Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC)

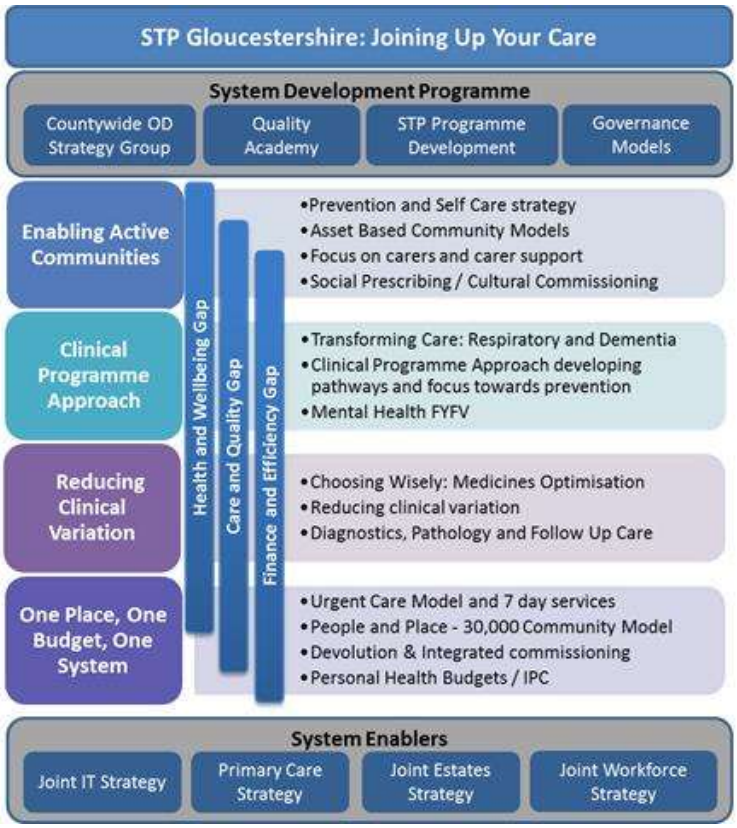
January 2019

One Gloucestershire ICS Lead Report

1. Introduction

These reports provide an update to HCOSC members on the progress of key programme and projects across Gloucestershire's Integrated Care System (ICS) to date.

Gloucestershire's STP commenced year two of four in April 2018, since then we have made progress in embedding and delivering key schemes outlined within the plan, in an increasingly challenging health and care environment. We continue to develop our delivery plans against our main priority programmes. In the July 2018 report we outlined the progress made in 2017/18 and the priorities for plans in 2018/19; in this report we provide an update on 2018/19 progress made against the priority delivery programmes and supporting enabling programmes included within Gloucestershire as we transition to an Integrated Care System (ICS).



Gloucestershire's STP Plan on a page

2. Enabling Active Communities

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

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

Key priorities for 2018/19 are:

- Reach the target of over 5,000 patients being on the National Diabetes Prevention Programme
- Appoint a GP Clinical Champion in Diabetes to further raise the profile of diabetic care in general practice (completed)
- Commission a new Child Weight Management Service and implement our new adult Weight Management Service Model to support people to reduce their weight in a sustainable way
- Continue to deliver an early identification and intervention model for victims of domestic abuse
- Develop a Breastfeeding Social Marketing campaign
- Progress the Gloucestershire Moves project (getting 30,000 inactive people active) and see the first pilots underway; including 'Beat the Street' and older people at risk of falls
- Launch a new postpartum contraception service
- Launch our new Gloucestershire Self-Management Education Programme called 'Live Better, Feel Better' and Support over 200 individuals through our new Self-Management Service
- Create a direct route into the community wellbeing service from urgent care (A&E, urgent treatment centres) to support people who attend for non-medical reasons
- Expand the arts on prescription service
- Increase our focus on support the following pathways with self-care and prevention schemes: adult mental health; paediatric epilepsy; paediatric Type 1 diabetes; Tier 3 obesity, adult chronic pain and adult respiratory pathways

Update on progress over the last two months:

Supporting Pathways

- There have been a total of 2,719 referrals to the National Diabetes Prevention Programme (NDPP) since August 2017. Initial data for Gloucestershire shows a mean weight reduction over 6 months of -4.7kg as a direct result of the NDPP, which again is better than the national picture (-3.4kg).
- The postpartum service for long-acting contraception formally launched on 16th November. A number of staffs have been trained under the project to date

