GDoc for the delivery of a new model of in-practice support through the provision of practice nurses for those practices in need. This new model provides qualified/experienced nurses directly to the practice for in-house mentoring in chronic disease and sexual health courses. It also offers mentoring support for new practice nurses and nurses new to general practice. For those nurses who have been in post for up to 3 years there will be access to mentoring support for immunisations, smears, travel and in-house training. Within the new model there is a practice nurse coordinator for each of the localities within Gloucestershire, which will be aligned to the PCN going forward. These nurses act as an advocate for the practice nursing staff within the county and work within the targets laid down in the 10 point plan (NHS England, 2017), help to raise the practice nurse profile and standardise clinical and competency based practice. The Nurse Coordinators will also support the input back to the CCG regarding training needs analysis and arrangements for protected learning, alongside the Deputy Director of Nursing for the CCG. The 'Parachute Nurse Service' will provide general/specialist practice nurses to GP surgeries in crisis – so at times of staff sickness or recruitment problems, help can be sought to enable practices to run business as usual.

The NHS LTP and new GP PCN contract include a large investment in increasing the numbers of staff working in primary care, increasingly through a diversified skill mix within the workforce, which is described at Commitment 3 below. Clinical pharmacists are one such role that is becoming increasingly mature in Gloucestershire, and as such, practices and patients are appreciating the services they can offer. With this in mind, the CCG has made available a number of experienced 'parachute' clinical pharmacists that also support general practice at times of crisis, using the same model as the nursing service, meaning that practices can continue to deliver great patient care even at times of burdening workload.

The Gloucestershire CCG's place-based approach described at Goal 1, including the establishment of ILPs, strongly recognises that self-care and prevention approaches are integral to patients' wellbeing. To this effect, the conversations which are currently taking place include working collaboratively with the local authority, district councils and VCS organisations for better outcomes for patients. Already this collaboration has resulted in the development of interventions such as the Complex Care at Home teams in Gloucester, Cheltenham and the Forest of Dean, which also support workload reduction in general practice. Through the PCTH we have funded three VCS organisations to support the implementation of place-based physical activity projects which include awareness of fall prevention in areas of Gloucester and Forest of Dean to support health inequalities. We are committed to working across our ICS to continue service developments

which help patients and the self-care and prevention agenda in both primary care and across non-medical settings, where appropriate. We will also support this through our ICS self-care agenda, inclusive of promoting digital alternatives, such as the NHS App.

We recognise the need to continually improve the interface between primary and secondary care, improving communication between professionals to improve patient care and reduce workload. This will be achieved through continued digital innovation, such as Cinapsis, expansion of E-Referrals and Advice & Guidance, along with other digital initiatives that share patient records, and increase collaboration see Goal 5 for further details. We also need to ensure communications between primary and secondary care are timely and appropriate to avoid needless appointments and disturbance for patients. To achieve this, we will work with our colleagues across the ICS, including the LMC, to address these areas through a specific task & finish group.

The following section, Commitment 3, is also vital to reducing the workload for GPs in general practices, supporting them to manage their overburdened workloads while improving patient access and maintaining high quality and safety, through the introduction of further new clinical roles.

### **Community Pharmacy**

We are currently participating in an NHSE pilot to support digital referral from the general practice front door to a community pharmacist. Across practices in England there are now GP reception teams that work with care navigators to support the process of booking patients to see the most appropriate member of the multidisciplinary team.

Pharmacists are already part of the practice team in many of our practices and PCNs (see below). However, for minor illness consultations community pharmacists are well placed to take referrals straight from the practice in the patient's own neighbourhood. This pathway will create some additional capacity for the practice to book patients into appointments that might otherwise have been filled that day or in a few days' time depending on the nature of the symptoms the patient reports.

The aim is for community pharmacists to work closely with the local GP teams by agreeing escalation routes and coordinating care. The practice will send a referral to a Community Pharmacist Consultation Service (CPCS) pharmacy, transferring the patient details electronically via the practice's clinical system. To support the project monitoring and as part of evaluation, regular reporting from participating pharmacies will be undertaken using anonymised data.

The pilot is running from September 2019 to March 2020 and will be evaluated independently to inform service design and future commissioning decisions.

### **Commitment 3: Introducing new roles**

Through the successful implementation of our original Primary Care Strategy and Primary Care Workforce Strategy, as evidenced in the baseline data shown in Commitment 1, we have supported the introduction of new, non-traditional, roles through CCG 'Transformation' funding: recurrent funding made available by the CCG. This funding has enabled specialist advanced roles to be based in primary care settings to both improve patient care and support the resilience of our practices. Further new roles have been introduced through how we have deployed Improved Access, asking our PCNs - then 'clusters' - to develop innovative workforce schemes to release the funding. At the time of writing this Strategy, introducing new roles to PCNs is a core feature of the LTP and the new GP contract. We are therefore well placed in Gloucestershire

to evolve the work we've already started, through practices already well used to employing and sharing staff collectively in their networks and by taking an ICS approach to workforce expansion.

Under the new GP contract, PCNs – live from 1 July 2019 across Gloucestershire (see Goal 1) – receive national recurrent funding for new workforce, starting from 2019/20. This funding allocation, called "Additional Roles Reimbursement" and the bulk of the new funding for general practice under the new GP contract, grows annually to match the increasing expectations of PCNs arising from the seven new national service specifications (see Goal 1). Where roles are 70% funded, it is the requirement of the PCN to find the further 30%. The dates these new roles are available from is also synced with sufficient numbers, nationally, of these staff becoming available following training. These new roles are as follows:

- Social Prescribing Link Workers – available from 2019/20; 100% reimbursed
- Clinical Pharmacists – available from 2019/20; 70% reimbursed
- Physician Associates – available from 2020/21; 70% reimbursed
- First Contact Physiotherapists – available from 2020/21; 70% reimbursed
- First Contact Paramedics – available from 2021/22; 70% reimbursed

For 2019/20, each PCN in Gloucestershire can claim reimbursement for 1 WTE clinical pharmacist and 1 WTE social prescribing link worker. From 2020/21, this changes to a financial allocation that increases year-on-year (more than tripling in value from 2020/21 to 2023/24) and it will be up to the PCNs to determine which of these roles they wish to employ, making decisions based on the new service specifications, their practices and their patient needs. Using national assumptions, we anticipate this will lead to nearly 200 of these staff joining general practice in Gloucestershire (see Commitment 1), but we will revisit these assumptions on an annual basis.

#### Case Study: Gloucestershire ICS Social Prescribing

*Gloucestershire ICS has a well-established social prescribing service, jointly commissioned between the CCG and Gloucestershire County Council, called the Community Wellbeing Service (CWS). Therefore we are supporting our PCNs to join-up their plans for social prescribing link workers with the countywide commissioned service.*

Under these assumptions, by 2024, we estimate that a typical Gloucestershire PCN will have:

- Five Clinical Pharmacists
- Three Social Prescribers
- Three First Contact Physiotherapists
- Two Physician Associates
- One First Contact Paramedic

PCNs will be employing these roles through mechanisms of their choice, which could be via one practice employing on behalf of the PCN or through a hosted employment model, as determined by their preferences and in line with the requirements of the national contract. Across the ICS, we will support the introduction of these new roles in a controlled and planned way, to ensure the sustainability of our system and building

the pipeline for the future, as we are aware that there is a finite pool of people available within the local and regional areas from which these staff can be employed. To this end, we have already been working with ICS system partners on the development of split role posts which allow for advanced practitioners to work in primary care, whilst their employment is hosted by an organisation that supports the staff member through provision of clinical supervision, professional speciality based training and contacts into a community or secondary care setting. We have found that this assists with longer-term staff development, system resilience, communication and establishment of relationships across primary care and existing services.

#### Case Study: Gloucestershire ICS Physiotherapists in Primary Care

*Gloucestershire ICS stakeholders including to GHCNHSFT, GP practices and commissioning leads have received national recognition for their contributions to the development of advanced practitioner roles in primary care. The service was a finalist in the category of 'Innovation in Primary Care' at the Health+Care Plus awards 2019. Our stakeholder workshops, which bring together ICS colleagues to collaborate for advanced physiotherapist practitioner roles, will continue to develop and progress to support system needs.*



Furthermore, through the PCTH and in partnership with HEE and our PCNs, we commit to developing a range of projects to enable opportunities for these new staff to have access to primary care based training and development for assurance of competence of advanced skills, and will enable discussions to take place across the Gloucestershire ICS colleagues to develop career pathways for specialist roles across the system. Our aim is to work across the ICS to develop skills based competency frameworks for these new roles in primary care. We recognise that these roles are in their infancy and will require the goodwill, knowledge and support of GPs, Practice Managers, professional leads (including our Local Pharmacy Committee), HEE, higher education institutes and commissioning leads to make this successful for patients, practices, PCNs and our system.

### Commitment 4: Attracting talent to traditional roles

#### GP recruitment

Training for GPs in Gloucestershire is of high quality, and we will be doing more to encourage those people who train in Gloucestershire to remain working in the county. We will work with our PCNs and GP practices, through the PCTH and by working with HEE, to facilitate:

- Quality assurance of primary care based training in Gloucestershire;
- Consistency of good practice;
- Raising standards of training quality in primary care;
- Understand contractual elements with higher education institutes to ensure training capacity for increasing numbers of medical undergraduate students can be catered for in Gloucestershire;

#### Case Study: Physician Associates

*Gloucestershire primary care is already hosting a number of Physicians Associates learners in county at post-graduate level which is extremely valuable for these highly qualified individuals who will gain experience of working in primary care. GP practices will be able to gain benefits by enabling the upskilling of their future potential workforce.*

- Development of multi-disciplinary training for primary care roles;
- Group/peer mentoring approach.

Our GP trainers and educators work hard to support learners and trainees in primary care and are currently implementing changes within the MB21 University of Bristol undergraduate medical school curriculum. This curriculum change, introduced in 2019, includes medical students spending treble the amount of time in primary care, providing significantly more exposure to promote this career option. We will continue engagement with lead GPs who are creating innovative solutions to learners and educator placement.

The CCG has worked with the BMJ to develop a ‘Be a GP in Gloucestershire’ campaign over the last few years. This campaign has now come to an end, but we have secured a discounted package for all Gloucestershire GP practices who wish to advertise for GP roles in this national journal which has both paper and online readership.



We have created the Primary Care Workforce Website, which will continue to develop over the course of this Strategy, to be a single website for all aspects of primary care workforce in Gloucestershire. Recognising that GPs are choosing to work in more flexible ways than the traditional GP partnership model, we do not wish to lose these GPs to our county. We will therefore host locum vacancies for all practices in county on the site, where practices can upload information on their immediate workforce gaps.



Learning from the successfully designed and delivered GP recruitment schemes – the Newly Qualified GP scheme and the Health Inequalities Fellowship – which have attracted GPs into vacant posts in Gloucestershire - we will apply the principles of these fellowships to further specialist areas of general practice, such as frailty. These schemes will evolve to incorporate the fellowships as required for PCNs under the national contract, while also to meet our population healthcare needs and attract GPs to remain working in Gloucestershire. We will also develop, through the PCTH, a GP Career Promotion Role. This role will work to engage with medical students, sharing opportunities with them about the primary care experience.

The GP Retainer scheme’s eligibility criteria enable a career bridging experience for GPs who are eligible for flexible working arrangements, due to work-life balance and as part of the annual workforce survey, to practices that have gaps and are able to support the GPs through the scheme. To support GP retention within county, we will continue to widely promote the national GP Retainer scheme and match up GPs to practices.

During 2019 we delivered the ‘Gloucestershire Next Generation GP Programme’ to ‘Engage, Energise and Empower’ early career GPs. The aim of the programme was to inspire early career GPs (trainees and first 7 years post CCT) to be informed leaders as well as excellent clinicians, with the insight and connections they need to change and improve the system in which we work. Informed by the evaluation of this programme, which we will undertake, we will continue to engage with this cohort of early career GPs to develop excellence in primary care and support GP resilience, retention and the next cohort of GP clinical leaders.

A partnership approach with HEE has enabled the recent recruitment of three GP fellowship roles within the county, covering leadership, education and attracting new talent to primary care. These roles will begin supporting a number of key workforce issues, including engagement with schools to promote all careers in

primary care, developing support for primary care leaders, and offering support packages to mid-career GPs. We are also committed to explore further GP retention activities, building on the work we already do with those approaching or considering retirement age to retain them in county, to expand to mid-career GPs or those requiring support to prevent exiting their career.

### **Nurse recruitment**

The CCG and GDoc are developing strategies and working collaboratively with other provider and commissioning teams in the South West to review and implement an action plan aligned to that of the General Practice Forward View 'Ten Point Plan' for General Practice Nursing. The plan describes what we are working on over the next few years in order to recruit, retain and return nurses into general practice. It also focuses on how Gloucestershire will build capacity and capability in primary care to manage the ever increasing workload, and joint working with other community teams to address the future challenges.

To support the principles of the 10 Point Plan for General Practice Nurses (GPNs) and Health Care Assistants (HCAs), a new team of Practice Nurse Coordinators are in post across the County who are part of a comprehensive Nursing service provided by GDoc and commissioned by the CCG. The aim will be to raise the profile and awareness of all career opportunities in Primary Care and engage with the workforce to support clinical competencies and ongoing educational development.

GDoc, through the five coordinators, the CCG and the PCTH are working together to support GPNs and Health Care Support Workers (HCSWs) with ongoing CPD, reviewing their training needs, mentorship and induction. It is expected more GPNs require roles in leading practice development at all levels and the opportunity to think differently about ways to improve access and outcomes is essential. The plan for Gloucestershire is to facilitate 3 events specifically aimed at the GPNs and to consider access to these at different times of day to maximise participation.

The events will cover elements of the GPN 10 Point Plan including:

- Celebrating and raising the profile of general practice nursing;
- Raising the profile of the leadership and educator roles in practice;
- Supporting the development of the new model and providing opportunities to share the experiences of NMC standards, education and training;
- Focusing on GPN leadership roles and inclusion of resilience in the workplace (managing pressures/ emotional intelligence);
- Raising the profile of PCNs and the PCTH.

This will be an opportunity for:

- GPNs to be more involved in the GPN 10 point plan and leadership as a group;
- Bringing together larger groups of GPNs to support the sustainability of the drive to achieve the GPN 10 point action plan;
- Focusing on future planning together for personalised care and being forward thinking and creative;
- Networking with the coordinators and sharing new roles and responsibilities;
- Motivational learning opportunities and time to reflect on practice.

These initial events will engage directly with practice nurses in Gloucestershire and create a strong Gloucestershire vision for the GPN 10 Point plan linked to the NHS LTP whilst focusing on recruiting, retaining and encouraging those who could return to practice.

Over the course of this Strategy, these coordinator roles will mature to engage with universities in promoting student nurse placements within Gloucestershire, linking with the principles of the General Practice Nursing 10 Point Plan and encouraging more student nurses to consider a career in Primary Care. This will dovetail with working closely with our local nurse coordinators to plan a rolling programme practice nurse education, based on a training needs analysis. We plan to then make this education programme available on a central website for all the practice nurses to access.

Nursing Associate is a new role within nursing teams in Gloucestershire and one that we are looking to expand and develop over forthcoming months and years. Nursing Associates work with healthcare support workers and registered nurses to deliver care across all fields of nursing. In primary care their duties are likely to include: undertaking clinical tasks such as venepuncture and ECGs; performing and responding to clinical observations such as blood pressure, temperature, respirations and pulse; promoting health and preventing ill health; improving the safety and quality of care and contributing to integrated care. This new support role sits alongside existing nursing teams to deliver hands-on care for patients.

GDoc have recently expanded their nursing team to include phlebotomists and HCAs. This will help support practices further by ensuring the right skill mix for the clinical competencies required. This model encourages increased efficiency for registered nurse hours. Additional mentorship and support for the HCAs will be provided by the Nurse Coordinators and Matron for Clinical Learning and all HCAs will be invited to join Gloucestershire's education events and training. Our Educational Matron will also be working with the University of Gloucestershire to promote student nurse placements, linking with the principles of the 'ten point plan' and encouraging more student nurses to consider a career in primary care.

### Commitment 5: Developing the team

We have commenced, and commit to expand, working with higher education institutions in our region, to increase placements for all roles in primary care so that learners at under-graduate and post-graduate level have increased exposure to GP practices and can consider primary care as a career destination. We will also work with these institutes to create mechanisms for our experienced advanced practitioners working in primary care to be able to influence their relevant subject curriculum.

Experiential learning and on the job training is another area that we will cultivate, as we know that training away from the work environment can pose a challenge to our committed staff, who may have caring responsibilities as well as take precious time away from providing patient care. Experiential learning has recently expanded to include a City and Guilds qualification for staff at practices, which is on the job training for staff to support a GP, or a number of GPs, in the smooth running of clinics, called a GP Assistant Role – see the Case Study blue box right.

#### Case Study: GP Assistants

*The GP Assistant role has been developed by Wiltshire CCG, with the training funded by HEE for rollout across our South West region, and has been taken up by a number of our Gloucestershire practices. The GP Assistant undertakes the more routine administration and clinical tasks on behalf of the GP, thus freeing up their time on their clinical skills in supporting patients.*

We will use the learning from this project to evolve the on the job training approach to be based in practices, such as working with GDoc to explore design and delivery of an accredited HCA training course, based in experiential learning environments.

We will continue to host annual events for our practice managers and have recently completed a survey of Practice Manager training and support needs and will be working with GDoc and the LMC to deliver tailored initiatives to practice manager’s needs and embed a peer support system.

As referred to in Commitment 2 of this chapter, we will continue to support clinical and admin colleagues through delivery of care navigation and clinical correspondence training. Through funding from the PCTH, some PCNs have undertaken training for frontline receptionists and back office staff around resilience and patient facing skills which has been well received – we will continue to highlight areas of best practice through our Primary Care Workforce Website so other PCNs are aware of benefits and can choose to implement as part of their training offer to their staff.

**Case Study: Developing the wider workforce**

*Over the last two years, new roles in primary care have developed in partnership with host employers across the ICS, including mental health practitioners employed by 2gether NHS Foundation Trust and physiotherapist practitioners employed by Gloucestershire Care Services (now the merged organisation of Gloucestershire Health and Care NHS Foundation Trust). The PCTH has financially supported advanced level education modules to enable the development of these new roles. We plan to expand this in accordance with the PCNs growing their multi-disciplinary workforce over the course of this Strategy.*

We will work with ICS colleagues on the development of an ICS wide Apprenticeship Hub, looking to increase apprenticeships for admin, clerical and clinical roles at both entry and advanced level for functions in primary care.

All primary care colleagues will continue to have access to change management training and development through the One Gloucestershire Quality Service Improvement Redesign programme. One Gloucestershire ICS is involved in the pilot development for a High Potential Talent Scheme which will be available for managers and clinical staff working in and supporting primary care to increase their knowledge, skills and capability, through having increased exposure to other parts of our system through placements in other settings within the ICS.

**PCN Development and Leadership**

Over the last 3 years we have been developing leaders in primary care through local programmes such as two Gloucestershire cohorts of General Practice Improvement Leaders, investing in visits to other areas or searching courses or other opportunities for local self-identified leaders to develop their knowledge and skills. Primarily, it has been these members of staff which have come forward to take leadership roles in PCNs, either as Clinical Directors or as management leads. At the time of writing, we are awaiting the national support offer for PCN and Clinical Director development, but we feel confident that the work we have already been doing, through local organisational development and leadership programmes, has given our PCNs and their leaders a competent basis from which to accelerate their plans. However, we know we need



to continue this development and ensure all PCN and ILP leaders have access to high quality development and education. The national PCN Development Support Prospectus has seven domains:

- Organisational development and change;
- Leadership development support;
- Supporting collaborative working;
- PHM;
- PCN set up and support;
- Social prescribing and asset based community development;
- Identifying, evaluating and sharing learning on PCN sites.

We will assess, with our PCNs, what their individual needs are and whether these needs are met by the national programme. If not, we commit to working with them to design a sustainable programme over the next five years to ensure the development of our PCN workforce, and that their new leaders have access to such development opportunities. Alongside this, we will enable fellowships for GPs who are newly qualified – and for other members of the general practice team – who aspire to be local leaders of their PCN or ILP, building on our existing award winning fellowships in county.

#### **Case Study: South Cotswold Sexual Health in Rural Areas**

*Due to changes in the public health funding structures which led to a reduction of sexual health services in some rural areas, supported by the Primary Care Training Hub, colleagues in the South Cotswold PCN chose to increase skills by:*

- *Conducting a Training Needs Analysis on Sexual Health;*
- *Delivering large group training and awareness of on sexual health issues;*
- *Specialist Training on Intra-Uterine Devices, Implants, Pessaries, Vasectomy Training and Menopause Training.*

#### **Case Study: Stroud Frailty**

*Colleagues in the Stroud and Berkeley Vale area have developed a plan where all three of their PCNs will be investing into staff resources and training infrastructure to meet the needs of frail patients in the locality. The funding available from the Gloucestershire Primary Care Training hub will also support the development of 100 volunteers living in the Stroud and Berkeley Vale locality area to become more aware of frailty based issues within their communities and support the aims and values for Stroud as a 'Compassionate Town'.*

## Summary of our priorities for Goal 4

### Goal 4: Developing the Workforce Strategic Commitments

Our strategic commitments to this goal during the timeframe of this Strategy are as follows. We will:

- Continue to **Understand Demand and Capacity** at Primary Care level using a number of data sources, local and national intelligence as well as continuing discussions with system wide partners and stakeholders to support workforce transformation for better patient care.
- Enable GP practice to **Reduce the Workload** by supporting them with training and development opportunities and providing additional resources where required.
- Offer support and quality assurance around the **Introduction of New Roles** to support practices and PCNs through funding for new roles and training and development based on professional best practice.
- Continue to work closely with our practice and PCNs to **Attract Talent to Traditional Roles** by working with educational providers and improving communications on the innovative ways to recruit and retain this precious staff resource.
- Continue to **Develop the Team** working with wider educational stakeholders to deliver appropriate and relevant training to support staff through a variety of learning mechanisms.

## 4.5 Goal 5: Digitally Enabled

As outlined within Chapter 1, we have made significant progress since the original Primary Care Strategy in rolling out digital initiatives for both our patients and our care professionals. Our plans for the next five years are no less ambitious, while the NHS LTP sets out a number of digital initiatives. As a minimum, we will deliver these initiatives to the target dates and national aspirations, however we will be looking to go further with these aspirations in order to extend the benefit to our patients and our workforce.

### Supporting the Primary Care Vision

Our Primary Care Strategy, and indeed our ICS’s LTP, is underpinned by significant developments in the use of digital technology, whilst the NHS LTP sets down ambitious targets to transform the model of care to digital-first. By targeting “greater utilisation of digital technologies to join-up care, focus on prevention and improve access to primary care services”, we will realise Gloucestershire’s anticipatory and personalised locality based care model and address some of the key challenges facing primary care in the county. Further details on how Digital supports the primary care Vision are available at Appendix 7.

### Our Digital Primary Care Vision for 2024

For patients and care professionals, we will be creating a more streamlined and satisfying experience of care and care provision.

**For our patients:** more digital options to access and manage personalised care throughout their journey.

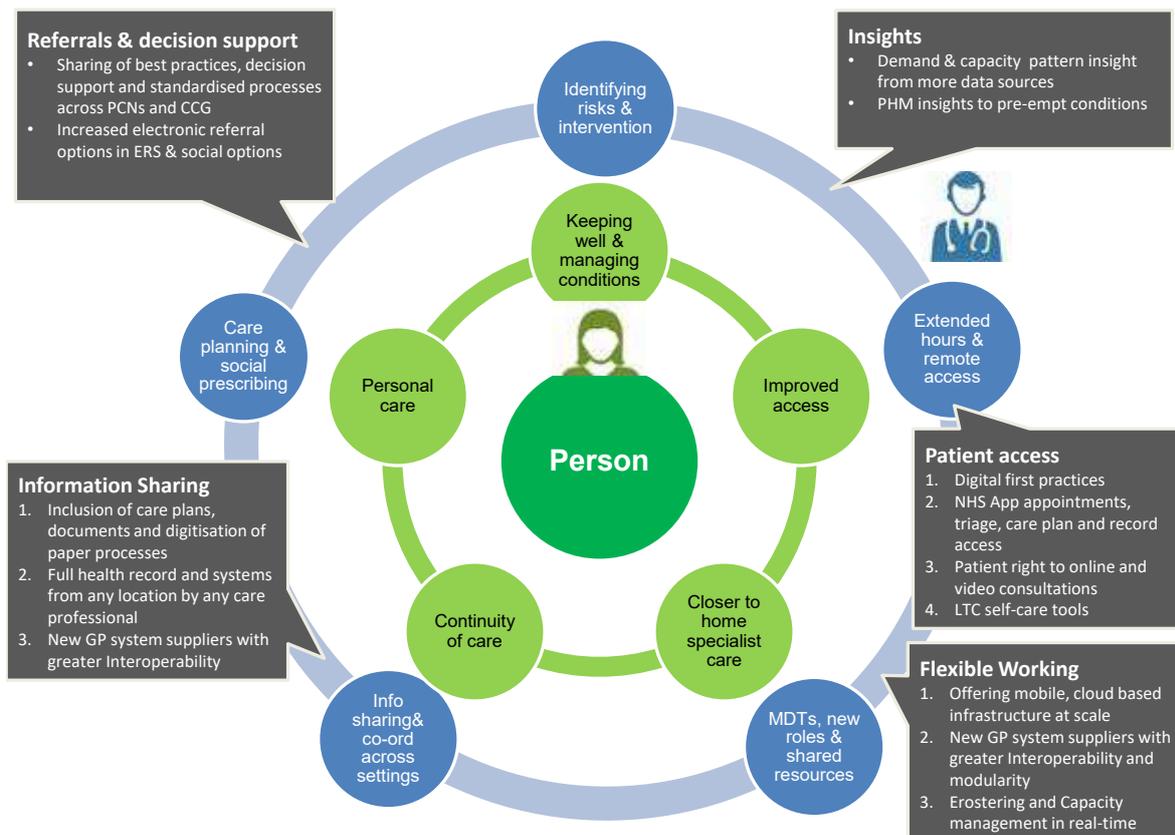


- Personalised triage in app
- More sites to access acute type care
- Manage appointments online
- Online consultation & messaging
- Access to Record, plans & results
- Patient contribute to records & plans
- Self care online tools access

**For our care professionals:** providing care more appropriately, efficiently, informed and collaboratively.



- Demand managed via online triage, direct booking & dashboards
- Online consultations save time & increase access
- Ubiquitous digital care record, triage info & alerts
- Decision support & clinical messaging
- Digital imaging, ordering & prescribing across care settings
- Reporting across care & diagnostic networks
- Ongoing digital monitoring & risk alerting



In delivering on these digital themes, the following capabilities will be focused on:

- **Enhanced referrals and decision support** to connect patients to best care options for them, and offer guidance to clinicians to deal with a wider range of needs locally;
- **Information sharing** to provide care plans and records to a person’s circle of care;
- **Insights to understand demand and capacity patterns** and pre-empt deterioration of health;
- **Patient Access** to empower patients to participate in their own health plans and access help remotely;
- **Remote and collaborative working** to move care to where it is most needed and make the most of limited resources;
- **Automation and reduced technical barriers** to free up time to care, increase back office responsiveness and speed up care for patients.