Supporting People

- Domestic Abuse awareness training has now been delivered to a total of 116 hospital staff and 22 members of the public under this project. The 'How to ask the question' training has been delivered to 84 hospital staff and Specialist DASH training delivered to 28 hospital staff. In addition to this 18 bespoke training packages have been delivered. A total of 30 surgeries have now reached stage 5 statuses with at least 1 nominated DA champion. In total 59 professionals have taken on the DA Champion Role across the county's 76 surgeries
- Gloucestershire Care Services NHS Foundation Trust has delivered group education sessions in Patient Activation Measures

- The Living Well with Pain programme has commenced a piece of joint work with Churchdown Practice, targeting support to people with chronic pain.

Supporting Places & Communities

- There have been over 3266 referrals received from 1st October 2017 - 30th October 2018 into the Community Wellbeing Service. Providers continue to report higher complexity of referrals than seen in the previous social prescribing service 2014-17. Increased volumes of mental health referrals are contributing to this.
- The quantitative and qualitative evaluations for Beat the Street have now been finalised. Key highlights include;
    - Total of 10,156 people took part
    - 12% participants had a long term condition
    - The proportion of adults reporting meeting the recommended 150mins of moderate physical activity per week increased by 11% immediately after the game (42% increasing to 53%)

Supporting Workforce

- The second monthly **Workplace Health and Wellbeing** newsletter was sent out to businesses containing information and useful links to help improve health and wellbeing of the workforce. These will continue to be produced on a monthly basis.
- Health coaching approaches training have now been delivered to 69 staff across various professions, working primarily in the Berkeley Vale Cluster area as a test and learn initiative. Participants rated their overall perception of the course very positively with 86% rating the programme "good" or "very good."

Live Better Feel Better Case Studies

Case Study 1

"I have suffered with a number of debilitating long term health conditions for well over 15 years, none of which have any medical related cure. In summary these conditions meant I was in pain and I felt totally exhausted and washed out. My declining health meant I was growing more dependent upon my family and as I was unable to work in any capacity I had to take an ill health early retirement. Self management has been invaluable in helping me turn my life around"

Case Study 2

"When I arrived on week one of my self-management course I was in a bad place; my health was suffering. An injury left me scarred both physically and mentally. In the years following I got one health condition after the next and I was struggling to manage my life. Between the pain, low mood, fatigue and anxiety I was finding it increasingly difficult to make it from day to day.

It took me a few weeks of self-management sessions to connect the dots but slowly and surely I had a light bulb moment where I realised what self-management could be for me. I realised that if I had the right tools and the determination that I could take small manageable steps and rebuild me inside and out, and that's exactly what I did!

Now that I have seen the success that self-management has had for me I feel passionately that other people who have long term health conditions should have the chance to experience it for themselves. That was the main reason behind deciding to become a self-management tutor and it has been an incredible journey so far, that I am enjoying so much. Helping others is something that truly makes me happy and witnessing the changes in people is amazing. Everyone deserves a chance to have access to these tools to help them to live and feel better."

3. Clinical Programme Approach

The Clinical Programme Approach has been adopted across our local health care system to ensure a collaborative approach to systematically redesign the way care is delivered in our system, by reorganising care pathways and delivery systems to deliver right care, in the right place, at the right time.

	Priorities 2018/19	Progress So Far…
Respiratory	Deliver a comprehensive education and training package for health care professionals working in primary care and managing long term respiratory conditions. Support primary care to stop prescribing steroids where they are not having a significant impact on an individual's quality of life Continue to bring together the hospital and community respiratory teams together into one integrated team	Hot advice and hot clinics were in place countywide from 5th November 2018 providing patients with rapid advice and assessment in an outpatient environment. The full COPD pathway available on the live GP information system. The Integration lead role is now working with the respiratory team in secondary care to map out the final stages of the integrated pathway. A working group has been established for the Bronchiectasis to agree the patient pathway supporting IV antibiotics in the community / at home.
Musculoskeletal	Embed the Advanced Practitioner Service providing physiotherapy support to patients in primary care. Roll out MSK triage service which provides expert clinical review at the point of referral. Design and implement a countywide integrated approach to falls prevention	Almost 90% of referrals for the Advanced Practitioner Service and Orthopaedics are now going through MSK Specialist Triage service and total demand for the services appears to be decreasing. The Lead Emergency Department consultant has engaged well with Trauma Triage Service (TTS) and referrals from ED have gone down. There is a plan for further training sessions to build relationships, improve quality of referrals and overall TTS process.
Circulatory	Improvements to heart failure care Develop proposal for cardiac rehabilitation Progress community stroke rehabilitation	The Blood Pressure (BP) Steering Group has been established to oversee the implementation of the British Heart Foundation bid. There have been agreed changes to proposed service specification for Community BP Testing Service. The Project Manager attended an event to gather feedback from the Wave 1 BP Award sites and to network with fellow Wave 2 sites.

Eye Health	Explore the enhanced community eye care offer to provide additional eye care services Implement the new NICE guidelines within Ophthalmology	Additional clinics have taken place within the Gloucestershire Hospitals Ophthalmology service at the same time as reviewing patients waiting for follow up appointments. An recent audit has shown that the move to community-based care of second eye cataract patients undertaken by accredited community optometrists has been successfully and safely initiated in Gloucestershire.
Diabetes	Recruit a part-time Consultant Diabetologist Training to care homes on "caring for patients with diabetes"	GDoc nurses have now begun to deliver Initial Assessment appointments offering a significant boost in capacity, in relation to the National Diabetes Prevention Programme (NDPP). Multi-disciplinary foot outpatient clinics continue at GRH and CGH with consistent input from Diabetologist, podiatry, Vascular and Orthopaedic consultants. As expected, we are observing a downwards trend in major amputations and a slight upwards trend in minor amputations.
Cancer	Progress towards the 2020/21 ambition for more cancers to be diagnosed at the earliest stages Deliver the Prostate Cancer Surveillance Project	A GP Masterclass held 9th October focused on colorectal Cancer. An event review held with very positive feedback. Plans for 2019 GP Masterclass to be confirmed and Macmillan Group Education Grant to be applied for to fund 2019 schedule.
Children & Maternity	Develop community hubs and integrate better together services that support women and families in the early years Implement our 'Safer Maternity Care' Action plan Develop models of care supporting women to have the same carer throughout pregnancy, birth & post-natal care Aim to have 30 to 40 children with Personalised Care Plans by Mar 19	Young Gloucestershire have been commissioned to facilitate person centred planning and management of the personal budgets for the children and young people which should increase the number of people able to personalise their support. As part of the Better Births Programme, the recruitment of an Information and Data Analyst has meant that we will gather more accurate data to support delivery of our plan. Maternity support workers are now well established & will support our new Postnatal Pathway, trial to take place in Stroud & Cirencester prior to countywide launch.

Learning Disability	Enabling individuals with a Learning Disability to use Personal Health Budgets to ensure they have control of the support they receive Embed the "Stopping Over Medication of People with LD" campaign to reduce the prescriptions of anti-psychotic drugs where they are not clinically recommended Ensure that 75% of people with a LD on the GP LD Register receive an Annual Health Check by Quarter 4 19/20	The Learning Disability and Autism Clinical Programme Group has highlighted the need for a better understanding of people living in Gloucestershire to give them a more robust evidence base for planning future commissioning activities in line with the Building Better Lives & Building The Right Support Vision. The output from this project will be an evidence base which we are calling a Learning Disabilities & Autism Joint Strategic Needs Analysis (JSNA). Inclusion Gloucestershire have been commissioned to run co-produced engagement events and input into the development of the survey.
Mental Health	Continue to take steps to Improve Access to Psychological Therapies (IAPT), to ensure we meet standards for access, recovery and waiting times to treatment Make further improvements to the Eating Disorder Pathway Implement an all age Autism strategy Roll out mandatory mental health training for staff in schools Improve support to foster carers and children entering the care system Procure emotional support for children who have experienced sexual assault / abuse	New Gloucestershire Intensive Recovery and Intervention Service (IRIS) for Children and Young People is being developed. This initiative focusses on a different approach to working with children and young people with mental health issues. The Mental Health Crisis Care Workforce Development Group has been set up to oversee the implementation of the agreed multi-agency multi-professional workforce development strategy (3-5 years) for Gloucestershire. The Suicide Prevention Strategy has been developed by the Gloucestershire Suicide Prevention Partnership Forum (GSPPF), with input from partners across the public and voluntary sectors. The new holistic Mental Health Acute Response System (MHARS) Crisis model was commissioned in April 2017 in line with new Police guidance and legislation. This provides a single point of access and clear, concise pathway of care. The waiting room in the Maxwell Suite has been identified as a Place of Safety if required. An extended hours (9AM-11pm) Hub and Spoke Approved Mental Health Professionals (AMHP) model was introduced in July 2018 and it is the intention of the County Council to commission a standalone 24/7 AMHP