## The next stage: Digital Service Transformation at scale

In order to now fully deliver on the promise of digital technology in primary care, we need to move towards being Digitally Transformative (see Figure 17):



Figure 17: Moving to digital transformation (FutureGov, 2017)

Being 'Digitally Transformative' means developing the way we prioritise and deliver services, so that digital capabilities are built into the wider service transformation of our PCNs, ILPs and ICS, rather than being layered on existing processes, or treated as parallel activities. This requires multidisciplinary digital service design teams, partnering with digitally skilled practice teams and patients to redesign services that meet clear needs using effective new processes.

The first part of this shift is to build more skills in change management, business analysis and agile service design within our delivery teams. This will emphasise delivering the greatest value, addressing evidenced user needs and remapping processes to realise benefits. The second challenge to transformation can be overcome through developing the underlying digital skills and literacy of the primary care workforce. Through raising the levels of all professionals via broader digital capability training, and the career development of clinical and non-clinical digital champions in each PCN, we will have a more empowered and distributed way of designing and implementing successful solutions. Frontline staff can also then play a role in educating patients around the benefits of digital interactions, alongside broader digital marketing and education programmes in the ICS, as patient digital literacy will be key to achieving our digital-first ambitions.

We also need to start doing more at scale; the focus of the new General Practice IT operating model is for individual practices to embed shared ICS-wide technologies into PCN and ILP-wide processes, rather than managing their own IT solutions and suppliers. The provision of analytics, networks, security and digital solutions, increasingly needs to be collectively managed at ICS level for economies of scale, expertise

requirements, consistency of patient experience and performance. This model will also increase our ability to share data and workforce across sites, removing the current barriers that exist to PCN and cross-organisational working. Opportunities for innovation will still exist for individual practices through structured evaluation processes with a view to scale, but we need to make ensure that we are not creating silos and barriers to join up care with one-off initiatives.

## Being Digital-First

Evidence from the national patient survey suggests that three-quarters of our patients have not used an online service to access services from their practice in the last 12 months (Ipsos MORI, 2019). Therefore, we are seeing an opportunity for the adoption of a fuller and more consistent patient-facing digital service in Gloucestershire, which could be offered in a virtual clinical hub or multiple hubs, which will be part of our design consultation with our PCNs. A well developed, remotely accessed, digital-first service could increase access to services for patients, potentially add to the clinical workforce through flexible working patterns, and reduce the administrative burden on practices. Creating such an offer negates the need for other commercial services, thereby maintaining continuity of care from local clinicians for our patients and maintaining stability for our practices. In addition, we would be able to divert a number of necessary consultations to more efficient direct online consultations. We will utilise lessons learned from digital-first exemplar sites (Ipsos MORI, York Health Economics Consortium & Salisbury, 2019), but we recognise that this is an opportunity we must explore further in our plans with central funding support.

## The Need for Flexibility in Our Plan

The technology landscape for primary care is changing quickly with new solutions offered at a national level, such as the NHS App, Windows 10 and Office 365. New suppliers are beginning to enter the market through the GP Futures framework this year, which could give us more options to realise our vision. In addition, locally we are undertaking major infrastructure and clinical system changes in the ICS, including increased practice mergers and an acute Electronic Patient Record (EPR) system change that will improve interactions with secondary care. This Strategy therefore needs to remain agile, setting a course, but being flexible as new capabilities and options become clearer.

To allow us to move forward in such a changing landscape we have developed eleven principles to act as criteria for prioritising digital primary care activities and how we undertake digital transformation at scale. These will allow us to meet the NHS LTP targets, support the ambitions of this Strategy and offset risks to the sustainability of high-quality care.

## Our 11 Principles of Digital Enablement

1. **Reduce the bureaucratic burden:** reduce blockers, friction and workload for routine activities in practices and help to focus energies on where the greatest value can be added.
2. **Deliver joined up infrastructure at scale:** support mobile working, collaboration and reliability.
3. **Standardise digital processes:** to allow data to flow accurately and consistently across settings, support the workforce to move between care settings more swiftly and reduce clinical variation with greater decision-making support.
4. **Converge systems and standards:** to allow for better information sharing, easier staff mobility and technical support at scale to deliver efficiencies.

- 5. Enable hub and remote delivery of services:** to provide flexible provision of care and IT services from where capacity and expertise exists.
- 6. Design for Digital-First access:** making digital interactions an easy and attractive way to interact, by scaling self-care, self-service and being more responsiveness to needs. In turn, this increases capacity for those unable to use digital solutions.
- 7. Deliver real-time insights on demand and capacity:** to allow timely resource management and service planning.
- 8. Deliver accessible and accurate PHM tools:** to identify cohorts, interventions and impacts in an easy to interpret way.
- 9. Offer Digital, Data and Technology learning programmes with care professionals, support staff and patients:** to increase adoption and understanding of how new digital capabilities and insights can change patterns of care.
- 10. Ensure robust and agile digital service design and operational processes:** to deliver the most needed, usable, secure and sustainable solutions. This includes investment in robust pilot evaluation, creating blueprints and co-ordinated plans to scale up quickly where successful.
- 11. Data driven, continual improvement processes and cultures across the workforce:** to enable quality and improvement practices to be used to enhance our digital and wider services.

## Our Roadmap

In developing our roadmap, we have scheduled activities required in the LTP and the GP Contract to the supporting capabilities to deliver the ICS primary care model. The roadmap is a live document that will adapt with the changing primary care landscape, technology shifts, financial circumstances and information on PCN needs as they develop. Our current roadmap is shown by theme in the sections that follow.

### ICS Digital Roadmap workstream: Empower the Person

2020/21	2021/22	2022/23	2023/24
NHS App & GP Online Consult	OP&Care Home Online Consult	Digital 1 <sup>st</sup> for GP	PHR & Maternity Record
Website & app consolidate	Self Care Apps re-review	E-redbook	App alerts
			Remote & telecare

Empower the Person	
<b>Aim:</b>	Empower patients to participate in their own health planning and access clinically robust guidance remotely.
<b>Primary Care Vision</b>	<ul style="list-style-type: none"> <li>Improved access to care 7 days a week</li> <li>More patient control over their own health</li> </ul>
<b>Digital Capability area</b>	<ul style="list-style-type: none"> <li>Patient access</li> <li>Remote and collaborative working</li> </ul>
<b>User needs</b>	<p><b>Patients</b></p> <ul style="list-style-type: none"> <li>“Quicker access to care, so I can reduce my pain and anxiety, and those around me.”</li> <li>“See the right expert first or as soon as possible.”</li> <li>“A clear and simple route to get help so I can improve someone in my care’s situation”</li> <li>“Help myself to tools and advice to improve my health”</li> </ul> <p><b>Clinicians</b></p> <ul style="list-style-type: none"> <li>“See appropriate patients for my skillset”</li> <li>“Reduce the time spent doing unrewarding admin”</li> </ul> <p><b>Practices, PCNs and ILPs</b></p> <ul style="list-style-type: none"> <li>“Make best use of the resources we have”</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>Improve access</li> <li>Reduce demand where appropriate</li> <li>Triage to more suitable care settings</li> <li>Identify new conditions earlier</li> <li>Improve known condition outcomes</li> <li>Reduce admin and clinical productivity</li> <li>Offset risks of commercial competition</li> <li>Create more flexible and efficient resourcing models</li> </ul>
<b>Phases</b>	<ol style="list-style-type: none"> <li>Design consistent access routes and core capabilities</li> <li>At scale digital-first delivery with patient input</li> <li>Personalised and remotely guided care</li> </ol>

Programmes					
NHS App and 111 Online	Online and Virtual Consultations	Digital-First Access	Self-care and Online Therapies	Remote Monitoring and Patient Generated Data	Personal Health Records and Personalise Care
A consistent front door to our services and patient control of their record and plans.	Ability for patients to access appointments remotely and at the most convenient time.	Online remote access to 7 day and extended hours clinical advice and services.	Always on digital coaching for people to manage their long-term conditions.	Sharing of vital changes in health with clinicians for those at risk of deterioration.	Personalised recommendations and co-creation of care plans with people based on their holistic needs.

## Roadmap workstream: Digital Maturity & Capabilities (Clinical systems)

2020/21	2021/22	2022/23	2023/24
Fax removal	Lloyd George digitisation		Decision Support review
Enhanced GP Templates	PCN clinical system mergers		GP Futures migrations?
	Digital-only patient letter options	Primary Care e-rostering	E-Rostering across ICS

Clinical systems	
<b>Aim:</b>	Develop highly usable and functional clinical IT systems to support assessment, diagnosis, prescription and the capture of sharable meaningful information.
<b>Primary Care Vision</b>	<ul style="list-style-type: none"> <li>Improved access to care 7 days a week</li> <li>Support more joined up PCNs and ILPs</li> </ul>
<b>Digital Capability area</b>	<ul style="list-style-type: none"> <li>Enhanced referrals and decision support</li> <li>Remote and collaborative working</li> </ul>
<b>User needs</b>	<p><b>Patients</b></p> <ul style="list-style-type: none"> <li>"I want the same care and processes wherever I am"</li> </ul> <p><b>Clinicians</b></p> <ul style="list-style-type: none"> <li>"I need to access the full patient record so I can make safe and more appropriate decisions"</li> <li>"Reduce the time spent doing unrewarding admin"</li> </ul> <p><b>Practices, PCNs and ILPs</b></p> <ul style="list-style-type: none"> <li>"Make best use of the resources we have"</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>Increase admin and clinical productivity</li> <li>Create more flexible and efficient resourcing models</li> <li>Reduce clinical variation in care provision</li> <li>Reduce medication costs</li> <li>Improve clinical outcomes</li> <li>Improve referral appropriateness</li> </ul>
<b>Phases</b>	<ol style="list-style-type: none"> <li>Consolidate systems and standardise processes</li> <li>Develop improved decision support and mobility</li> <li>Personalise decision support</li> </ol>

Programmes				
GP system Convergence and Enhancements	Clinical Guidance and Decision Support	Medicines Decision Support	eRostering	Paperless Communications and Corporate Systems
Synchronising GP systems and improving their efficiency.	Developing increasingly advanced guidance and decision support for care staff personalised to the patient.	Providing insights and guidance to improve the precision and efficiency of medicines prescribing and administration.	Sharing information about schedules, capacity gaps and skills needs. This will match care professionals to demand in increasingly rapid and targeted ways.	Getting rid of the fax infrastructure, digitising of Lloyd George Records and the replacement of paper letters to patients.

## Roadmap workstream: Information Sharing

2020/21	2021/22	2022/23	2023/24
Clinical Image and Labs sharing	Docs & correspondence sharing		
Clinician to Clinician Messaging & real-time collaboration		System-wide direct booking & e-referrals	
PCN record sharing & booking			Patient flow monitor & alerting
Acute, Social Care feeds in JUYI	Shared Care Plans	LHACR Direct care, PHR and PHM delivery	
MH & Urgent real-time demand & capacity	Real-time acute bed state	Full automated real-time demand & capacity	

Information Sharing	
<b>Aim:</b>	<p>Providing a holistic view of the patient’s needs and the ability to co-produce care plans with clinicians.</p> <p>Sharing a wide range of care options in the context of demand and capacity insights, to direct people to their best care options and enable services to be developed around them.</p>
<b>Primary Care Vision</b>	<ul style="list-style-type: none"> <li>• Support PCNs and ILPs to work in a joined up way through data sharing</li> <li>• Provide patients with anticipatory care and personalised care</li> <li>• Support PCNs and ILPs to provide a greater range of services for larger numbers of patients</li> </ul>
<b>Digital Capability area</b>	<ul style="list-style-type: none"> <li>• Information sharing</li> <li>• Remote and collaborative working</li> </ul>
<b>User needs</b>	<p><b>Patients</b></p> <ul style="list-style-type: none"> <li>• “I need my information to be available when I access care across settings &amp; locations”</li> </ul> <p><b>Clinicians</b></p> <ul style="list-style-type: none"> <li>• “I need to communicate across integrated care teams”</li> </ul> <p><b>Practices, PCNs and ILPs</b></p> <ul style="list-style-type: none"> <li>• “We need to share workload across practices to meet demand for general and specialist expertise”</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Improve timeliness and usefulness of information</li> <li>• Increase admin and clinical productivity</li> <li>• Create more flexible and efficient resourcing models</li> <li>• Improve referral appropriateness</li> <li>• Triage to more suitable care settings</li> <li>• Speed up care pathways</li> <li>• Co-ordinate care across settings</li> <li>• Improve clinical outcomes</li> </ul>
<b>Phases</b>	<ol style="list-style-type: none"> <li>1. Share digitised paper processes, care transfers and team collaboration</li> <li>2. Share structured information about treatments, extended care options and capacity options</li> <li>3. Personalise treatments and care route options base of improved data richness</li> </ol>

Programmes				
Clinical Documentation, Letters, Imaging and Diagnostics Sharing	Service Information	Clinical Messaging and Task Management	Shared Care Records and Plans	Referrals and Direct Appointment Booking
Digitising and structuring data from clinical documents across the ICS. Sharing observations, investigations and medicines information.	Developing the Directory of Services to offer more comprehensive care options and demand information. Development of real-time data feeds on system demand and capacity. Developing dashboards, predictive models and alerting to support operational decision making.	Enabling clinicians to have real-time digital communication across a range of care experts to inform clinical decisions and co-ordinate multi-team care.	Providing a set of care records and plans that multiple care providers and carers can view and contribute to. To make sure that care is co-ordinated around a person and their circle of care.	Allowing booking of appointments directly between care settings from digital services (such as GPs and pharmacy) Providing digital ways to refer into services and personalising the services suitable for patients.

### Roadmap workstream: Infrastructure

2020/21	2021/22	2022/23	2023/24
ICS Network Redesign	Single desktop & sign on	Wifi Upgrade	ICS-wide Unified Comms
ICS Cyber Security Programme		ICS Data Centre & Server Consolidation (inc cloud review)	
Windows 10	Office 365 roll out	Collaboration tools	

Infrastructure	
<b>Aim:</b>	Deliver robust, secure joined up primary care infrastructure at scale to support mobile working, collaboration and reliability.
<b>Primary Care Vision</b>	<ul style="list-style-type: none"> <li>Support PCNs and ILPs to work in a joined up way</li> <li>Support PCNs and ILPs to provide a greater range of services for larger numbers of patients.</li> </ul>
<b>Digital Capability area</b>	<ul style="list-style-type: none"> <li>Information sharing</li> <li>Automation and reduced technical barriers</li> </ul>
<b>User needs</b>	<p><b>Patients</b></p> <ul style="list-style-type: none"> <li>"I want the same care and processes wherever I am"</li> </ul> <p><b>Clinicians</b></p> <ul style="list-style-type: none"> <li>"I need to access the full patient record so I can make safer and more appropriate decisions"</li> <li>"I need to communicate across integrated care teams"</li> </ul> <p><b>Practices, PCNs and ILPs</b></p> <ul style="list-style-type: none"> <li>"We need to share workload across practices to meet demand for general and specialist expertise"</li> <li>"Make best use of the resources we have"</li> </ul>

<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Increase admin and clinical productivity</li> <li>• Create more flexible and efficient resourcing models</li> <li>• Reduced travel costs</li> <li>• Reduce operational costs</li> </ul>
<b>Phases</b>	<ol style="list-style-type: none"> <li>1. Network upgrade and modernise IT estate</li> <li>2. Virtualise IT infrastructure and move software to the cloud</li> <li>3. Move infrastructure to the cloud and mobilise workforce</li> </ol>

Programmes				
Modernise the Network	Desktop and Software Upgrade	Cyber Security, Asset and Identity Management	IT Service Management	Mobile and Remote Working
Upgrade to high speed modern health network on a single domain, with public sector access. Deliver internet based voice services to save costs, route calls and provide call demand analysis.	Upgrade to new generations of devices, desktop software and cloud based office software. Provide a single virtual desktop to allow access for care professionals to access the range of tools needed across settings. Manage delivery of all updates remotely.	<p>Enhance cyber security teams and tool sets across the network to spot and stop threats.</p> <p>Develop single sign in option across a range of systems needed in PCNs.</p>	<p>Development of IT Service desktop processes and accreditation.</p> <p>Extend support to match staff working patterns and needs.</p>	<p>Provide devices, mobile device management and secure high speed mobile access to staff.</p> <p>Developing common collaboration tools for use across the ICS.</p> <p>Developing partnerships to improve mobile coverage and speeds.</p>

**Roadmap workstream: : Whole Systems Intelligence**

2020/21	2021/22	2022/23	2023/24
PHM reporting tool roll out	ML low level in use		
PHM as BAU in Clinical Progs, PCNs & Localities			
ICS PHM platform implement & procure		LHACR data for research & insights	

Whole Systems Intelligence	
<b>Aim:</b>	Delivering Population Health Management infrastructure, analytical solutions and data solutions, to allow more personalised care to be delivered.
<b>Primary Care Vision</b>	<ul style="list-style-type: none"> <li>• Support PCNs and ILPs to work in a joined up way</li> <li>• Provide patients with anticipatory and personalised care</li> <li>• Utilise population health to tackle inequalities, assessing our local population by risk of unwarranted health outcomes to make services available where they are most needed.</li> </ul>
<b>Digital Capability area</b>	<ul style="list-style-type: none"> <li>• Insights to understand demand and capacity patterns and pre-empt deterioration of health.</li> </ul>

<b>User needs</b>	<p><b>Patients</b></p> <ul style="list-style-type: none"> <li>• <i>“My information to be available when I access care across settings and locations”</i></li> </ul> <p><b>Clinicians</b></p> <ul style="list-style-type: none"> <li>• <i>“Access the full patient record so I can make safe and more appropriate decisions”</i></li> <li>• <i>“Access common guidance and admin resources for my PCN, so I can re-use best practices and collaborate”</i></li> <li>• </li> </ul> <p><b>Practices, PCNs and ILPs</b></p> <ul style="list-style-type: none"> <li>• <i>“Share workload across practices to meet demand for general and specialist expertise”</i></li> <li>• <i>“We need to understand demand on the system , so we can try to manage our services to meet it”</i></li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Improve timeliness and usefulness of information</li> <li>• Create more flexible and efficient resourcing models</li> <li>• Improve referral appropriateness</li> <li>• Triage to more suitable care settings</li> <li>• Improve clinical outcomes</li> </ul>
<b>Phases</b>	<ol style="list-style-type: none"> <li>1. Data quality, demand &amp; capacity basics and PHM infrastructure design</li> <li>2. Real-time demand and capacity , personalise interventions based on current data sets</li> <li>3. Personalise treatments and care route options base of improved data and AI pattern matching.</li> </ol>

Programmes				
Data quality	BI and Data Visualisation for PHM	PHM Platform	Governance	Education and Engagement
Developing a data quality programme to report back to teams managing systems and teams using them to target improvements and tools to correct issues.	Deploying and configuring industry standard data visualisation tools for analysts and shared dashboards for self-service to up to date data.	Designing, procuring and delivering an architecture to allow for analysis of clinical data to anticipate potential future conditions at person level.	Development of Information Sharing Agreements, policies and standards to allow new type of data to be used across settings, for secondary use purposes and precision medicine.	<p>Developing the analytical skills within the ICS, both in specialists and non-specialist leaders who need to interpret the data.</p> <p>Public engagement programmes to clarify how the data insights will be used and can help.</p>

### Roadmap workstream: Workforce development and digital delivery capabilities

2020/21	2021/22	2022/23	2023/24
Champions Network	Literacy Framework Adoption		
Digital governance & process reshape	Informatics Development		NHS Team convergence

#### Workforce development and digital delivery capabilities

<b>Aim:</b>	Develop the primary care leadership, care staff and informatics delivery teams to design and use digital technology and data to improve models and provision of care. Help our patients understand the opportunities to access digitally enabled care.
<b>Primary Care Vision</b>	<ul style="list-style-type: none"> <li>• Support PCNs and ILPs to work in a joined up way</li> <li>• Provide patients with anticipatory care and personalised care</li> <li>• Support PCNs and ILPs to provide a greater range of services for larger numbers of patients.</li> <li>• Grow our multi-disciplinary primary care teams.</li> </ul>
<b>Digital Capability area</b>	<ul style="list-style-type: none"> <li>• Enhanced referrals and decision support</li> <li>• Information sharing</li> <li>• Insights</li> <li>• Patient Access</li> <li>• Remote and collaborative working</li> </ul>
<b>User needs</b>	<p><b>Patients</b></p> <ul style="list-style-type: none"> <li>• <i>“I want to help myself to tools and advice to improve my health”</i></li> </ul> <p><b>Clinicians</b></p> <ul style="list-style-type: none"> <li>• <i>“I need to access common guidance and admin resources for my PCN, so I can re-use best practices and collaborate”</i></li> <li>• <i>“I need to be confident and competent with digital tools and processes, so I can use them efficiently, safely, accurately and reassure citizens of their benefit”</i></li> </ul> <p><b>Practices, PCNs and ILPs</b></p> <ul style="list-style-type: none"> <li>• <i>“We need to share workload across practices to meet demand for general and specialist expertise”</i></li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Reduce admin clinical productivity</li> <li>• Create more flexible and efficient resourcing models</li> <li>• Gain greater benefits for investments in new technical capabilities</li> </ul>
<b>Phases</b>	<ol style="list-style-type: none"> <li>1. Develop training and development programmes</li> <li>2. Embed digital transformation processes at all levels</li> </ol>

#### Programmes

Digital Leadership	Digital Literacy and Culture	Clinical Informatics Development	Digital Champions	Digital Delivery and Governance
Developing PCN, Locality and ICS level leadership teams so they can lead for digital transformation programmes.	Assessing and raising all primary care staff to a basic level of rounded digital capabilities.	Development of career pathways and skills development programmes for clinical staff to lead, design and deliver on digital technology use and data driven decision making.	Developing a network of digital champions across PCNs. Through training and development programmes, champions will be developed to skilfully manage the PCN digital services and change projects.	Developing the primary care digital service delivery teams’ capacity and capability to deliver in more agile and user centred ways. Process analysis and digital service design practices will be supplemented by quality and value focused agile technical delivery in new team structures.

In developing such an ambitious and wide-ranging plan, we recognise the potential risks that exist in delivery and the need to ensure appropriate mitigations are in place. These are detailed at Appendix 8.

## Next Steps

The next steps for this digital element of our Strategy are to qualify resources and cost ranges, as well as readiness to refine what is possible in the timeframes. Further work is also needed with newly formed PCNs and a range of patients, to understand their needs in more detail. We will also align to the wider ICS Digital Strategy to ensure this is embedded in the system-wide plan, ensuring joined up and sustainable care is offered in Gloucestershire in accordance with our long term plan.

## Summary of our priorities for Goal 5

### Goal 5: Digital Enablement Strategic Commitments

Our strategic commitments to this goal during the time-frame of this Strategy are as follows. We will:

- Deliver **robust, secure joined up primary care infrastructure at scale** to support mobile working, collaboration and reliability.
- **Empower patients** to participate in their own health planning and access clinically robust guidance remotely.
- **Develop highly usable clinical digital systems** to support assessment, diagnosis, prescription and the capture of sharable meaningful information
- **Provide a holistic view of the patient's needs** and the ability to co-create care plans with their circle of care.
- Share a wide range care options in the context of demand and capacity insights, to **direct people to their best care options and develop our services** around them.
- **Deliver Population Health Management infrastructure**, analytical solutions and data solutions, to allow more **personalised** care to be delivered.
- **Develop the primary care leadership**, care staff and informatics delivery teams to design and use digital technology and data to improve models and provision of care.

## 4.6 Goal 6: Estates

Our original Primary Care Infrastructure Plan (PCIP) 2016-2021, as described earlier, has made a significantly positive difference to the primary care estate across our county since its publication, with completed or approved schemes and remaining priorities summarised at Appendix 4. This investment in our estate has seen our annual delegated premises budget rise from £7.7m in 2015/16 to £8.6m in 2019/20, which demonstrates our commitment to invest in our primary care surgery premises for the benefit of our patients.