		service (currently 11pm-9am is provided by Glos EDT). A review of the self-harm pathway has been undertaken and a multi-agency action plan is currently being implemented focussing on the following: • Improving what happens when people who are self-harming or in extreme emotional distress present themselves to ED • Strengthening prevention • Making it easier for children and young people to get help • Joining up the services that we already have • Specific needs, e.g. personality disorder, children and young people with physical health conditions The Cavern continues to provide regular support including everyday over the holiday period from 6-11pm.
Dementia	Develop a countywide approach to community dementia services Implement the Community Hospital Mental Health Liaison Team pilot	Dementia Diagnosis Rate Has recovered its previous above NHSE target position and the Dementia Advisor service has increased activity by 50%. The Memory Assessment Service (MAS) have been encouraged to make automatic referral on diagnosis to DA service so that more families can benefit from support.

Focus on End of Life Care Clinical Programme

Each year in Gloucestershire approximately 5,900 people die from a wide range of causes. In common with the rest of England, the largest single underlying causes of death are Cardiovascular disease, Respiratory disease and Cancer. Across Gloucestershire, people die in a range of places, 44.6% occur in a hospital setting; 25.2% of people die at home; 24.2% in a care home; and 3.1% in a hospice.

NHS Gloucestershire Clinical Commissioning Group (CCG) and partner organisations are working together to improve services for people who require palliative and end of life care. As a health and social care community, we recognise that sustainable change and improvements can only be realised if we all work in partnership and have a shared vision.

An End of Life Care Strategy has been developed which has been an important step in making improvements happen. It has been drawn up with input from a wide range of people, across health and social care providers, the voluntary sector, families and carers. The strategy outlines how we would like to take forward the development of palliative and end of life care services in Gloucestershire over the period 2016-2020.

The Gloucestershire End of Life Care Strategy is guided by the themes in the 'National End of Life Care Strategy 2008', the subsequent annual reports and more recently the 'Ambitions for Palliative and End of Life Care 2015'. You can read the strategy by accessing the following link: https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2012/03/End-of-Life-Strategy-FINAL-nov-2016.pdfv

As well as the development of the strategy, an End of Life Care Clinical Programme Group has been established to oversee the implementation of the Gloucestershire End of Life Care Strategy 2016-20 and ensure there is a clear evidence based approach to the commissioning and delivery of end of life care services in Gloucestershire. The vision is for high quality palliative and end of life care to be available in all settings, accessed and used by those who require it, irrespective of age, diagnosis, gender, ethnicity, religious belief, disability, sexual orientation or socioeconomic status.

To do this, the CPG has identified 6 key work-streams within the Programme:

1. Timely Identification of End of Life
2. Reduce Variation
3. Education and Training
4. Care is Co-ordinated
5. Each Community is Prepared to Help
6. Stand Alone Projects

Research into end of life care in Gloucestershire

The End of Life Care Clinical Programme Group (CPG) commissioned Healthwatch Gloucestershire (HWG), which has a seat on the CPG to ensure the voice of local people is heard and considered at a high level, to conduct independent research with the public regarding their experience of End of Life Care in the county. HWG's End of Life report: *Evaluation of non-clinical support* is based on findings from over 50 responses to a survey of the public's experiences on accessing information around end of life care in the county.

The aims of the research are to understand and explore in more depth what non-clinical support is available locally and nationally to identify gaps in information provision.

Most people who responded to the survey said that they went to medical professionals when they wanted information and support around end of life care, such as their community team (60%), their GP (57%), hospice team (34%) and practice nurse (31%). However, many relied on their friends and family (46%). Most people said that they preferred to receive information face-to-face or via a leaflet/booklet (both 81%). In comparison only 39% preferred to receive information via online or text. Individuals would predominantly like to find hard copies of information in healthcare environments such as the GP surgery (90%), hospital waiting areas (81%) and local pharmacies (74%). Some people would like more information on the last stages of life including health changes and post death advice. Others felt information on the psychological and emotional support available to them would be helpful; whilst others such as unpaid carers said support for their mental health and emotional wellbeing was one of the most helpful things during the end of life period. Some of the participants said that they were given enough information and couldn't think of an unhelpful or a bad piece of information provided to them. Others mentioned that they received conflicting information from some information sources, which they found unhelpful and some people found the amount of information they received was overwhelming and difficult to process.