In refreshing our Primary Care Strategy, we have also taken the opportunity to refresh our PCIP, which is now extended to 2026 and is included within this Strategy at Appendix 4.

In summary, the PCIP has been updated to reflect the changing landscape reflected in this Strategy, including PCNs, ILPs, the LTP, a review of housing plans and population growth, and the need to increasingly align primary care estate with the ICS estate. This still includes the need to deliver improved general practice estates to accommodate planned population increases, changes in working practice within primary care, aspects of ‘Enabling Active Communities’ (see start of this Chapter) around voluntary sector service delivery and supporting a resilient and sustainable primary care. In addition it extends to maximising opportunities to share space within the ICS to facilitate service integration, making it easier for our community and voluntary sectors to utilise our estate to mobilise services while minimising running costs.

The 74 practices in our county are providing services from 100 buildings, where 60 of the buildings are owned by the practices themselves, 39 buildings are leased and one building is part-leased and part-owned. Housing forecasts and population growth by district council (Table 6) allows us to make assumptions on the registered list size growth for all of our practices, shown as an aggregated position for each of our six ILPs at Table 7, which has been utilised in developing our estates planning assumptions over the course of the refreshed PCIP.

District	Number of new houses April 2019 to March 2031	Population growth assumption**
Cheltenham	9,368	15,176
Corswolds	5,030	8,149
Forest of Dean*	3,417	5,535
Gloucester	10,325	16,727
Stroud	7,295	11,818
South Gloucestershire	1,370	2,219
Tewkesbury (incl Wychavon)	4,887	7,917
<b>Total</b>	<b>41,692</b>	<b>67,541</b>

\*Forest of Dean housing plans to 2026

\*\* Based on 1.62 people per household - assumes a 1/3 of homes are bought/rented by single individuals and that 10% result from individuals leaving existing households (a dilution effect of existing homes)

**Table 6: Housing and population growth assumptions by District**

ILP	Baseline (July 2014)	PCIP 2016 version growth assumption	PCIP predicted list size 2031 in 2016 plan	List size Jan 2019	Allocation of number of homes*	List size growth assumption**	Revised list size estimate in 2031
Cheltenham	151,475	21,000	172,475	158,483	10,219	16,555	175,038
Cotswolds	85,707	18,000	103,707	90,405	5,030	8,149	98,554
Forest of Dean***	62,495	11,000	73,495	63,678	2,974	4,818+ 3,441	71,937
Gloucester	165,612	25,500	191,112	174,477	13,536	21,928	196,405
Stroud & Berkeley Vale	120,003	9,000	129,003	121,509	6,368	10,316	131,825
Tewkesbury***	42,253	6,000	48,253	43,945	3,565	5,775+ 510	50,230
<b>Total</b>	<b>627,545</b>	<b>90,500</b>	<b>718,045</b>	<b>652,497</b>	<b>41,692</b>	<b>71,492</b>	<b>723,989</b>

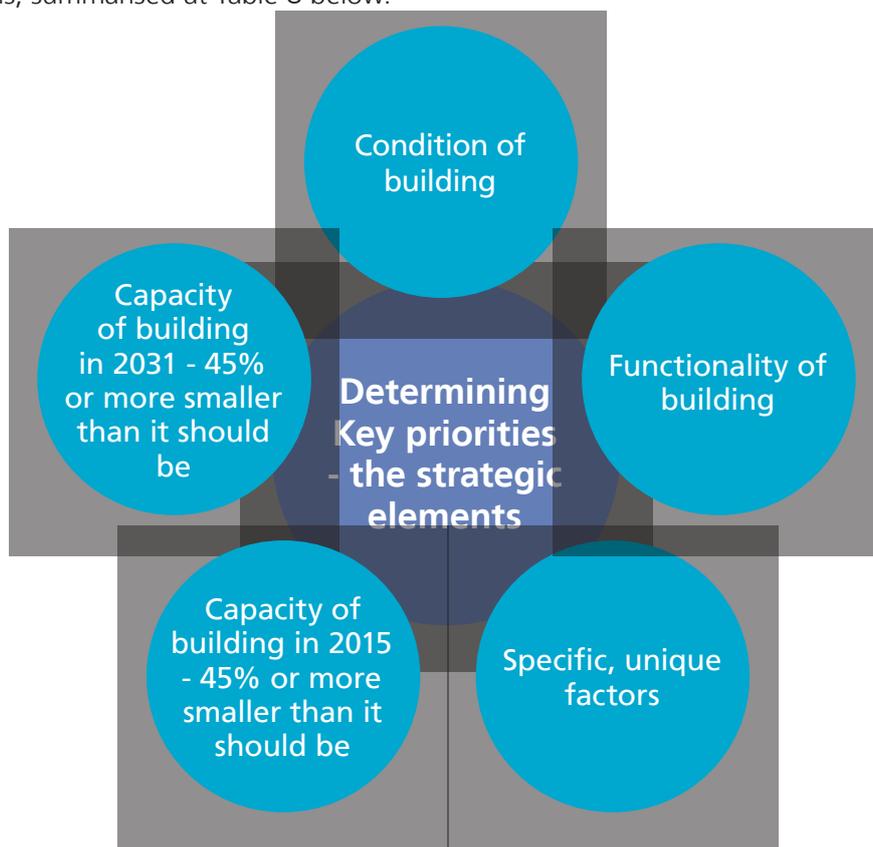
\*Based on an assessment of existing housing strategies and discussion of these plans with District Councils. It is recognised plans change and these are forecast assumptions.

\*\* Based on 1.62 people per household - assumes a 1/3 of homes are bought/rented by single individuals and that 10% result from individuals leaving existing households (a dilution effect of existing homes)

\*\*\*Additional 5 years list size growth added from April 2026 to March 2031 based on average annual estimated housing growth until 2026. Two practices in Tewkesbury ILP included.

**Table 7: List growth assumption by ILP**

The strategic prioritisation of our estates programme going forward considers five elements, including the condition of the building, the capacity of the building at the time of our six facet survey in 2015 and the capacity of the building by 2031, see figure 18 below. This prioritisation exercise has identified six priority premises proposals, summarised at Table 8 below.



**Figure 18: Determining Key Priorities for Infrastructure**

ILP	Premises proposal
Cheltenham	Development/replacement of facilities for the Overton Park and Yorkleigh surgeries, ideally as collocated services in one building for around 22,000 patients
Forest of Dean	Review of primary care facilities requirements across Drybrook and Mitcheldean to support long term provision of local services with a single site for around 11,000 patients
Gloucester City	Review of options for the development of Bartongate surgery in Gloucester City for around 9,000 patients - expected extension
Gloucester City	Review of options for the development or replacement of Cheltenham Road surgery in Gloucester for around 10,000 patients in addition to improvement of Highnam surgery
Cotswolds	Review of options for the development or replacement of Campden surgery in Chipping Campden for around 6,000 patients
Stroud & Berkeley	Development of Chipping surgery in Wotton-under-Edge, which was adopted as a priority in 2018/2019 as being delivered through improvement grant

**Table 8: Summary of new premises priorities 2021 - 2026**

This creates a comprehensive programme across the county for 2019 – 2026 as summarised at Table 9 below. Delivery of this programme will result in our primary care estates delegated budget rising from £8.6m in 19/20 to £9.2m by 2020/21 and to £11.6m by 2025/26.

### Summary of our priorities for Goal 6

ILP	Premises proposal	Estimated delivery year (open)	Estimated m2 (GIA)	Estimated capital cost
Cheltenham	Single development for Overton Park and Yorkleigh surgeries for around 22,000 patients	2024/ 2025	1,626	£6.7m
Cheltenham	New surgery for North West Cheltenham due to new housing developments for around 10,000 patients	2025/ 2026	869	£3.5m
Cotswolds	Development of new GP surgery in Chipping Campden to replace existing building for around 6,000 patients	2023/ 2024	520	£2.2m
Cotswolds	Phoenix Health Group - development of new facility at Chesterton to replace existing building and accommodate housing development for around 11,500 patients	2021/ 2022	980	£4.0m
Cotswolds	Cirencester health Group – new primary care centre to replace Avenue and St Peters surgery and possible Park Surgery (Upper Thames) for around 22,000 patients	2023/ 2024	1,658	£6.5m
Cotswolds	Replace Romney House with a new surgery building in Tetbury for around 10,000 patients	2021/ 2022	874	£3.8m
Forest of Dean	Development of a single primary care centre for Lydney and south of the Forest of Dean area for around 17,000 patients	2022/ 2023	1,315	£4.7m
Forest of Dean	Development of primary care facilities for Drybrook and Mitcheldean for around 11,000 patients	2024/ 2025	926	£3.4m
Forest of Dean	Development of a single primary care centre in Coleford to replace current health centre and Brunston surgeries for around 12,500 patients	2021/ 2022	993	£3.9m
Gloucester City	Development of primary care facilities for Alney Practice at Cheltenham Road for around 10,000 patients and a small extension to Highnam surgery	2026 onwards for new surgery	869	£3.5m
Gloucester City	Development of existing Bartongate surgery through refurbishment of overall building to accommodate up to 9,000 patients – brought forward as improvement grant funding likely to be available	2020/ 2021	150	£0.5m
Gloucester City	New surgery to replace the Brockworth and Hucclecote surgeries and cover major population growth with total list size of 23,000 - 25,000	2021/ 2022	1,892	£8.0m
Stroud & Berkeley Vale	Refurbishment and extension of Chipping Surgery in Wotton under Edge to accommodate up to 10,500 patients- brought forward as ETTF improvement grant funding available	2019/ 2020		£1.6m
Stroud & Berkeley Vale	Joint development of new facility for Locking Hill and Stroud Valleys Family Practice for around 15,500 patients	2021/ 2022	1,300	£4.4m
Stroud & Berkeley Vale	Development of Beeches Green Health Centre for around 9,000 to 10,000 patients	2025/ 2026	788	£3.1m
Stroud & Berkeley Vale	Replace the existing Minchinhampton surgery for around 8,500 patients	2021/ 2022	808	£2.5m
<b>Grand Total</b>				<b>£62.3</b>

**Table 9: Our planned primary care estates programme 2019 - 2026**

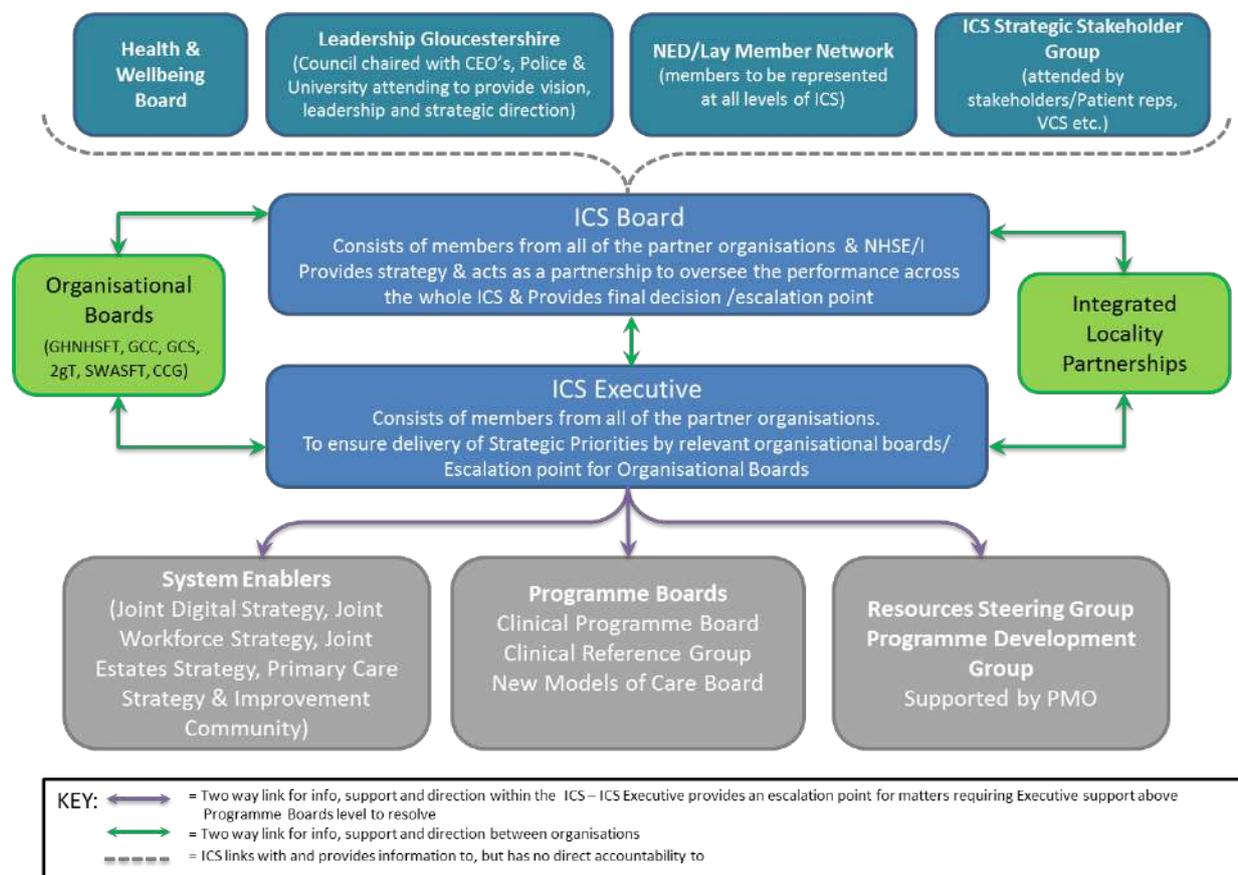
The full version of our refreshed PCIP, and accompanying appendices, can be found at Appendix 4.

## 5. Governance

This Primary Care Strategy is an ICS document as part of our Long Term Plan response. The governance of our One Gloucestershire ICS centres around matrix working between the four key elements of the system:

- Partner Organisational Board
- Integrated Locality Partnership at place level
- Transformation Programmes
- Enabler Programmes

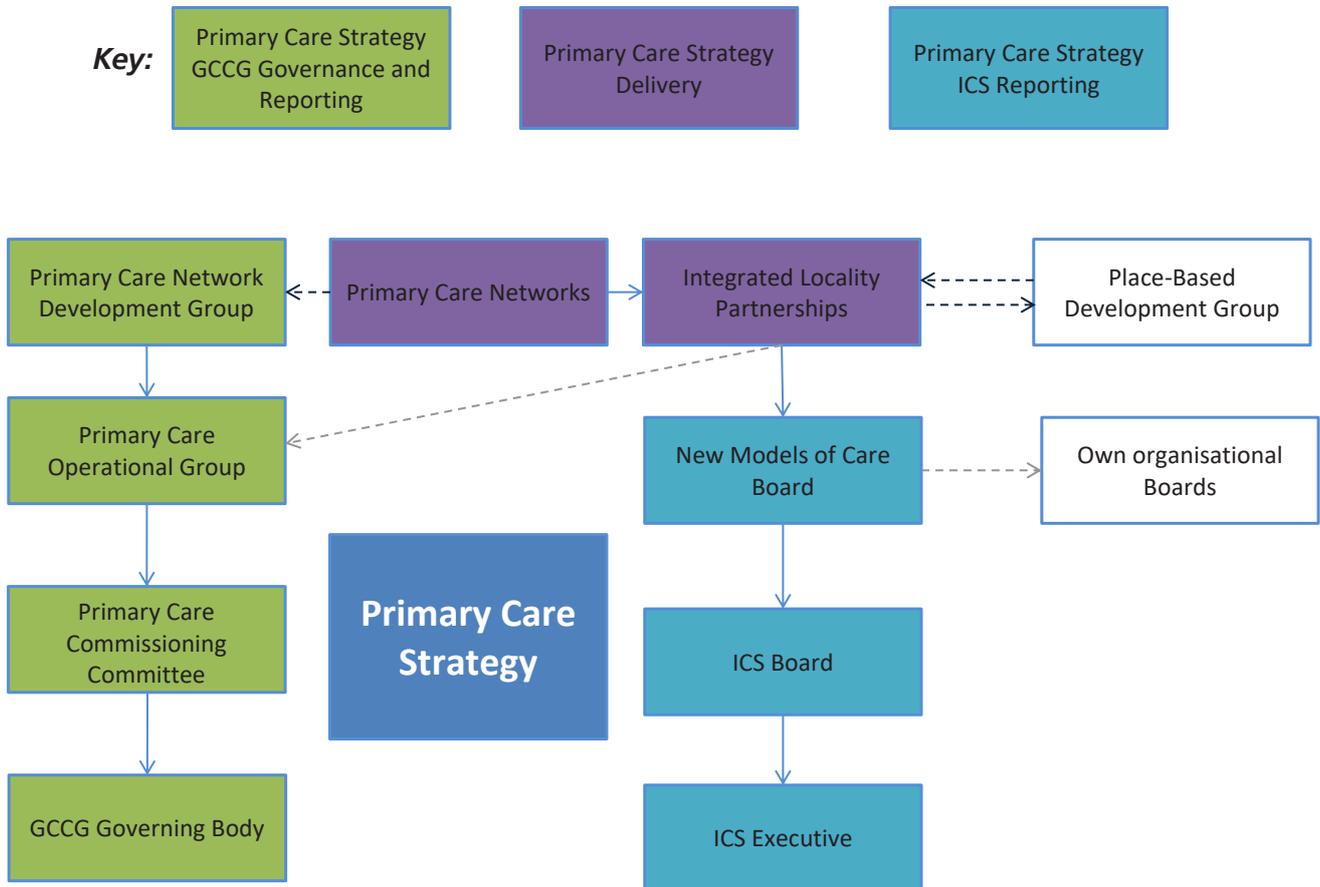
The main forum of the ICS is the ICS Board which is responsible for ensuring that the system delivers its vision, of which this Strategy is a key enabler, the governance of which is shown at Figure 19. Further details on the ICS Governance can be found in our Long Term Plan.



**Figure 19: Our ICS Governance Overview**

Beneath the ICS governance structure, this Primary Care Strategy's governance will be through the Primary Care Operational Group and Primary Care Commissioning Committee, delivered through the PCNs and ILPs, with reporting through to the New Models of Care Board and up through to the ICS Board and ICS Executive. Following finalisation of this document, a comprehensive Primary Care Strategy implementation programme plan will be developed across the six goals, assigning responsible owners from across the ICS to demonstrably track progress.

Overall responsibility for the sign-off and implementation of the Strategy resides with the CCG Governing Body, as the statutory organisation with responsibility for primary care commissioning through delegated authority from NHS England. This governance structure is shown at Figure 20.



**Figure 20: Primary Care Strategy Governance Overview**

## 6. Engagement and Equality

This Strategy utilises and explicitly builds upon continuous engagement which was initially undertaken for the first iteration of the Primary Care Strategy (2016 – 2021). We have worked with and alongside our Patient Participation Group (PPG) Network and with our PALS team to develop both the previous iteration and this one. We view engagement as a continuous dialogue, working together to ensure our Strategy and implementation plans are built around and with our patients. This includes patient representatives supporting the development of specifications and being fully involved members of our procurements, such as our recent online consultation procurement panel. We will continue to involve our patients in this way and we are planning to include patient representatives on our ILPs across the county.



We have also been engaging with the public to capture their views on our Long Term Plan for Gloucestershire. We have been working with Healthwatch Gloucestershire, the county's independent health and social care champion, to ensure that local people are at the centre of everything we do and that their voice is heard. We will be developing a patient-facing version of this Strategy, working with the PPG Network, Healthwatch Gloucestershire and our PALS team.



We have been engaging with patients using material such as the booklet below, to explain: our plans, how our practices are forming PCNs to deliver more local services and appointments, how we're growing our primary care workforce, how we're developing our urgent care offer, the support offer for long term conditions and our plans for the future and how we're supporting our workforce and developing more digital services.



## 6.1 Healthwatch Gloucestershire

Healthwatch Gloucestershire is the county's independent health and social care champion; Healthwatch Gloucestershire exists to ensure that people are at the heart of care. The service is commissioned from Evolving Communities by Gloucestershire County Council, with a contribution from the CCG to enhance the provision of information to local residents.



Dedicated teams of staff and Healthwatch Gloucestershire volunteers listen to what people like about local health and care services, and what could be improved. These views are then shared with decision-making organisation e.g. the CCG, so together a real difference can be made. We work closely with Healthwatch Gloucestershire, with their volunteers taking part in CCG led programmes and activities and the CCG and other ICS Partners commission Healthwatch to gather feedback from local people.

For further information and support about patient engagement and equality visit: <https://www.gloucestershireccg.nhs.uk/about-you/>

or contact the Patient Engagement and Experience team: [glccg.consultation@nhs.net](mailto:glccg.consultation@nhs.net)

## 7. Financial Investment

As described earlier, this Primary Care Strategy is explicitly an enabler to the One Gloucestershire ICS's LTP and therefore supports our ICS vision for how public-funded health and care services can support a healthier Gloucestershire, which is socially and economically strong and vibrant. Through delivery of this Primary Care Strategy, we believe this will significantly contribute to achieving an improved and more sustainable health and care system.

The NHS LTP and the new GP contract framework announced significant additional funding for primary care over the course of 2019 – 2024. This additional investment funds the aspirations described nationally in Chapter 1 of this document, while our local plan for achieving those national aspirations and our local ICS Strategic Intent for Primary Care are outlined in Chapter 3 and detailed in Chapter 4.

Our local share of this additional national funding is shown in the growth of our allocations below at Table 10.

	Primary Care Allocation				
	2019/20	2020/21	2021/22	2022/23	2023/24
	£'000	£'000	£'000	£'000	£'000
<b>Allocation</b>	86,659	90,792	96,046	100,380	104,926
<b>Growth</b>	6.32%	4.77%	5.79%	4.51%	4.53%
<b>Growth per capita</b>	5.56%	4.02%	5.06%	3.81%	3.85%
<b>Opening DfT per capita</b>	-2.15%	-2.49%	-2.38%	-2.24%	-2.11%
<b>Final closing DfT</b>	-2.99%	-2.87%	-2.69%	-2.51%	-2.32%
<b>Allocation Adjustment</b>	-2,494	-2,607	-3,494	-2,947	-1,917
<b>Allocation after Adjustment</b>	<b>84,165</b>	<b>88,185</b>	<b>92,552</b>	<b>97,433</b>	<b>103,009</b>

**Table 10: Gloucestershire's Primary Care Allocation: 2019 – 2024**

The above funding covers GMS/PMS/APMS contract expenditure, as well as premises costs and other nationally set allowances, and includes uplift for cost inflation and growth. In addition, as part of its programme allocation, the CCG funds:

- The drug costs of GP prescribing: c.£84m
- Local Enhanced Services: c.£7m
- Primary Care IT: c.£1.8m
- PCN Transformation Funding: c.£1.2m
- Social Prescribing: c.£0.6m

The revenue impact to the CCG of the PCIP is set out within the main document at Appendix 4, section 9.9.

We will also continue to receive national allocations from NHSE for specific programmes. For example, the legacy General Practice Forward View schemes described in this document, which includes schemes such as: Improved Access and training for care navigation for GP practice receptionists. The LTP sets out national funding of £1.8bn by 2023/24 for additional workforce (described in Goal 4 and included in our allocation above) and a Network Investment and Impact Fund (described in Goal 1) of £300m by 2023/24. While we do not yet know the value of these allocations for Gloucestershire over the course of this Strategy, we do commit to ensuring all of this funding is ring-fenced to PCNs to ensure they receive the funding they need to deliver the Vision described by this Strategy, and ultimately, the ICS, for the benefit of our patients.

## 8. Conclusion

This Primary Care Strategy sets out how Gloucestershire ICS is responding to the national and local context of primary care as we enter the biggest change to the sector for at least 15 years, if not longer. We are facing unprecedented pressures due to national workforce shortages, increasing workload, changing patient demographics and associated need, while maintaining our ambition to deliver high quality care that is centred around our patients.

We have set out a strategic intent to dissolve the historic divide between primary and community care organisations through the closer alignment and greater integration between our ICS organisations through our PCNs and ILPs. This is at the heart of our plans and will enable us to:

- Provide patients with more control over their own health, anticipatory care and personalised care when they need it, and support early cancer diagnosis. We will utilise population health to tackle inequalities, assessing our local population by risk of unwarranted health outcomes to make services available where they are most needed;
- Grow our multi-disciplinary teams, attracting and retaining the best staff through promoting Gloucestershire as a great place to live and work, creating a better work-life balance for staff, and offering excellent training opportunities;
- Ensure good access to primary care seven days a week, meaning better support for patients while also reducing urgent demand at our hospitals to enable them to care for the most acutely poorly patients;
- Digitally-enable primary care to maximise the use of technology;
- Support PCNs and ILPs to explore how they can provide a greater range of services for larger numbers of patients.

The six Goals described in this document set out a range of commitments to achieve this vision and we look forward to working with our patients, our member practices, our LMC, our ICS colleagues and all our stakeholders to deliver this Strategy. We will resource them appropriately, providing clinical and managerial support to ensure we achieve them. We will now develop detailed action plans and key performance indicators for each of these Goals.

## 9. References

- BMA & NHS England (2019). Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan. Retrieved from <https://www.england.nhs.uk/publication/gp-contract-five-year-framework/>
- FutureGov (2017). Assessing your organisation’s digital maturity. Retrieved from [http://futureoflocalgovernment.org.au/files/2018/02/item\\_10\\_vic\\_digital\\_maturity\\_assessment\\_proposal\\_december\\_2017.pdf](http://futureoflocalgovernment.org.au/files/2018/02/item_10_vic_digital_maturity_assessment_proposal_december_2017.pdf)
- Gloucestershire CCG (2016). Gloucestershire CCG Primary Care Strategy 2016 – 2021. Retrieved from <https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2017/01/H-Primary-Care-Strategy.pdf>
- Gloucestershire CCG (2018). Gloucestershire CCG Primary Care Workforce Strategy 2018 – 2021. Retrieved from [https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2018/10/Primary\\_Care\\_Workforce\\_Strategy\\_V1\\_0.pdf](https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2018/10/Primary_Care_Workforce_Strategy_V1_0.pdf)
- Ipsos MORI (2018). GP Patient Survey: NHS Gloucestershire CCG. Retrieved from <https://www.gp-patient.co.uk/downloads/slidepacks/2018/11M%20-%20NHS%20GLOUCESTERSHIRE%20CCG.pptm>
- Ipsos MORI (2019). GP Patient Survey: NHS Gloucestershire CCG. Retrieved from <https://gp-patient.co.uk/downloads/slidepacks/2019/11M%20-%20NHS%20GLOUCESTERSHIRE%20CCG.pptx>
- Ipsos MORI, York Health Economics Consortium, & Salisbury, C. (2019). Evaluation of Babylon GP at hand: Final evaluation report. Retrieved from <https://www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf>
- NHS Digital (2018). Quality and Outcomes Framework (QOF): England 2017-18. Retrieved from <https://app.powerbi.com/w?r=eyJrIjojODliN2M3NTQ0OGFjMC00NjMxLTk5ZWMTMjg2MmQ0NDI3Nzk5IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMlIsImMiOjh9>
- NHS Digital (2019). Quality and Outcomes Framework (QOF): Achievement, Prevalence and Exceptions. Retrieved from <https://app.powerbi.com/w?r=eyJrIjojODliN2M3NTQ0OGFjMC00NjMxLTk5ZWMTMjg2MmQ0NDI3Nzk5IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMlIsImMiOjh9>
- NHS England (2015). Primary Care Transformation Fund promises major upgrades to GP premises. Retrieved from <https://www.england.nhs.uk/2015/10/primarycaretransfund/>
- NHS England (2016). General Practice Forward View. Retrieved from <https://www.england.nhs.uk/publication/general-practice-forward-view-gpfv/>
- NHS England (2017). General Practice – Developing confidence, capability and capacity: A ten point action plan for General Practice Nursing. Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2018/01/general-practice-nursing-ten-point-plan-v17.pdf>
- NHS England (2019). The NHS Long Term Plan. Retrieved from <https://www.longtermplan.nhs.uk/>
- The King’s Fund (2019). What does improving population health really mean? Retrieved from <https://www.kingsfund.org.uk/publications/what-does-improving-population-health-mean>



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## Appendices



15.1

## Appendix 1: Gloucestershire Primary Care: Our GP Practices

We have 74 GP practices across our county, which can be found by clicking the button below.

### GP Practices

These 74 practices are spread across 100 buildings across the county. They have a combined 650,000 patients and are organised into 14 PCNs and 6 ILPs – details of which can be found at Appendix 2.

The majority of our practices (64) are contracted under the GMS contract, with 4 PMS contracts and 3 APMS contracts. The average QOF figures for Gloucestershire in 2017/18 was 544.54 points (97.41%), rising to 550.18 (98.42%) in 2018/19 (NHS Digital, 2019), compared with the 2017/18 national average of 538 points (96.24%) (NHS Digital, 2018).

As at the end of October 2019, our practice CQC ratings are as follows:

- 4 Gloucestershire practices are rated as 'outstanding'
- 68 practices are rated as 'good'
- 2 practices are rated as 'requires improvement'

In addition to our Primary Care Offer, described in Chapter 4 (Goal 3), we offer a range of local enhanced services to our practices to provide to their patients, including:

- Anti-coagulation service
- Older People Care Homes support
- LD/PD Care Homes support
- Deep Vein Thrombosis service
- Diabetic patient support
- High Risk Drug Monitoring
- Secondary to Primary Care services – supporting more care out of hospital
- Provision of Minor Surgery to Non-registered Patients
- Ear Irrigation
- Prophylaxis with Antiviral Drugs In and Out of Season

We also offer some targeted enhanced services to particular practices where specific additional needs are identified.

## Appendix 2: Our Primary Care Networks and Integrated Locality Partnerships

Integrated Locality Partnerships	Primary Care Networks (PCNs)	Practices	List Size (1 Jan 2019)
Cheltenham	Cheltenham Central	Berkeley Place Surgery	54,164
		Crescent Bakery Surgery	
		Overton Park Surgery	
		Royal Crescent Surgery	
		Underwood Surgery	
		Yorkleigh Surgery	
	Cheltenham Peripheral	Cleevelands Medical Centre	52,849
		The Leckhampton Surgery	
		Sixways Clinic	
		Stoke Road Surgery	
		Winchcombe Medical Centre	
	St Paul's	The Corinthian Surgery	48,131
		The Portland Practice	
		Royal Well Surgery	
		St Catherine's Surgery	
St George's Surgery			
Cotswolds	North Cotswold	Campden Surgery	30,723
		Cotswold Medical Practice	
		Mann Cottage Surgery	
		Stow Surgery	
		White House Surgery	
	South Cotswold	Cirencester Health Group	59,682
		Hilary Cottage Surgery	
		Phoenix Health Group	
		Rendcomb Surgery	
		Upper Thames Medical Group	
Forest of Dean	Forest of Dean	Blakeney Surgery	63,678
		The Brunston & Lydbrook Practice	
		Coleford Family Doctors	
		Dockham Road Surgery	
		Drybrook Surgery	
		Forest Health Centre	
		The Lydney Practice	
		Mitcheldean Surgery	
		Newnham Surgery	
		Severbank Surgery	
Yorkley & Bream Practice			

<b>Gloucester City</b>	<b>Aspen</b>	Aspen Medical Practice	<b>29,763</b>
	<b>HQR</b>	Rosebank Health	<b>48,466</b>
		Hadwen Medical Practice	
		Quedgeley Medical Centre	
	<b>Inner City</b>	Bartongate Surgery	<b>42,756</b>
		Gloucester City Health Centre	
		Gloucester Health Access Centre	
		Kingsholm Surgery	
		Partners in Health	
	<b>North &amp; South Gloucester</b>	The Alney Practice	<b>53,492</b>
		Brockworth Surgery	
		Churchdown Surgery	
		Hucclecote Surgery	
		Longlevens Surgery	
	<b>Stroud &amp; Berkeley Vale</b>	<b>Berkeley Vale</b>	Acorn Practice
Cam & Uley Family Practice			
The Chipping Surgery			
Culverhay Surgery			
Marybrook Medical Centre			
<b>Severn Health</b>		Walnut Tree Practice	<b>41,609</b>
		Frampton Surgery	
		High Street Medical Centre	
		Locking Hill Surgery	
		Prices Mill Surgery	
		Regent Street Surgery	
		Stonehouse Health Clinic	
<b>Stroud Cotswolds</b>		Stroud Valleys Family Practice	<b>40,156</b>
		Beeches Green Surgery	
		Frithwood Surgery	
	Minchinhampton Surgery		
	Painswick Surgery		
<b>Tewkesbury</b>	Rowcroft Medical Centre	<b>47,284</b>	
	Church Street Medical Practice		
	Mythe Medical Practice		
	Newent Doctors Practice		
	Staunton & Corse Surgery		
West Cheltenham Medical			

*The Primary Care Networks can be seen diagrammatically on the following page.*

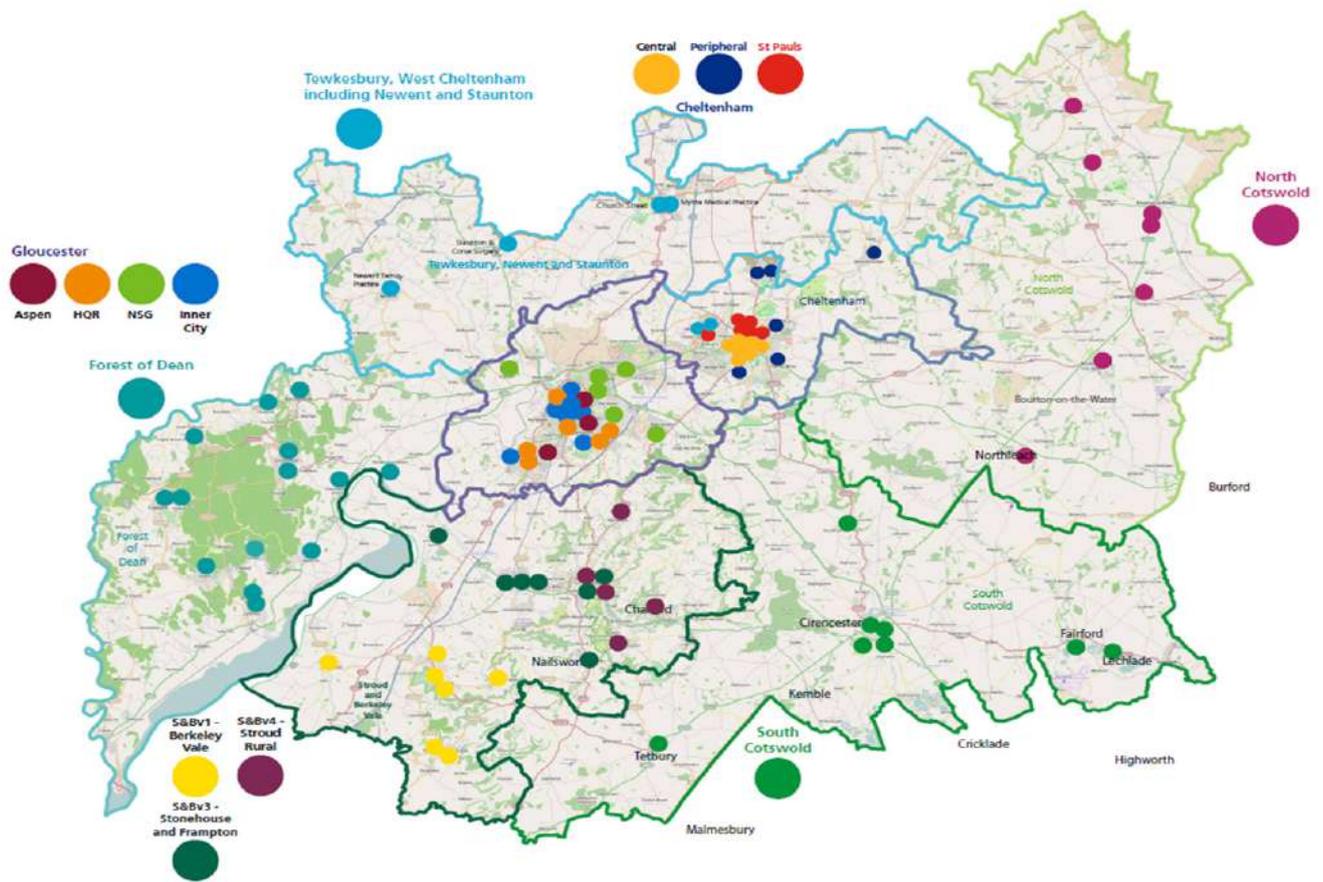


Figure A1: Our 14 Primary Care Networks

## Appendix 3: Our Six Integrated Localities: Summaries and Profiles

### Cheltenham ILP

The Cheltenham locality covers a mainly urban population comprised of Cheltenham, Winchcombe and Bishops Cleeve. The total area covers around 155,144 patients in sixteen practices. The locality includes three PCNs: Central, Peripheral and St Pauls (see Appendix 1 for further details of constituent practices).

#### People and Place

- Life expectancy for men (80.4%) is higher than the County (80.2%) and England average. Life expectancy for women (83.1%) is lower than the County average (83.7%) but higher than England.
- Cheltenham is the 3rd most deprived district in Gloucestershire and the district has 3 Lower Super Output Areas (LSOA) that rank in the top 10% most deprived in England - St Mark's 1, Hester's Way 3, and St Paul's 2. About 13% (2,500) of children live in low income families.
- Cheltenham's worst ranking domain is "Crime and Disorder" with 26% of the district population living within 19 LSOAs that fall into the most deprived national quintile for this domain.
- The Locality has a slightly younger profile than the county as a whole although it should be noted that several practices have an older demographic.

#### Lifestyle and Prevention

- The number of adults in Cheltenham District doing the recommended level of physical activity dropped from 74% in 2015/16 to 72% in 2016/17.
- In 2017/18 the directly age standardised rate of admission episodes for alcohol specific conditions in Cheltenham District was significantly higher (at 616 per 100,000 population compared to 570) than England.
- Smoking prevalence is around 11%, which is lower than the county average of 14%.

#### Long Term Conditions

- 31.7% of adults; 12.1% of older people (65+) and 1.9% of children have Long Term Conditions (LTCs).
- Prevalence of smoking (23.4% vs 15.9%), COPD (2.2% vs 1.9%) and depression (19.1% vs 15.5%) in St Paul's PCN are all higher than the county rates.
- Prevalence of all LTCs in Central PCN is lower than the county rate.
- Prevalence of Cancer (5% vs 4%), CHD (3.4% vs 3.2%) and dementia (1% vs 0.9%) in Peripheral PCN are all higher than the county rate.

#### Screening and Immunisations

- Screening coverage and uptake is significantly lower than the county for bowel and cervical screening.
- Flu vaccination coverage is significantly lower than the county.
- MMR vaccination coverage is significantly lower than the county.

## Avoidable Mortality

- Neoplasms continue to be the leading cause of avoidable mortality for women followed by cardiovascular disease and unintentional injuries.
- For men the leading cause of avoidable mortality is cardiovascular.

[Click here to view full profile for Cheltenham](#)

## Cotswolds ILP

The Cotswolds is a mainly rural locality with two PCNs – North Cotswolds and South Cotswolds (see Appendix 1). It spreads out across a wide geographical area including Gloucestershire, and parts of Warwickshire, Oxfordshire and Worcestershire. The total area covers around 90,405 patients.

### People and Place

- The Cotswolds ILP area has an older population profile than the CCG average. There are a high proportion of people aged 65+ and 85+ which has implications for age-related Long Term Conditions, while a higher rate of Cotswolds patients live on their own compared to the CCG norm (13.6% vs 11.9%).
- The growth in the registered list size for Cotswolds over the past 2 years has exceeded CCG growth, showing higher levels of month-on-month growth, (3.4% vs 2.5%). Greater growth still can be seen in the 65+ age bracket which has grown by 5.6% over the same time period, whereas the CCG has grown by 2.9%.
- Cotswolds is one of the 20% least deprived districts/unitary authorities in England, however about 8% (1,100) of children live in low income families and ranks as the most deprived district in the county for 'Barriers to Housing and Services'.
- Life expectancy for both men and women is higher than the England average.
- The rate of people reported killed or seriously injured on roads in Cotswold is significantly higher than across Gloucestershire and England.
- The number of people with caring responsibilities is higher than the Gloucestershire average.
- The gap in employment rate between those with long term conditions and those without is 19.2% which is 8.7% higher than for Gloucestershire.
- The percentage of children in Cotswold achieving a good level of development by the end of reception is higher than in the county as a whole. However, if we look at those eligible for free school meals there are inequalities; the level of development is much lower (and lower than the same cohort at county level).

### Lifestyle and Prevention

- The number of young people drinking alcohol has fallen from 56% in 2010 to 37.6% in 2018 but this is still higher than the overall rate for Gloucestershire (34.8%).
- The % of adults doing 150 minutes of exercise per week has fallen to 64.5% compared with 69.2% for Gloucestershire
- Smoking prevalence for adults is lower than the Gloucestershire rate but for young people it is marginally higher

### Long Term Conditions

- Cotswolds generally has a lower rate of long term conditions than the CCG as a whole, aside from cancer (4.7% vs 3.9%) and coronary heart disease (3.3% vs 3.2%).

- Stroke prevalence in Cotswolds place is marginally higher than the CCG norm (2.1% vs 2.0%).
- In North Cotswolds, compared with the county, there is higher prevalence of cancer and CHD and a lower prevalence of smoking.
- In South Cotswolds, prevalence of long term conditions is lower than the county.

### **Avoidable Mortality**

- The leading causes of avoidable mortality for women in Cotswold in 2018 were cancer; CVD and unintentional injuries
- The leading causes of avoidable mortality for men in Cotswold in 2018 were cardiovascular disease; cancer and respiratory disease

[Click here to view full profile for the Cotswolds](#)

## Forest of Dean ILP

The Forest of Dean ILP is one PCN consisting of all eleven practices which covers almost 64,000 patients.

### People and Place

- The health of people in Forest of Dean is varied compared with the England average. Life expectancy for men is higher than the England average.
- Projected overall growth rates are lower for the Forest of Dean than for Gloucestershire and England as a whole.
- The Annual Population Survey (October 2015 – September 2016) indicates that 3.1% of the population are from an ethnic minority group.
- 19.1% of patients are under 18 years old and 24.2% are 65 years and older.
- The locality has higher numbers of older people than the county average for both males and females and lower numbers of working age adults.
- The Forest of Dean is the district in Gloucestershire that displays the fewest extremes in deprivation however about 13% (1,800) of children live in low income families.
- The district has no LSOAs that rank in the top 10% most deprived in England, but 1 that ranks in the top 20% - Cinderford West 1.
- “Barriers to Housing and Services” is the Forest of Dean’s most deprived domain of deprivation with 25% of the district’s population living within LSOAs in the most deprived national quintile.
- The proportion of social and private homes that failed to meet the decent homes standard is significantly higher than the Gloucestershire average and the highest in the County.
- The Forest of Dean has a higher number of patients with caring responsibilities (18.3%) than both the England (16.7%) and Gloucestershire (17.2%) average.
- The locality has the highest unemployment rate in the county at 3.9%.
- The gap in employment rate between those with a long term condition and overall employment is almost twice as high in the Forest compared to the county.
- The percentage of children in the Forest of Dean achieving a good level of development by the end of reception is lower than in the county as a whole and for those eligible for free school meals, the level of development is lower than in both the locality and the county.

### Lifestyle and Prevention

- Prevalence of obesity in reception age children is currently higher than the county with an upward trend.
- Prevalence of obesity in Year 6 children is also slightly higher (19.2%) than the county prevalence (17.8%).

- The number of adults in the Forest of Dean doing the recommended level of physical activity dropped from 68.2% in 2015/16 to 65.8 in 2016/17 and this is the second lowest activity level in the county.
- Smoking prevalence is around 15%, which is higher than the county average of 14%.
- Forest has the second highest percentage of young people drinking alcohol in the county at 38.6%.

### Long Term Conditions

- The Forest has a higher than county prevalence for cancer, CHD, COPD, dementia, depression, diabetes, obesity and smoking.
- Prevalence of stroke in the Forest is 2.5%, which is higher than both the CCG (2%) and England (1.8%).

### Screening and Immunisations

- For those over 65 years of age coverage of seasonal flu vaccination is 71.1% which is slightly lower than the Gloucestershire average (74.7%)
- Seasonal flu vaccination coverage for pregnant women is 45.8% which is lower than the county rate of 49.4%.

### Avoidable Mortality

- Neoplasms continue to be the leading cause of avoidable mortality for women in the Forest locality, followed by unintentional injuries and cardiovascular disease.
- For men, the leading cause of avoidable mortality is cardiovascular disease, followed by unintentional injuries and neoplasms.
- Respiratory disease is the fourth highest cause of mortality for both men and women.

[Click here to view full profile for the Forest of Dean](#)

## Gloucester City ILP

Gloucester City covers a mostly urban patient population of around 175,000 patients and includes four PCNs: Aspen, HQR, Inner City and North & South Gloucester – full details of constituent practices can be found at Appendix 1.

### People and Place

- The health of people in Gloucester is varied compared with the England average. Life expectancy for both men and women is lower than the county and England average.
- 10 out of 13 of Gloucestershire's top 10% most deprived LSOAs nationally are located in Gloucester district and Gloucester has the highest proportion of all districts living in the most deprived areas (23% of district). About 16% (4,100) of children live in low income families.
- 27% of the district population are living within 22 LSOAs that fall into the most deprived national quintile for "Education Skills and Training".
- The Standardised Admission Ratio (SAR) is a summary estimate of admission rates relative to the national pattern of admissions and takes into account differences in a population's age, sex and socioeconomic deprivation. Gloucester City's SAR at 120 is higher than the countywide SAR value and 20% above expected.
- When comparing first outpatient appointment rates for the Gloucester City population, by specialty and indexed to the CCG rate, it appears that for all specialties apart from Paediatrics, the levels are below the county position.
- Gloucester City has the second highest rate of unemployment in the county.
- 0.2% of social and private homes failed to meet the decent homes standard which is slightly lower than the county average and the lowest of the six districts.
- Hospital admissions for violent crime (rate per 100,000) is almost double the county rate.
- The percentage of children in Gloucester achieving a good level of development by the end of reception (67%) is lower than in the county as a whole (69.2%), while for those eligible for free school meals, this drops further to 48.3%.

### Lifestyle and Prevention

- Childhood obesity for Year 6 children is significantly higher than the county rate.
- The number of adults in Gloucester doing the recommended level of physical activity is at 64.4%, the lowest level in the county.
- Smoking prevalence is around 21% of the population of Gloucester City, which is much higher than the county average of 14%.

### Long Term Conditions

- Prevalence in lifestyle related conditions are notably above the overall CCG rate. Smoking prevalence

is 3.5% higher in Gloucester City than in the CCG population as a whole, with Inner City practices also having some of the highest rates of COPD. Obesity and Diabetes are also significantly above CCG prevalence for all PCNs, most notably for Aspen.

- 10.3% of older adults across the locality have a Long Term Condition but this varies considerably by PCN and Practice.
- The Locality has a higher than county prevalence for depression, diabetes, obesity and smoking.
- The rate of Asthma and COPD admissions for Gloucester City registered patients is considerably above the rate per 1000 population for the CCG as a whole.

### Screening and Immunisations

- Overall levels of screening coverage and uptake are below the county rate for breast, bowel and cervical cancer.
- Seasonal Flu vaccinations for 2-4 year olds and 'at risk' individuals are lower than the county rate.
- Childhood vaccinations for DTaP/IPV and MMR are lower than the county rate.

### Avoidable Mortality

- Neoplasms, cardiovascular disease, respiratory disease and unintentional injuries are the biggest causes of avoidable mortality in the locality for both men and women.

[Click here to view full profile for Gloucester City](#)

## Stroud & Berkeley Vale ILP

The ILP area covers a mixture of rural spaces and small towns and villages to the south of the county with a total patient population of almost 122,000. There are three PCNs in the locality, made up of a total of eighteen GP Practices: Berkeley Vale, Severn Health and Stroud Cotswold (see Appendix 1 for full details).

### People and Place

- Stroud is one of the 20% least deprived districts/unitary authorities in England, however about 10% (1,900) of children live in low income families. Life expectancy for both men and women is similar to the England average.
- Stroud district ranks well in the county in terms of overall deprivation, and consistently well across the domains of deprivation.
- The district's worst ranking domain in the IMD 2015 is "Barriers to Housing and Services" with 8,745 people (8% of district population in 2015) living within 5 LSOAs that fall into the most deprived national quintile for this domain.
- The Stroud & Berkeley Vale registered list size has shown steady growth since 2017, showing slightly lower levels of month-on-month growth compared to the overall CCG position. This trend is consistent across the three PCNs.
- ONS Population projections show that the number of older people (65+) are set to increase by 56.6% by 2041.
- The percentage of children in Stroud achieving a good level of development by the end of reception (71%) is slightly higher than in the county as a whole (69.2%). However, for those eligible for free school meals, the level of development is much lower (49%).
- The locality has more patients living in care homes compared to the CCG average.
- The SAR is lower (0.93) than the countywide SAR value and 7% below expected unplanned admissions. At a PCN level both Berkeley Vale and Severn Health have a SAR of 95, however Stroud Cotswolds is lower at 88 meaning the admissions are 12% lower than expected.

### Lifestyle and Prevention

- The number of young people drinking alcohol is significantly higher than the county average.
- The number of young people smoking is significantly higher than the county average.

### Long Term Conditions

- Prevalence of depression in the Berkeley Vale PCN is higher than the county average.
- All three Stroud & Berkeley Vale PCNs have a higher rate in the 'Health Older People' and 'Older People with LTCs' segments, when compared to the indexed CCG position. Severn Health has a higher rate of 'End of Life' patients compared to the County, however, it should be noted that this represents a small volume of patients. Berkeley Vale has a slightly higher rate of 'Children with LTCs' compared to the County.

- Stroud and Berkeley Vale have a slightly higher prevalence of Cancer and Dementia compared to the overall CCG rate, with lower prevalence in lifestyle related conditions.

### **Avoidable Mortality**

- The leading causes of avoidable mortality for both men and women are cancer, CVD and unintentional injuries, followed by drug use disorders for men and respiratory disease for women.

[Click here to view full profile for Stroud & Berkeley Vale](#)

## Tewkesbury ILP

Tewkesbury Locality covers Newent, Staunton, Tewkesbury Town Centre and parts of West Cheltenham. The locality has one PCN and has a total patient population of around 47,000; full details of constituent practices can be found at Appendix 1.