The findings from the survey will now go to the End of Life Care Clinical Programme Group. The full report can be viewed at www.healthwatchgloucestershire.co.uk

Our Commitment to the Gloucestershire Community

We want to make sure that the highest quality end of life care services are available to all who need it, Effective and compassionate care and support will be in place for people who are approaching end of life so that they can have a dignified, peaceful and supported death. Families and carers needs both during and after a person's death will be recognised and addressed.

We want to ensure that people are given the opportunity to express their preferences about where and how they are cared for, supported and die, and to make it possible for health and social care services to enable their wishes to be met. Irrespective of whether people have expressed their preferences, our aim is that everyone should experience a 'good end to their life'.
We will design, commission and deliver services in order to provide:

- equitable access to services for all people needing end of life care;
- end of life services based on best practice models; ensuring the best possible care for all people needing end of life support;
- patient-led care which is responsive to the dying person's needs and wishes;
- a choice of place of care and death, where possible; acknowledging that the physical environment has a direct impact on peoples experiences at the end of their lives and on the memories of those closest to them.
- a pleasant and supportive environment of care where dignity and respect are facilitated
- appropriate support services for both the dying person and those closest to them; in particular pre and post bereavement support.
- good communication between all professionals and with the patient and those closest to them;
- access to timely information and advice for patients, families, carers and staff
- improved co-ordination of care across all service providers;
- Increased education and training for staff;

We will:

- involve local people, patients and carers in the development and improvement of end of life care services;
- work in the spirit of partnership with health and social care organisations, both statutory and voluntary; and
- review services we commission and deliver regularly to ensure that they reflect best practice and are responsive to the needs of service users

Workstream 1: Timely Identification of End of Life

An evaluation of GP survey data and follow up support has been highlighted below:

- Lack of clarity in: whom to inform of Do Not Resuscitate/Advance Care Plan and how, who can see GP Summary Care Record, which paper resources to use
- Recognition of Gold Standards Framework (GSF) meetings as improving care
- Lack of time to provide adequate conversations and support to patients and families and a wish to provide this proactively rather than during a crisis
- Requests for roll out of Just in Case Boxes beyond pilot area

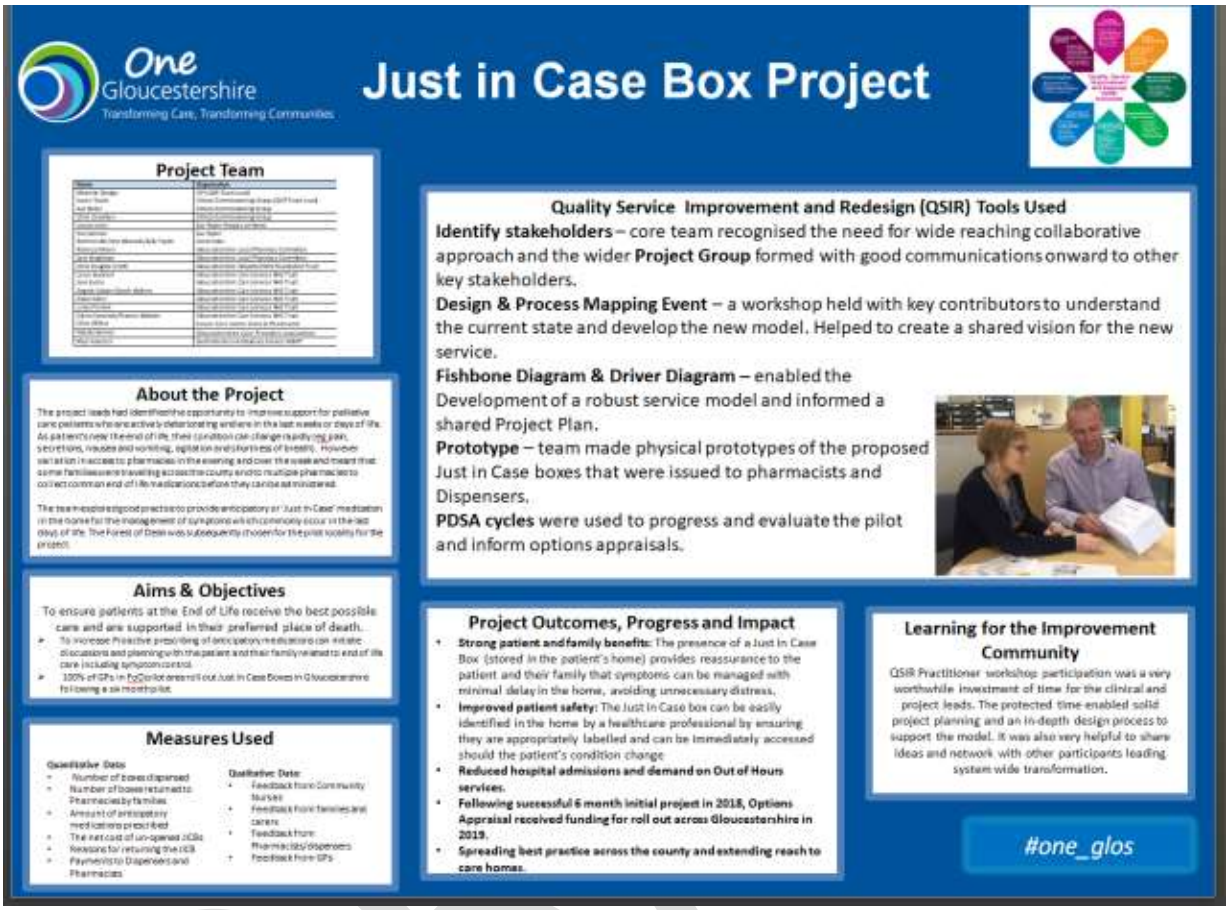
As a result the End of Life Care section of G-care (GP information system) has been reviewed and updated. Plans under way to clarify areas of uncertainty identified and promote/support GSF meetings. A new summary page will show a 'road map' for the last year of life mapped to the GSF (Green – last few months/Amber – last few weeks/Red – last few days) with suggested actions to consider at each point. Aim to show that smaller conversations/steps over the last year of life can be more productive than one very long conversation in the last few weeks/days of life. Potential for "roadmap" to be adapted for other healthcare professionals/care homes.