### People and Place

- The health of people in Tewkesbury Borough is generally better than the England average. Tewkesbury is one of the 20% least deprived districts/unitary authorities in England, however about 11% (1,700) of children live in low income families. Life expectancy for both men and women is higher than the England average.
- Tewkesbury Borough has 2 LSOAs that rank in the top 20% most deprived in England. These are Tewkesbury Prior's Park 2 and Tewkesbury Prior's Park 3.
- Tewkesbury Borough's worst ranking domain is "Barriers to Housing and Services", with 22% of the district's population living within areas ranked in the most deprived national quintile.
- The change in the registered list size for the locality has been consistently higher than the overall CCG position, showing growing variation month-on-month.
- The SAR for the locality is at 111, 11% above expected.
- When comparing the outpatient procedure distribution for the TWNS population by specialty and indexed to the CCG rate, Rheumatology, T&O and Urology all have a higher % of the overall activity compared to the CCG average.
- The percentage of term babies born below 2500g is significantly higher (3.3% in 2016) than the county value (2.2% in 2016).
- The percentage of children in Tewkesbury achieving a good level of development by the end of reception is broadly in alignment with the county rate of 69.2%, however for those eligible for free school meals the level of development is much lower (46.7%).
- Tewkesbury has a slightly higher (17.7%) number of patients with caring responsibilities than both the England (16.7%) and Gloucestershire (17.2%) average.
- The rate of people reported killed or seriously injured on roads in Tewkesbury between 2015 and 2017 is significantly higher (57.6 per 100,000 population) than across Gloucestershire (45.3) and England (40.8).

### Lifestyle and Prevention

- Prevalence of obesity in reception age children is broadly in line with the county average (10% vs 9.9%), although with an upward trend. For Year 6 children prevalence is 19.5% compared to 17.8%.
- The percentage of young people drinking alcohol in Tewkesbury Borough is falling at 37.8% (47.9% in 2010), but is still higher than the county rate of 34.8%.

- Prevalence of smoking amongst young people aged 14 to 15 is the third highest in the county at 10.5%, compared with the county rate of 9.2%.
- Smoking prevalence is around 16% (county average of 14%).

### **Avoidable Mortality**

- In line with the county and nationally the three biggest causes of avoidable mortality are neoplasms, cardiovascular disease and respiratory disease.

[Click here to view full profile for Tewkesbury](#)

## Appendix 4: Our Primary Care Infrastructure Plan: 2019 to 2026

Click the buttons below to view the documents:

[Main Primary Care Infrastructure Plan \(PCIP\) document](#)

[PCIP: Appendix 1](#)

[PCIP: Appendix 2](#)

[PCIP: Appendix 3](#)

[PCIP: Appendix 4](#)

[PCIP: Appendix 5](#)

[PCIP: Appendix 6](#)

## Appendix 5: Full workforce trajectories 2019-2024

Notes:

- September 2017: Primary Care Workforce Strategy Baseline
- All figures represent WTE

GPs	Actuals			Planned Trajectory				
	Sep-17	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24
GPs FTE (excluding registrars)	358.8	357.9	367.8	378.0	387.2	393.4	398.6	403.8
GP Registrars	18.0	17.0	48.0	44	44	44	44	44
<b>Total GPs FTE</b>	<b>376.8</b>	<b>374.9</b>	<b>415.8</b>	<b>422.0</b>	<b>431.2</b>	<b>437.4</b>	<b>442.6</b>	<b>447.8</b>

Nurses	Actuals			Planned Trajectory				
	Sep-17	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24
Nurses FTE	203.7	205.0	212.8	212.8	212.8	212.8	212.8	212.8

Other Direct Patient Care	Actuals			Planned Trajectory				
	Sep-17	Mar-18	Mar-19*	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24
Health Care Assistants	70.5	72.4	73.5	73.5	73.5	73.5	73.5	73.5
Dispensers	69.7	67.9	70.6	70.6	70.6	70.6	70.6	70.6
Phlebotomists	9.8	9.4	8.0	8.0	8.0	8.0	8.0	8.0
Pharmacists	5.9	7.4	26.3	44.3	51.8	59.3	66.8	74.3
Pharmacy Technicians	0.0	0.0	1.7	1.7	1.7	1.7	1.7	1.7
Podiatrists	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Physiotherapists	0.8	0.8	2.0	2.0	12.5	23.0	33.5	44.0
Therapists	0.0	3.2	3.2	3.2	3.2	3.2	3.2	3.2
Physician Associates	0.0	0.0	0.0	0.0	7.0	14.0	21.0	28.0
Paramedics	0.9	1.4	3.6	3.6	3.6	8.3	13.0	17.6
Nursing Associates	0.0	0.0	0.0	0.4	0.8	1.0	1.1	1.2
Apprentices	1.5	0.6	0.7	1.7	2.7	3.7	4.7	5.7
Social Prescribers	0.0	0.0	16.7	27.7	35.5	43.2	51.0	58.7
Other Direct Patient Care	3.7	3.8	3.3	3.3	3.3	3.3	3.3	3.3
<b>Total Other DPC FTE</b>	<b>162.8</b>	<b>166.9</b>	<b>209.6</b>	<b>240.0</b>	<b>274.1</b>	<b>312.8</b>	<b>351.3</b>	<b>389.8</b>

\* Updated to include staff captured in baselining exercise for Additional Roles Reimbursement, including those funded by CCG (e.g. transformation clinical pharmacists) to form 31 March 2019 baseline

Total Clinical FTE	Actuals			Planned Trajectory				
	Sep-17	Mar-18	Mar-19*	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24
Total GPs	376.8	374.9	415.8	422.0	431.2	437.4	442.6	447.8
Total Nurses	203.7	205.0	212.8	212.8	212.8	212.8	212.8	212.8
Total Other DPC	162.8	166.9	209.6	240.0	274.1	312.8	351.3	389.8
<b>Total Clinical FTE</b>	<b>743.3</b>	<b>746.8</b>	<b>838.2</b>	<b>874.8</b>	<b>918.1</b>	<b>963.0</b>	<b>1,006.7</b>	<b>1,050.4</b>

\* Updated to include staff captured in baselining exercise for Additional Roles Reimbursement, including those funded by CCG (e.g. transformation clinical pharmacists) to form 31 March 2019 baseline

## Appendix 6: Long Term Plan Targets: Digital Primary Care Provision

All practices will ensure at least 25% of appointments are available for online booking by July 2019	July 2019	Care Plans available in the Summary Care Record	April 2021
SNOMED-CT Implementation across all Primary Care systems	Oct 2019	100% Cyber Standards Compliance	April 2021
E-correspondence for transfers of care	Dec 2019	GP activity and waiting times published monthly	April 2021
Supporting the promotion and utilisation of the NHS App	Autumn 2019	All patients to be offered online and video consultations	April 2021
Move over to the GPIT Futures supplier framework	Dec 2019	Population Health Management solutions in place across every ICS	April 2022
Every patient with a long term condition will have access to their health record through the Summary Care Record accessed via the NHS App	Jan 2020	Community mobile access to records and plans	April 2022
Digitisation of Lloyd George records	Feb 2020	CIO or CCIO at Board Level in every organisation	April 2022
Full online access to patient data for all patients	April 2020	All practices will be offering and promoting electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate as a default	On-going
Eradicate faxes	April 2020	Personalised care and health budget model rolled out	April 2024
All patients to will have the right to online consultation	April 2020	Digital-first primary care will become a new option for every patient improving fast access to convenient primary care.	April 2024
All patients have access to online correspondence unless opted out	April 2020	Autism and Learning Difficulty flag in care records	April 2024
All practices updating SCR in as real-time as possible	April 2020	Implement Artificial Intelligence Clinical Decision Support	April 2024
All practices will need to have an up to date and informative online presence including a patient facing email	April 2020	Whole system capacity alerts available to GPs and patients	April 2024
Patients able to add own information to own health records	April 2020	Delivery of Personal Health Records via LHACR, including reminders and alerts	April 2024
1 practice appointment per day per 3000 patients with a minimum of 1 appointment per practice per day offered to 111 for Direct Booking	April 2020	Increased CEO and Non-executive Director digital leadership	April 2024
Secure sharing of information with Care Homes	Dec 2020	The information technology revolution in the NHS also needs to make it a more satisfying place for our staff to work	April 2024

*National digital requirements that we will implement locally*

## Appendix 7: Details on how Digital Supports the Primary Care Vision

Vision Area	Digital enabler theme	Challenge addressed
Continue the dissolution of the historic divide between services through PCNs and ILPs.	Joined up infrastructure delivered at scale Standardisation of digital processes Convergence of systems and standards	Technology barriers to care staff working together and sharing information.
Provide patients with more control over their own health, anticipatory care and personalised care when they need it and support early cancer diagnosis.	Digital-First Access  Enabling hub and remote delivery of services	An increase in patients with complex health conditions that need earlier diagnosis and more appropriate care.
Ensure good access to primary care 7 days a week, meaning better support for patients while also reducing urgent demand at our hospitals to enable them to care for the most acutely poorly patients.		Inadequate access for patients (feedback shows 14% are unsatisfied with appointment times locally; while this compares favourably to the national average (18%) we want to improve further (Ipsos Mori, 2019)).  Lack of clarity on where to access care out of hours.
Support PCNs and ILPs to explore how they can provide a greater range of services for larger numbers of patients.		Pressure on acute services and related delays to patient care.  Availability of expertise in specialisms.  Commercial digital services taking lower complexity patients with potential for practice destabilisation.
Utilise population health to tackle inequalities, assessing our local population by risk of unwarranted health outcomes to make services available where they are most needed.	Real-time insights on demand and capacity Population Health Management tool adoption Data driven continual improvement processes and cultures	Health inequalities across populations, potential unmet demand and potential late diagnosis.
Grow our multi-disciplinary primary care teams, attracting and retaining the best staff through promoting Gloucestershire as a great place to live and work, creating a better work-life balance for staff, and offering excellent training opportunities.	Digital, Data and Technology learning programmes with care professionals, support staff and patients  Robust digital service design and operational processes	Increasingly difficult to recruit GPs, especially in certain pockets of our county.  Increase in demand and workload.  Difficulty embedding technology into working processes.

## Appendix 8: Digital Risks and Mitigations

Risk	Mitigation	RAG
Operational impacts of investing in solutions that don't realise the benefits required for the new model, or add extra effort to practices.	Digital, clinical and admin resource digital delivery skills development.	Amber-Red
Competition from commercial Digital only services harvesting patients with lower complexity or not providing holistic sustainable care	Develop digital-first alternative solution and accelerate online consultation programme and national solution adoption.	Amber
Data and Security risks from not being able to manage a plethora of systems managed individually at a practice level against data privacy incidents and security attacks	Network upgrade, software upgrades, cyber programme delivery and system consolidations.	Amber-Red
Demand risks of increasing the number of people directed to inappropriate settings or creating unnecessary surges in demand through digital -first services	Developing user tested digital patient pathways and robust evaluation activities into new patient facing technology projects.	Amber
Care continuity risks of information existing in silos or being incomplete across settings, with an increasingly multi-disciplinary and multi-organisational care model	Information sharing programmes. Procurement from NHS frameworks and approved through an ICS Technical Design Authority and Digital Board.	Amber
Lack of funding and resources to deliver such a large programme, based on the small amount in place now.	Look to consolidate programme teams where there's duplication, work with other ICS' for scales of economy, converge the number of systems and options in use, look for alternative funding options and develop skills to improve productivity.	Red
Retention and recruitment risks if digitisation results in greater bureaucracy to complete tasks, doesn't reduce demand and creates an arduous always-on work pattern	Invest in user centred design practices and business process analysis ahead of wholesale changes. Don't go ahead with projects that add additional burden to staff.	Amber
Capability risks if staff are not supported to use and advocate the use of technologies and digital processes;	Embed digital projects into broader change programmes and develop digital workforce programmes	Amber-Red

<p>Quality of care risks if more virtual and remote models of care reduce care professionals' ability to understand and collaborate with patients on their care improvement</p>	<p>Developing user tested digital patient pathways and robust evaluation activities into new patient facing technology projects.</p>	<p><b>Amber</b></p>
<p>Patient access inequalities, if care access rules are inconsistent or exclude those not using particular channels</p>	<p>Undertake accessibility and equality impact assessments for new digital services to reduce chances of digital exclusion. Work with other organisations and staff on patient digital literacy programmes.</p>	<p><b>Amber</b></p>
<p>Financial and supplier risks if each practice or PCN goes alone in the selection of tools and technology platforms. This will miss opportunities to gain economies of scale, as well as making GPIT support more expensive and less responsive to needs</p>	<p>Encourage alignment and options papers on technology choices with PCN Directors and teams, reviewed at ICS level.</p>	<p><b>Amber-Red</b></p>
<p>Converging on a single supply may mean that a failure or issue with a single supplier will affect the whole system rather than just part of it.</p>	<p>Evaluate long-term roadmap of supplier and carefully manage service level agreements, in conjunction with user groups and central GPIT teams.</p>	<p><b>Amber-Green</b></p>

### Audit and Risk Committee Chair’s report

Agenda Item	Title	Author/ Date
16.1	Chair of Audit Report	Colin Greaves
<b>This report is for</b>		
Decision		
Discussion		
Information / noting		Information/noting
<b>This report identifies the following key themes which have been assessed</b>		
Equality		
Quality		
Risk issues		
Legal issues		
Finance issues		STP Solutions
Patient & Public Involvement		
Conflicts of interest & how they were managed		
<b>Key issues discussed at the Audit and Risk Committee meeting held on 10 September 2019</b>		
<p>The Governing Body is requested to receive this report on the Audit and Risk Committee meeting on 10 Sep 19. The Committee considered a range of reports/items including:</p> <p><u>Internal Audit</u> Cyber Security – moderate design, limited operational effectiveness; Safeguarding Children – moderate design, moderate operational effectiveness.</p> <p><u>Gifts and Hospitality Register</u> – report noted.</p> <p><u>Risk Management Report</u> – report noted and CRR and GBAF reviewed.</p> <p><u>STP Solutions Report</u> – report noted.</p>		
<b>Decisions / approvals given</b>		
Committee approved risks KI3, K14, K15 (integration risks) and Q5 (quality risk) for inclusion on CRR and, where appropriate > 12 onto the GBAF		
<b>The Audit and Risk Committee was</b>		
<ul style="list-style-type: none"> <li>• Assured on Safeguarding Children</li> <li>• Partially assured on Cyber Security</li> </ul>		
<b>Any follow-up work required</b>		
Ongoing work on cyber security		

in the Trust has this been discussed before (meeting / dates)

**Gloucestershire Clinical Commissioning Group**  
**Audit & Risk Committee**  
**Minutes of the meeting held at 9:30am 10 September 2019**  
**Board Room, Sanger House**

<b>Members Present:</b>		
Colin Greaves	CG	Lay Member, Governance (Chair)
Alan Elkin	AE	Lay Member, Patient and Public Experience
Dr Hein Le Roux	HLR	Deputy Clinical Chair
Peter Marriner	PM	Lay Member, Business
Will Haynes	WH	GP Liaison Lead, Gloucester City
<b>In Attendance:</b>		
Gerald Nyamhondoro	GN	Governance Officer (taking minutes)
Christina Gradowski (Agenda Items 8 & 9)	CGi	Associate Director of Corporate Affairs
Cath Leech (Agenda Items 14 & 16)	CL	Chief Finance Officer
Lee Sheridan (Agenda Item 7)	LS	Head of Counter Fraud, Counter Fraud Services
Haydn Jones (Agenda Item 13)	HJ	Associate Director, Business Intelligence
Justine Turner (Agenda Item 5)	JT	Internal Audit Manager, BDO
Alex Walling (Agenda Item 6)	AW	Grant Thornton, Engagement Lead

<b>1.</b>	<b>Apologies</b>
1.1	An apology was received from Jo Davies.
1.2	The meeting was confirmed to be quorate.
<b>2.</b>	<b>Declarations of Interests</b>
2.1	WH and HLR declared a general interest of GPs in healthcare services. The committee considered the declaration and concluded that the participation of WH and HLR with full rights of members was not prejudicial to the proceedings, or to the CCG, or to the health partners, or in any other conceivable way.
<b>3.</b>	<b>Minutes of Previous Audit &amp; Risk Committee Meetings</b>
3.1	The minutes of the meeting held on Tuesday 7 May 2019 were approved as an accurate record.  The minutes of the meeting held on Tuesday 21 May 2019 were noted as an accurate record, subject to the following amendments:
3.2	Paragraph 5.32 should read as follows ' <i>AS explained that the CCG was fully compliant in areas such as the keeping of registers of interests, gifts and hospitality. The CCG was also compliant in areas such as procurement decisions, decision making processes and contract monitoring.</i> '
3.3	The minutes of the meeting held on Tuesday 2 July 2019 were noted as an accurate record, subject to the following amendments:  The resolution on page 14, paragraph 10.8 should read as follows ' <i>RESOLUTION: The Audit &amp; Risk Committee noted the contents of the Risk Management Report, Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR) and the</i>

	<i>circulation of the reports to members for approval.'</i>
<b>4.</b>	<b>Matters Arising</b>
4.1	<b>02/07/2019, Item 5.5 &amp; 5.8 <u>Feedback on CHC Internal Audit Recommendations</u>.</b> AE enquired as to what role the Gloucestershire County Council (GCC) played in easing the pressures which CHC faced. DS stated that the CHC team was working closely with GCC. CG expressed the hope that GCC shared the same commitment despite the resource pressures they experienced. CL suggested that the CHC team should be invited to a future Governing Body Business Development session. <b>Item Open.</b>
4.2	<b>02.07.19, Item 7.10 <u>External Audit Report Item</u>.</b> CG stated that the creation of an ICS environment brought new control and governance challenges for the CCG. The committee hoped that internal and external auditors would widen their focus to cover new challenges. CL noted that there was a possibility of the CCG facing situations where priority was given to the interests of the ICS as this could provide greater benefit to patients, over those of the CCG. This was acknowledged as a national issue, not specific to Gloucestershire. The committee requested that Grant Thornton and CL hold a discussion over the concern raised. <b>Item Open.</b>
	<i>Haydn Jones joined the meeting at 09:40am</i>  <i>The Chair directed the meeting to Agenda Item 13</i>
<b>13.</b>	<b>STP Solutions Report</b>
13.1	HJ stated that STP Solutions focused on the actual delivery of tangible benefits and there were risk sharing arrangements in place within the system. HJ stated that the CCG 2019/20 savings programme amounted to £17.287m, with a forecast delivery of £16.061m as at month 4.

13.2	<p>HJ explained that the main risks to the financial delivery of savings were:</p> <ul style="list-style-type: none"> <li>• delayed implementation of schemes;</li> <li>• providers not fully supporting development and delivery of the programme/schemes;</li> <li>• nationally driven changes to tariff/pricing structures.</li> </ul>
13.3	<p>HJ outlined some of the risk mitigation measures as follows:</p> <ul style="list-style-type: none"> <li>• the CCG had a risk share agreement with Gloucestershire Hospitals NHS Foundation Trust (GHFT) for specific schemes whereby the contractual value of the Point of Delivery (POD) would be reduced by an agreed amount;</li> <li>• GHFT had agreed a block contract for all activity which (excluded some drugs). This meant that even if there were slippage on a specific scheme, the financial risk to the CCG for 2019/20 would be minimised;</li> <li>• the CCG had a risk share arrangement with Gloucestershire Care Services (GCS) for specific schemes.</li> </ul>
13.4	<p>HJ cited some schemes which created a risk on the CCG savings plan as follows:</p> <ul style="list-style-type: none"> <li>• no definitive commissioning decision had been made regarding the 'Macmillan Next Steps Cancer Rehabilitation (MNSCR);</li> <li>• the 'Respiratory Integration' scheme faced pressure from an increase in respiratory emergency admissions;</li> <li>• the 'Standardisation of Follow-Up Criteria (All Specialties)' 2018/19 planned savings target had slippage and had been rolled over to 2019/20 with limited mitigation to offset this.;</li> <li>• the 'Patient Led Bookings' planned savings target for this scheme was rolled over from 2018/19 but was not currently</li> </ul>

	<p>being progressed;</p> <ul style="list-style-type: none"> <li>the impact of the IVF policy change created 3 months of slippage against plan which would equate to £45,000 with no mitigations to offset this;</li> <li>development of 'Virtual Clinics (Cinapsis)' for Ophthalmology had been more challenging and much slower than expected;</li> <li>'High Cost Placements' pressures risked a shortfall of £450,000 and there were no mitigations to offset the shortfall.</li> </ul>
13.5	PM raised a concern regarding what appeared to be prolonged failure to contain pressures that caused the slipping of the savings target. CL responded that the CCG was committed to working with GHFT in an effort to drive down costs and achieve savings target.
	<p><i>Haydn Jones left the meeting at 09:55am.</i></p> <p><i>The Chair redirected the meeting to Agenda Item 5.</i></p>
13.6	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the 2019/20 STP Solutions Programme position at month 4.</b>
5.	<b>Internal Audit</b>
5.1	<u>Internal Audit Progress Report</u>
5.1.1	JT presented the report and advised that there were no changes to the internal audit plan. JT stated that the approach taken by BDO LLP was designed to enable the auditors to give assurance on risk management and the internal control processes. JT stated that the auditors were making good progress in the delivery of the 2019/20 audit plan.
5.2	<u>Cyber Security</u>

5.2.1	<p>JT stated that BDO LLP reviewed the CCG cyber environment and concluded that the cyber risk inherent in the design of the information system platforms was 'moderate risk' with 'limited' operational effectiveness.</p>
5.2.2	<p>PM raised the concern that some platforms were running on Windows 2003 operating software and such old software could pose a cyber risk. CL explained that some of the hospital equipment was old and could not be programmed to recognise newer versions of Windows operating systems. CL reassured members that mitigation had been taken through alternative technologies to protect the platforms that ran on Windows 2003.</p>
5.2.3	<p>JT explained that the National Health Service (NHS) would receive free-to-adopt, world class perimeter security services as 'NHS Digital' signs contract with Accenture such as:</p> <ul style="list-style-type: none"> <li>• next-generation firewall;</li> <li>• secure filtering for web content;</li> <li>• network intrusion detection and prevention capabilities;</li> <li>• data loss prevention;</li> <li>• secure DNS services https</li> </ul> <p>Expert security specialists within the NHS would now have a broader view of cyber threats across the NHS, allowing them to spot and respond quickly to emerging problems, while reducing cyber risks.</p>
5.2.4	<p><u>Safeguarding Children</u></p>
5.2.5	<p>JT summarised the safeguarding areas of good practice as follows:</p> <ul style="list-style-type: none"> <li>• an annual safeguarding report was produced as required;</li> <li>• safeguarding policies were in place and inter-agency working and how they should meet legislative and guidance requirements were explained;</li> <li>• the CCG facilitated 'GP Safeguarding Forums' three times</li> </ul>

	<p>yearly;</p> <ul style="list-style-type: none"> <li>• the CCG worked alongside the Local Authority and the Police to commit to the new 'Working Together to Safeguard Children' guidance;</li> <li>• lessons learnt from Serious Case Reviews (SCRs) were being disseminated to the appropriate staff.</li> </ul>
5.2.6	<p>JT stated that BDO LLP's knowledge of assessing good safeguarding practices derived from broad knowledge and experience in assessing safeguarding across the health sector.</p>
5.2.7	<p>JT summarised the safeguarding challenges as follows:</p> <ul style="list-style-type: none"> <li>• there was currently no ratified Children's Safeguarding Strategy in place at the CCG;</li> <li>• there was no training framework detailing the staff groups across the CCG who required safeguarding training or the level of training required;</li> <li>• there were no adequate arrangements for quality assurance made by the CCG to assure themselves that the organisations to which they commissioned had effective safeguarding arrangements in place.</li> </ul>
5.2.8	<p>WH stated that the GPs were committed to safeguarding good practice as demonstrated though the fact that each GP practice had a GP Lead dedicated to assuring safeguarding. WH emphasised the need for the CCG to further improve its safeguarding engagements with the GPs and expressed concern over the thinly spread staffing level within the health visiting sector. WH added that the risk created by the low level of staffing was exacerbated by the lack of optimal access to essential information from safeguarding partners.</p>
5.2.9	<p>CG emphasised that the primary responsibility of safeguarding lay with GP practices and, as the CCG needed safeguarding</p>

	reassurance from practices; a more robust engagement mechanism was required.
5.2.10	CG further stated that there was need to review and improve safeguarding education, training and monitoring mechanisms. CG added that there was a need to improve the safeguarding statistical tools and data to help identify safeguarding areas of need, staff numbers and levels of training needs. <b>ACTION: CGI</b>
5.3	<u>Internal Audit Follow-Up of Recommendations</u>
5.3.1	<p>JT recommended that:</p> <ul style="list-style-type: none"> <li>• safer recruitment should be reviewed to ensure that all officers undertaking interviews and recruiting new staff were aware of the checks required prior to a formal offer of employment;</li> <li>• All STP Savings Solutions should have quantitative data/dashboards available to enable the substantiation of the saving reported and a gap analysis outcomes; should be undertaken to assess the adequacy of the dashboards for all savings reported;</li> <li>• conflicts of interest annual training should be completed by all CCG employees, Governing Body and committee members;</li> <li>• the constitution should be updated to reflect the current governance structure in place.</li> </ul>
5.4	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the Internal Audit Report.</b>
6.	<b>External Audit Progress Report</b>
6.1	AW presented the report and explained that the auditor was mindful of the changes happening in the health sector and the movement of the health sector toward the Integrated Care System (ICS) and how

	this impacted on the CCG.
6.2	AW stated that the financial pressures and growing demand necessitated a paradigm shift in the delivery of health and social care services. AW emphasised that technology and the estate were key enablers for the delivery of required change.
6.3	AW explained that the Primary Care Networks (PCNs) formed a key building block of the NHS long-term plan. AW emphasised that bringing general practices together to work at scale had been a policy priority for some years for a range of reasons. AW explained that the benefits brought by PCNs included: <ul style="list-style-type: none"> <li>• improving the ability of practices to recruit and retain staff;</li> <li>• managing financial and estates pressures;</li> <li>• providing a wider range of services to patients.</li> </ul>
6.4	AW stated that people's physical and mental health outcomes improved when medicines were used in the optimal, or best, way. AW cautioned that incorrect prescription or administration of medicines could be harmful to patients. HLR drew attention to the seven clinical standards which were due for introduction, which would be a driver to good clinical standardisation and practice.
6.5	AW gave an update on Mental Health Investment Standard. CG reminded members that it had been agreed that a MHIS report could be presented before the Audit & Risk Committee on 26 September 2019, for approval. <b>ACTION: AW and CL.</b>
6.6	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the External Audit Update report.</b>
7.	<b>Counter Fraud</b>
7.1	LS presented the report and emphasised that Counter Fraud