Workstream 2: Reduce Variation

Re-commissioning Care at Home for Continuing Healthcare (CHC) Fast-track Patients Project: We explored with our Hospice providers if they would like to undertake all of the initial assessments and reviews. The rational for this is that their specialist knowledge enables them to identify patients who really are rapidly declining and therefore we would expect to see a reduction in fast track packages being awarded. Our Hospice providers declined at this point in time as they felt it would impact too much on their ability to deliver of Hospice at Home care. The learning captured, however, has enabled commissioners to clarify the expert skill set required to improve the quality of fast track assessments.

A review of best practice across comparator areas has been undertaken to understand how other areas have successfully improved the knowledge of the generalist workforce and seen a reduction in the number of fast track awards.

Just In Case Medication Pilot:



4. Reducing Clinical Variation

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

Key priorities for 2018/19 are

- The successful Prescribing Support dietetics role will be expanded to support change in the recommendation of oral vitamin B vs Vitamin B injections, advice and support around optimising the use of calcium and vitamin D, as well as reviewing and producing infant milk guidance to ensure appropriate support to patients via primary care
- Continue to support, develop and extend the Repeat Prescription Ordering Service for Gloucestershire patients to support the reduction of prescribed waste medication.
- Continue to support reducing Polypharmacy (the use of multiple medications at the same time) in patients, initial focus on frail patients, and extend it to groups such as those in care homes with the aim of reducing unwanted side effects
- Implement a paper referral switch off so that all referrals to consultant led services are made via an electronic system by October 2018 (in line with national guidance.)
- Implement patient led booking to give patients more control over their follow up care.
- Implement GP peer review of referrals to support consistency of patient management at a locality level.
- Continued development of alternatives to face to face follow up appointments
- Reducing the number of people who failed to attend a booked hospital appointment through a public awareness campaign and by establishing a reminder services
- Continue to make improvements to Operating Theatre, Radiology and Pathology pathways to reduce waste

What we've achieved so far:

- The 2018/19 Savings Plan supports a saving opportunity of £5m across a range of treatments. The Prescribing Improvement Plan (PIP) continues within practices.
- Use of Prescription Ordering Line (POL) to manage continence and stoma prescription requests is developing. Practices have expressed interest in making use of this service for these prescription groups. Staffing is being increased to ensure capacity to manage the planned increase in demand and the extra staffing will be fully in place by the end of November 2018.
- Advice and Guidance (A&G) continues to increase with a total of 8,166 requested made between April and October 2018, significantly above the year to date target level of 5,477. The service rollout continues with 16 specialties now live. Two further specialties are due to be rolled out as part of the CQUIN.
- The new Community Urology Service mobilised from 1st October as planned, including the enhanced triage element.
- Within Dermatology, there is an increased focus on improving access to rapid specialist advice and diagnosis through A&G supported by dermascopic images. Funding has been secured to run a GP dermoscopy education event in 2019 and work is underway to design the Cinapsis screens to support the implementation of this approach.
- Monthly G-care site views have increased by 34% since April, and a range of new content has been published. G-care search function has been redesigned to improve usability. The revised search function went live on 9th November.
- The social media videos and posters for the DNA campaign are complete and the campaign launched on 10th December 2018.

5. One Place, One Budget, One System

New Models of Care & Place Based Model

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

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

Key priorities for 2018/19 are

- Led by ICS partners, pilot three Integrated Locality Boards in both rural and urban areas. The pilots will be in Stroud and Berkeley Vale, Forest of Dean and Cheltenham. These aim to give more control to local GPs to develop and tailor services to best meet the needs of people in the local area.
- Increase the range of roles in primary care available to support GPs and patients including the use expanding paramedics, clinical pharmacists and mental nurses
- Support the roll out of the Community Dementia pilot across the county, following the completion of evaluation and a feasibility study.
- We will continue to work with practices to support them through merger or federation conversations as required.

What we've achieved so far:

- At the End of October we were honoured to receive a visit from Chris Ham, Chief Executive of The Kings Fund and Don Berwick, former advisor to Barack Obama and founding CEO of the Institute for Healthcare Improvement. Cheltenham Integrated Locality Partnership pilot had an opportunity to showcase their work during the afternoon.
- Finalisation of the frailty model for the Forest of Dean which is based on the Complex Care at Home Model. Recruitment of Matrons for this service has commenced. Service will run out of Colliers Court in Cinderford with a plan to commence in late January.
- Pathology clinics on Saturday mornings in the Forest of Dean are going well as are nurse clinics. Evening nurse clinics commenced in December.
- Established a new Multi-Disciplinary Team in St Paul's Cluster in Cheltenham. Initially the MDT is between Practices, Complex Care at Home, ICT and Rapid Response,
- The South Cotswolds Frailty Service was nominated for a Gloucestershire NHS 70 Award in the Exemplary Community Partnership category.
- The team have developed a process to share information between the South Cotswolds Frailty Service and Great Western Hospitals Trust relating to patients admitted from South Cots locality.
- So far we have visited Cirencester (Market Place), Stroud (King Street) and Bishops Cleeve (outside library) on the NHS information bus to promote "Living Better with Frailty". We have engaged with approx. 260 people and had representation from providers/organisations

5. One Place, One Budget, One System

Urgent Care

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

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

Regular updates on the One Place Programme have been shared with HCOSC, 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. Since this update work has continued to develop the programme timetable, engaging with clinicians, patients, and staff and community partners to develop the proposals for consultation.

Throughout September and October there has been careful review of the work that has taken place and the progress made. In particular we have received strong feedback that we need to build in more time for engagement in advance of formal consultation and that people want to understand the whole model. In response to this the ICS Delivery Board has agreed that more time is needed to focus on co-designing options and proposals with clinicians, community partners, patients and the public before we move to consultation.

A new scope, co-production approach, governance and timeline will be finalised shortly. In the meantime the current pilots within Trauma & Orthopaedic, Gastroenterology and General Surgery will develop as agreed.

Alongside this we will progress the commissioning of a new NHS 111, Clinical Advice and Assessment Service. This will be informed by learning from the current ‘test and learn’ initiatives and ensuring the critical links with other parts of the urgent care system are maintained.

The Urgent Treatment Centre test and learn project has refocused on achieving compliance with the NHS England national standards and agreeing priorities for implementation before Winter 2018/19.

6. Enabling Programmes

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

Joint IT Strategy – Local Digital Roadmap Governance has been established and will be managed by the Countywide IM&T Group with Project Boards and work streams established for the key IM&T Enablers. 75 out of the 76 GP practices are all live on the wifi project. Patient Online has been rolled out to 96% of Gloucestershire practices, and currently Gloucestershire has 22% of patients with an online account. eConsultation procurements are complete for a patient triage application which will begin in 5 pilot practices. Wi-Fi infrastructure software upgrade has been completed; initial testing suggests a number of outstanding issues have been resolved as a result of this. Gloucestershire signed up to the South West LHCRE bid and we have been told that, subject to a successful plan, the South West LHCRE will receive some capital funding in 2018/19.