	Services was committed to enhancing the CCG measures designed to minimise the risk of fraud. LS added that such efforts had resulted in the development of a relationship.
7.2	LS stated that counter fraud measures should be embedded at all levels across the organisation to ensure effectiveness of fraud containment mechanisms. LS advised that recommendations made by the NHS Counter Fraud Authority should be fully considered and implemented.
7.3	LS emphasised that Counter Fraud Service was further developing a more robust counter fraud plan to contain acts of bribery and corruption.
7.4	LS stated that Counter Fraud Service effectively engaged with the CCG staff and had attended two inductions and made four bespoke fraud awareness presentations to staff groups since April 2019. Furthermore, Counter Fraud Service issued a newsletter to staff via Team Brief.
7.5	LS added that a Counter Fraud Service developed an 'E-Learning' package collaboratively with NHS CFA. LS clarified that undertaking the package was mandatory, just like the face to face fraud awareness sessions.
7.6	CG reiterated that counter fraud measures should be embedded in both the CCG system and the wider ICS at every level of the system development. CG further emphasised that the CCG and its partners required a formal and institutionalised approach to fraud containment and this would be driven by a closer working partnership with Counter Fraud Service. CG requested that CL review the engagement process with Counter Fraud Service across the system, and the formalisation of embedded processes. <b>ACTION: CL and LS.</b>

7.7	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the Counter Fraud report.</b>
8.	<b>Registers</b>
8.1.1	<u>Gift and Hospitality Register</u>
8.1.2	CGi presented the Register of Gifts and Hospitality to the committee.
8.1.3	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the contents of Gifts and Hospitality Register.</b>
8.2	<u>Commercial Sponsorship and Rebates</u>
8.2.1	CGi presented the Register of Commercial Sponsorship and Rebates to the committee.
8.2.2	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the contents of the Register of Commercial Sponsorship and Rebates.</b>
9.	<b>Risk Management Report</b>
9.1	CGi stated that the absence of a fit for purpose Corporate Risk Register (CRR) could result in risks not being identified or acted upon, or reported. CGi explained that the CCG had been using spreadsheets as a corporate risk management tool and the limitations of such tool compromised the risk management and assurance drive.
9.2	CGi presented the new risks, the Corporate Risk Register and the Governing Body Assurance Framework before the committee. CGi explained that the spreadsheets would be replaced by a more effective tool called '4Risk' which was supplied and supported by RSM UK. She added that a RSM UK trainer, Craig Duff, would run a

	workshop on 16 September, at Sanger House to train the risk leads. CGi advised that she would give a demonstration of the 4Risk tool at the next Audit & Risk Committee meeting. <b>Action: CGi.</b>
9.3	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the Risk Management report and, reviewed the contents of the Corporate Risk Register and the Governing Body Assurance Framework.</b>
10.	<b>Summaries of Procurement Decisions</b>
10.1	There were no new procurement decisions.
10.2	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted that there were no new procurement decisions.</b>
11.	<b>Register of Waiver of Standing Orders</b>
11.1	One Waiver of Standing Orders approved by CCG executive managers was reviewed by the Audit & Risk Committee.
11.2	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee reviewed and noted one Waiver of Standing Orders.</b>
12.	<b>Declarations of Interests Update Report</b>
12.1	<p>GN presented the report and explained that there was a significant positive shift in compliance levels. GN summarised as follows:</p> <ul style="list-style-type: none"> <li>• as of 11 December 2018, 87.5% of members had complied with the requirement to declare interests; and as of 31 August 2019, all members had complied with the requirement to declare interests;</li> <li>• as of 11 December 2018, 21.4% of One Place members had complied with the requirement to declare interests; and as of 31</li> </ul>

	<p>August 2019, 80% of One Place members had complied;</p> <ul style="list-style-type: none"> <li>• as of 31 August 2019, 120 General Practitioner (GP) Partners had declared their interests.</li> </ul>
12.2	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the Declarations of Interest report.</b>
	<i>The Chair directed to meeting to Agenda Item 14 as Agenda Item 13 had already been covered.</i>
14.	<b>Losses and Special Payments Register</b>
14.1	<p>CL presented the register and explained that the CCG had made three special payments totalling £571.90 during the current financial year. The payments were broken down as follows:</p> <ul style="list-style-type: none"> <li>• a payment of £121.90 relating to a compensation payment made to a patient;</li> <li>• a payment of £350.00 compensation for failure to provide S117 aftercare to a patient;</li> <li>• payment of £100.00 compensation for failure to provide S117 aftercare to a patient.</li> </ul>
14.2	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the contents of the Losses and Special Payments register.</b>
15.	<b>Debt Write-offs</b>
15.1	There were no new items to report.
15.2	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted that there were no new items to report.</b>

<b>16.</b>	<b>Aged Debt Report</b>
16.1	CL explained that the report presented the level of outstanding debt as at 21st August 2019 reflected on the Sales Ledger.
16.2	CL stated that the outstanding debt was £712,644 of which £452,953 was NHS and £259,692 was non NHS. CL clarified that 45% of the debt was not yet due for payment.
<b>16.3</b>	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee noted the contents of the Aged Debt report.</b>
<b>17.</b>	<b>Audit &amp; Risk Self-Assessment</b>
17.1	CG presented self-assessment templates to the members for review and endorsement. Regular attendees were, for the purpose of this exercise, treated as members. Members and regular attendees endorsed the self-assessment templates. CG requested GN to circulate the templates for completion by the members. <b>ACTION: GN.</b>
<b>17.2</b>	<b><u>RESOLUTION:</u> The Audit &amp; Risk Committee endorsed the use of the templates for self-assessment.</b>
<b>18.</b>	<b>Any Other Business</b>
18.1	The Chair suggested a 'one to one' meeting between each member of the Audit & Risk Committee with a member of internal audit and a member of external audit respectively, preferably in December 2019. The Chair requested that CGi and GN facilitate the meetings. <b>ACTION: CGi and GN.</b>
18.2	The Chair suggested a 'one to one' meeting between each member of Audit & Risk Committee with an official of the Counter Fraud

	Service, preferably in January 2020. The Chair requested that CGi and GN facilitate the meetings. <b>ACTION: CGi and GN</b>
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**The meeting was closed at 11:25am**

**Date and time of the next meeting:**

**The next meeting would be held at 09:30am on Tuesday 17 December 2019, in the Board Room, Sanger House.**

Minutes Approved by the Audit & Risk Committee:

Signed (Chair): \_\_\_\_\_ Date: \_\_\_\_\_

### Audit and Risk Committee Chair’s report

Agenda Item	Title	Author/ Date
16.2	Chair of Audit Report	Colin Greaves
<b>This report is for</b>		
Decision		
Discussion		
Information / noting		Information/noting
<b>This report identifies the following key themes which have been assessed</b>		
Equality		
Quality		
Risk issues		Reputational Risk
Legal issues		
Finance issues		
Patient & Public Involvement		
Conflicts of interest & how they were managed		
<b>Key issues discussed at the Extraordinary Audit and Risk Committee meeting held on 29 October 2019</b>		
<p>The Governing Body is requested to receive the report on the Extraordinary Audit and Risk Committee meeting on 29 Oct 19. The Committee considered the report from the External Auditors on the Mental Health Investment Standard (MHIS).</p> <p>The External Auditors report stated that they would be issuing a “qualified except for” opinion on the basis that the CCG’ original figures did not include prescribing.</p> <p>.</p>		
<b>Decisions / approvals given</b>		
Committee approved the Accountable Officer’s MHIS statement and accepted the auditor’s qualified except for opinion.		
<b>The Audit and Risk Committee was</b>		
Partially assured on MHIS, noting that this was the first year of the audit with guidance issued up to the point of the audit and the unpredictable nature of prescribing expenditure		
<b>Any follow-up work required</b>		

in the Trust has this been discussed before (meeting / dates)

## Gloucestershire Clinical Commissioning Group

### Audit & Risk Committee

Minutes of the extraordinary meeting held at 10:30am, 29 October 2019

Board Room, Sanger House

<b>Members Present:</b>		
Colin Greaves	CG	Lay Member, Governance (Chair)
Alan Elkin	AE	Lay Member, Patient and Public Experience
Peter Marriner	PM	Lay Member, Business
<b>In Attendance:</b>		
Gerald Nyamhondoro	GN	Governance Officer(taking minutes)
Cath Leech ( <i>Agenda Items 3</i> )	CL	Chief Finance Officer
David Johnson ( <i>Agenda Item 3</i> )	DJ	Audit Manager, Grant Thornton

<b>1.</b>	<b>Apologies</b>
1.1	Apologies were noted from Dr Hein Le Roux, Dr Will Haynes and Jo Davies.
1.2	The meeting was confirmed as quorate.
<b>2.</b>	<b>Declarations of Interests</b>
2.1	There were no interests declared.
<b>3.</b>	<b>Mental Health Investment Standard (MHIS)</b>

3.1	CL presented the report and explained that Gloucestershire Clinical Commissioning Group (thereafter “the CCG”) was required to demonstrate, by way of a formal statement, that it had complied with the MHIS. In the event of not complying, the CCG was required to provide the reason as to why it had not complied.
3.2	CL stated that there was requirement for the statement to be validated by auditors. The CCG’s Auditor Panel had appointed Grant Thornton to carry out such a validation exercise. CL added that there was also a requirement to publish a statement as to whether the CCG had complied with the MHIS. CL stated that the deadline for publishing the statement was 31 October 2019.
3.3	<p>CL explained the CCG had originally calculated expenditure against the MHIS in 2017/18 and 2018/19 excluding prescribing costs as at that time it was felt that it was difficult to establish an accurate prescribing baseline for mental health. Guidance subsequently issued in June 2019, clarified the expectation that prescribing costs should be included and gave more detail on what should be included.</p> <p>In calculating the MHSI, CL explained that market pressures emanating from the general shortage of preferred prescription drugs (known as NCSO, no cheaper stock option), in the period covering 2017/18, led to the use of more expensive alternative drugs and this resulted in an increase in costs which were beyond the control of the CCG. This shortage in specific drugs was not seen to the same extent in 2018/19 resulting in a reduction in the overall cost of drugs in 2018/19.</p>
3.4	CL further explained that the CCG had not complied with the MHIS, and added that compliance with the MHIS would have been achieved if the increase in costs of the prescription drugs seen in 2017/18 were excluded from the calculation. CL clarified that the requirement to achieve the MHIS did not allow for fluctuations in the cost of prescription drugs.

3.5	AE concurred and added that as far as complying with the MHIS was concerned, what could be achieved was achieved and the drug prescription cost factor was beyond the control of the CCG.
3.6	DJ stated that the auditor appreciated the position of the CCG. The auditor was however bound by audit guidance, which had resulted in giving a qualified except for opinion. This was because the CCG had changed the original MHIS expenditure figures by including prescribing, which was a material change to the MHIS figures, however, the CCG statement of compliance is shown correctly.
3.7	<p>CL presented the Accountable Officer's MHIS statement which read as follows:</p> <p><i>The planning guidance for 2018/19 stated that each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall published programme funding.</i></p> <p><i>As the Accountable Officer of Gloucestershire CCG, I am responsible for the preparation of the Mental Health Investment Standard Compliance Statement (the "Statement") for the year ended 31 March 2019 and for the financial information that forms the basis of the calculation on which the Statement is derived. This includes the design, implementation and maintenance of internal control relevant to the preparation of the Statement to ensure that mental health expenditure is correctly classified and included in the calculations and that the Statement is free from material misstatement, whether due to fraud or error.</i></p> <p><i>To the best of my knowledge and belief I have properly discharged my responsibilities, with regard to reporting against the Mental Health Investment Standard</i></p>

	<p><i>NHS Gloucestershire CCG considers that it has not complied with the requirements of the mental health investment standard for 2018/19. The Gloucestershire ICS system had planned for and prioritised the required funding to deliver against the increase required by the Mental Health Investment Standard. However, the compliance assumes an adjustment relating to the non-recurrent national increased cost in primary care drug costs between the years relating to unavailability of preferred drugs and the required use of more expensive alternatives.</i></p> <p><i>If the national changes to drug prices are removed from the calculation, the CCG shows an increase in expenditure between the two years. The expenditure on services excluding primary care drugs shows an increase of 3.18% in 2018/19 compared to the CCG's allocation increase of 2.8%.</i></p> <p><i>In addition, in 2018/19, Gloucestershire spent £1,142k on the following areas:</i></p> <ul style="list-style-type: none"> <li><i>- Perinatal Mental Health Services (£711k)</i></li> <li><i>- Integrated Personal Commissioning (£130k)</i></li> <li><i>- Trailblazer for MH in Schools (£301k)</i></li> </ul> <p><i>This expenditure for services such as perinatal mental health does not count towards the Mental Health Investment Standard as it represents additional funding for 2017/18 and 2018/19. This funding has now been picked up as a local priority in 2019/20.</i></p>
3.8	<b>RESOLUTION:</b> The Audit & Risk Committee approved the Accountable Officer's MHIS statement and accepted the auditor's qualified except for opinion.
4.	<b>Any Other Business</b>
4.1	There was no other business to conduct.

**The meeting was closed at 10:55am**

**Date and time of the next meeting:**

**The next meeting would be held at 09:30am on Tuesday 17 December 2019, in the Board Room, Sanger House.**

Minutes Approved by the Audit & Risk Committee:

Signed (Chair): \_\_\_\_\_ Date: \_\_\_\_\_

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

**Minutes of the meeting held at 9.45am on 31 October 2019  
Boardroom, Sanger House**

<b>Present:</b>		
Alan Elkin (Chair)	AE	Lay Member, Patient and Public Engagement
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Julie Clatworthy	JC	Lay Member, Registered Nurse
Colin Greaves	CG	Lay Member, Governance
Andrew Hughes ( <i>deputising for Mark Walkingshaw</i> )	AH	Associate Director, Commissioning
Haydn Jones ( <i>deputising for Cath Leech</i> )	HJ	Associate Director of Finance (Business Intelligence)
<b>In Attendance:</b>		
Dr Tristan Cooper	TC	GP, Minchinhampton Surgery
Helen Goodey	HG	Director of Locality Development and Primary Care
Paul Atkinson	PA	Chief Clinical Information Officer
Declan McLaughlin ( <i>item 5</i> )	DMc	Senior Primary Care Project Manager
Jo White ( <i>item 5</i> )	JWh	Programme Director, Primary Care
Jeanette Giles ( <i>item 5</i> )	JG	Head of Primary Care Contracting
Fiona Robertson ( <i>item 6</i> )	FR	Associate Director for Digital Transformation, CSU
Lauren Peachey	LP	Governance Manager (minutes)

<b>1.</b>	<b><u>Apologies</u></b>
1.1	Apologies were received from Mary Hutton, Mark Walkingshaw, Cath Leech, Cllr Roger Wilson, Dr Andy Seymour, and Jo Davies.

1.2	It was confirmed that the meeting was quorate.
<b>2.</b>	<b><u>Declarations of Interest</u></b>
2.1	There were no declarations of interest raised.
<b>3.</b>	<b><u>Minutes of the Meeting held on 29<sup>th</sup> August 2019</u></b>
3.1	<p>The minutes of the meeting held on Thursday 29<sup>th</sup> August 2019 were approved subject to the following amendments:</p> <ul style="list-style-type: none"> <li>• Becky Parish should be recorded as ‘in attendance’;</li> <li>• Page 16: ‘JS’ should be changed to ‘JC’. JC requested that the section was expanded on to further clarify the requirement of clinical supervision and clinical governance. JC requested that it was made clear that a non-medical clinician would require a professional supervisor.</li> </ul>
<b>5.</b>	<b><u>Primary Care Strategy Final Version</u></b>
5.1	<p>HG introduced the final version of the Primary Care Strategy (PCS) and highlighted the following key points:</p> <ul style="list-style-type: none"> <li>• The Governing Body approved the original PCS in 2016;</li> <li>• There was an NHSE requirement for CCGs to refresh the PCS to reflect the NHS Long Term Plan (LTP);</li> <li>• The PCS reflected development themes for the next five years which had evolved from the original strategy to form six goals;</li> <li>• HG presented the PCS to the Integrated Care System (ICS) Board during October and noted that the ICS Board members were offered the opportunity to feedback;</li> <li>• HG emphasised that there had been a substantial amount of stakeholder engagement and input in to the</li> </ul>

	<p>PCS;</p> <ul style="list-style-type: none"> <li>The PCS was brought to the attention of the PCCC members for formal approval prior to being presented at the Governing Body on the 28<sup>th</sup> November 2019.</li> </ul>
<p>5.2</p>	<p>JC commended the Primary Care Team on the work that had been done to refresh the PCS. JC expressed concern that the PCS did not appear to show enough appetite for innovation with regards to Practice Nurses; for example additional detail on Practice Nurses within Primary Care in the report was far down the document. JC expressed concern that the information included in the PCS indicated no increased planning for the number of nurses working in Primary Care. JC however noted that there were some useful examples included within the PCS which expanded on the Primary Care nursing roles and recruitment.</p> <p>JC stated that there was a lot of work underway with regards to nurse recruitment and expanding the nursing role; however this was not being presented enough in the formal strategy. JC emphasised pressures were expected as a consequence of the volume of the nursing workforce due to retire. JC acknowledged that at this stage it may not be possible to offer more clarity around the future Practice Nurse roles and recruitment.</p>
<p>5.3</p>	<p>AE reiterated that, due to the volume of nurses who were expected to retire, there was an expected challenge in maintaining the current number of Practice Nurses. The lack of increase in planned primary care nurses may have been a reflection of this challenge.</p>
<p>5.4</p>	<p>HG acknowledged the feedback from JC and emphasised that nursing was recognised as a highly valuable service within Primary Care. HG highlighted an example of the Parachute Nursing Service, which had been led by GDoc and Julie Symonds, Deputy Director of Nursing at the GCCG. The service had been well-utilised and highly</p>

	<p>appreciated within Primary Care.</p> <p>However, HG reflected on the NHS England (NHSE) position with regards to the five additional reimbursable Primary Care roles and suggested that the reason why there were no additional nurses included as part of these roles was likely to be due to an ambition to protect the existing nursing services within the NHS. HG emphasised that Community and Primary Care nursing was key to integration.</p>
5.5	<p>AE highlighted there was need for strong links between nursing role in Primary Care and in the community. AE further noted that the community nursing role had expanded to cover aspects of nursing which were traditionally considered part of Primary Care nursing, and vice versa. HG agreed with AE and emphasised the benefit of an integrated way of working between the two nursing roles.</p>
5.6	<p>HG reiterated the need to protect the existing nursing service. MAE explained that whilst there had historically been a clear separation between primary care nursing and community nursing, she believed that this separation would dissolve and therefore result in a holistic service and integrated nursing resource for the population.</p>
5.7	<p>MAE stated that a Clinical Matron of Education and Clinical Development had recently been appointed. Part of this role was to identify the skills and expertise which were needed in Primary Care.</p>
5.8	<p>JW added that there were pilots underway which involved taking an integrated approach to working between primary care and community services. One such example included nurses undertaking minor illness work for GP practices, which benefited from Improved Access funding. The nurses were gaining experience in both injury and illness work and</p>

	building portfolio roles.
5.9	From a governance perspective CG cautioned that there needed to be clarity in that the ICS Board had an interest in PCNs from a strategic perspective although it was not the role of the ICS Board to become involved in operational aspects of the PCNs. AE concurred and indicated that this was a challenging area which needed to be set out clearly.
5.10	AE emphasised that it was important that the ICS should not be de-stabilising to other parts of the NHS. HG concurred that decision making would remain with the PCCC. HG added that PCCC had the delegated authority to make decisions on the GP contracts. HG stated that the PCNs formed part of the ICS and therefore the ICS Board were rightfully positioned to steer structures from a strategic level.
5.10	AE expressed some concern that if the structures were not clearly set out then there would have been a risk of decision making devolving to the ICS. HG agreed and noted this would become an issue to be kept under review.
5.11	JC observed that there was a significant amount of detail included in the digital section of the PCS.
5.12	<b>RESOLUTION: PCCC recommended the Primary Care Strategy to go to the Governing Body for approval.</b>
4.	<b><u>Matters Arising</u></b>
4.1	<b>Item 8.1, 28/03/2019, Primary Care Premises Report</b> AH advised that this item was to be covered during the confidential section of PCCC <b>Item to be closed</b>
4.2	<b>Item, 8.4, 29/08/2019, Primary Care Quality Report:</b>

	<p><b>Practice Nurse Newsletter</b></p> <p>MAE confirmed that the Practice Nurse Newsletter had been circulated.</p> <p><b>Item to be closed</b></p>
4.3	<p><b>Item 8.5, 29/08/2019, Primary Care Quality Report: PALS support to the CCG</b></p> <p>BP had included a summary of the support undertaken by the Patient Engagement Team within the PALS section of the Primary Care Quality Report.</p> <p><b>Item to be closed</b></p>
<b>6.</b>	<b><u>Primary Care Strategy Goal 5: Digitally Enabled</u></b>
6.1	<p>FR presented an update on the Primary Care Strategy Goal 5: Digitally Enabled. FR summarised the key points as follows:</p> <ul style="list-style-type: none"> <li>• There were a vast number of systems and ways of working across the ICS;</li> <li>• The aims were to develop ways to simplify and improve the ability of working digitally to identify actions that could be taken across the system. These would ensure a good foundation to find digital solutions to support better ways of working for clinicians and patients;</li> <li>• The digital aspect of the PCS was focussed on specific areas which included upgrading infrastructure, joining up business intelligence and reporting solutions, and streamlining systems and tools;</li> <li>• The digital strategy was divided into six work-streams.</li> </ul>
6.2	<p>FR explained that the first work-stream namely “Empowering the Person” focused on supporting patients and residents to use technology wherever it was appropriate for them to do so. This would include simplifying the route for appointment booking or repeat prescription services.</p> <p>FR described the two online consultation systems being rolled out across the county and the programme of work</p>

	<p>around consolidation of websites across General Practice in the county to facilitate patient usability.</p> <p>FR added that all practices were using Patient Online which enabled patients to access their records online and approximately 26% of patients were using this new tool.</p>
6.3	<p>AE queried the feedback from General Practice on the guidance which stated that practices were to ensure that 25% of daily appointments were made available online.</p> <p>PA advised that practice feedback indicated a low level of tension between two targets which included the aim of making 25% of daily appointments available online and the work underway which focussed on care navigation. PA highlighted the need to consider the ways in which these targets could be interpreted. AE agreed with this statement and noted the need to take a practical approach and understand the pressure and demand on the practices.</p>
6.4	<p>PA emphasised that it was not only GP appointments that could be booked online but could include a wider range of appointments, including phlebotomy appointments. PA explained that there was evidence which strongly suggested that patients who booked their own appointments were more likely to cancel if they were unable to attend.</p>
6.5	<p>FR continued the presentation and highlighted that an increasing number of patients were using Electronic prescribing Service (EPS).</p> <ul style="list-style-type: none"> <li>• The next version of EPS was due to be rolled out which would make it easier for patients to receive electronic prescriptions;</li> <li>• Gloucestershire population was above national average of people using the EPS.</li> </ul>
6.6	<p>FR provided an update on the second work-stream namely 'Digital Maturity' and advised that this work-stream focused on the systems that were being used and improving the digital maturity. FR noted that there had been a number of</p>

	<p>requests from practices to change systems and this was due to PCNs' realisation of the benefits of sharing an integrated system. FR noted the local cost burden of changing systems. Furthermore, due to a change in contract, a re-procurement of all GP clinical systems was going to be required over the next 12 months.</p>
6.7	<p>FR highlighted that there was work underway to support GPs to obtain advice from clinicians in secondary care. GPs were able to contact clinicians across a number of disciplines within secondary care. Initial reports indicated that this project had been making a positive impact. It had been indicated that, when a GP used this service, 57% of patients either avoided an Emergency Department attendance; or were managed in Primary Care; or were referred directly to the most appropriate service. PA added that there had been very positive feedback received from clinicians regarding this service.</p>
6.8	<p>FR summarised the third work-stream namely 'Information Sharing' and drew the attention of the committee to the following key points:</p> <ul style="list-style-type: none"> <li>• 'DocMan': a system to support the sharing of electronic documentation was being rolled out;</li> <li>• Joining up Your Information (JUYI) had been in place for just over 12 months and had had over 50,000 views. This was considered to be a high usage;</li> <li>• The next stage of JUYI was to share acute data and roll it out across GP practices;</li> <li>• There was work underway with One South West Local Health &amp; Care Record (LHCR) to review how to share information across the South West;</li> <li>• Summary care records and 111 appointment booking were due to be implemented.</li> </ul>
6.9	<p>CG enquired as to whether Gloucestershire Hospitals NHS Foundation Trust (GHNSFT) was due to be transitioning from their current system to an Electronic Patient Record</p>

	(EPR) system. FR advised that this was being implemented and the underlying data was to be taken from the existing database. This was going to be a two year programme.
6.10	In terms of the fourth work-stream namely 'Infrastructure', FR highlighted that over the next 12 months the equipment and software in GP practices would be upgraded and this represented a significant amount of work. In addition to this a Single Domain was to be implemented which would enable GP practices to more easily share documents and information. FR added that anti-virus software was going to be upgraded and cyber security tools were being developed. With regards to supporting collaboration, 'Skype for Business' was being trialled in the Cotswolds for the Multi-Disciplinary Team (MDT) meetings.
6.11	FR stated that the fifth work-stream namely 'Whole Systems Intelligence' which involved ensuring the right information could be provided to practices and other service in the system. FR added that Gloucestershire had a rich pool of joined up data which enabled a substantial source of pseudonymised data. FR clarified that the ambition was to link this data with adult social care data.  In terms of demand and capacity management FR outlined a system called 'SHREWD' which allows real time data to be accessed. This system provided urgent care teams the ability to quickly identify system pressures and take prompt action at an early stage. FR explained that the pressure to the system however lay in that it relied on data being input at a real-time pace.
6.12	FR summarised that the final work-stream namely 'Workforce and Delivery' was key to supporting the digitally enabled aims.
6.13	FR concluded the presentation by explaining that there had

	<p>been a Network Outage during October 2019 which took time to fully resolve. JC suggested to FR that this issue was formally reported as an incident. CG however expressed concern over the length of time it took to resolve the issue. FR responded that the problem was challenging to fully resolve quickly due lack of contract management of the N3 contract with British Telecommunications (BT). The link had been repaired quickly however it was not robust and continued to fail.</p> <p>CG noted with concern that, at a meeting with BT, FR had challenged them on network reliability and assurance had been provided that this issue would not happen. FR advised that a lesson had been learnt and a report had been submitted to the GCCG.</p>
6.14	<p>AE suggested that it would be helpful if there was a demonstration of the clinical systems. FR could arrange a demonstration which could take the committee through a patient journey on the system.</p> <p>It was agreed that a dedicated systems demonstration workshop would be held for members.</p> <p><b>ACTION: Arrange system demonstration workshop. FR/PA to liaise with LP.</b></p>
6.15	<p><b>RESOLUTION: The committee noted the contents of the presentation.</b></p>
6.16	<p><i>PA and FR left at 10:50</i></p>
6.17	<p><i>Dr Tristan Cooper (TC) joined the meeting at 10:50</i></p>
7.	<p><b><u>Business Case for a new Premises for Minchinhampton Surgery</u></b></p>
7.1	<p>AH introduced Dr Tristan Cooper, a partner from Minchinhampton Surgery who had joined PCCC to take questions from the committee with regards to the premises.</p>

7.2	<p>The business case for the new premises proposal was taken as read and AH summarised the following key points:</p> <ul style="list-style-type: none"> <li>• The business case explained the rationale of relocating the Minchinhampton Practice at Bell lane to a purpose built centre at Cirencester Road;</li> <li>• The new premises would be large enough for a list size of approximately 9000 patients;</li> <li>• The premises would include facilities to support GP training;</li> <li>• Subject to approval the premises would be open in Autumn 2021;</li> <li>• The total capital costs were estimated at £3.65m;</li> <li>• There were upwards of 50 car parking spaces planned;</li> <li>• AH confirmed that the full revenue rental requirements was £182,600;</li> <li>• The total annual revenue requirements net request was £224,598 and there was an existing reimbursement of rates of £49,222 per annum therefore resulting in a net request of £175,376;</li> <li>• The business case had factored in the GP IT requirements;</li> </ul> <p>AH stated that the business case adequately set out the case for change, objectives, key benefits and outcomes, and the financial implications for the new premises.</p>
7.3	<p>HJ asked AH to elaborate on the whether this would be a departure from the Premises Costs Directions. AH advised that this was not a departure and explained that there was a reimbursement model which was followed.</p>
7.4	<p>AE commended AH on the report on the business case and stated that the explanation given in the report supported effective decision making.</p>
7.5	<p>MAE noted that there was an active Patient Participation Group (PPG) at Minchinhampton Surgery and it was</p>

	encouraging to note that the group had been actively involved in the planning, and their ideas had been included in the design. TC concurred and advised that, subject to approval, the PPG would continue to be involved this project.
7.6	JC enquired about potential hidden costs of building on the site. TC advised that there had been no indication that there would be additional costs, however there had been a contingency fund allocated. JC added that there were going to be surveys undertaken at the site upon the approval of the business case.
7.7	With regards to sizing AH explained how the practice size was determined including space for training and on site pharmacy. The size of the premises had factored in population growth.
7.8	MAE asked if there would be any issues regarding planning permission and AH responded that the premises development were subject to planning approval. TC added that the former owner of the land had stipulated that the land should be used for public good and the Parish Council was in support of this. MAE noted that this was encouraging.
7.9	HG enquired about the population growth and AH advised that there were housing developments planned nearby which would be in the catchment area of the new premises.
7.10	CG enquired about the 'one off' IM&T cost and asked if there would be reimbursement from NHSE. <b>Action: HJ to confirm the IM&amp;T cost and asked if there would be reimbursement from NHSE.</b>
7.11	CG further enquired about the issue of transport and observed that the new premises would be out of town. TC responded that there was a bus route and a bus stop nearby; however the bus ran infrequently. TC informed the

	committee that there was a very active PPG volunteer driving scheme.
<b>7.12</b>	<b>RESOLUTION: The committee approved the business case for the new premises for Minchinhampton Surgery.</b>
<b>8.</b>	<b><u>Primary Care Quality Report</u></b>
8.1	MAE informed the committee that CareUK 111 Southwest had recently been inspected by the CQC and was awarded an 'Outstanding' rating. The CCG had written a formal letter of congratulations to CareUK 111 commending them on their efforts. MAE clarified that this related specifically to the CareUK 111 service and not the Out of Hours service.
8.2	MAE informed the committee that the National Institute of Clinical Excellence (NICE) had issued a Technology Appraisal (TA) with regards to the use of direct-acting oral anticoagulants (DOACs). This had been issued with tight restrictions. The NICE TA recommended that DOACs were to be prescribed for a specific cohort of patients who had peripheral vascular disease and heart failure. The current guidance had a cost impact of approximately £500,000 per annum.
8.3	With regards to safeguarding MAE noted that the update would be limited to the areas which had a direct impact on Primary Care. MAE explained that the independent review of the Multi-Agency Safeguarding Hub (MASH) had been completed. Due to the demanding workload going into the MASH the CCG Core Group had agreed the investment for a Band 6 WTE Nurse. MAE explained that when the additional nurse was in post, GPs would start to receive feedback on their referrals.
8.4	In terms of CQC inspections MAE advised that the new Annual Regulatory Reviews (ARRs) system was underway with a significant number of practices having completed this process. This involved practices providing information to the CQC followed by a phone call in which the information was

	<p>discussed. There would be a follow up visit by the CQC if there were still concerns following the phone call. All practices who had a review score of good or outstanding had maintained their score and it was expected that several practices would be improving their rating from good to outstanding in the following year.</p>
8.5	<p>MAE advised members that if a GP surgery changed their registration they were subject to a full CQC inspection within their first year.</p> <p>CG asked if CQC still reserved the right to undertake an unannounced inspection at General Practice and MAE confirmed that they had such right.</p> <p>MAE advised that there had been a significant incident at a GP surgery in Gloucestershire in which a patient had passed away on the premises. MAE explained that this had been reported to the CQC and the CQC was satisfied with how the incident had been handled by the GP surgery.</p>
8.6	<p>MAE highlighted that a good amount of progress had been made at the Dean Neurological Centre care home. Hannah Williams, from the CCG, continued to visit the care home on a regular basis. MAE had been contacted by other CCGs querying whether they could place patients at the Dean Neurological Centre and MAE advised that they could place patients at this care home. MAE added that a new service director for the Dean Neurological Centre had been appointed and was due to commence in post from the end of November 2019.</p>
8.7	<p>With regards to patient experience MAE highlighted that there was additional information about the 'other' category of calls within the Patient Advice and Liaison Service (PALS) team. MAE provided a brief update on the issues that were raised. MAE summarised that a number of these calls were not appropriate for the GCCG PALs and included</p>

	requests for phone numbers for other services and GHFT PALS.
8.8	MAE summarised that the GCCG Patient Experience and Engagement and Communications Teams had been involved in planning Fit for the Future engagements.
8.9	MAE stated that some changes were due to be made to the Friends and Family Test (FFT). AE commented that the changes were subtle; however the case studies provided in the FFT NHSE guidance were useful. AE enquired as to whether the FFT had produced case studies or encouraged change within the Gloucestershire system. MAE responded that there were no changes known with regards to this specifically relating to Gloucestershire.
8.10	MAE explained that GCCG Engagement Team continued to provide support to General Practice particularly where there were significant practice changes underway. MAE added that the PPG network continued to be well attended.
8.11	<p>In terms of Primary Care Education MAE highlighted that the CCG had received an increase in funded places for Non-Medical Prescribers from NHSE for the academic year 2019/20. MAE noted that the CCG had provided additional funding in addition to these places. Furthermore NHSE had funded £10,000 to support practice nurse development.</p> <p>The GCCG Clinical Learning and Development Matron had commenced post and had been working with local providers to identify training needs and support practice nurses.</p>
8.12	With regards to a prescribing update MAE stated that there was a prescribing savings plan being worked through, however there were significant challenges arising from Category M pricing changes. In addition to this there was a

	<p>lack of some lower cost prescriptions being available resulting in more expensive prescriptions being issued. MAE stated that the shortage was an ongoing issue.</p> <p>MAE highlighted that there had been concern raised due to the recruitment of Prescribing Support Pharmacists (PSPs) to GP practices to work as Clinical Pharmacists as this resulted gaps in prescribing support coverage in the county. MAE stated that the recruitment of additional PSPs and pharmacist technicians was underway.</p>
<p>8.13</p>	<p>MAE provided an update on the work underway with Prescribing Support Dieticians to include supporting the implementation of Over The Counter (OTC) prescribing guidelines such items such as Vitamin D.</p> <p>New guidance relating to the prescribing of Vitamin b12 was being formalised with the aim of ceasing prescribed vitamin b12 injections and encouraging patients to purchase oral supplements of vitamin b12 over the counter following recent evidence on the effectiveness of oral supplements of vitamin b12.</p>
<p>8.14</p>	<p>In terms of flu vaccinations MAE stated that there was a seasonal flu vaccination plan in place. MAE added that from November onwards, there were weekly multi-agency telecoms in place in which real-time information could be shared and actions could be identified regarding infection control and managing outbreaks.</p> <p>MAE also stated that flu vaccinations for the under 65s had been delayed; however these were due to begin arriving. MAE added that there had also been a shortage of the nasal spray flu vaccinations for children of primary school age which were also due to begin arriving.</p>

8.15	<b>RESOLUTION: The contents of the Primary Care Quality Report were noted.</b>
9.	<b>Primary Care Delegated Financial Report</b>
9.1	<p>The report was taken as read and HJ summarised the following key points:</p> <ul style="list-style-type: none"> <li>• As at 30<sup>th</sup> September 2019 there was a year to date underspend of £117,000 on the delegated primary care budget;</li> <li>• The reasons for the underspend were outlined within the report;</li> <li>• There were a number of risks to the budget which had been explained within the report;</li> <li>• The CCG was forecasting a £23k overspend against the delegated budget for 2019/20.</li> </ul>
9.2	<p>AE asked HJ to expand on the internal processes which had been put in place to try to mitigate the risk relating to sickness and maternity pay. HJ responded that spend commitments were being reviewed and identifying where there could be slippage elsewhere within that system. AE expressed that there was a concern that the CCG was receiving post-dated claims.</p> <p>JG added that the Primary Care team were meeting with practice managers on a regular basis and during these meetings they were reminding them to submit their claims on a timely basis.</p>
9.3	<p>AE requested that HG to elaborate on the risk around pharmacists and HG responded that this risk reflected the NHSE wave pharmacists who were expected to form part of the Primary Care workforce and the financial costs to the GCCG for this year. HG clarified that the cost of these pharmacists would be reimbursable from the financial year 2020/21.</p>

9.4	With regards to the figures in the report CG observed that the budget was not balanced and speculated that this was due to changes within the GMS and APMS contracts. HG agreed that this was due to a temporary contract. CG stated that this issue was expected to be resolved for the following year.
9.5	<b>RESOLUTION: The committee noted the contents of the Primary Care Delegated Financial Report.</b>
10.	<b><u>Any Other Business</u></b>
10.1	There was no other business raised.
	The meeting closed at 11:35
11.	<b><u>Date and time of next meeting</u></b>
	The next PCCC will be held on Thursday 19 <sup>th</sup> December 2019 at 9.45am in the Board Room, Sanger House.

## Quality and Governance Committee (Q&GC)

**Minutes of the meeting held on Thursday 10<sup>th</sup> October 2019 at  
9.30am, in the Boardroom, Sanger House**

<b>Present:</b>		
Dr Caroline Bennett	CB	Chair GP Liaison Lead (Quality Lead GHFT)
Dr Marion Andrews-Evans	MAE	Executive Nurse & Quality Lead
Mark Walkingshaw	MW	Deputy Accountable Officer and Director of Commissioning Implementation
Alan Elkin	AE	Lay Member, PPE
Dr Will Miles	WM	GP Governing Body member (Quality Lead – GCS)
Katie Hopgood	KH	Consultant in Public Health, GCC
Dr Lawrence Fielder (09:35 – 12:00)	LF	Commissioning Lead, GP Governing Body member ( <i>Quality Lead – 2G</i> )
Cath Leech	CL	Chief Finance Officer
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Teresa Middleton	TM	Deputy Director of Quality
Dr Lesley Jordan	LJ	Secondary Care Specialist
Peter Marriner	PM	Lay Member

<b>In Attendance:</b>		
Lauren Peachey	LP	Governance Manager (minutes)
Becky Parish	BP	Associate Director, Engagement and Experience
Hannah Williams	HW	Senior Nurse Lead- Community Quality and Commissioning
Julie Symonds	JS	Deputy Director of Nursing

<b>1.</b>	<b>Apologies</b>
1.1	Apologies were received from Julie Clatworthy, Julie Symonds, Dr Alan Gwynn, Mary Hutton, and Annette Blackstock
1.2	The meeting began at 9:35 am.  It was confirmed that the meeting was quorate.
<b>2.</b>	<b>Declarations of Interest</b>
2.1	WM raised a declaration of interest with regards to the agenda item 5.4: GHFT Quality Report in which a patient who had been referred to had made a complaint to the practice.  AE raised a declaration of interest for agenda item 8: Mental Capacity Act (MCA) policy as his wife had undertaken a significant amount of work in Gloucestershire relating to Mental Health.  The usual GP interests were raised specifically with regards to the item under AOB: Vitamin b12 Suggested Regimes and Criteria.
<b>3.</b>	<b>Minutes of the Meeting held on Thursday 8 August 2019</b>
3.1	The minutes of the meeting held on 8 August 2019 were agreed on the condition that the following amendments were made: <ul style="list-style-type: none"> <li>• <b>Attendances:</b> PM to be included on the list of members present.</li> <li>• <b>Item 10.5.1:</b> CB requested that this was re-worded to: “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.”</li> </ul>
<b>4.</b>	<b>Matters Arising and Actions</b>
4.1	<b>QGC Item 5.1, 18/10/2018, Children’s Services</b>  <b>Update 10/10/2019</b> MAE informed the committee that a monitoring visit took place on the 5 <sup>th</sup> September 2019. There had been an Improvement Board which

	<p>was attended by MAE, Deborah Lee (Chief Executive, GHFT) and Mary Hutton (Accountable Officer, CCG). The focus of the monitoring visit was on Children in Care (CiC). An action monitoring letter had identified two key issues to include a lack of mental health support to young people leaving care; and a health passport for children aged over 16 not being received by all eligible children. The latter issue had been further investigated and it was found that children aged over 16 were receiving their health passport. A further OFSTED visit was expected to be arranged to take place early in 2020. MAE noted that there had been some improvements however record keeping and the reliance on agency staff were still a concern.</p> <p>CB asked if MAE had the opportunity to raise concerns at the Improvement Board in terms of Children's Services communication with GPs. MAE confirmed that these concerns had been raised and the local authority had claimed that they were unable to inform GPs of the children's transitions through the system due to data protection considerations.</p> <p><b>Item to remain Open.</b></p>
4.2	<p><b>Q&amp;GC Item 5.1.6, 13/06/2019, Research and Development</b></p> <p><b>Update 10/10/2019</b> BP advised the committee that an editorial of the Research and Development Conference which had been discussed previously was being produced and this editorial would be circulated when it was complete.</p> <p><b>ACTION: The editorial on Research and Development conference to be circulated to the committee when available.</b></p> <p><b>Item to remain open</b></p>
4.3	<p><b>Q&amp;GC Item 5.3.iii, 13/06/2019, Palliative Care in relation to Training and DOLs and the MCA</b></p> <p><b>Update 10/10/2019</b> CGi informed the committee that this matter would be addressed under Agenda Item 8: Mental Capacity Act (MCA) Policy. CGi had circulated a link to the online MCA training to members of the committee. CGi further advised that Simon Thomason was planning a visit to the CCG to lead a 'Lunch and Learn' session on the MCA and extended an invite to members of the committee to join. The Continuing Health Care</p>

	<p>(CHC) team at the CCG have received training on the MCA.</p> <p><b>Item to be closed</b></p>
4.4	<p><b>Item 5.7.4, 13/06/2019, LeDeR</b></p> <p><b>Update 10/10/2019</b> MAE and JS advised that the LeDeR was due to be published and would be circulated to the members of the committee. MAE informed the committee that additional funding had been received to continue with the LeDeR work.</p> <p><b>ACTION: The LeDeR Report to be circulated to members of the committee when it had been published.</b></p> <p><b>Item to remain open</b></p>
4.5	<p><b>QGC Item 5.1.3 13/06/2019, Clinical Effectiveness and TAs</b></p> <p><b>Update 10/10/2019</b> This item was going to be addressed within Agenda Item 6: Presentation on DOAC and the Impact on Stroke Rates.</p> <p><b>Item to be closed</b></p>
4.6	<p><b>Q&amp;GC Item 5.1.3, 08/08/2019, Risk: Nursing Home Agency Staff</b></p> <p><b>Update 10/10/2019</b> CGi advised that the recording of the 'high use of agency staff in nursing homes' as a risk formed part of a wider piece of work around inputting risks on to the recently implemented risk management software, 4Risk. CGi and LP had booked training sessions with colleagues to record risks and input them on to 4Risk.</p> <p><b>Item to be closed.</b></p>
4.7	<p><b>Q&amp;GC, Item, 5.0.7, 08/08/2019, Quality Report, PALS</b></p> <p><b>Update 10/10/2019</b> MAE had discussed the 'other' category of calls with the PALS team and provided a brief update on the issues that are received. It was summarised that there were a number of unusual issues that do not fit into a pre-existing category. Some of these issues included requests for phone numbers for non-NHS related services, general information, relationship advice and some phone calls were intended for GHFT</p>

	<p>PALS and were subsequently redirected.</p> <p><b>Item to be closed</b></p>
4.8	<p><b>Q&amp;GC, Item, 5.4.1.1, 08/08/19, GHFT CQRG Minutes, Videofluoroscopy Issue</b></p> <p><b>Update 10/10/2019</b></p> <p>JS has received an update with regards to the videofluoroscopy issue previously highlighted in the GHFT CQRG minutes. GHFT were exploring the option of loaning equipment as an interim measure whilst their equipment was out of service. HW advised that that GCS had trialled laryngeal imaging equipment which can be used as an alternative to videofluoroscopy. The funding to purchase this equipment had been agreed. CB asked if HW was assured that there was no harm coming to patients as a result of this issue and HW responded that, due to the acquirement of laryngeal imaging equipment, patients had received the appropriate assessment.</p> <p><b>Item to remain open</b></p>
<b>5.0</b>	<b>County Wide Quality Report</b>
5.0.1	<p>The report was taken as read and MAE stated that the CareUK 111 service had recently received an 'Outstanding' OFSTED report and noted that this was the first 111 service in the country to receive this rating. An emphasis was put on the outstanding rating for the 'safety' category in the report. The CCG had written a letter to CareUK to congratulate them on this achievement.</p>
5.0.2	<p>With regards to the South West Ambulance NHS Foundation Trust (SWASFT) there had been a risk recorded with regards to response times which had a risk rating of 25. This had prompted a Single Issue Quality Surveillance Group (QSG) to look at the risk of 'call stacking'. MAE advised that the risk score had been downgraded to 20 earlier in 2019. Following a further assessment the local risk score had been confirmed at 12 and this was the score that reflected the service that Gloucestershire patients were receiving. This score was on par with surrounding CCGs.</p> <p>MAE informed the committee that the Single Issue QSG was to be stood down for this item.</p>

	MW acknowledged that this remained a serious issue and although there was a strong overall SWASFT position within the county there had been significant additional investment this year which had enabled SWASFT to purchase an additional ambulance.
5.0.3	<p>LF highlighted that paramedics were a limited resource and were also in demand within the Primary Care Networks (PCNs) in addition to ambulance services. MAE noted that the local university recruited a full cohort of paramedics during the latest intake. MW added that SWASFT were training emergency care assistants to work alongside paramedics.</p> <p>WM observed that the nature of paramedic work involved in Primary Care was significantly different to the more traditional paramedic work and MAE agreed with this observation. MAE added that the next cohort of paramedic training at the local university was fully subscribed with applicants. It was expected that this cohort of paramedic trainees were going to complete some of their training in Primary Care.</p> <p>PM asked if SWASFT were up to quota with both vehicles and staffing levels and MW advised that both of these in line with the plan.</p>
5.0.4	With regards to Clinical Effectiveness TM advised that there was a decrease being seen in Over The Counter (OTC) prescribing and added that there was still further opportunity to decrease OTC prescribing in Gloucestershire. There had been a national drive to encourage patients to purchase their medicines over the counter when available and it was acknowledged that this had an impact locally.
5.0.5	MAE drew the attention of the committee to item 5.3: The Gloucestershire Multi-Agency Safeguarding Hub (MASH) Health Function Review Report.
<b>5.3</b>	<b>Gloucestershire MASH Health Function Review – Report</b>
5.3.1	MAE summarised that referrals into the MASH had increased since Children’s Service were placed under special measures. The report was clear that additional resources were required, and funding had been agreed for a part time band six nurse, however a reorganisation of the resources was also identified as necessary for service improvement. MAE noted that the MASH had significantly improved since receiving a poor OFSTED rating.