Joint Workforce Strategy –Following a very successful celebration event of the first two cohorts of the '5 elements for successful leadership programme', a further two cohorts have been funded through an additional for through the SWLA 'System Development Offer'. A full evaluation of the programme is underway and discussions are already taking place to incorporate a day's Quality, Service Improvement & Redesign training to ensure methodology embedded and supported across One Gloucestershire's leaders. A One Gloucestershire expression of interest to participate in a national High Potential Talent Scheme that was submitted in October was successful. There are seven pilot sites and it will be rolled out in three phases. One Gloucestershire has requested to participate in phase three; planning will commence around August 2019.

Joint Estates Strategy – the estates strategy is moving forwards with a number of strands of work. Within Primary Care, planning permission has been granted for a new Cinderford Health Centre and Practices within Coleford have decided to proceed to develop a new GP Led business case for a single site within the town. There have been Initial meetings held with Lydney and Severnbank Practices to set out a way forward for the potential development of a new primary and community facility aligned to wider Forest of Dean Community Infrastructure Programme. There has been agreement at ICS health estates group that organisational Estates Strategies to be updated and subsequent ICS strategy to be completed for March 2019 with 2031 as the planning timeline. The Business case programme for GHFT strategic site development in also line with plan.

Primary Care Strategy – the Primary Care Strategy works alongside One Place, One Budget, One System to ensure we have really high quality primary care provision. Improved access has been successfully rolled out across all seven localities within Gloucestershire and in addition to improved access, clusters have been able to utilise funding to support additional workforce innovations across the ICS. There are a majority of workforce schemes and initiatives within Gloucestershire to help attract, develop and maintain workforce. Schemes include; Health Inequalities Fellowship, Newly Qualified GP Scheme, GP Retention Scheme, International GP Recruitment scheme and Next Generation GP scheme. Within the Community Education Provider Network (CEPN) scheme. Work has been undertaken to identify a standard generic Primary Care induction model as a multi-disciplinary tool to ease the burden on practices and to both improve and standardise the student's experience. We are planning a two-tiered approach for Online Consultations to test the benefits for patients and practices, while keeping an eye to the future developments with 111 Online and the NHS App. With this in mind, we have developed proposals for a 'Core' and an 'Enhanced' offer.

7. Integrated Care

A national announcement was made by NHS England that Gloucestershire in June 2018 to confirm that Gloucestershire is to become one of only 14 Integrated Care Systems (ICS) across the country; we will be one of 4 new systems to join the other 10 systems who have been working in a ICS way during 2017/18.

There was an excellent visit to the system by Don Berwick, President of the Institute for Healthcare Improvement (USA) and Sir Professor Chris Ham, Chief Executive of the King's Fund on the 29th October. The visit included a workshop on supporting the continuous quality improvement approach across our system and it was a chance to celebrate some of the great progress being made and involve staff and stakeholders from across the system. Alongside this we are currently engaging in support for the Gloucestershire Strategic Forum to undertake a review of system-level priorities which will be the first steps towards developing a refreshed 5 year plan for One Gloucestershire in line with the national timeline of Summer 2019.

Our System Development programme is focussed on developing the ways we work together as Health and Social Care organisations to support our shared system transformation objectives. This includes working on our shared Governance approaches for decision making, considering how we further pool our budgets and resources, and how we share responsibility for achieving key system targets. A national Memorandum of Understanding (MOU) between ICS systems and NHS England has been developed and will be publicly available once finalised. This describes how ICS' will develop their relationship with NHS England in the future to take on more delegated local responsibility for delivery.

Being a new ICS includes receiving a range of development support offers; during December it was confirmed that we would be supported by NHS Clinical Commissioners to bring together a network of Non Executive Directors and Lay-members to support system working between Boards. Alongside this we are currently engaging in support for the Gloucestershire Strategic Forum to undertake a review of system-level priorities which will be the first steps towards developing a refreshed 5 year plan for One Gloucestershire in line with the national timeline of Summer 2019.

8. Recommendations

This report is provided for information and HCOSC Members are invited to note the contents.

Mary Hutton
ICS Lead, Gloucestershire ICS