5.3.2	<p>Annette Blackstock had undertaken a visit to the 'Outstanding' rated MASH service in Hampshire as a learning exercise and it was observed that a referral would prompt a ten minute focussed strategic discussion. MAE stated that a similar discussion in Gloucestershire could have taken up to one hour.</p> <p>CB asked MAE what additional risks were manifesting as a result of the additional workload into MASH and MAE responded that the staff team were working hard to manage risks; however this way of working was not sustainable. CB queried the staff turnover in the MASH team and MAE stated that, despite the heavy workload and stressful environment, staff turnover was very low.</p>
5.3.3	<p>PM queried what the timescales were to achieving the planned recovery milestones and MAE advised that MASH were promptly carrying out the actions as soon as feedback was identified. The actions relevant to the CCG had been completed and additional proposed actions were planned to go to the MASH Board where decisions on which actions to take forward would be made.</p>
5.3.4	<p>The Children in Care (CiC) team had struggled to manage the substantial workload. It was noted that every child under the age of five had a six monthly health checks and children aged six and over had an annual health check. MAE emphasised this was a considerable volume of work to undertake. There were approximately 1000 children requiring these regular health checks in Gloucestershire.</p> <p>MAE had requested that the CiC team explore digital alternatives to face to face health checks; following appropriate risk assessments.</p> <p>BP noted that the environmental impact on taking children to hospital for their annual health checks should be considered and there was a brief discussion on the harmful effects of traffic pollution on respiratory health.</p>
5.3.5	<p><b>RESOLUTION: The committee noted the Gloucestershire MASH Health Function Review – Report</b></p>
5.0.6	<p>MAE took the committee back to the County Wide Quality Report. Regarding the Serious Incidents and Significant Events in Primary Care it was confirmed that a patient had collapsed and died whilst on GP</p>

	<p>premises and this patient was registered with a Forest of Dean practice. It was noted that when the patient collapsed on the site the appropriate actions were taken by the practice team. It was agreed that the learning from this would be captured. The committee discussion touched on the robustness of the practices arrangements for organising locum cover.</p>
5.0.7	<p>HW provided an update on 'The Dean Neurological Centre'. HW informed the committee that there were currently 49 residents in The Dean Neurological Centre. There had been a temporary suspension on admissions which had been subsequently lifted in agreement with the Care Quality Commission (CQC). The admission criteria had also been revised.</p> <p>There had been no serious incidents reported within the last 8 weeks and The Dean Neurological Centre was continuing to submit monthly reports to the CQC. The CQC had advised the CCG they were satisfied with the level of detail being shared with them. The CQC had advised that they were considering reviewing the 'Well Led' aspect of their report during November 2019.</p>
5.0.8	<p>In terms of staffing at The Dean Neurological Centre there was a newly appointed Hospital Director, Sue Field, and HW advised that a clinical matron had not yet been recruited. Three full time registered nurses had been recruited and one at 0.53 FTE which meant that there was a full complement of nursing staff. HW informed the committee that all of these nurses had strong experience in neuro-rehabilitation. There was a Clinical Trainer who had been in post for eight weeks.</p> <p>HW had discussed The Dean Neurological Centre with Wiltshire and Bristol CCG and they had reported to HW that they were confident that improvements were being made. Local GPs also reported improved communication. HW had also discussions with the pharmacy and they had noticed subsequent improvements in the quality of prescriptions and a reduction in the number of delivery errors and missed medication doses.</p>
5.0.9	<p>An audit at The Dean Neurological Centre was ongoing and the findings were being shared with the CQC and the CCG. A new mandatory training programme, Confident to Care, had been launched within the last eight weeks and it was noted that this had been well responded to.</p>

	<p>There had been no recent concerns raised by the patient's family members and HW highlighted that, historically, family members had always been confident with raising concerns.</p> <p>CB asked HW if the GHFT residents had been discharged back to The Dean Neurological Centre and HW advised that this had not happened yet and there was a phased approach planned.</p>
5.0.10	<p>CB directed the group to discuss the Patient Experience and Engagement aspect of the County Wide Quality Report and BP advised that alterations to the Friends and Family Test (FFT) had been announced. The details of the changes were yet to be confirmed; however it was known that the response options had been added to and it was expected that this may have provided a richer data-set.</p>
5.0.11	<p>BP updated the committee on the Fit for the Future engagement. A number of workshops had been held and there was an upcoming focus on locality workshops. An engagement hearing was planned for 24<sup>th</sup> October 2019 in which attendees could put forward their views to a panel of clinicians and senior managers. The engagement hearing would be held in public and in would also be live screened and recorded. BP advised that there were seven individual groups and individuals who had confirmed attendance.</p> <p>The planning and recruitment for a Citizens Jury, which would focus on the Centres of Excellence questions, was underway. It was highlighted that the Citizens Jury recruitment was not managed by the NHS.</p> <p>KH queried if Urgent Care would be included as part of the Citizens Jury and BP advised that, in terms of Urgent Care, items specifically relating to Acute Emergency Medicine aspect of urgent care would be considered.</p>
5.0.12	<p>Regarding Primary Care Education JS informed the committee that the CCG Clinical Learning and Development Matron, Helen Acock, had commenced post. Funding had been secured to run a number of practice nurse events focussed around the needs which had been identified during a training needs analysis. This included but was not limited to the Parachute Model and new G-Doc nurse coordinators.</p>
5.0.13	<p>With regards to Non-Medical Prescribing training MAE noted that the CCG had been allocated an increase in funded places for the academic year 2019/20.</p>

5.0.14	<p>MAE noted that there was a concern that the recruitment of Practice Prescribing Support (PSP) Pharmacists into GP practices as Clinical Pharmacists had created short-term gaps in the prescribing support coverage. A recruitment process had commenced to recruit replacement PSPs.</p> <p>WM highlighted that there had been feedback received from pharmacists relating to the significant amount of time taken to track down medication that had been in short supply. It was discussed that some hard to find medications could be more cost effective. The result of these not being available could lead the GPs to resorting to less cost-effective options.</p> <p><b>ACTION: TM to discuss the difficulty to source medications and the cost effective options with Mark Gregory.</b></p>
5.0.15	<p>CB drew the attention of the committee to the item under AOB: Vitamin B12 Suggested Regimes and Criteria.</p>
5.0.16	<p><b>Vitamin B12 Suggested Regimes and Criteria</b></p>
5.0.17	<p>CB summarised that the Pathology Optimisation Group had undertaken a review of the prescribing of Vitamin B12 moving from injections to oral consumption. A guideline on this had been written and this had been taken to the Clinical Effectiveness Group (CEG).</p> <p>The Over The Counter (OTC) oral vitamin B12 was available in a larger dosage to the prescribed injection of vitamin B12.</p> <p>CB suggested that the committee recommended the provision of re-visiting the original guideline and noted that this would require the support of the Medicines Optimisation team and a review of the evidence and costs involved. It was agreed that this would need to be brought back to Q&amp;GC at a later date.</p> <p>MAE noted that the cost of prescribing vitamin B12 was significantly more than the cost of purchasing it over the counter which was about £10 /year.</p> <p>TM and MAE highlighted that there needed to be clear guidance available for patients and GPs.</p>
5.0.18	<p>CL emphasised that this represented a cost impact to the CCG if the</p>

	<p>transfer to oral was not an OTC and requested that clear timescales for a resolution on how this would proceed were promptly identified.</p> <p>TM advised that the next Clinical Effectiveness Group was due to take place in November 2019 and it was agreed that a paper with recommendations would be taken to this group.</p> <p><b>ACTION: TM to take recommendations to the Clinical Effectiveness Group in November 2019 and feed back to the Q&amp;GC in December 2019.</b></p>
5.0.19	<p>With regards to informing GPs of the potential changes to be made to the prescribing of vitamin B12, CB suggested that a holding statement was sent out to all practices in the interim and it was further suggested that this could also be made available on G-Care.</p> <p><b>ACTION: A holding statement relating to the prescribing of vitamin B12 to be included on to G-Care. CB.</b></p>
5.0.20	<b>RESOLUTION: The committee supported the review of the prescribing of vitamin B12</b>
5.0.21	<p>In terms of Flu vaccinations MAE informed the committee that countywide Flu vaccination plans were in place.</p> <p>LF observed that children's flu vaccination had been slow to be made available and queried if there were any issues with this. CB advised that there were now no issues and the children's vaccinations were coming through.</p>
<b>5.1</b>	<b>Clinical Effectiveness Group (CEG) Minutes</b>
5.1.1	<b>RESOLUTION: The committee noted the Clinical Effectiveness Group (CEG) Minutes</b>
<b>5.2</b>	<b>Effective Clinical Commissioning Policies (ECCP) Working Party Minutes</b>
5.2.2	<b>RESOLUTION: The committee noted the Effective Clinical Commissioning Policies (ECCP) Working Party Minutes</b>
<b>5.4</b>	<b>GHFT Quality Report</b>

5.4.0.1	<p>The report was taken as read and JS informed the committee that since the previous report there had been one Never Event which resulted in a patient in the Department of Critical Care (DCC) being connected to air instead of oxygen for a brief amount of time. JS informed the committee that no harm had come to the patient and the error had been quickly rectified. There had been a subsequent removal of the air flow meters from DCC on both hospital sites.</p> <p>LJ noted that this was not an unusual Never Event and was known to happen in other hospitals in the country. MAE highlighted that this matter had been raised at the Quality Surveillance Group.</p>
5.4.0.2	<p>JS continued the update by summarising that of the Serious Incidents (SI) reported in the GHFT Quality Report there was a complex case which was being investigated further. There was also a Serious Incident cluster report whereby four patients were found to have a Clostridium Difficile infection on a ward at GHFT. Since this occurrence of Clostridium Difficile an estates review and infection control investigation had commenced. There had been concerns about contaminated mattresses and JS advised that these mattresses had been disposed of and new mattresses had been purchased.</p>
5.4.0.3	<p>JS stated that they attended the bi-monthly Quality Alert meetings and advised the committee that these meetings offered opportunities to review the quality alerts that were brought to the attention of the CCG. The key areas of discussion were around delayed discharge summaries, medication errors and communication which required improvement. There had been case reviews investigated as part of the quality alerts.</p>
5.4.0.4	<p>In terms of risks, a new risk had been added to the GHFT Corporate Risk Register. This was described as 'the risk of serious harm to the deteriorating patient as a result of inconsistent use of National Early Warning Scores (NEWS2) throughout GHFT'. LJ added that it was reassuring that this risk had been acknowledged.</p>
5.4.0.5	<p>LJ stated that, with regards to ED performance, GHFT had observed a slight improvement recently despite recent increased activity. There had also been a significant increase in re-admission rates.</p>
5.4.0.6	<p>JS informed the committee that the recent CQRG meeting was cancelled; however CB and JS had held a separate meeting with the Chair of Quality and Performance Committee and JS added that this</p>

	was a useful and positive meeting.
5.4.0.7	JS concluded the update by informing the committee that the GHFT had held a Quality Summit for preventing harm. The Quality Summit took a focus on two key areas to include Hospital Acquired Pressure Ulcers and Falls. JS noted this was a helpful exercise and it had identified specific improvements and learning for these two areas.
5.4.0.8	<b><u>RESOLUTION:</u> The committee noted the GHFT Quality Report</b>
<b>5.5</b>	<b>2G Quality Report</b>
5.5.1	LF highlighted that there was some information not included in the report that should be brought to the attention of the committee. The most recent CQRG meeting was held prior to the 2g and GCS merger and LF advised the committee that separate CQRG meetings would be held for the mental health aspects and community aspects within Gloucestershire Health and Care (GHC).
5.5.2	There had been a significant risk around staffing levels within some areas of GHC and there had been a considerable spend on locum cover and agency costs. LF noted that staffing levels had an impact on safety and the timely reporting of incidents. LF emphasised the Quality Lead for GHC should identify, follow and continue to maintain the risk register for the recently formed organisation.
5.5.3	With regards to the Trailblazer Programme LF informed the committee that mental health services in schools was being piloted across five areas within the county. Staffing for this included 16 frontline mental health workers. LF had been advised previously that these mental health workers would be new staff; however it had come to light that there could be a small number of seconded staff included within this number. MAE stated that she had raised this as concern at Core Group and had requested further investigation. MW reiterated that this had been flagged as a concern and added that Kim Forey, the Director of Integration at CCG, was taking action. MW highlighted the need to ensure that investment was being used as intended.  MAE explained that the Secretary of State for education had visited the Gloucestershire Trailblazer programme.
5.5.4	There had been another concern raised regarding the risk register and LF was pleased to see that the Care Homes risk register had been

	<p>incorporated into the CCG risk register, particularly the risk concerning 'In to County Placements'. LF elaborated that there were people in these placements who were not known to 2g but had then presented to 2g in crisis. LF expressed concern that there was a lack of effective handover of care to the 2g services with regards to the In-to-County placements.</p> <p>HW suggested that some of the learning from The Dean Neurological Centre could be applied to this situation.</p>
5.5.5	With regards to flu vaccination accessibility MAE advised that the Learning Disabilities team at the CCG had been undertaking work around ensuring accessibility and support for people with learning disabilities to access flu vaccinations.
5.5.6	<b><u>RESOLUTION:</u> The committee noted the 2G Quality Report.</b>
5.5.7	<i>LF left the meeting at 12:00</i>
5.6	<b>2G CQRC Minutes</b>
5.6.1	<b><u>RESOLUTION:</u> The committee noted the County Wide Quality report.</b>
5.7	<b>GCS Quality Report</b>
5.7.1	The report was taken as read and WM summarised the key points. Under 'Serious Incidents' WM informed the committee that a patient had a fall whilst on hospital premises and had since made a full recovery. There had been one 'Never Event' which was a child who had a wrong tooth extraction by the GCS Dental Service.
5.7.2	With regards to the Safety Thermometer, focussing on new harms, this had remained stable and was above national target. There had been some anomalies in the June data for pressure ulcers due to misreporting which had since been corrected. The GCS PACE team continued to work with operational staff to ensure any harms were reported correctly.
5.7.3	WM noted that Prevention of Pressure Ulcers was listed as one of eight GCS Quality Priorities. Figures for this area were not yet reaching the planned targets and WM noted that the targets were to become

	increasingly challenging. WM highlighted that it was becoming more widely recognised that collaborative working was important to effectively reach targets.
5.7.4	WM raised a concern regarding 'Training and Supporting Front Line Colleagues to Recognise and Manage Deteriorating Patients'. WM noted that NEWS2 was initially intended for hospital usage and LJ responded that NEWS2 was being used to perform a baseline measure and it could be used to support effective communication and decision making. WM agreed with this in principle and highlighted the need to ensure that it was being used appropriately. LF concurred with this.
5.7.5	CB suggested that a further discussion could be held about the appropriate way in which to use NEWS2 from within a community setting at a future meeting. LJ advised that Hein le Roux was leading on a piece of work around this and LJ and HLR were due to meet. HW noted that this was a Quality Priority for the Trust.
5.7.6	WM explained that GCS had identified that there was a need to improve the practice of assessing mental capacity of patients in situations where capacity was in doubt. Mental Capacity Assessment training was planned for September 2019, December 2019 and March 2020.
5.7.7	WM added that improving management of Catheters in Community Settings had also been identified as an area which required improvement. Trials With Out Catheters (TWOC) were being encouraged with patients and WM noted that progress in this area was being made.
5.7.8	WM stated that MSK physiotherapy waiting times had increased and a deep dive review identified recommendations which included ceasing out of county referrals with the exception of the Gloucestershire residents who were registered with Welsh GPs. WM added that there had been a significant number of referrals originating from Worcestershire. WM stated that some of the recommendations made included extending triage into the Out of Hours service and shortening the physiotherapy appointment time slots.
5.7.9	WM stated that with regard to Adult Speech and Language Therapy,

	there had been a concern around recruitment and GCS had struggled to retain clinicians. However, there had now been success with recruitment and GCS continued to progress recruitment as per the agreed plan. WM added that funding to purchase a system which can be used for laryngeal imaging had been set aside.
5.7.10	In terms of the GCS risk register WM noted that there was a new risk namely 'no formal microbiologist access within IV Therapy'. This had been occurring on an informal basis but GCS are working with GHNHSFT to formalise the process.
5.7.11	LF asked if the RESPECT tool had been rolled out across all Gloucestershire community hospitals. HW responded that all community hospitals had received their training packs and relevant forms and staff had participated in the bespoke training offer.
5.7.12	PM enquired about the recent information on the bed usage in community hospitals and asked if this was likely to have an impact on the plan for the Forest of Dean community hospitals? CL advised that it was possible that it may have an impact. MW concurred with this and added that there were a set of assumptions that were published when the engagement exercise took place in the Forest of Dean. There may be an impact on the Length of Stay however in a broad sense the initial assumptions still applied. There was a difference in position between the CCG and GCS regarding bed numbers required in the new hospital and this was being worked through as part of the process.  MAE added that at the Clinical Senate a key topic was on community hospitals and bed numbers and a recommendation regarding this was due out.
<b>5.7.13</b>	<b><u>RESOLUTION:</u> The committee noted the GCS Quality Report.</b>
5.7.14	<i>CB directed the members back to item 5.4.1 'Serious Incidents'</i>
<b>5.4.1</b>	<b>Serious Incidents Presentation</b>
5.4.1.1	RM presents on the Serious Incidents Presentation.
<b>6</b>	<b>Presentation on DOACs and the Impact on Stroke Rates</b>
6.1	MAE presented on DOACs and their impact on stroke rates, highlighting the following key points: <ul style="list-style-type: none"> <li>• there had been a transfer from using Warfarin as an</li> </ul>

	<p>anticoagulant to DOACs;</p> <ul style="list-style-type: none"> <li>• there was an aging population in Gloucestershire and there was potential that this would be a contributing reason to the observed increase in Stroke rates;</li> <li>• it was generally accepted that a number of patients had not complied with taking medication as instructed;</li> <li>• patients on Warfarin were regularly monitored and therefore they would have multiple opportunities to discuss taking their medication; failing to take medication as instructed would be brought to the attention of the clinician;</li> <li>• in comparison to this DOAC patients were only seen twice a year and would therefore not be subject to these routine conversations;</li> <li>• MAE highlighted the differences in the half-life of DOACs and Warfarin. The half-life of DOACs was very short so not taking it at the correct time made it notably less effective whereas Warfarin's half-life was much longer;</li> <li>• The commonly used DOACs should be taken with meals and if patients did not take it with meals absorption can be reduced thereby also reducing the drug effectiveness;</li> <li>• If patients failed to follow instructions on how to take DOACs it would be less likely to be picked up due to the reduced regularity of clinical contact compared to those who took Warfarin;</li> <li>• MAE added that clear information on how to take DOACs had been prepared.</li> </ul>
<p>6.2</p>	<p>WM agreed that action needed to be taken to support patients to correctly take their medication. WM expressed that there was a cost saving on DOACs because it required less monitoring than Warfarin. This enabled practices to free up staff as they did not need to do as many checks as they did for patients taking Warfarin.</p> <p>MW stated that for patients taking Warfarin the clinicians would have spent reasonable time explaining the drug, the effects it would have, the risks involved and why regular checks which were required. This was not being done in the same way with DOACs.</p> <p>CB agreed that additional time with patients on a regular basis could be beneficial and this could be done by a Health Care Assistant who could have a conversation with the patient and ensure they were taking the medication properly. It was noted that this would not be a 'monitoring'</p>

	<p>appointment.</p> <p>KH queried if adjustments had been made to the data to account for the aging population and MAE responded that, although this was not shown on the graph in the presentation, the aging population had been factored in. It was also noted that the increased stroke rates correlated with the switch from Warfarin to DOACs.</p> <p>MAE added that a NICE TA was due to be published with regards to the use of DOACs for the prevention of peripheral vascular disease and heart failure however this had been put on hold due to the evidence of the cost vs benefit analysis.</p>
6.3	WM reiterated that there needed to be sufficient clinical time allocated to the patient when they were first prescribed DOACs.
6.4	<p>PM asked if there was a technological solution to the issues raised and reiterated that it may be unnecessary for patients to physically attend the GP practice for a follow up appointment to discuss taking their medication as instructed.</p> <p>WM noted that patients may not be aware that they were taking the medication incorrectly.</p> <p>CB suggested that this be further discussed at a future meeting and it was agreed that this could be discussed at a Thursday afternoon GP Session.</p>
6.5	<b><u>RESOLUTION:</u> The committee noted the contents of the Presentation on DOAC and the Impact on Stroke Rates</b>
7.	<b>Safeguarding</b>
7.1	<b>Internal Audit Report – Safeguarding Children</b>
7.2	<p>The Internal Audit Report on ‘Safeguarding Children’ was taken as read and CGi noted that this had also been scrutinised at the Audit and Risk Committee.</p> <p>CB noted that the report was for information only and asked the members to bring to attention any specific gaps regarding the contents of the report.</p>

	PM noted that, included within the report was a recommendation for the Safeguarding Strategy to be brought to the committee for ratification.
7.3	<b>RESOLUTION: The committee noted the Internal Audit Report – Safeguarding Children.</b>
8.	<b>Mental Capacity Act (MCA) Policy</b>
8.1	<p>The Mental Capacity Act (MCA) Policy was taken as read and CGi highlighted the key points. The MCA policy included a number of appendices to facilitate and ease guidance.</p> <p>It was noted that CGi was the CCG representative on the Multi-agency Mental Capacity group in Gloucestershire. CB asked if this policy applied to every health and care provider in Gloucestershire and CGi replied that it did. CGi explained that Simon Thomason, MCA Governance Lead, for the CCG and GCC, had coordinated the MCA policy and appendices with input from the group.</p>
8.2	CGi iterated that the MCA policy and appendices set out the framework for understanding the MCA and health and care staff responsibility with regards to mental capacity assessments, including when to undertake an assessment and the appropriate course of action if an individual were to refuse assessment. It distilled the essential elements of the MCA (2005) in a concise manner. CGi clarified that the MCA policy applied only to individuals aged 16 and over.
8.3	AE noted that changes to the Liberty Protection Safeguards were expected in 2020 and there was no inclusion of guidance relating to this matter. CGi responded that the LPS Code of Practice was still awaiting publication, it was due in 2020. Once published the MCA Governance Lead would develop the appropriate policy / procedures to support the implementation of the LPS, along with a training programme for staff in health and care organisations.
8.4	CB emphasised that the MCA policy and guidance were appropriate for a community setting; however questioned the practicality within an acute setting. CGi responded that in her experience most acute trusts had robust policies and procedures for undertaking a MCA assessment. LJ concurred and added that lifesaving treatment could be delivered in the best interest of a patient. LJ reiterated that if a patient refused treatment and there was doubt that they had mental capacity

	<p>then an assessment would be appropriate.</p> <p>MAE outlined the common sense approach to undertaking Mental Capacity Assessment which was followed.</p>
8.5	<p>CGi concluded that the Multi-Agency Group had been involved in developing the MCA policy and guidance. The Multi-Agency Group included representatives from GHFT, 2g and GCS and was presently going through the governance process of each organisation.</p> <p>It was suggested that Simon Thomason could attend a Governing Body Business Session to present on the MCA.</p> <p><b>ACTION: Simon Thomason to be invited to a Governing Body Business Session to present on the MCA.</b></p>
8.6	<b>RESOLUTION: The committee approved the Mental Capacity Act (MCA) policy and guidance.</b>
9.	<b>Risk Management Report</b>
9.1	<b>Corporate Risk Register</b>
9.2	The report was taken as read and CGi explained that the report had been brought before the Audit and Risk Committee. It was highlighted that each Directorate had a Directorate Risk Register. CGi asked the group to advise if there were additional risks that they had recognised that needed to be included in the Corporate Risk Register.
9.3	PM asked CGi to further elaborate about the significance of the risk K13, 'the risk that the agency being used by the CCG may not be meeting the needs of the Children's Continuing Care Needs'. CGi responded that this related to some very specific concerns around children who were experiencing multiple health issues and highly complex clinical concerns which created additional challenges in sourcing the right care. CGi added that Hannah Russell and Jess Glenn in the Children's Commissioning team were looking at how to procure the best care options for these children with complex needs.
9.4	PM queried whether a score of 9 was appropriate for the risk K14 relating to the length of wait for health checks for those experiencing an eating disorder and CGi explained that this score reflected an

	improving position; MW concurred with this statement. The improving position was supported by a recently commenced 'Eating Disorder' service.
9.5	<b><u>RESOLUTION:</u> The committee noted the Corporate Risk Register</b>
10.	<b>Update on Effective Clinical Commissioning Policies</b>
10.1	<b>Oxygen in Smokers Policy</b>
10.2	<p>TM presented and pointed that there had been two amendments made to the Oxygen in Smokers Policy:</p> <ul style="list-style-type: none"> <li>• On page three of the policy there was an updated contact;</li> <li>• There had been additional reference relating to the NICE Guidance on not offering long-term oxygen therapy to people who continue to smoke despite being offered smoking cessation advice and treatment;</li> </ul>
10.3	TM highlighted that, in Gloucestershire, there were 1.5% of individuals who smoked and were also receiving oxygen therapy. Comparative data was showed that a nearby county had a rate of 20% of people who smoked who were also receiving oxygen therapy.
10.4	There was a brief discussion about the fire risks associated with prescribing oxygen to individuals who smoked; including risk to the residents who lived in the immediate vicinity of the patient receiving oxygen therapy. WM emphasised the need to establish fair but firm control ensuring that not every patient who smoked was offered oxygen therapy due to these risks. MW explained that the policy appeared to advocate using a case by case approach and therefore minimising any potential risk to patients and their families.
10.5	PM asked if there was an implication if the patient did not smoke but instead their carer/household members did, and TM responded that this was considered within the policy. The carer/household member would be referred to smoking cessation and they would not be permitted to smoke near the oxygen.
10.6	<b><u>RESOLUTION:</u> The committee approved the Oxygen in Smokers Policy</b>
11.	<b>HR Update: Dashboard July and August 2019</b>
11.1	CGi highlighted that the HR Dashboard showed a steady increase in

	the CCG staff turnover rate and it had reached a peak of 18% turnover compared to 12% the same month in the previous year. It was noted that a high rate of staff turnover was costly due to the costs relating to going out for recruitment and training new staff.
11.2	CGi stated that it had become apparent that most of the CCG staff leavers over the year were leaving to pursue promotions in other organisations. However some leavers had left in order to pursue an improved work/life balance.
11.3	CGi noted that, over recent years, time had been put towards improving the approach to flexible working in the organisation which was expected to support staff to maintain an effective work life balance and this improvement had been reflected in staff surveys.
11.4	<b>RESOLUTION: The committee noted the contents of the HR Dashboard for July and August 2019</b>
12.	<b>Terms of Reference</b>
12.1	<b>Self-assessment results and report</b>
12.1.1	CB noted that this item should be included at a committee meeting where the usual chair, Julie Clatworthy, was present. CGi highlighted that the report included several recommendations as a response to the results of the self-assessment.  <b>ACTION: The Terms of Reference to be included on the Q&amp;GC agenda for December 2019. CGi/LP</b>
13.	<b>Data Security &amp; Information Governance Update</b>
13.1	<b>Information Governance &amp; Data Security Update</b>
13.1.1	CL provided an update on the CCG Data Security & Information Governance arrangements. This included an update on the Cyber-Security arrangements. CL highlighted that Data Security & Information Governance staff training had progressed well and there was also training arranged for the CCG Governing Body for November 2019.
13.1.2	As part of the action plan for 2019/20 data security toolkit there was an interim baseline assessment submission due to NHS Digital required

	by the 31st October 2019 with the full toolkit submission due on the 31 <sup>st</sup> March 2020. The CCG's internal auditors would be completing a review of the draft toolkit submission during January 2020.
13.1.3	CL highlighted that the CCG was required to provide a Data Protection Officer (DPO) service to Primary Care. This had been made available within Gloucestershire from the 1 <sup>st</sup> October 2019 and was being provided by the South West and Central Commissioning Support Unit (SWCCSU).
13.1.4	With regards to the Population Health Management (PHM) Wave 2 programme, CL noted that an integrated data set was required to be used within the analytics element of the programme. It was highlighted that this was an intensive programme of work.
13.1.5	In terms of cyber security, CL noted that additional progress needed to be made in terms of the network.
13.1.6	<b><u>RESOLUTION:</u> The committee noted the Information Governance &amp; Data Security Update</b>
13.2	<b>Data Security &amp; Assurance Working Group: minutes of the meeting held on 14<sup>th</sup> August 2019</b>
13.2.2	<b><u>RESOLUTION:</u> The committee noted the Data Security &amp; Assurance Working Group: minutes of the meeting 14th August 2019</b>
13.3	<b>Minutes of the Gloucestershire Information Governance Group Meeting</b>
13.3.2	<b>RESOLUTION: The committee noted Minutes of the Gloucestershire Information Governance Group Meeting</b>
14.	<b>Any Other Business</b>
14.1	There was no other business raised.
14.2	<b>The meeting closed at 13:05 pm.</b>
	<b>Date of Next Meeting: Thursday 12<sup>th</sup> December 2019, 9:30am in the Boardroom, Sanger House.</b>

This is verbal discussion